HOUSE OF REPRESENTATIVES—*Thursday, October 28, 1993*

The House met at 10 a.m.

The Chaplain, Rev. James David Ford, D.D., offered the following prayer:

Lift our thoughts, O God, above the ordinary to see more clearly the beauty of the day; raise our sights, O God, to see the needs of justice and the call to freedom; strengthen our faith, O God, so we can walk through the shadows of evil knowing You are with us; give us peace, O God, all our days and may Your blessing never depart from us. Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER. The Chair recognizes the gentleman from North Carolina [Mr. BALLENGER] to lead us in the Pledge of Allegiance.

Mr. BALLENGER led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Hallen, one of its clerks, announced that the Senate had passed without amendment bills of the House of the following titles:

H.R. 927. An act to designate the Pittsburgh Aviary in Pittsburgh, PA, as the National Aviary in Pittsburgh; and

H.R. 2824. An act to modify the project for flood control, James River Basin, Richmond, VA.

The message also announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 2492) "An act making appropriations for the government of the District of Columbia and other activities chargeable in whole or in part against the revenues of said District for the fiscal year ending September 30, 1994, and for other purposes."

The message also announced that the Senate agrees to the amendments of the House to the amendments of the Senate numbered 6, 10, 19, 22, 23, 25, 29, 31, and 33 to the above-entitled bill.

PUT AMERICAN PEOPLE FIRST ON HEALTH CARE

(Mr. VISCLOSKY asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. VISCLOSKY. Mr. Speaker, yesterday President Clinton delivered on his pledge to provide Congress with the details of a comprehensive plan to boldly reform our country's health care system.

President Clinton has also challenged the Congress and the Nation to make his plan better with the caveat that any change would have to include provisions for health security, comprehensive benefits, cost control, simplification, improving quality, and increasing choice.

The President has put his cards on the table.

Now it is time for this body to rise to President Clinton's challenge. It is time for every Member to put partisanship aside and put the American people first.

Mr. Speaker, the people want health care that is always there. Now, let us follow President Clinton's lead and deliver a health care system that really works.

NEW JERSEY EXPERIENCE LINKED TO FAILED POLICIES OF BIG GOVERNMENT

(Mr. BALLENGER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BALLENGER. Mr. Speaker, a politician promising not to place new taxes on middle-income workers. A promise broken. Taxes increased through legislative arm twisting. Spending increased faster than inflation. New spending programs invented. No rethinking of old failures.

What will happen?

Well, sadly we know what will happen. For the tragic situation I just outlined is what happened to citizens of New Jersey when Jim Florio brought his free spending and high tax policies from Washington and decided to treat the New Jersey taxpayer's money like it was Monopoly money—or with the contempt he treated the Federal taxpayer's money—$2.8 million in new taxes were heaped on the families of New Jersey, 280,000 jobs were lost. Since 1989, New Jersey has experienced a 7.5 percent jobs loss while the rest of the Nation grew jobs at 3 percent.

While the United States created 3.2 million new jobs, New Jersey has lost 277,000.

Higher taxes. Higher Government spending. More regulation. What will happen to us? Sadly, just what happened to New Jersey. I urge President Clinton to listen to the unemployed families of New Jersey and reject the false and failed policies of bigger Government.

PASS COMPREHENSIVE HEALTH CARE BILL

(Mr. KLEIN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KLEIN. Mr. Speaker, earlier this month I was one of 700 people who attended the benefit dinner for one of my constituents whom I will call James, who came to this country some 30 years ago, worked hard all his life, raised a fine family, and represented everything that is good about our country. Then 3 months ago at age 56, he was stricken with leukemia. He faces hundreds of thousands of dollars in medical bills which his insurance does not cover and which he cannot afford. I am proud of my community which has rallied to his aid, but I am not proud that our great country doesn't provide him with adequate health care and the peace of mind that goes with it.

Yesterday President Clinton presented us with a health care plan that addresses this and other basic problems in our health care system, such as containing skyrocketing costs. We can amend it, improve it, or hone it, but in the end, for the sake of James and all Americans, we have a solemn duty to pass a comprehensive health care bill in this session of Congress.

CONGRESSIONAL REORGANIZATION

(Mr. HEFLEY asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HEFLEY. Mr. Speaker, the Joint Committee on the Organization of Congress has become a caricature of much of what is wrong with this institution.

Not only have many of the joint committee members found it difficult to attend the committee's extensive and ambitious litany of hearings, they are also struggling to produce a final report by its legislative due date of December 31.

AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

It is no wonder that their attendance record is poor and their report delayed, when you consider that there are 266 committees and subcommittees in Congress meeting on a regular basis. Simple math tells us that for every two Members there is one committee or subcommittee.

Mr. Speaker, it is time for us to slash committees and subcommittees by at least 25 percent. It is time to ban proxy voting in committees and subcommittees. And, it is time for the Joint Committee on the Organization of Congress to issue its final report and dissolve itself.

HEALTH CARE REFORM—A NEW MOMENT IN HISTORY

(Mr. DERRICK asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DERRICK. Mr. Speaker, I rise today to express my strong support for the historic health care reform effort that was launched yesterday by the formal introduction of the President's Health Security Act. After years of inaction on an issue that is central to the health of our economy as well as our population, health care reform is now underway.

The up-coming debate will be long and tortuous, but we must all agree, in the end, we will have a plan that will ensure every American the security of knowing their health needs will always be met—and they will be met at a reasonable cost and a high degree of quality.

The current system is complicated, inefficient, and costly. We must do better. A comprehensive plan that creates a system where all the parts work together in the same direction—rather than against each other—can increase the security, simplify the process, reduce the cost, and improve the quality of every American. Let us get started, and let us do it right.

REAL REFORM NEEDED IN HEALTH CARE

(Mr. THOMAS of Wyoming asked and was given permission to address the House for 1 minute.)

Mr. THOMAS of Wyoming. Mr. Speaker, I rise today also to talk about health care. I think it is the issue that most of us are concerned about. But I come from Wyoming, and maybe it is because there are not too many of us, but we are pretty accustomed to saying the way it is. We are pretty accustomed to talking in terms of facts that folks can understand. And I think we owe it to ourselves to do that in this debate.

We need to be honest about where we are going and what we can do.

Let me tell you why this comes to mind. Mr. ROCKEFELLER yesterday said, "You had better be for real." And I agree with that. "Once Mr. Clinton has said it, you can bank on it."

The evidence of that is not very clear, when you talk about middle-class tax cuts and other kinds of things. But the fact is we do not need Hollywood hype, we do not need historic meetings to talk about all the things we are going to do in general. We need to be specific about what we are going to do for people at home, so they can hear it and say what does this mean to me? What does this mean to cost? What does this mean to coverage?

Most people do not have the faintest idea what we are talking about when we talk about all these fancy words that are there now. Let us get real. Let us talk about real facts and real reform in the health care program.

□ 1010

REPUBLICANS ON HEALTH CARE

(Mr. MORAN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MORAN. Mr. Speaker, for several weeks now, since Mrs. Clinton introduced the administration's health security plan, we have listened to our friends on the Republican side voice any number of criticisms of this plan.

I would remind the American people, it took Mrs. Clinton 9 months to come up with a plan, after Republican Presidents took 12 years to avoid coming to grips with our health care crisis.

And let me suggest to my colleagues that when we get embraced by all these businesses that are so pleased to hear us criticizing Hillary's health plan, remind them, perhaps, that 97.5 percent of their profits are being taken up by increased health insurance costs that cannot go into improving the employment picture, cannot go into increased productivity or international competitiveness, because we have failed to get this crisis under control.

THE PROXY VOTE

(Mr. ALLARD asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. ALLARD. Mr. Speaker, in my opinion the one reform that would have the most profound impact on the number of committees on which a Member of Congress serves is to ban the proxy vote. The most important, detail oriented, work on legislation is intended to happen at the committee level. However, if on any given day you were to check a committee for attendance you would notice that half, and sometimes fewer of the members on a committee are present for the work. Part of the reason is because they are trying to balance their other committee assignments. The proxy is a blessing and a crutch. While it allows Members to claim service on more committees than is humanly possible, it reduces their participation in committee. The result is too many lawmakers who fail to spend quality time on any one subject. A proxy ban would force Members to prioritize. They would be enabled to assume a quality role in their priority committee or committees. Part of the reason people are upset with Members of Congress is they feel we waste a lot of time with little to show for it. A ban of the proxy vote would make us more accountable to them and make our work and attendance in committee more evident. Who can tell perhaps the redirected attention would even produce better legislation.

SOMALIA

(Mr. WELDON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WELDON. Mr. Speaker, it has now become clear that the much ballyhooed truce in Somalia is not worth the paper it is printed on. Fighting between the two main rival clans broke out again this week in Mogadishu, raising the troubling specter of a return to all-out clan warfare.

The question is raised yet again, why are we in Somalia? We are not keeping peace. We are merely carrying water for the United Nations. Once again, our troops are sitting ducks, just waiting to be picked off by some well-armed clansmen looking for attention.

If we stay, how much longer before one of these clans trains its sights on our American soldiers in the hopes of forcing us to again take sides? Mr. Speaker, we were promised a vote on this issue on this House floor, but we know that is not going to happen. The leadership does not want us to debate and vote our continuing involvement in Somalia.

Mr. Speaker, our colleagues can force a vote if they will sign Discharge Petition No. 9, which would force House Resolution 227, introduced on July 27 by our colleague, the gentleman from Ohio [Mr. BROWN], force a vote on this issue.

I urge my colleagues, Mr. Speaker, to sign Discharge Petition No. 9, if they want us to fully debate the issue of how quickly and expeditiously we should remove our troops from that troubled land.

NAFTA

(Ms. KAPTUR asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. KAPTUR. Mr. Speaker, a just-released study by the congressional Joint Economic Committee found that

NAFTA will cost the United States 500,000 more lost jobs and further erode U.S. wages. The study concludes NAFTA's purported economic benefits are far outweighed by its social costs.

My State of Ohio has already lost over 100,000 jobs to Mexico, where wages are one-seventh of our own. Large multinational corporations have been exacting wage-and-benefit concessions from our workers, while pitting them against their lower-paid Mexican counterparts who are being exploited at average wages of $1.55 an hour. The days of sweetheart trade deals that benefit the few at the expense of the many should be over.

Defeating NAFTA is the first step. Our jobs, our future and democratic reform in this hemisphere hang in the balance.

CHOICE?

(Mr. GOSS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GOSS. Mr. Speaker, yesterday the President, amid great fanfare and in festival atmosphere, gave this Congress his final legislative language for his health bill. Or at least we thought he did. But as we have seen before, what the President says and what the White House delivers are often two unrelated things.

As it turns out, we will not get the actual language for another 10 days or so. We still do not have the true cost numbers. Remember way back in April, before the leaves were on the trees? That is when we were supposed to have this health care plan. Now the leaves are off the trees again, and we still do not have it.

Mr. Speaker, the President's commitment to health care reform is admirable. We applaud it. His commitment to Government-run health care is not. Having a national health board dictate to me how I choose my health care gives a whole new meaning to choice, a meaning I do not like and most Americans do not like.

HEALTH CARE REFORM

(Ms. LAMBERT asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. LAMBERT. Mr. Speaker, today I join my colleagues in answering a call that has gone unanswered for far too long. That is a call for access to affordable health care.

I have been extremely pleased by the Members of this body—both Democrats and Republicans—who have expressed a willingness to work together to create a health care plan that will take care of the American citizens without bankrupting our Federal coffers. The issue before us is controlling health care costs while giving all of us the assurance that we will have health care. Without reform, 1 in 4 people will lose health care coverage in the next 2 years. Right now, someone loses their coverage every 30 seconds.

In the First District of Arkansas, where I live, 16 rural hospitals have closed over the past year. So I will give special consideration to ensuring that our rural hospitals are preserved and their client bases are protected. I also would like to see incentives for general practitioners to move to rural areas. But our key focus must be on guaranteeing that everyone has access to affordable full coverage, quality care, and individual choice.

CAMPAIGN REFORM BEGINS AT HOME

(Mr. CALVERT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CALVERT. Mr. Speaker, during the last Presidential campaign, candidate Bill Clinton talked a lot about the issue of campaign finance reform.

Although this issue seems to have gotten lost in the shuffle of events in Somalia, Russia, and Haiti, the two-party system will not let it just fade away.

Republicans are offering a comprehensive campaign reform package, which I am proud to support.

Our bill contains several important reforms, but there is one in particular that I believe is essential to making candidates more responsible to the people who elect them.

That reform is a requirement that a candidate for Congress must raise a majority of his or her campaign funds from the people he seeks to represent.

In many campaigns for Congress today, candidates raise almost all of their campaign funds from sources outside their district.

Americans are tired of these outside special interests influencing elections.

They are tired of candidates raising more money from outsiders than from people in their own communities.

□ 1020

They believe that true campaign reform must begin at home.

I share this frustration of the American people. I believe that no campaign finance reform will work unless candidates for Congress are required to raise the majority of their campaign funds from the people they seek to represent.

JOINING WITH THE ADMINISTRATION IN HEALTH CARE REFORM

(Ms. LONG asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. LONG. Mr. Speaker, the President's health care reform proposal does more to address the health care crisis than ever before.

In 1992, we spent more public and private dollars on health care than on education, defense, prisons, farm subsidies, food stamps, and foreign aid. While combined spending has already nearly doubled since 1970 and will double again by the year 2000, the value and quality of that health care have not doubled. The President is very much on target with the principles of savings, security, personal choice, and quality.

We can deliver the same, or better, quality health care at less cost if we change the incentives, simplify the system, and increase information for both consumers and providers.

With health care reform, we must create a market where health care plans compete on the basis of costs and quality—a market that creates incentives for providers to keep quality high and cost low. Reform must include simplification of the system with a universal benefits package, use of a standard form, and the reduction of administrative burdens for small businesses and individuals in order to control skyrocketing health care spending.

I am pleased that there is so much commitment to President Clinton's proposals. I look forward to working with the administration and my colleagues on this important issue.

SMALL BUSINESS FORESEES BIG PROBLEMS IN HEALTH CARE PACKAGE

(Mr. COLLINS of Georgia asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. COLLINS of Georgia. Mr. Speaker, the President's socialistic health care proposal is axing jobs before the jobs can be created.

Yesterday I received a call from a constituent in Newnan GA, who expressed her concern about the President's health care employer mandate.

The lady and her husband have been planning to open a new business. However, after juggling figures in every way possible, they cannot find a way to afford the cost of the health care mandate.

She said, "This is really going to hurt small business.

With this cost I cannot afford to lock myself into a 5-year lease on the shop space.

"My husband and I have juggled figures and we can't figure how we could pay for this. This really discourages people to open startup businesses.

"Clean up the waste in Government health care programs first."

Mr. Speaker, for the sake of jobs and small business, Congress must listen to the warnings of the people in the real world and ax this socialistic idea.

AMERICA NEEDS PENSION FUNDING REFORM

(Mr. PICKLE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PICKLE. Mr. Speaker, I call the attention of the Members to the recent collective bargaining agreement by General Motors [GM] and the United Auto Workers [UAW], which includes very generous pension benefit increases and early retirement subsidies. While many will think that this is all very wonderful, Members should be aware that the GM pension plans are currently underfunded by $19 billion, and with these new benefits, it is estimated that their underfunding may reach $25 billion. This massive underfunding represents about half of the pension underfunding in the Federal insured pension system, and is a significant contingent liability for the American taxpayer.

Today I am joining with Chairman ROSTENKOWSKI and Chairman FORD upon request, in introducing the administration's pension funding reform package. This is generally a good package, and the administration should be commended. However, as it is now drafted, it will not prevent companies from continuing to promise benefit increases in severely and chronically underfunded plans without paying for them. It is my hope that this shortcoming will be addressed before these important legislative reforms are finally enacted.

INTRODUCTION OF LEGISLATION TO PROVIDE A DAIRY SUPPLY MANAGEMENT PROGRAM

(Mr. SANDERS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SANDERS. Mr. Speaker, from one end of this country to the other, our family farmers are being driven off of the land.

In my own State of Vermont we had over 8,000 dairy farms in 1960, and today we're down to 2,200. In Vermont, because of the low milk prices that dairy farmers are receiving, young people are hesitant to follow their parents in farming. The same story is being played out in Wisconsin, Minnesota, and all over this country.

Mr. Speaker, when we destroy family farming in America, and centralize the production and distribution of food, we endanger the security and well-being of the entire Nation. Our country should not be dependent upon a handful of agribusiness corporations—or foreign nations—for the food that we require. We must maintain vigorous, decentralized agriculture based on the family farm.

This week I have introduced H.R. 3370—a two-tier, supply management program which will provide dairy farmers with a fair price for their product and, at the same time, allow the Government to purchase inexpensive dairy products to be used in our national nutrition programs. In my view, there is no so-called milk "surplus" in this country when 5 million children go hungry.

We must save the family farm; we must feed the hungry children; we must protect our rural way of life. H.R. 3370 does that.

THE FINE PRINT ON SOVEREIGNTY

(Mrs. BENTLEY asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. BENTLEY. Mr. Speaker, debate over the issue of sovereignty in the North American Free-Trade Agreement [NAFTA] is increasing, just as the debate over sovereignty in the trade agreements in the European Community is heating up. It is a valid debate. This is why the American people should make certain to read the fine print in this so-called trade/economic agreement.

The GAO report on NAFTA points out on page 87 that the dispute panels operate much like the courts they replace. In this instance, the GAO is referring to the U.S. courts. The model for the dispute panels in NAFTA is the Canadian Free-Trade Agreement [CFTA]. Those dispute panels under CFTA have in two-thirds of the panel decisions, reversed U.S. laws and regulations, including three International Trade Commission [ITC] decisions. What will happen with the Tri-national panels under NAFTA? Sovereignty is the ability to govern your country. How do we do that with international panels making decisions for us?

NAFTA REPRESENTS ANOTHER NEW BIG GOVERNMENT PROGRAM

(Mr. BROWN of Ohio asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BROWN of Ohio. Mr. Speaker, the supporters of the North American Free-Trade Agreement are playing funny with the numbers again. This new math, this so-called NAFTA math, tells us that it only costs $2.5 billion to implement NAFTA, and they finally admitted that it costs $2.5 billion. As the Assistant Treasury Secretary, Jeffrey Shafer, said, "I regret to say the administration does not yet have a complete answer" on how to fund NAFTA.

What they will not talk about is that NAFTA is a $50 billion new Government program, $10 billion for Texas that the Governor of Texas has asked for, another $5 billion for Arizona, $5 billion for New Mexico, $10 billion or $15 billion for southern California, not to mention tens of billions of dollars for environmental cleanup on the border, not to mention several hundreds of millions of dollars, if not a couple of billion dollars, for worker retraining, not to mention money for Customs officials and all we need for the border.

The fact is, it is a $50 billion new program. The American people should write their Congressman and ask him, write their Congresswoman and ask her, where is the $50 billion? How are we going to pay for NAFTA?

It is a bad idea. It deserves to be defeated.

THE ADMINISTRATION'S HEALTH CARE PLAN, MORE LIKE CANADIAN SYSTEM THAN MANAGED COMPETITION

(Mr. GINGRICH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GINGRICH. Mr. Speaker, I urge all of my colleagues to look at the Washington Post this morning, page A-16, where I think the best single sentence analysis of the Clinton health plan is as follows:

> "What they did was to take the form of managed competition and filled it up with content that looks a whole lot like a Canadian-style Government system," a Clinton adviser said this week, deviating from the official White House line.

□ 1030

Now I think that tells it all. Whatever the words are, the underlying substance is a Government-controlled, Government-dominated, Government-run system that translates your health premiums into taxes that has the Government compelling you to pay those taxes and that gives the Secretary of the Treasury the power to impose an employee payroll tax on a single State when he decides it is necessary. This is an extraordinary grant of power to the Federal Government.

The plan is fundamentally flawed, and I urge my colleagues to look at affordable health care now and other plans based on a more American system.

JUSTICE DEPARTMENT'S APPEAL OF THE MEINHOLD DECISION

(Mr. NADLER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. NADLER. Mr. Speaker, I rise to express my dismay that the Justice Department has chosen to appeal the decision by U.S. District Court Judge Hatter in the Keith Meinhold case, declaring unconstitutional the discriminatory treatment of lesbians and gay men in the military under the so-called "Don't ask, don't tell" compromise.

Earlier this year, the President predicted that if the political branches did

not take action to end the policy of discrimination, the courts would do so, because of its blatant unconstitutionality. The so-called compromise Congress adopted reaffirmed blatant and invidious discrimination as official policy. Can the administration possibly have convinced itself otherwise?

It is hard to understand why the Clinton Justice Department not only is appealing Judge Hatter's decision but has asked the Supreme Court to hear that appeal directly on an "emergency" basis. The Meinhold case gives the President the opportunity to see his principles vindicated.

I strongly urge the President to stick by his principles and direct that the appeal of the Meinhold decision be withdrawn.

SOUTHERN CALIFORNIA FIRES

(Mr. DREIER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DREIER. Mr. Speaker, having listened to my friends, Mr. BROWN and Mrs. BENTLEY, I would love to stand here and talk about the North American Free-Trade Agreement. But I am very saddened to have to refer to the tragedy that exists in my State.

Over the past several years California has suffered from devastating earthquakes, riots, and most recently a recession which has created an unemployment rate of between 9 percent and 10 percent. Now, within the past 48 hours we have all seen that there are around 15 fires continuing to burn in southern California, including the Pasadena area, which I am privileged to represent.

I have to say that I hope that President Clinton declares a national disaster for those who are affected in southern California.

I would also like to say that I have heard some courageous stories of people who have stepped forward and provided tremendous assistance—local officials, firefighters, and others. We have had some static accidents in the Altadena fire, but in two particular instances many volunteers stepped forward and helped 50 people evacuate a convalescent home, and at St. Luke Hospital 170 people were evacuated.

This is a real tragedy, and I hope that we will come together to provide necessary assistance to the largest State in the Union.

NATIONAL EMERGENCY IN SOUTHERN CALIFORNIA

(Mr. COX asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. COX. Mr. Speaker, as millions of people around the world watching television know, southern California has been hit with devastating fires. We have looked on with horror as thousands of people have been forced from their homes. These fires have raged near my own home, and we evacuated in the middle of the night.

Mr. Speaker, I urge President Clinton to accept Governor Wilson's declaration request for a Federal emergency. I urge the immediate appointment of a Federal coordination officer who can deal with California. I urge FEMA, the Federal Emergency Management Agency, to establish disaster application centers in each of our affected California counties. And I urge the heads of all of the Federal agencies who can help, the U.S. Forest Service, the Bureau of Land Management, the National Park Service, to give priority attention to this matter and give this fire emergency the attention it deserves.

Mr. Speaker, the tens of thousands of Californians who are bravely fighting these fires, which still continue, deserve our immediate attention, our compassion, and our help.

CONTINUED POLITICAL UPHEAVAL IN EL SALVADOR

(Mr. HAMBURG asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HAMBURG. Mr. Speaker, Francisco Velis Castellanos, FMLN candidate for the National Assembly in El Salvador, was killed this week as he walked with his daughter to her nursery school. Gunmen opened fire at close range and shot him in the head.

The Los Angeles Times reported that, "The girl, about 2, ran from the scene covered with her father's blood, but was not hurt."

Velis' daughter, a few months older than the peace process in El Salvador, ran from the scene covered with blood. But El Salvador cannot run from the scene. El Salvador and the peace process remain covered with blood.

Last week the United Nations reported an increase in human rights violations with the approach of the elections scheduled for next March: the reappearance of death squads, arbitrary executions, and torture.

The House Foreign Operations Subcommittee temporarily froze disbursement of $70 million in aid to El Salvador to demonstrate concern over the slow pace of voter registration for the upcoming election.

The registration tide cannot be turned if political executions go unpunished. The credibility of the political and electoral process is throttled most effectively by perpetuation of an environment of fear.

We must continue to insist that the Salvadoran Government demonstrate real progress in registering voters and in maintaining an environment free of threat to the political process.

HIGHER TAXES EQUALS LESS JOBS

(Mr. BOEHNER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BOEHNER. Mr. Speaker, I keep hoping that one day the Democrats will learn the lesson I, and my Republican colleagues, have been preaching: The Government cannot tax its way to prosperity; higher taxes equals more Government spending and fewer jobs.

Right now the tax-and-spend policies that the Democrats are so famous for is being spotlighted in the State of New Jersey. Three years ago, Governor Florio increased taxes by $2.8 billion on the people of New Jersey, the largest tax increase in the history of that State. Before that tax increase, New Jersey had an unemployment rate that was 2 percent below the national average. Today, the unemployment rate is 2 percent above the national average. In fact, New Jersey now has the highest unemployment rate in the Nation among all industrialized States; 277,000 jobs have been lost since the 1991 tax increase.

Mr. Speaker, New Jersey is an example everyone should learn from: Raising taxes increases government spending, slows economic growth, and causes the American people to lose their jobs.

SPECIAL COMMISSION ON BREAST CANCER RECOMMENDATIONS

(Ms. DELAURO asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. DELAURO. Mr. Speaker, this morning I opened up the Washington Post and read this headline: "Presidential Panel Calls Breast Cancer Research Underfunded." The Special Commission on Breast Cancer has reported that Federal agencies need to spend at least $500 million a year to make substantial progress against this killer disease.

Estimates are that nearly 500,000 American women will die of breast cancer in this decade while research projects are stalled for lack of funding. That's unforgivable. This study recommends that Congress needs to allocate at least $500 million more per year for critical breast cancer research. That would require an approximate increase of $100 million over what we currently authorize. It is an increase that we can and must commit to.

The commission also recommends:

Enactment of official standards for mammography examinations and an effort to promote use of the screening technique.

Development of treatment techniques that improve the quality of life for breast cancer patients.

Support for advocacy organizations to help ensure access to care for all

women and expand breast cancer education.

It is fitting that the panel makes these recommendations during this, Breast Cancer Awareness Month. What this study means for those of us in Congress is that we can take an active role in finding a cure for this deadly disease. Millions of American women are counting on us.

□ 1040

SPENDING SPREES AND TAX HIKES: UNNATURAL DISASTERS

(Ms. PRYCE of Ohio, asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. PRYCE of Ohio. Mr. Speaker, the Founding Fathers foresaw the States as places for experiments in democracy—good ideas at the State level might be implemented by other States and might be sound policy at the national level.

Equally important, bad laws at the State level would be avoided by other States and questionable ideas might be tested locally before they were imposed on the Nation.

New Jersey has just performed a 4-year experiment of Clintonomics—that is, what happens when you massively increase taxes and let spending explode.

This was the experiment imposed on an unsuspecting New Jersey where taxes were raised $2.8 billion. Spending by the State grew 25 percent in 3 years—three times the rate of inflation.

What happened? New Jersey lost 280,000 jobs—10,000 jobs were lost in the last month alone.

The tax and spending spree of the current administration failed. Higher taxes killed jobs and businesses. Let us in the rest of the Nation bring the news to our own State legislatures that they might avoid such unnatural disasters. And certainly, let us learn in Washington that tax hikes kill jobs and opportunity.

NAFTA: BAD FOR U.S. WORKERS AND BAD FOR U.S. COMPANIES

(Mr. APPLEGATE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. APPLEGATE. Mr. Speaker, the International Machinists Union recently sent members to Mexico who were arrested by the Mexican authorities at the request of Canadian- and American-owned businesses, detained for 3 hours and sent packing, only because they wanted to look and find out about labor practices in Mexico.

Agents of Mexico tried to extort $1 million from IBM so that they could get a Government contract. American and Canadian and Mexican industries are polluting the Rio Grande River with the absolute worst kind of chemicals, killing many thousands of babies. But that is okay; the supporters of the North American Free-Trade Agreement are now saying that President Salinas is going to change all that.

Ladies and gentlemen, autocratic rule does not change unless you change it; it gets worse.

The United States wants free trade with Mexico, underpriced tariff-free products at $7-a-day labor. Stop listening to special interests and start listening to the people.

A LOT MORE THAN A DAY LATE AND A DOLLAR SHORT

(Mr. SMITH of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SMITH of Texas. Mr. Speaker, yesterday the President continued his striptease approach to revealing his long-awaited health care plan to Congress.

The good news is we got to see a little more of it. The bad news is that from what we got to see, it looks even more like another tax bill.

There are $160 billion worth of new taxes in the plan so far and that's before a Democrat Congress even gets its hands on it.

While the taxes are sure to go up, the promised deficit reduction has already started to come down.

Originally, the plan was to reduce the deficit by $91 billion; now the deficit reduction projection is down to $58 billion. And that's before reality gets its hands on it.

If you remember watching the President's budget plan then, you know what to expect from his health care plan now.

The taxes America pays will go up and the money the Government is supposed to save will go down.

The President with his health care plan has added new meaning to the phrase "a day late and a dollar short."

END OF AN ERA: COLEMAN YOUNG'S RETIREMENT

(Miss COLLINS of Michigan asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Miss COLLINS of Michigan. Mr. Speaker, today I pay tribute to one of the most important and history-making public servants of our time, Mayor Coleman Alexander Young of Detroit.

Mayor Young's retirement after serving almost 20 years will mark the end to one of the greatest periods in Detroit's history. When others forecast Detroit's demise, Coleman Young engineered its revival. Coleman Young dismantled the walls of exclusion brick by brick to become Detroit's first African-American Mayor, and conquered impossible odds to do it.

Mayor Young then made city hall accessible to people who were not welcome there before; African Americans, the working class, and women. For the first time, ability determined how far their careers would lead them, not race or gender.

Certainly, no mayor had a brighter vision for Detroit or worked harder to recapture the city's pride than Coleman Young. His courage and leadership will be engraved in history. Mayor Young's exemplary achievements have made him a legend in his own time.

NAFTA: GOOD FOR FLORIDA AND ALL AMERICAN WORKERS

(Mr. KOLBE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KOLBE. Mr. Speaker, last week some members of the Florida delegation gathered with certain interest groups to denounce the North American Free-Trade Agreement and its impact on Florida fruit and vegetables and to urge Members and Americans to buy American. They even sported hats, "Dump NAFTA." But there is just one problem: The hat is made in China.

Mr. Speaker, nothing so perfectly illustrates the dilemma the protectionists have today. They oppose open markets, but they use tools to fight it that are produced in other countries. Of course, that is the reality of today's world economy. We live in a global economy in which goods move freely across the borders.

Baseball caps are produced in China, computers are produced in the United States, vegetables are grown in Mexico and exported to America while other vegetables and soybeans are grown in the United States and exported to Mexico.

Last weekend I stood in the world's largest Wal-Mart in Mexico City and one entire shelf of the cooler was filled with Florida orange juice.

NAFTA will be good for Florida as it will be good for all American workers.

SOME LUDDITES AMONG US?

(Mr. BACHUS of Alabama asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BACHUS of Alabama. Mr. Speaker, I fear there may be some Luddites among us. Who were the Luddites? Some of you may remember in the 19th century of England the Luddites led a highly emotional campaign against the use of machinery. Shortsightedly, they cried that machines will cost us our jobs, no machines in our factories.

Today many of our colleagues are sounding like Luddites, claiming that

free trade, like machines and technology, will cost Americans their jobs. I disagree. If the Luddites had been successful in their campaign against machinery, the British economy would have remained stagnant while the rest of the world mechanized.

Likewise, if we listen to the opponents of NAFTA, the rest of the world will enter into beneficial trade agreements and leave us behind.

England mechanized and became the world's dominant economic force and prospered. Today we have the same choice. We must progress. We must pass NAFTA.

CLINTON REJECTS D.C.'S PLEA TO CALL UP THE NATIONAL GUARD

(Mr. MICA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MICA. Mr. Speaker, under the Constitution, the President has the authority to call out the National Guard to help stem the murder and violence in the District of Columbia.

This week he and the Attorney General rejected a plea for help by Mayor Kelly. These are the same administration officials who sent unprecedented Federal force into an armed religious compound.

This is the same President who sent dozens of our men to sacrifice their lives, far across distant oceans for ungrateful Somalis.

This the same President who has surrounded Haiti with a flotilla of United States naval warships.

President Johnson called out the National Guard in the District when only a score were killed.

Governor Chiles called out the Guard when several dozen died in a Florida natural disaster.

Governor Clinton called out the Guard in Arkansas when prisoners rioted.

But beyond the White House lawn, this President cannot hear the pleas of the Mayor nor the nightly screams of the 382 murder victims and their families.

The Congress will give the Mayor the right to act, so Mr. Speaker, the President can sleep tight.

□ 1050

MEXICO'S RECORD OF INJUSTICE RAISES DOUBTS ABOUT SUPPORT FOR NAFTA

(Mr. SHAW asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SHAW. Mr. Speaker, I rise today to bring to the attention of this Chamber a matter of great injustice and inequity between the United States and Mexico. In May of this year gang members from southern California were involved in the senseless murder of a Mexican cardinal in Guadalajara, Mexico. It took little time for the Mexican Government to issue arrest warrants and request United States assistance in extraditing these criminals, at least two of which are United States citizens, to Mexico. Our Government is cooperating with that request, in accordance with normal U.S. policy.

But the Mexican Government has refused to help us in extraditing to the United States a Mexican citizen accused in the horrible kidnapping and rape of a 4-year-old girl in Riverside County, CA, in September 1992. Yes, Mr. Speaker, they have blatantly refused to cooperate in this extradition. This is normal Mexican policy.

I ask this body whether this is the kind of cooperation we can expect from Mexico in resolving serious disputes that are bound to arise under NAFTA? Certainly, U.S. citizens have the right to expect more, much more.

I have not decided how I will vote on NAFTA, but I can guarantee this body that issues such as this will definitely affect my decision.

"THE CHECK IS IN THE MAIL—I'M FROM THE GOVERNMENT AND I'M HERE TO HELP YOU"

(Mr. EWING asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. EWING. Mr. Speaker, I speak today about New Jersey, my wife's home State. What is happening there is very important to us and very real to our families.

You never want to hear the promise about the check being in the mail. But if you live in New Jersey, you have a special reason for running fast if you hear "I'm from the State government and I'm here to help."

In 1990, taxes were increased by $2.8 billion. This was the largest tax hike in any State to that point. The State government obligated to serve the people began to think the job of the people was to feed its endless appetite—New Jersey government truly demonstrated Ronald Reagan's observation that government is like a baby with an endless appetite at one end no sense of responsibility at the other.

Those jobs in New Jersey as a result of the tax increase did not simply disappear—they were destroyed. At the time when the Nation was creating 3.2 million new jobs, New Jersey lost 277,000 jobs. That is failure created by State misgovernment, by wasteful spending and destructive taxation.

Some 280,000 jobs killed. It is a bad joke. And no one in New Jersey is laughing.

SECRECY AT THE WHITE HOUSE

(Mr. BURTON of Indiana asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BURTON of Indiana. Mr. Speaker, Some time ago a Federal judge instructed the White House Health Care Task Force chaired by Mrs. Clinton, to open its meetings to the public. The judge based his decision on sunshine laws passed by Congress to ensure there is oversight in every arm of Government.

Now, the White House is embroiled in yet another secrecy SNAFU; one that could find its way into the headlines and the courts again. Despite repeated queries from House Members, the Clinton administration has refused to provide a complete list of White House staff. To add insult to injury, the administration refuses to reveal the salaries paid to some of its known staffers.

For instance: Thomas (Mack) McLarty, chief of staff to the President—salary unknown; George Stephanopoulos, senior advisor for policy and strategy—salary unknown; Bruce Lindsey, assistant to the President and senior advisor—salary unknown; and even David Gergen, counselor to the President—salary unknown.

Mr. Speaker, the House and the American people want this information—now.

MISUNDERSTANDING A JOB WELL DONE

(Mr. WOLF asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WOLF. Mr. Speaker, I want to commend two individuals today. One is the gentleman from Florida, Mr. HARRY JOHNSTON, and professional basketball player Manute Bol.

As many people know, there is a famine and war going on in Sudan, and 1.2 million people have died.

Congressman JOHNSTON, who is chairman of the Foreign Affairs Committee's Africa Subcommittee, had a series of meetings last week to focus attention on the Sudan crisis where he brought the rebel leaders from southern Sudan together to try and work out a peace accord, in opposition to the Khartoum government.

At that meeting was Manute Bol, the basketball player from the Miami Heat, who is also from the Sudan.

Manute Bol stayed because he is a Dinka and he cares deeply about his people. As a result he missed two exhibition games and was fined by General Manager Louis Schaffel of the Miami Heat.

I would urge the general manager of the Miami Heat to give Manute Bol the benefit of the doubt and to revoke the fine, because the gentleman from Florida, Mr. HARRY JOHNSTON, and Manute Bol, who represents the basketball team in Florida, were doing their best

to bring the sides together for reconciliation to save hundreds of thousands of lives in Sudan.

The gentleman from Florida, Mr. HARRY JOHNSTON, and Manute working together, I believe personally, have probably helped to save hundreds of thousands of women and children, and I would urge the Miami Heat first, to commend Congressman JOHNSTON; but second, to commend Manute Bol and revoke the $25,000 fine.

I submit for the RECORD a copy of a letter I have sent to the Miami Heat management:

HOUSE OF REPRESENTATIVES,
Washington, DC, October 27, 1993.

Mr. LOUIS SCHAFFEL
General Manager, Miami Heat, Miami, FL.

DEAR MR. SCHAFFEL: I am writing to strongly urge you to drop Manute Bol's fine of $25,000 for missing two preseason games for attending the Congressional conference "Sudan: the Forgotten Tragedy."

Having been to Sudan three times and seen the death, robbing and slavery first-hand, I can only say that I applaud Manute's personal commitment to a crisis which he is almost alone in raising. As you may be aware, Manute has personally spent thousands of dollars to open the eyes of the United States to the decimation of his people in southern Sudan. I have heard him weep over the brutalities faced daily in southern Sudan, where Christian Africans are the targets of a genocidal campaign against them from the militant Islamic government in Khartoum. I have heard him tell of seeing the thousands of children who walk for miles across Sudan in search of food between scarce refugee camps. He reports that the weakest of these children are often left behind to be attacked and eaten by packs of wild animals with their friends too weak to bury them.

It was in this deeply burdened spirit that he attended the entire conference—the first of its kind—in Washington last week. He was unaware in making his plans that the second day of the conference would be postponed in order to wait for the arrival of the two rebel leaders fighting for the south. Because of the high-profile stance he has taken on Sudan, his absence would have been obvious and would have been a great detriment to the success of the conference. But he stayed in order to make his personal plea to the two leaders of the southern opposition—whose cooperation is a crucial first step in bringing needed relief to southern Sudan. He stayed to make his points passionately and well.

Enclosed you will find pictures of only a few of the literally millions of lives for whom Manute missed the preseason games. And you will find a recent article chronicling present-day slavery in Manute's native land.

Considering Manute's commitment in both time and money to the neglected cause of his suffering people, I ask you once again to revoke the unjust and heavy fine you gave him. I understand your actions, but am sharing the other side of the story in the hope that you will change your mind.

Sincerely,

FRANK R. WOLF,
Member of Congress.

WHERE IS THE CONGRESSIONAL REFORM BILL?

(Mr. SOLOMON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SOLOMON. Mr. Speaker, for my colleagues who are disappointed that reform week has been called—for lack of reforms—let me give you cause for some real disappointment: Last September was supposed to be congressional reform month.

Yes, you heard me right. The Joint Committee on the Organization of Congress, was supposed to bring a congressional reform bill to the floor of this House nearly 2 months ago. And now we are being told it is off until sometime next year.

Mr. Speaker, where is that bill? I am embarrassed to tell you as a member of that joint committee that I don't know where it is.

As near as I can tell, it is being filibustered to death in the Democratic caucus before it has even been written, let alone reported.

Mr. Speaker, I have held my peace until now when it comes to criticizing the joint committee. But when I hear that a few bulls and leaders in the Democrat Party are trying to dictate what this bipartisan, supposedly independent joint committee can and cannot put in its own bill, I begin to lose patience.

Now we are being told that we can not have any reforms in House committee procedures unless the Senate abolishes the filibuster. That is the goofiest, most illogical disconnect I have ever heard.

It's a little like telling your doctor you will not take your medicine until your neighbor stops having those noisy, all-night parties.

Come on Democrats, stop making excuses and start taking your medicine. Physicians, heal thyselves.

PROVIDING FOR CONSIDERATION OF HOUSE JOINT RESOLUTION 283, FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 1994

Mr. MOAKLEY. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 287 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 287

Resolved, That upon the adoption of this resolution it shall be in order, any rule of the House to the contrary notwithstanding, to consider in the House the joint resolution (H.J. Res. 283) making further continuing appropriations for the fiscal year 1994, and for other purposes. Debate on the joint resolution shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations. The previous question shall be considered as ordered on the joint resolution to final passage intervening motion except one motion to recommit.

The SPEAKER pro tempore (Mr. TORRES). The gentleman from Massachusetts [Mr. MOAKLEY] is recognized for 1 hour.

Mr. MOAKLEY. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Florida [Mr. GOSS] pending which I yield myself such time as I may use. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, House Resolution 287 allows this body to consider House Joint Resolution 283, making further continuing appropriations for fiscal year 1994, in the House—any rule of the House to the contrary notwithstanding. The hour of debate time will be equally divided and controlled by the chairman and ranking minority member of the Appropriations Committee. The rule provides one motion to recommit.

House Joint Resolution 287 is a one-sentence joint resolution, simply changing the end date for the continuing resolution from October 28 to November 10.

Mr. Speaker, the situation is not hard to understand. Tonight, the short-term continuing resolution will run out. Congress has cleared 11 of the 13 appropriation bills: 5 bills have been signed into law; the other 6 are either on the President's desk awaiting his signature or on their way from Congress to the President's desk.

The two remaining bills are Interior and DOD. The House passed the Interior conference report and it is pending in the Senate. Yesterday we appointed conferees for the DOD appropriation bill. I have every confidence we can come to quick resolution on these measures.

Mr. Speaker, Congress should be able to clear the last two bills in the next few days. If this continuing resolution is in place, it will allow the President his constitutionally mandated 10 days to decide whether to sign or veto each of the appropriation bills without the threat of shutting down the Government.

I have described the rule and the continuing resolution. Now I want to address the concerns of those who would vote no.

Mr. Speaker, those in opposition are animated largely by nongermane issues, so I ask your indulgence if I should stray from the matter at hand.

The other side wants to waive the germaneness requirement in order to address their scorekeeping worries on health care reform proposals. How a permanent change in the scorekeeping rules would fit in a temporary continuing resolution, I do not understand. In my view the amendment proposed by the minority leader and the gentleman from Ohio [Mr. HOBSON] does not belong on the continuing resolution. It is both premature and dangerous.

The danger, Mr. Speaker, lies in what a House nongermane amendment would

invite from the other body. We have been disciplined this year.

The continuing resolution is usually an attractive vehicle for nongermane amendments but Congress has so far this year been clean and simple on the continuing resolution. There is no telling what manner of mischief we invite if we in the House do not maintain the requirement of germaneness.

The amendment is also premature. It is an interesting and important debate about when to treat Federal mandates as Federal taxes. The Office of Management and Budget, the Congressional Budget Office, and the Joint Tax Committee are engaged in a serious discussion of the issue. It seems to me premature to gag those staffs, to direct the outcome of their debates.

We hire those people for their expertise in public finance and their independent judgment. Why should we preempt them? Why would be rob ourselves of the opportunity of hearing the full debate on the subject by directing them to keep score in a certain way? As a general principle, we ought to be suspicious of directed scorekeeping and especially before we even know the full arguments on both sides of the issue.

The second source of opposition comes from those who are upset about the demise of the principle of majority rule in the other body. There are some who would shut down the entire Federal Government, who want especially to close the national parks and museums, to make that point about Senate rules. If the House defeats the rule and the continuing resolution, attention will be drawn to problems in the House, perhaps to Congress' inadequacy as a whole, but not specifically to the Senate filibuster rule.

Finally, Mr. Speaker, some will vote no because they oppose continuing resolutions on principle. Mr. Speaker, I doubt there is a single Member who likes continuing resolutions, who thinks this is the way to do business. There is no secret strategy to delay the bills and use continuing resolutions to fund the Government.

The Appropriations Committee struggled mightily to get the bills done on time. No one has been louder in opposing the use of continuing resolutions than the chairman of the Appropriations Committee.

The fact is that we have been slowed down by some serious and important issues. If the most important thing was to get the bills done on time and avoid a continuing resolution, we could have skipped the debate on ASRM or the super collider. But these were important differences between the Senate and the House and the debate was certainly worthy of the time spent. If the Congress ought to have engaged in those debates, we must accept the delay, face the consequences, adopt this rule and pass this continuing resolution.

Mr. Speaker, the joint resolution before us is a simple, clean extension through November 10 of the most restrictive form of a continuing resolution: Providing the lowest amount among last year's level, the House-passed or the Senate-passed amount for each account.

House Resolution 283 is a fair rule and I urge its adoption.

□ 1100

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank the distinguished chairman, the gentleman from Massachusetts [Mr. MOAKLEY], for yielding.

Mr. Speaker, I am sure most Americans know the expression "3 strikes and you're out." We just finished a very exciting World Series where strike-outs were strictly enforced. So today, as we take up continuing resolution No. 3, I wonder if the majority leadership is ready to concede they have struck out on getting our work done on time.

One week ago today, I stood here and reviewed the problems with our budget process and observed the growing opposition to so-called continuing resolutions. I also predicted I would be back today. CR's, as they are called, are essentially C.Y.A. measures that allow deadlines to slip. Despite the strong wishes and many efforts of the distinguished chairman of the Appropriations Committee, the gentleman from Kentucky [Mr. NATCHER], and ranking member, the gentleman from Pennsylvania [Mr. MCDADE], who have repeatedly exhorted this Congress to get its important work done on time, we are now going to grant ourselves until November 10 to do the work that we were supposed to have finished by October 1. That is an extra 41 days.

But have we used that grace period to put our shoulders to the wheel and get things done? Well, last week, upon passage of the second CR, the House leadership declared itself a 4-day weekend, instead of staying here to thrash out the remaining obstacles to completing our business.

Now the leadership is preparing for a 5-day long-weekend. No wonder people across the land question how serious we are about the Nation's urgent business. Regardless of how you dress this up, the conclusion is the same: Congress is failing to fulfill its obligations in a timely and responsible way, choosing to fall-back on one CR after another instead of putting in the time to do our jobs. Is anyone betting that when this third CR expires on November 10 that the work will be done? Despite how unsettling this CR, process is to fiscally responsible Americans, despite the fact that it erodes Congress' credibility, there is another very serious problem confronting us.

Mr. Speaker, we had testimony yesterday in the Committee on Rules about a very important measure designed to bolster that credibility. In the name of our minority leader, the gentleman from Illinois [BOB MICHEL], a prudent and reasonable proposal was offered to put an end to the deceitful numbers games for which the Federal Government is infamous—specifically, as we begin the complex task of reforming health care and figuring true costs the Michel proposal would ensure truth in accounting at the Congressional Budget Office, the Office of Management and Budget and the Joint Committee on Taxation as they begin analyzing health care legislation.

My colleague, the gentleman from Ohio [Mr. HOBSON], spokesman for the proposal, made it very clear that we cannot expect to achieve responsible reform when we are trying to compare apples and oranges. Especially when apples from the White House are still missing. We have all got to be working with the same numbers if we ever hope to make meaningful change. But the majority members of the Committee on Rules, operating under instructions from their leadership, refused to allow the minority leader an opportunity to bring this matter to the floor. In fairness, they argued for a clean CR—but this need for truth in numbers about health care far outweighs their arguments.

Mr. Speaker, I urge a "no" vote on this rule, but should it pass I hope my colleagues will join me in voting "no" on the CR, and I do intend to ask for a recorded vote. Judging by our $4-plus-trillion-and-rising national debt, I would say truth in budgeting is long overdue—and the "three strikes and you're out" rule is more than fair. Americans are ready to enforce it.

OPEN VERSUS RESTRICTIVE RULES 95TH–103D CONGRESS

Congress (years)	Total rules granted [1]	Open rules		Restrictive rules	
		Number	Percent [2]	Number	Percent [3]
95th (1977–78)	211	179	85	32	15
96th (1979–80)	214	161	75	53	25
97th (1981–82)	120	90	75	30	25
98th (1983–84)	155	105	68	50	32
99th (1985–86)	115	65	57	50	43
100th (1987–88)	123	66	54	57	46
101st (1989–90)	104	47	45	57	55
102d (1991–92)	109	37	34	72	66
103d (1993–94)	41	11	27	30	73

[1] Total rules counted are all order of business resolutions reported from the Rules Committee which provide for the initial consideration of legislation, except rules on appropriations bills which only waive points of order. Original jurisdiction measures reported as privileged are also not counted.

[2] Open rules are those which permit any Member to offer any germane amendment to a measure so long as it is otherwise in compliance with the rules of the House. The parenthetical percentages are open rules as a percent of total rules granted.

[3] Restrictive rules are those which limit the number of amendments which can be offered, and include so-called modified open and modified closed rules, as well as completely closed rule, and rules providing for consideration in the House as opposed to the Committee of the Whole. The parenthetical percentages are restrictive rules as a percent of total rules granted.

Sources "Rules Committee Calendars & Surveys of Activities," 95th–102d Cong.; "Notices of Action Taken," Committee on Rules, 103d Cong., through Oct. 27, 1993.

OPEN VERSUS RESTRICTIVE RULES: 103D CONGRESS

Rule number date reported	Rule type	Bill number and subject	Amendments submitted	Amendments allowed	Disposition of rule and date
H. Res. 58, Feb. 2, 1993	MC	H.R. 1: Family and medical leave	30 (D–5; R–25)	3 (D–0; R–3)	PQ: 246–176. A: 259–164. (Feb. 3, 1993).
H. Res. 59, Feb. 3, 1993	MC	H.R. 2: National Voter Registration Act	19 (D–1; R–18)	1 (D–0; R–1)	PQ: 248–171. A: 249–170. (Feb. 4, 1993).
H. Res. 103, Feb. 23, 1993	C	H.R. 920: Unemployment compensation	7 (D–2; R–5)	0 (D–0; R–0)	PQ: 243–172. A: 237–178. (Feb. 24, 1993).
H. Res. 106, Mar. 2, 1993	MC	H.R. 20: Hatch Act amendments	9 (D–1; R–8)	3 (D–0; R–3)	PQ: 248–166. A: 249–163. (Mar. 3, 1993).
H. Res. 119, Mar. 9, 1993	MC	H.R. 4: NIH Revitalization Act of 1993	13 (d–4; R–9)	8 (D–3; R–5)	PQ: 247–170. A: 248–170. (Mar. 10, 1993).
H. Res. 132, Mar. 17, 1993	MC	H.R. 1335: Emergency supplemental Appropriations	37 (D–8; R–29)	1(not submitted) (D–1; R–0)	A: 240–185. (Mar. 18, 1993).
H. Res. 133, Mar. 17, 1993	MC	H. Con. Res. 64: Budget resolution	14 (D–2; R–12)	4 (1-D not submitted) (D–2; R–2)	PQ: 250–172. A: 251–172. (Mar. 18, 1993).
H. Res. 138, Mar. 23, 1993	MC	H.R. 670: Family planning amendments	20 (D–8; R–12)	9 (D–4; R–5)	PQ: 252–164. A: 247–169. (Mar. 24, 1993).
H. Res. 147, Mar. 31, 1993	C	H.R. 1430: Increase Public debt limit	6 (D–1; R–5)	0 (D–0; R–0)	PQ: 244–168. A: 242–170. (Apr. 1, 1993).
H. Res. 149 Apr. 1, 1993	MC	H.R. 1578: Expedited Rescission Act of 1993	8 (D–1; R–7)	3 (D–1; R–2)	A: 212–208. (Apr. 28, 1993).
H. Res. 164, May 4, 1993	O	H.R. 820: Nate Competitiveness Act	NA	NA	A: Voice Vote. (May 5, 1993).
H. Res. 171, May 18, 1993	O	H.R. 873: Gallatin Range Act of 1993	NA	NA	A: Voice Vote. (May 20, 1993).
H. Res. 172, May 18, 1993	O	H.R. 1159: Passenger Vessel Safety Act	NA	NA	A: 308–0 (May 24, 1993).
H. Res. 173 May 18, 1993	MC	S.J. Res. 45: United States forces in Somalia	6 (D–1; R–5)	6 (D–1; R–5)	A: Voice Vote (May 20, 1993)
H. Res. 183, May 25, 1993	O	H.R. 2244: 2d supplemental appropriations	NA	NA	A: 251–174. (May 26, 1993).
H. Res. 186, May 27, 1993	MC	H.R. 2264: Omnibus budget reconciliation	51 (D–19; R–32)	8 (D–7; R–1)	PQ: 252–178. A: 236–194 (May 27, 1993).
H. Res. 192, June 9, 1993	MC	H.R. 2348: Legislative branch appropriations	50 (D–6; R–44)	6 (D–3; R–3)	PQ: 240–177. A: 226–185. (June 10, 1993).
H. Res. 193, June 10, 1993	O	H.R. 2200: NASA authorization	NA	NA	A: Voice Vote. (June 14, 1993).
H. Res. 195, June 14, 1993	MC	H.R. 5: Striker replacement	7 (D–4; R–3)	2 (D–1; R–1)	A: 244–176.. (June 15, 1993).
H. Res. 197, June 15, 1993	MO	H.R. 2333: State Department. H.R. 2404: Foreign aid	53 (D–20; R–33)	27 (D–12; R–15)	A: 294–129. (June 16, 1993).
H. Res. 199, June 16, 1993	C	H.R. 1876: Ext. of "Fast Track"	NA	NA	A: Voice Vote. (June 22, 1993).
H. Res. 200, June 16, 1993	MC	H.R. 2295: Foreign operations appropriations	33 (D–11; R–22)	5 (D–1; R–4)	A: 263–160. (June 17, 1993).
H. Res. 201, June 17, 1993	O	H.R. 2403: Treasury-postal appropriations	NA	NA	A: Voice Vote. (June 17, 1993).
H. Res. 203, June 22, 1993	MO	H.R. 2445: Energy and Water appropriations	NA	NA	A: Voice Vote. (June 23, 1993).
H. Res. 206, June 23, 1993	O	H.R. 2150: Coast Guard authorization	NA	NA	A: 401–0. (July 30, 1993).
H. Res. 217, July 14, 1993	MO	H.R. 2010: National Service Trust Act	NA	NA	A: 261–164. (July 21, 1993).
H. Res. 218, July 20, 1993	O	H.R. 2530: BLM authorization, fiscal year 1994–95	NA	NA	
H. Res. 220, July 21, 1993	MC	H.R. 2667: Disaster assistance supplemental	14 (D–8; R–6)	2 (D–2; R–0)	PQ: 245–178. F: 205–216. (July 22, 1993).
H. Res. 226, July 23, 1993	MC	H.R. 2667: Disaster assistance supplemental	15 (D–8; R–7)	2 (D–2; R–0)	A: 224–205. (July 27, 1993).
H. Res. 229, July 28, 1993	MO	H.R. 2330: Intelligence Authority Act, fiscal year 1994	NA	NA	A: Voice Vote. (Aug. 3, 1993).
H. Res. 230, July 28, 1993	O	H.R. 1964: Maritime Administration authority	NA	NA	A: Voice Vote. (July 29, 1993).
H. Res. 246, Aug. 6, 1993	MO	H.R. 2401: National Defense authority	149 (D–109; R–40)		A: 246–172. (Sept. 8, 1993).
H. Res. 248, Sept. 9, 1993	MO	H.R. 2401: National defense authorization			PQ: 237–169. A: 234–169. (Sept. 13, 1993).
H. Res. 250, Sept. 13, 1993	MC	H.R. 1340: RTC Completion Act	12 (D–3; R–9)	1 (D–1; R–0)	A: 213–191–1. (Sept. 14, 1993).
H. Res. 254, Sept. 22, 1993	MO	H.R. 2401: National Defense authorization		91 (D–67; R–24)	A: 241–182. (Sept. 28, 1993).
H. Res. 262, Sept. 28, 1993	O	H.R. 1845: National Biological Survey Act	NA	NA	A: 238–188 (10/06/93).
H. Res. 264, Sept. 28, 1993	MC	H.R. 2351: Arts, humanities, museums	7 (D–0; R–7)	3 (D–0; R–3)	PQ: 240–185. A: 225–195. (Oct. 14, 1993).
H. Res. 265, Sept. 29, 1993	MC	H.R. 3167: Unemployment compensation amendments	3 (D–1; R–2)	2 (D–1; R–1)	A: 239–150. (Oct. 15, 1993).
H. Res. 269, Oct. 6, 1993	MO	H.R. 2739: Aviation infrastructure investment	N/A	N/A	A: Voice Vote. (Oct. 7, 1993).
H. Res. 273, Oct. 12, 1993	MC	H.R. 3167: Unemployment compensation amendments	3 (D–1; R–2)	2 (D–1; R–1)	PQ: 235–187. F: 149–254. (Oct. 14, 1993).
H. Res. 274, Oct. 12, 1993	MC	H.R. 1804: Goals 2000 Educate America Act	15 (D–7; R–7; I–1)	10 (D–7; R–3)	A: Voice Vote. (Oct. 13, 1993).
H. Res. 282, Oct. 20, 1993	C	H.J. Res. 281: Continuing appropriations through Oct. 28, 1993	N/A	N/A	A: Voice Vote. (Oct. 21, 1993).
H. Res. 286, Oct. 27, 1993	O	H.R. 334: Lumbee Recognition Act	N/A	N/A	
H. Res. 287, Oct. 27, 1993	C	H.J. Res. 283: Continuing appropriations resolution	1 (D–0; R–0)	0 (D–0; R–0)	

Note.—Code: C-Closed; MC-Modified closed; MO-Modified open; O-Open; D-Democrat; R-Republican; PQ: Previous question; A-Adopted; F-Failed.

ROLLCALL VOTES IN THE RULES COMMITTEE ON MOTIONS ON THE RULE FOR HOUSE JOINT RESOLUTION 283—MAKING FURTHER CONTINUING APPROPRIATIONS

(Wednesday, October 27, 1993)

1. Michel amendment—To provide for budget scorekeeping which will show the true cost of proposed health care plans. Rejected: 4–6. Yeas: Solomon, Quillen, Dreier, and Goss. Nays: Moakley, Derrick, Beilenson, Frost, Hall, and Slaughter. Not voting: Bonior, Wheat, and Gordon.

2. Adoption of Rule—Adopted: 6–4. Yeas: Moakley, Derrick, Beilenson, Frost, Hall, and Slaughter. Nays: Solomon, Quillen, Dreier, and Goss. Not voting: Bonior, Wheat, and Gordon.

□ 1110

Mr. Speaker, I reserve the balance of my time.

Mr. MOAKLEY. Mr. Speaker, I yield 6 minutes to the gentleman from California [Mr. MILLER].

Mr. MILLER of California. Mr. Speaker, I reluctantly rise in support of the rule on the continuing resolution.

I say reluctantly because this CR includes funding for the Department of the Interior—and it is included in the CR for one very simple reason: Because a minority of the U.S. Senate continues to defy the President, defy the Interior Secretary, defy two-thirds of this body, defy its own conferees, and to deny a majority of the Senate itself by filibustering the Interior appropriations bill.

I think the American people are fed up, and I know this House is fed up, with obstructionism and gridlock taking place in the Senate. To protect the subsidized interests of 18,000 holders of Federal grazing permits—nearly all of whom can afford to pay the increased fee the majority supports—that Senate minority is prepared to shut down a major department of this Government, the Department of the Interior.

So am I, and so is the Secretary, if that is what is necessary.

Because there is a critical principle at stake here:

Is the House, and are the American people, going to continue to let a minority of people in the Senate totally frustrate the operations of our Government? Here in the House, you get your day in court; you vote on the tough issues when they come to the floor, up or down.

In the Senate, a handful of people can ignore the will of the majority of that body and prevent a bill from being considered, even when their majority votes are in place on bipartisan basis to support and to pass that legislation, as is the situation with the Interior appropriations conference report.

So let me tell you what the result is going to be. Yes, the funds for the Department of the Interior will be continued now for another 10 days. But when the dollars run out, the Senate minority is going to shut down, they say, shut down, because they do not want to give the bad news to a few thousand special interest ranchers in a few States that the day of the federally taxpayer subsidized gravy train is over. That you are now going to have to pay a reasonable rate, a rate comparable to what is paid on State lands and private lands in your State to graze your cattle. The days of the deep pocket subsidy of Uncle Sam are over.

Here is what they are willing to shut down in that fight. They are willing to shut down the Washington Monument, the Smithsonian Institute, Independence Hall in Philadelphia, the Alamo, and the Statue of Liberty. All because they insist upon carrying on a fight and a filibuster to prevent the Senate from voting a bill where the majority of the Senate is prepared to vote and to pass that legislation. That is the bad news, that they can shut that down.

I think what is important and at stake here is to understand that should we resist this filibuster and should we stick to the House position, that the taxpayers of this country will get a reform that stops the drain on the Treasury, and those concerned about the environment will get a better stewardship of the public lands that are owned by the people of this country. That is what is at stake.

What we see is a band of Senators today berating Members of the House, the committees of the House, on a bipartisan basis. Nobody has withheld from their objections and their personal remarks about Members of this body, so that they can protect those few special interests.

This fight will not end today with the passage of the CR. The House will

not change its position. The leadership will not change its position with respect to the House position. The Secretary of the Interior will not change his position, nor will the President of the United States.

I find it interesting that the Senators from Pennsylvania would threaten to shut down Independence Hall when a majority of their delegation, 17 of the 19 in the House, voted to increase the grazing fees. In the State of New York they say they will shut down the Statue of Liberty, where 30 out of 31 Members of this House on a bipartisan basis voted to increase the grazing fees. But the Senate would rather shut down the Statue of Liberty. The Everglades Park in Florida, where 20 out of 23 Members on a bipartisan basis of this House voted to increase the grazing fees and grazing reforms, the Senators from Florida say they would rather shut down the Everglades Park than to raise the grazing fees on a few special interests.

Time and again, overwhelmingly, on a State-by-State basis, the Members of this House have voted for these reforms, and yet we see Members from that same State suggesting that they are going to risk the enjoyment of their citizens, the benefit of their taxpayers, by shutting down the national parks, by shutting down the national monuments, and the historic sites, so that they continue to act as obstructionists, engage in gridlock, between their special interest grazers in the far West, rather than let the Senate vote.

We voted with over 319 votes on a strong bipartisan basis, as we have each and every year, for grazing reforms. We must now force that vote to take place in the Senate.

They have refused to engage in this issue for over a decade. The time has come now. And that is why I will reluctantly support this continuing resolution, because it does involve the Department of Defense and the District of Columbia. But at some point we are going to come down to this confrontation, and the Senate will have to decide whether it is going to represent the American people or a handful of special interests who are deep into the pockets of the American taxpayers.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. TORRES). At this time the Chair would ask and caution Members to desist against references to the Senate and its Members.

Mr. MILLER of California. Mr. Speaker, I appreciate the position of the Chair. I would only say on a bipartisan basis Members of the House of Representatives have been characterized as prating about this one. Our Republican colleagues have been called shabby rascals. It goes on and on and on in the Senate about individual Members of this House who are engaged in trying to support this legislation. And I would hope at some point the leadership of the House would discuss this with the leadership of the Senate. It got so bad the other day that Senator BYRD had to take the floor to admonish Members of the Senate that they could not engage in that kind of debate.

Mr. GOSS. Mr. Speaker, I am privileged to yield such time as he may consume to the distinguished minority leader, the gentleman from Illinois [Mr. MICHEL].

Mr. MICHEL. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, normally on continuing resolutions, our inclination has been over any number of years to keep a continuing resolution just as clean as you possibly can, for obvious reasons. But today I have to express my regret that the Committee on Rules did not see fit to make in order our amendment, which is designed to ensure accurate and credible cost analysis of the various health care reform proposals.

There has been considerable concern expressed on both sides of the aisle, as well as by numerous economists and other experts, over the accuracy of the numbers in the President's health reform proposal. In fact, the President is proposing that we not even count as part of our budget calculations the increased payroll taxes and the increased Government spending these taxes are designed to finance.

How can we possibly determine the overall cost impact of the proposal if we do not include under the Federal budgetary framework all the Federal mandated receipts and expenditures.

Our amendment would rectify this problem by requiring the Office of Management and Budget, the Congressional Budget Office, and the Joint Committee on Taxation, in scoring health reform proposals, to treat any taxes or premiums imposed on employers or other individuals as Federal receipts, and any expenditures resulting from such receipts as Federal outlays.

The President himself said yesterday in Statuary Hall that he wants a true accounting of the costs of his proposal, and this amendment would accomplish that objective.

Mr. Speaker, we believe it is essential that this language be included in the continuing resolution because this is the last legislative vehicle available to us prior to the commencement of analyses by these agencies of the President's proposal and other proposals. As I indicated, that is my one reason for deviating from the generally time-honored procedure that has been around here to keep continuing resolutions as clean as possible. But we are getting up to the end of the session, and it is my understanding that some of the hearings on the health proposal of the administration may very well be taking place during the period when Congress is in adjournment.

If we meet our adjournment date, as I hope we will for this session, a few days before Thanksgiving, and there is the entire month of December for whatever hearings may or may not be scheduled, I think we ought to be honoring this principle that I have embodied in my amendment.

Congress needs to establish a framework for these analyses, because we are talking about proposed changes that affect one-seventh of our economy and impact on every American.

□ 1120

The manner in which the analyses take place will have a key impact on the overall health care debate and, thus, should not be merely left up to the bureaucracy to determine.

I thus urge that we defeat the rule so that the Committee on Rules can immediately bring back a rule making this amendment in order. We have an obligation to assure the American people that an accurate and straightforward cost analysis will in fact take place.

Mr. Speaker, I thank the distinguished gentleman from Florida for yielding time to me that we might make these remarks. Hopefully, they will be persuasive enough to provoke a negative vote on the rule.

Mr. MOAKLEY. Mr. Speaker, I yield 4 minutes to the honorable gentleman from Minnesota [Mr. SABO], chairman of the Committee on the Budget.

Mr. SABO. Mr. Speaker, I thank the chairman of the Committee on Rules for yielding time to me.

I would just simply like to indicate that I think that the chairman of the Committee on Rules made a compelling argument, as he made his presentation of this rule and why we should not deal with the question of scoring of health care at this point.

Clearly, it is premature. The Congress, all the committees involved are going to have extensive hearings on health care legislation, how it is financed. The numbers will all be before us.

Mr. Speaker, I would go one step further and speak to the substance of the argument that is being made today. Somehow it is being argued that the health insurance premiums paid by private employers in this country should be counted as part of the Federal budget. I, frankly, think that is nuts. They pay health insurance premiums today. They will continue to pay health insurance premiums under the Clinton plan. Those are clearly private expenditures, not public expenditures.

There are certain portions of the health care plan that clearly are within the Federal budget. Those payments made to cost share with small business, to cost share with other people of low income so that they can have access to this health care plan clearly are public expenditures. They need to be clearly

defined. They need to be clearly understood. And those clearly will be in the Federal budget. But to somehow suggest that those premiums which are fundamentally, today, paid by private employers will continue to be paid by private employers, is somehow part of the Federal budget, in my judgment, simply makes no sense.

I commend the chairman of the Committee on Rules for not dealing with that issue at this point. It clearly is premature, plus, I would add, I think also a suggestion that is simply wrong.

Mr. GOSS. Mr. Speaker, I yield 4 minutes to the gentleman from New York [Mr. SOLOMON], the distinguished ranking member of the Committee on Rules.

Mr. SOLOMON. Mr. Speaker, I do not support continuing resolutions and today is just one more vindication of my position. This is the third so-called CR we have had for fiscal year 1994, and this one will fund the Government through November 10—some 41 days into the new fiscal year.

The very term "continuing resolution" is a misnomer because CR's don't resolve anything. They should really be called continuing irresolutions since they are damning evidence of our lack of resolve to finish our work on time around here.

My colleagues will recall that a week ago, when we granted a second CR for 1 week, the House promptly adjourned for 4 days—hardly an action designed to keep the appropriators' noses to the grindstone.

And just as sure as I am standing here, that is what we will do again, as soon as the CR is passed—take another break—this time for 5 days—during which nothing will be done to complete our work.

Mr. Speaker, we have our own perverse version of Parkinson's Law around here. Instead of work expanding to fill the time allowed to complete it, here in Congress work is delayed for the amount of time extended to complete it.

The gentleman from Wisconsin [Mr. OBEY] testified before the Rules Committee and proposed that we omit one of the appropriations bills from coverage under the CR—a bill that is now the subject of some extended debate in the other body.

I would suggest that rather than selectively shutting down one department, we should just say no to another CR. Nothing focuses the attention of our two great bodies more than a government shutdown; nothing forces cloture faster than a threatened Government closure.

Mr. Speaker, I realize that the fix is probably in on this CR, and it will probably pass, notwithstanding my persuasive arguments to the contrary.

If that is the case, let us at least use this opportunity for the kind of constructive purpose recommended to the Rules Committee by our Republican leader, the gentleman from Illinois [Mr. MICHEL] and the gentleman from Ohio [Mr. HOBSON].

What they have proposed is a truth in budgeting amendment to the CR for the health care legislation submitted to us yesterday by the administration.

Under the Michel-Hobson amendment submitted to the Rules Committee, OMB, CBO, and the Joint Tax Committee would all be required to use the same scorekeeping respecting any health care proposal, such as the administration's Health Security Act.

The Michel-Hobson amendment would ensure that we deal with that reality up front as an actual matter of Government taxes and spending, which it is. Right now, everybody is throwing around different numbers and speaking in mixed, if not forked, tongues.

If we do not start talking the same language from the beginning, we will all soon find ourselves wandering around lost in fantasyland. That doesn't bode well for dealing with the real health care problems of the American people.

In conclusion, Mr. Speaker, I urge my colleagues to vote down this rule so that the Rules Committee can report back a truth-in-budgeting amendment for the health care plan. Failing that, I urge defeat of the CR.

That scorekeeping would specifically treat any obligations, payroll tax, assessment, premium, or fee required of an employer or other individual as a Federal receipt, and any related expenditure as a Federal outlay.

Mr. Speaker, that makes eminent good sense, especially when you consider that the administration is talking about keeping their entire health plan off budget to hide its true costs, and that means uncontrolled taxing and spending and regulating without Congress having anything to say about it all.

Putting it off budget is not going to make the real costs of the plan go away. It is like trying to hide an elephant under a peanut shell. You can pretend you do not see it and it is not really there. But eventually you are going to have to face up to its reality and deal with it.

Mr. MOAKLEY. Mr. Speaker, I yield 1 minute to the gentleman from Minnesota [Mr. SABO], chairman of the Committee on the Budget.

Mr. SABO. Mr. Speaker, let us be clear about one thing: Direct Federal expenditures paid by the Federal Government to States, alliances, or whatever mechanism will be created to handle health care, are on the Federal budget. That is clear.

Private premiums are not. They are not today, and they should not be under the proposed health plan.

Mr. SOLOMON. Mr. Speaker, will the gentleman yield?

Mr. SABO. I yield to the gentleman from New York.

Mr. SOLOMON. Mr. Speaker, I have had extensive conversations with Members on both sides of the aisle. They are concerned that these new alliances are going to be given the right to borrow money without our approval, to raise fees without our approval. We cannot abdicate our responsibilities like that.

Mr. SABO. Mr. Speaker, I would suggest to the gentleman from New York that those are legitimate items to talk about, debate, but they are not Federal expenditures.

□ 1130

Mr. GOSS, Mr. Speaker, I yield 1 minute to the distinguished gentleman from Illinois [Mr. HASTERT].

Mr. HASTERT. Mr. Speaker, I rise today to call on my colleagues to defeat this rule so that Congress can have the opportunity to vote on the health reform cost credibility amendment. This amendment ensures all Americans that Congress will not try to hide the taxes or penalties that are needed to make the President's plan work.

Congress received President Clinton's health plan yesterday. But before we begin consideration of the plan, it is essential that American families and businesses know that the debate will be on an open and honest basis.

Americans need health care reform. But Americans also need a true and honest accounting of the various health care proposals. Congress must pass an amendment that ensures that no accounting gimmicks or phony financing is used in the health care debate and thus, I ask my colleagues to defeat this rule.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Ohio [Mr. HOBSON], who was the spokesperson for this proposed amendment yesterday.

Mr. HOBSON. Mr. Speaker, I rise to express my opposition to the rule. Yesterday, I went before the Rules Committee and asked the panel to make in order an amendment to set guidelines for how the CBO and OMB would score the President's health care reform bill.

The amendment was rejected.

Yet we need to make sure that the cost of the Clinton health plan is accurately depicted to the American people. Without a clear and complete understanding of those costs, their uncertainty will dominate the health care debate, not the merits of health care reform.

This continuing resolution offers the last legislative vehicle available for requiring that the cost analysis of the President's health reform plan is performed in a fair and accurate manner.

Mr. Speaker, this health care debate is too important to the American people to have it sidetracked by questions of phony numbers.

Mr. SABO. Mr. Speaker, will the gentleman yield?

Mr. HOBSON. I yield to the gentleman from Minnesota.

Mr. SABO. Mr. Speaker, I would just like to indicate to the gentleman that I have no interest in phony numbers. I think the numbers have to be thoroughly analyzed. They need to be scrutinized. We have to make sure they are right.

A significant part of the funding of health care today is private premiums paid for health care. The biggest part of the payment for the new plan will continue to be private premiums paid for health coverage. Those are not Federal expenditures.

Mr. HOBSON. Mr. Speaker, I would say to the gentleman, we have changed the manner in which that is done.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas [Mr. ARMEY], the conference chairman of the Republican Party.

Mr. ARMEY. Mr. Speaker, what is at issue here is whether or not the minority party will be allowed to put in place for consideration an amendment to the proposed rule. The rules of this House under which a bill is taken under consideration are defined by the Committee on Rules, which has nine Democrats and four Republicans. As we all too well know, those nine Democrats can, by themselves, determine what the rule will be.

Mr. Speaker, what we are saying is let us offer here an amendment that clarifies the language by which we keep track of the Nation's business: Will a tax be called a tax, or will it be called something other? Will it be disclosed to the American people, or will it be hidden?

Especially, as this is taken in consideration of the pending legislation that may, if passed into law, create a new government-controlled health care plan that will be the largest entitlement plan in the history of this Nation, will we call expenditures under this expenditures, account for them in the budget? Will we call taxes levied to finance this taxes, counted in the budget, for will we not?

The President called on the Republicans yesterday for bipartisan participation. The Democrat leadership said they hoped there would be bipartisan participation. The Republicans are trying to participate. We are trying to get the nine-member panel dictators of the Committee on Rules from the Democrat side of the aisle to allow us to offer for consideration, for debate, and for a vote by the entire Congress of the United States this one amendment that will address this critical issue: Will the Congress of the United States deal honestly or deceptively, as they report to the American people what is the business of the American people conducted with the incomes of the American people?

Here is our chance. Do we vote for honesty, or do we vote for deceptive government practices?

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Pennsylvania [Mr. WALKER].

Mr. WALKER. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I have two problems with this rule and with this continuing resolution. The first problem is that we are dealing with a continuing resolution, period. The Democrats promised at the beginning of this session of Congress that, if given the majority in the House and the majority in the Senate and the White House, they would be able to govern. What we now find is that they cannot govern. There is no gridlock in this particular issue because of anything the minority party has caused. It is simply an inability of the Democrats to get their work done.

As a result, the legislative schedule is getting further and further behind. We are incapable of accomplishing the things we need to do as a Nation, and the Democrats seem incapable of even managing this place in a way that allows us to do the basic business.

Given that situation, we now have a whole new wave of legislation coming on the Hill called health care. Republicans are saying there are very few vehicles, given the Democrat mismanagement, on which we have a chance to assure that we get real numbers.

The chairman of the committee on the Senate side that will handle much of the health care package has called the President's numbers in his original proposal a fantasy. We have decided that the numbers that we operate under in the House ought not to be fantasyland figures. The only way we have to assure that we do not deal with fantasyland figures is to get an amendment such as that which the minority leader sought to offer.

All we asked the Committee on Rules to do in this particular bill was to give us the legislative vehicle to assure that, as the House begins consideration of health care, that we do not deal with fantasyland numbers. Instead, the Committee on Rules has come forward with a rule that will assure that we will have no such vehicle to deal with that issue, and that in the end, that we will be dealing with kind of Alice in Wonderland, fantasyland and all kinds of deceptive and phony numbers. We cannot afford to do that as a Nation.

If we want to assure that we both break the gridlock on continuing resolutions and deal with real numbers in health care, we ought to vote no on the rule.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from the other great Commonwealth, the gentleman from Virginia [Mr. BLILEY].

Mr. BLILEY. Mr. Speaker, the budget is the process by which Congress and the President allocate scarce resources among competing public priorities. The administration's health care proposal will have the Federal Government reallocating hundreds of billions of dollars, or approximately 14 percent of the economy. If allowed to do so off-budget, Congress and the public will be deprived of the essential measurement of the fiscal and economic impact of these policy decisions.

This is a critical issue, because the administration's reform proposal calls the employer's payroll tax a nonfederal private transaction. Although universal coverage is popular, taxes are not, and so the administration is attempting to characterize a mandatory tax and a large Federal regulatory activity as private transactions.

I strongly disagree. When legislation invokes the sovereign power of the Government to compel the payment of funds, defines a class of beneficiaries, guarantees specific benefits, and establishes a Federal regulatory apparatus, that legislation has created a Federal activity financed by a Federal tax.

But rather than debate what is a tax or a Federal activity, let us look at legislation enacted last year under Senator ROCKEFELLER's leadership in the Senate Finance Committee, when Mr. Bentsen was the chairman. The law is the United Mine Workers of America [UMWA] health benefit plan, which addresses the financing of health benefits for UMWA retired coal workers.

To help compare the structure of the UMWA health benefit plan the alliance structure under the President's bill, we will use these two charts. First, the law mandates the coal operators make mandatory, annual premium contributions to the combined benefit fund, which is specifically characterized as a private plan. No premium contributions are ever transferred to the Federal Government. The combined fund is managed by a board of trustees made up exclusively of private individuals. The class of eligible individuals is specified in statute. The health care benefits are specified in statute. The first year premium is set in statute, and the law authorizes the Secretary of HHS to index the premium by the medical component of the CPI.

Now let us look briefly at the structural outlines of the administration's health care plan. We have federally mandated premium payments based on percentage of payroll. Additionally, we have Federal and State Medicaid and subsidy payments to the alliance. The alliance is managed by a State agency or nonprofit corporation. The class of eligible individuals will be specified in statute. The health care benefits will be specified in statute. The bill will set a method to determine the first year premium, and premiums are indexed by a consumer price index cap.

Now, in their key structural elements, the UMWA combined benefit fund and the administration's health reform proposal are indistinguishable.

Both bills attempt to characterize the premium contributions as a private transaction. Both have the transfer of moneys to the alliance rather than to the Federal Government. Both keep Federal officials off boards of trustees.

Since the combined benefit fund was enacted last year, there is one major difference—we do know how both CBO and OMB characterized it. And both CBO and OMB determined that since the statute invoked the sovereign power of the Federal Government to compel payments from coal operators, and since the statute defines benefits, the class of beneficiaries, and the premium levels, it is a Federal tax with both revenues and expenditures on-budget. This appears on P.1153 of the appendix of the Budget of the United States Government, fiscal year 1994. The Congressional Budget Office also characterizes the combined benefit fund as a tax, with both revenues and expenditures on-budget.

Clearly, the Congressional Budget Office and OMB will have no choice but to characterize the administration's payroll tax and bureaucracy as taxes and an on-budget Federal activity. To characterize the administration's proposal as off-budget would uphold a pretense that would lead to a serious erosion of fiscal discipline imposed by the budget and the budget process.

Mr. Speaker, can we distinguish any difference between the financing and operational processes of the coal miner's fund and the President's proposal? If the UMWA health benefits fund is on-budget as a tax, how can the employer payroll tax in the President's plan not be included in the Federal budget as a tax?

Mr. Speaker, I include for the RECORD a chart on the coal miner's fund and a comparison with the administration plan:

[Charts not reproducible in the RECORD.]

□ 1140

Mr. GOSS. Mr. Speaker, I yield 1 minute to my distinguished colleague and friend, the gentleman from Wyoming [Mr. THOMAS].

Mr. THOMAS of Wyoming. Mr. Speaker, I am just a little late in my response to the gentleman who spoke earlier about the grazing fees and the proposition that is going on in the Senate. I could not help but rise to comment on the hypocrisy of that.

We have chairmen in this place who wrote letters about the rules, who say we should not put legislation on appropriations. The rules in the Senate are such that they can have this kind of a process, and yet he complains about it. It seems to me that what we really had here was an addition of 19 pages of statute on an appropriation bill, and frankly, I hope that that does not continue. And I hope that they use the rules as we have all agreed to.

If the rules are not proper, we ought to change the rules. If the rule is improper for legislating on an appropriation, we ought not to do that.

It is a little hypocrisy when we say that is the rule and we do not want to do it, except if you like it. Then you do it. And I could not help but raise an objection to that kind of a concept. And I appreciate the gentleman yielding me the time.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the gentleman from Indiana [Mr. BURTON].

Mr. BURTON of Indiana. Mr. Speaker, I thank the gentleman for yielding the time.

Mr. Speaker, it is extremely important that we pass the Michel amendment and the rule that is being proposed will not allow it to take place. What does that mean to the American people?

It means that business can have their fees increased without any control. It is like a tax increase. Individuals can have fees increased, and they will not have any way of controlling it.

It is absolutely essential that we do this.

Let me give a little bit of historical background. When Medicare was passed in 1965 it was supposed to cost $9 billion, and yet in 1990 it was $106 billion. When Medicaid was passed in 1965 it was supposed to cost $1 billion, and last year it was $76 billion. Clinton's health care proposal is supposed to cost $331 billion. Now put a pencil to that and you will see how it will cost down the road. Maybe trillions of dollars.

We have to have some controls on spending and some accountability, and without the Michel amendment that will not be possible. And the Rules Committee should be taken to task for bringing us another closed rule. And that is one of the things that I have been fighting week in and week out, month in and month out.

Let us have some accountability. Let us have some fairness. Let the Republicans at least have a say.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Illinois [Mr. PORTER].

Mr. PORTER. Mr. Speaker, I thank my distinguished colleague for yielding me the time.

Mr. Speaker, over 1 month ago we enacted our first continuing resolution—it was necessary, we said, to give the Congress a few extra weeks to finish up its business. Reluctantly, this body went along.

After the 3 weeks had run out, we came back last week with our second CR. Unfortunately, we said, we could not quite get our work done and we needed yet another week.

Now we are here again, a full month into the fiscal year, with another CR to extend the Government again for another 2 weeks.

Mr. Speaker, there is a lesson in this, and it is a very simple lesson—CR's are addictive. Once you take one, you're hooked—they're too easy, too painless. They remove the pain of public condemnation for this Government failing to do its work on time. They are easy to pass because all they do is continue the status quo.

But like most addictive things, CR's are also extremely destructive.

They are destructive of change. This CR, in particular, will allow the Senate to continue its filibuster on grazing fees—to continue to block the wishes of the American people, the President, and this body that an unjustified and unnecessary subsidy be terminated.

CR's are destructive to good government. They wholly undermine the ability of Government to plan in anything remotely resembling a long-range manner. With this CR, some agencies of Government will operate for one-tenth of an entire year on a temporary, contingent basis. They are stuck in a holding pattern. That is wrong, that is inherently contrary to the effort to reinvent Government—to encourage sensible longer range budgeting and planning.

Mr. Speaker, CR's are also destructive in a subtle way to this Government's status. We have come under unprecedented condemnation by the American people. Condemnation for our inefficiency, condemnation for promoting gridlock, condemnation for our basic sloppiness in running our own affairs. This CR reinforces that judgment—it lends fuel to the fire of public opinion that is rapidly destroying the faith of Americans in their institutions of government.

Finally, Mr. Speaker, this CR is destructive to the President himself and the goals he seeks to accomplish. And I would urge the majority party to reflect carefully on this thought.

Our President has many things that he wishes to do, and he has claimed no higher priority than health care reform. But consider for a moment what this CR—and the ones that have preceded it—have done to the prospects for his top priority.

First, his budget was very, very late. When Congress finally completed action on it, the appropriations bills were naturally delayed. Now, some appropriations bills are extremely late. The President has been forced to devote huge amounts of time and attention to the budget as it ran off track and off schedule. The result for him was that he had to divert resources and attention from his health care bill, and delay its introduction. He gave a speech on health care 1 month ago, but we did not get the bill until yesterday, and it is still filled with many unanswered questions. Now, as Halloween, Thanksgiving, and adjournment loom, it is clear that the budget process has eaten the calendar—there will be no action on health care this year. Dealing with it next year, in 1 year, will be difficult and perhaps impossible.

In sum, the President's own top priority has been undermined because the budget process was allowed to ignore the calendar—the law that says it shall be done on time.

Mr. Speaker, we should not allow this and we do not have to let it happen. For today, the answer is to defeat this CR. For next year, the President must take a leadership role. He must—as President Clinton did at my request—insist that he wants a budget resolution on time, a reconciliation bill on time, and 13 separate spending bills on time. He must hold this body's feet to the fire on this issue, and we must kick the habit and allow no more CR's in this administration.

This Mr. Speaker, is the essence of good government. It is the definition of our fundamental responsibility to the American people, and it is high time this body did something to demonstrate that we are, in fact, responsible.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to my distinguished colleague, the gentleman from California [Mr. DREIER], a member of the Committee on Rules who is hardworking, and a brilliant spokesman for the cause.

Mr. DREIER. Mr. Speaker, I thank the extraordinarily adroit floor manager of this rule for yielding me this time, the very incisive gentleman from Sanibel.

As I look over here under the painting of Lafayette, I see the distinguished chairman of the Committee on Appropriations. And it is very sad that we have to proceed with a process that he strongly opposes.

As has been said, we are on the fourth continuing resolution. This is designed to go to November 10.

This is not the proper procedure. The gentleman from Kentucky [Mr. NATCHER] regularly says that he wants to see us proceed under the standard budget procedures of this House, but tragically, tragically we are not doing it with these continuing resolutions.

Now we have made a determination on our side that as we have looked at the fact that we are going ahead with a continuing resolution, we should seize this one opportunity to bring about a modicum of accountability into this process. And that is exactly what our distinguished Republican leader [Mr. MICHEL] and our colleague, the gentleman from Ohio [Mr. HOBSON] are trying to do by forcing us to account for what will be, as the gentleman from Virginia [Mr. BLILEY] said, 14 percent of the gross domestic product here. And that is this health care measure that is under consideration.

I say what we should do is defeat this rule. Let us come back with a package, if we are going to consider a continuing resolution, that at least allows the Republican leader to have his day in court so that this institution can finally be accountable to the people who sent us here.

Mr. GOSS. Mr. Speaker, I yield the balance of our time, 2 minutes, to the distinguished gentleman from Georgia [Mr. GINGRICH], the minority whip.

Mr. GINGRICH. Mr. Speaker, I thank my friend from Florida for yielding me the time. I rise to urge a no vote in order to make the point that the Michel-Hobson amendment should be made in order.

Every Member of our body and every American should understand what the purpose is of the Michel-Hobson amendment which is entitled "The Health Reform Cost Credibility Amendment."

□ 1150

Now, it is based on a very simple premise. If the Government requires you to pay it, if the Government is going to make you take it out of your wallet, if the Government is going to ensure that the money is gone from your choice, if the Government is going to control the expenditure of your money, that is called a tax.

And every time we have had a tax of that kind, we have called it a tax. There is a serious effort under way to disguise the way in which the Clinton health plan creates a massive tax on every working American. And I think it is very, very important that we adopt the Michel-Hobson amendment, which would require budget scorekeeping be honest about taxation. It says something very simple: "(1) any obligation, payroll tax, assessment, premium or fee required of an employer (which may be treated as an ordinary and necessary business expense) or of any other individual and which is to be paid to a particular entity and required to be established pursuant to federal law shall be treated as a federal receipt;"

Now, what that means in everyday ordinary language is if the Government is going to make you pay it, it is a tax, by definition.

There is a grave danger that if we leave this fall without having instructed these bodies to be honest and candid about this tax, that there will be an effort made in Washington to disguise for the American people what is being done.

So I urge my colleagues, vote "no;" give us a chance to offer the Michel-Hobson amendment. Let us be honest with the American people and let us have a health reform cost credibility amendment which makes clear when something is a tax it ought to be scored as a tax. I think it is vital that we pass this.

Mr. MOAKLEY. Mr. Speaker, to close debate for this side, I yield such time as he may consume to the gentleman from Minnesota [Mr. SABO], chairman of the Committee on the Budget.

Mr. SABO. I thank the chairman for yielding to me.

Mr. Speaker, let us be clear about a couple of things. The debate here, what we have before us, is a rule for the CR. Much of the debate is unrelated to that. I hope people will vote "yes" on that.

Let us deal with the side issue. Let us be clear: The issue is not about honesty and these other adjectives being used. Clearly, we are going to have full debate, full discussion on the merits, the demerits, of the President's health care program. We will have full debate on how it is paid for, between private premiums, between public expenditures, how we control costs, how we provide security to the American people, how we go about the process of providing for universal coverage in this country.

Clearly, that debate has to occur. Projections both for the current years and future years is part of the legitimate debate without being told that some of this is a dishonest plan.

It is an honest plan. We will now examine that through the congressional process. But what folks would like to do is all of a sudden change the description of a tax. All of a sudden, premiums paid by individuals or companies should be called a tax. That clearly is wrong. That are not tax today, they will not be a tax tomorrow.

Mr. GINGRICH. Mr. Speaker, will my friend yield?

Mr. SABO. I would be happy to yield to the gentleman from Georgia.

Mr. GINGRICH. I thank the gentleman for yielding.

The only point I am making, I think Mr. MICHEL and Mr. HOBSON are making, is that if the Government requires you to pay it, it is no longer a voluntary private premium, and we think—I do not think this is a minor thing.

Mr. SABO. I would tell the gentleman in my State, my State requires me to have auto insurance. They do not call that a tax. It is a premium I pay for my auto insurance.

So I would just say to the gentleman from Georgia, I am sure he and I probably disagree on how we should deal with the question of health care reform in this country. That is appropriate. We can debate those conflicting philosophies and conflicting approaches. But let us not start by saying that things are dishonest. That is not the case. We need to debate the pros and cons of the various cost factors in the various programs, their impact on reducing health care cost growth in this country. Those are legitimate debates.

But this early start by saying things are dishonest does a disservice to honest debate on the issue. And somehow to say that we now should change the description of a tax in this country so that private premiums are considered taxes, I frankly think, is simply wrong.

Mr. SOLOMON. Mr. Speaker, will the gentleman yield?

Mr. SABO. I would be glad to yield to the gentleman from New York.

Mr. SOLOMON. I thank the gentleman for yielding.

Mr. Speaker, this really is not a question of saying something is dishonest.

Mr. SABO. Well, I do not think so, but that is what I was hearing in the rhetoric this morning.

Mr. SOLOMON. It is a question of clarity. Even the Senator from my State, whom you all know, Senator MOYNIHAN, said those figures were all fantasy. So what we are looking for is clarity so the American people can understand and so you and I can understand, that is all.

Mr. SABO. I would respond to my friend from New York, his comments have nothing to do with the proposal that was before the Rules Committee. I think his concern was whether you could actually do Medicare, Medicaid cuts as proposed by the President. That is legitimate debate. It may or may not be. We will have hearings to find out whether those numbers are actual, can they actually be achieved.

Mr. SOLOMON. I would say to the gentleman that he is right, and that is the debate that we should have, but we are being deprived of it. The gentleman has talked about mandates on insurance in his State. That is a State mandate, not a Federal mandate. We are talking about Federal mandates.

Mr. SABO. I would say to the gentleman that the kind of debate on whether the numbers are accurate, those are legitimate debates. The administration begins with what they believe are honest numbers; clearly part of the legislative process is to examine those assumptions.

That process now starts. But that has nothing to do with all of a sudden changing it so that now we are going to say that private health insurance premiums are Federal taxes.

Mr. SOLOMON. The gentleman knows the bill is going to have some single taxpayer provision in there. We know that the second step after this foot-in-the-door is going to be a single-payer tax on all of the American people. That is why we have to be so careful with what we do right now. Let us have the debate on the floor, let us defeat the rule.

Mr. SABO. This is not the time to debate health care. That will occur. The numbers will be examined by a variety of committees. But changing the description of private health insurance premiums to a tax makes utterly no sense.

Mr. MOAKLEY. Mr. Speaker, I have no further requests for time, and I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore (Mr. TORRES). The question is on the resolution.

The question was taken, and the Speaker pro tempore announced that the noes appeared to have it.

Mr. MOAKLEY. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 252, nays 170, not voting 11, as follows:

[Roll No. 535]

YEAS—252

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barcia
Barlow
Barrett (WI)
Becerra
Beilenson
Bevill
Bilbray
Bishop
Blackwell
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Byrne
Cantwell
Carr
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (IL)
Collins (MI)
Condit
Conyers
Cooper
Coppersmith
Costello
Coyne
Cramer
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
Dellums
Derrick
Deutsch
Dicks
Dingell
Dixon
Dooley
Durbin
Edwards (CA)
Edwards (TX)
Engel
English (AZ)
English (OK)
Eshoo
Evans
Farr
Fazio
Fields (LA)
Filner
Fingerhut
Flake
Foglietta
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Glickman
Gonzalez
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Harman
Hastings
Hayes
Hefner
Hilliard
Hinchey
Hoagland
Hochbrueckner
Holden
Hoyer
Hughes
Hutto
Inslee
Jefferson
Johnson (GA)
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy
Kennelly
Kildee
Kleczka
Klein
Klink
Kopetski
Kreidler
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lehman
Levin
Lewis (GA)
Lipinski
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCurdy
McDermott
McHale
McKinney
McNulty
Meehan
Meek
Menendez
Mfume
Miller (CA)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Murphy
Murtha
Nadler
Natcher
Neal (MA)
Neal (NC)
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Parker
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Pickett
Pickle
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reed
Reynolds
Richardson
Roemer
Rose
Rostenkowski
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Sarpalius
Sawyer
Schenk
Schroeder
Schumer
Scott
Serrano
Sharp
Shepherd
Sisisky
Skaggs
Skelton
Slattery
Slaughter
Smith (IA)
Spratt
Stark
Stenholm
Stokes
Strickland
Studds
Stupak
Swett
Swift
Synar
Tanner
Taylor (MS)
Tejeda
Thompson
Thornton
Thurman
Torres
Torricelli
Traficant
Tucker
Unsoeld
Valentine
Velazquez
Vento
Visclosky
Volkmer
Washington
Waters
Watt
Waxman
Wheat
Whitten
Williams
Wilson
Wise
Woolsey
Wyden
Wynn
Yates

NAYS—170

Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)
Ballenger
Barrett (NE)
Bartlett
Barton
Bateman
Bentley
Bereuter
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Coble
Collins (GA)
Combest
Crane
Crapo
Cunningham
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Emerson
Everett
Ewing
Fawell
Fields (TX)
Fish
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gallo
Gekas
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Grams
Grandy
Greenwood
Gunderson
Hancock
Hansen
Hastert
Hefley
Herger
Hobson
Hoekstra
Hoke
Horn
Houghton
Huffington
Hunter
Hutchinson
Hyde
Inglis
Inhofe
Istook
Jacobs
Johnson (CT)
Johnson, Sam
Kasich
Kim
King
Kingston
Klug
Knollenberg
Kolbe
Kyl
Lazio
Leach
Levy
Lewis (CA)
Lewis (FL)
Lightfoot
Linder
Livingston
Machtley
Manzullo
McCandless
McCollum
McCrery
McDade
McHugh
McInnis
McKeon
McMillan
Meyers
Mica
Michel
Miller (FL)
Molinari
Moorhead
Morella
Myers
Nussle
Oxley
Packard
Paxon
Petri
Pombo
Porter
Portman
Pryce (OH)
Quillen
Quinn
Ramstad
Ravenel
Regula
Ridge
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Santorum
Saxton
Schaefer
Schiff
Sensenbrenner
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Snowe
Solomon
Spence
Stearns
Stump
Sundquist
Talent
Taylor (NC)
Thomas (CA)
Torkildsen
Upton
Vucanovich
Walker
Walsh
Weldon
Wolf
Young (FL)
Zeliff
Zimmer

NOT VOTING—11

Berman
Cardin
Clinger
Cox
McCloskey
Royce
Smith (OR)
Tauzin
Thomas (WY)
Towns
Young (AK)

□ 1219

The Clerk announced the following pair:

On the vote:

Mr. Berman for, with Mr. Smith of Oregon against.

Mr. CHAPMAN changed his vote from "nay" to "yea."

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

□ 1220

GENERAL LEAVE

Mr. NATCHER. Mr. Speaker, I ask unanimous consent that all Members

may have 5 legislative days in which to revise and extend their remarks on the consideration of House Joint Resolution 283, and that I may include tabular and extraneous material.

The SPEAKER pro tempore (Mr. TORRES). Is there objection to the gentleman from Kentucky?

There was no objection.

FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 1994

Mr. NATCHER. Mr. Speaker, pursuant to House Resolution 287, the rule just adopted, I call up the joint resolution (H.J. Res. 283) making further continuing appropriations for the fiscal year 1994, and for other purposes, and ask for its immediate consideration.

The Clerk read the joint resolution, as follows:

H.J. RES. 283

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That section 106(c) of Public Law 103-88, as amended by Public Law 103-113, is further amended by striking out "October 28, 1993" and inserting in lieu thereof "November 10, 1993".

The SPEAKER pro tempore. Pursuant to House Resolution 287, the gentleman from Kentucky [Mr. NATCHER] will be recognized for 30 minutes, and the gentleman from Pennsylvania [Mr. MCDADE] will be recognized for 30 minutes.

The Chair recognizes the gentleman from Kentucky [Mr. NATCHER].

Mr. NATCHER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, today we bring to the House an extension of the continuing resolution.

Last week when we brought out a 1-week extension to the initial continuing resolution, just 2 of our 13 regular appropriations bills had been signed into law. Now nine have been enacted. Two others, energy and water development and the District of Columbia, have been cleared for the President. Interior is pending in the Senate. Both the Defense authorization and appropriation bills are in conference.

Mr. Speaker, we have made good progress. But for one reason or another, we need another extension of the continuing resolution. It is apparent that action on the remaining appropriation bills will not be completed by midnight tonight, the expiration date of the continuing resolution.

To provide time for the Senate to complete action and for the President to review the bills and for conference action to proceed on the Defense bill, this further extension of the continuing resolution is necessary.

The resolution before the House simply extends the present continuing resolution until midnight, November 10. No extraneous provisions are included. This is a clean continuing resolution.

Mr. Speaker, we have continued to work hard, trying to get our conference reports on our appropriation bills adopted. I want all Members in the House to know that our committee appreciates their cooperation and assistance. We have almost completed our task.

Mr. Speaker, as you and I and other Members know, when the budget is submitted, we divide that budget into 13 parts. They are not equal money-wise. The largest bill money-wise, of course, is Defense. Next we have Labor, Health and Human Services, and Education. Hearings are held, markup decisions are made, we bring bills to the floor and the process continues until conference action is concluded on all 13 bills.

Mr. Speaker, we will have completed action on all appropriation bills now as far as this continuing resolution is concerned by midnight tonight, with the exception of the Interior and Defense bills. Programs in these bills will be the only ones funded by this continuing resolution. We will continue to work hard to get our remaining conference reports on these two appropriation bills adopted.

Mr. Speaker, I want all Members to know that I appreciate their cooperation. We have almost completed our task. This extension is absolutely necessary, and I urge its adoption.

Mr. Speaker, I reserve the balance of my time.

Mr. MCDADE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, as stated by the chairman, the distinguished gentleman from Kentucky, whom I am privileged to call my friend, while we are close to completing our work on the 13 annual appropriations bills, we are not quite there.

On the House side, what remains to be done is the Defense appropriations conference. As the Members know, our ability to act on that is dependent upon the Defense authorization bill conference, where our colleagues are meeting as we speak.

On the Senate side, there also remains the Interior appropriations conference report, which continues to be tied up due to a filibuster. That is again something over which our committee has no control.

Given this situation, and the fact that the current continuing resolution expires at midnight tonight, we are faced with a choice—extend the CR to allow completion of these two matters, or let the CR expire, and let the chips fall where they may.

Given that choice, I come down on the side of extending the CR, which is not a pleasant or popular course of action, but, in the final analysis, from my point of view the only choice.

There are few things that make the Congress look worse than getting into a situation leading to the shutdown of parts of the Government.

Even if the President were to exercise emergency powers to keep essential parts of unfunded Departments going, there is always a major degree of confusion accompanying the exercise of those powers, as well as nagging legal questions on the propriety of those powers.

Furthermore, since one of the Departments in question is Defense, there's a certain amount of risk in some kind of partial shutdown.

I will say that if the suggestion I made last week on consideration of the second CR had been adopted, which was to have provided an extra week, through November 5, for Defense to finish, we would not necessarily be in this situation.

Nonetheless, because of the situation we find ourselves in, I will support this simple extension of the continuing resolution through November 10.

Mr. Speaker, I reserve the balance of my time.

Mr. NATCHER. Mr. Speaker, I yield 3 minutes to the gentleman from Massachusetts [Mr. FRANK].

Mr. FRANK of Massachusetts. Mr. Speaker, I hope the continuing resolution is adopted. It is essential that no one who works for this Government or requires services in the Defense Department, the Interior Department, or elsewhere, be put in any jeopardy. It is important that we understand why we need a continuing resolution.

The gentleman from Pennsylvania [Mr. MCDADE] said earlier that he asked for an extra week for the Defense conference. Defense has been complicated by debates over some other issues. Unfortunately, even if we had done that, as the gentleman suggested, we would still have to be here.

Mr. Speaker, people should understand this, because there is a general interest in moving ahead. People do not like continuing resolutions. We have all resolved not to have them, and people should understand one of the reasons we have a continuing resolution is a filibuster in the Senate because people do not want to see higher grazing fees.

Mr. Speaker, that issue is not technically before us, but it is directly relevant to the issue of grazing fees. But it is relevant for people to understand that one reason we need a continuing resolution, and in fact we would have needed one even if we had acceded to the sensible suggestion of the gentleman from Pennsylvania [Mr. MCDADE], is that a minority of Members of the U.S. Senate believe that they have the right under the Senate rules to talk to death an effort to raise grazing fees.

Mr. Speaker, the majority in both Houses and the President of the United States are in favor of some increase in grazing fees. But under the rules that apply, if you do not get 60 of the 100 Senators to shut off debate, the bill cannot come to a vote. So we are here dealing with a continuing resolution in

substantial part because the minority of Senators are using the filibuster rule on behalf of higher grazing fees.

□ 1230

I would hope that this is the last time that the Congress would be forced into a continuing resolution because of that. I would hope that we would see changes in procedures. It certainly is hardly radical to suggest that majority rule ought to be the ultimate guide in the Congress of the United States, but we are here today dealing with the Interior Department not because of any failure here in the House, not because the subcommittee chairmen and the committee chairmen, who do excellent work, did not do their jobs, not because the conference committee could not come to an agreement. They did. But despite the agreement of the conference committee, the support of the majority and the support of the President, we cannot get a conference report adopted because the minority is allowed to talk and talk and talk and to prevent that vote.

That is not a situation that should be allowed to continue. I would hope we will not for much longer have to see the will of the President of the United States and majorities in both Houses frustrated by this kind of tactic.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. GLICKMAN). The Chair would remind Members of rule XIV of the House Rules on Decorum in Debate, that when Members discuss action or inaction of the other body relating to the pendency of a measure, it should be discussed in a factual way without characterizing the nature of those kinds of actions.

PARLIAMENTARY INQUIRY

Mr. FRANK of Massachusetts. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. FRANK of Massachusetts. Mr. Speaker, did anything in what I said violate that rule?

The SPEAKER pro tempore. When the gentleman referred to the other body, a few Members talking to death a proposal, the gentleman was characterizing, in the judgment of the Chair, the filibuster rules.

Mr. FRANK of Massachusetts. Mr. Speaker, further parliamentary inquiry, if I had said, if I had factually said, and I apologize for mentioning that the Senate was talking something to death, if I had simply said factually that a number of Senators, who happened to be in the minority, as a matter of fact, chose to talk and talk and talk with the purpose of preventing a vote, that would simply be factual. Would that be acceptable under the rules?

The SPEAKER pro tempore. The Chair does not have to rule hypothetically on the issue. The Chair wanted to bring the matter of the rule to Members' attention.

Mr. FRANK of Massachusetts. Mr. Speaker, I appreciate that the Chair need not rule hypothetically. I thought that the comment might have had something to do with what I said, but I will take into account the Chair's injunction. And when Senators are trying to talk and talk to prevent the bill from coming to a vote, because they would be outvoted, I will simply refer to that fact, and I will not characterize it according to any question about the principle of majority rule in the future.

The SPEAKER pro tempore. The Chair thanks the gentleman from Massachusetts for his understanding of the Chair's concern.

Mr. McDADE. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Delaware [Mr. CASTLE].

Mr. CASTLE. Mr. Speaker, I thank the gentleman for yielding time to me.

I would like to start by praising the chairman of the Committee on Appropriations and the ranking member. These are two men, in the few months I have been here in this Congress, who in my view have had in mind the idea that we need to pass our appropriations and we need to get them over to the Senate, to the White House and to get them done in a timely fashion.

Having said that, we still are passing, I guess, our third continuing resolution. By the time it is expired, we are going to be 6 weeks or so beyond the beginning of the fiscal year. It just introduces something that bothered me back before I came to Congress. And I think it bothers a lot of people in the United States of America, which is not really at fault here in the House of Representatives this year, which may be at fault in the Senate, may be at fault in the White House, but I think it is more at fault in the system which we use to go through our appropriation processes and our budget processes here in the Congress of the United States.

We seem to have no intention of being able to actually meet these deadlines or no definition that if that does not happen that it can bode ill to the United States of America.

We lack other processes I would like to see such as a balanced budget amendment, a line-item veto. I think it is very significant that we in this Congress of the United States concentrate on the fact that we are not passing our budget in time, that the continuing resolution is just that. It is not a final determination of what the expenditures are going to be.

We are already into the fiscal year. Decisions are being made. Planning cannot be carried out properly and appropriately. We have spent, I do not know what percentage of our time in this year on the appropriation and budget process, but it is a huge percentage of our time. Perhaps we can just take the whole schedule and move it up to an earlier time so that we can consider this in a timely fashion and, in the future, do what so many of the States and local governments do across the United States of America, make absolutely sure that when midnight tolls on the day a fiscal year begins that we have a budget in place.

We are soon going to have the opportunity to consider a reduction in the budget expenditures and even an amendment that will exceed that, which I hope will also be given full consideration by this body. If there is nothing else that we do in the course of a year, Mr. Speaker, I would hope that we develop a budget discipline and we develop a knowledge of what these programs are, what they mean to the United States of America, what they actually cost, how we reduce some of that cost and make the process of running this Federal Government more streamlined than it is today.

I agree with what I have heard today. We probably have no other choice to pass this. But I would hope in the future we will be able to avoid it.

Mr. FAZIO. Mr. Speaker, will the gentleman yield?

Mr. CASTLE. I yield to the gentleman from California.

Mr. FAZIO. Mr. Speaker, I appreciate the gentleman's point, and I am sure, as a Governor of a State that probably, if not always, had its budget passed on time, this may seem like an untidy process for him. But I did think it was important to point out that for the first time in many, many years, the outgoing President did not present the incoming President with a budget.

Now, even though their priorities may have differed on the margins, and we know when we are talking about budgets, it is always on the margins, we found that this President was required to build from the bottom up and, therefore, delay the introduction of his budget well beyond the February 1 deadline. I think that has contributed greatly to the delay that we are meeting today.

Mr. McDADE. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. NATCHER. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to House Resolution 287, the previous question is ordered on the joint resolution.

The question is on the engrossment and third reading of the joint resolution.

The joint resolution was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the joint resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. WALKER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 256, nays 157, not voting 20, as follows:

[Roll No. 536]

YEAS—256

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barcia
Barlow
Barrett (WI)
Bateman
Becerra
Beilenson
Bevill
Bilbray
Bishop
Blackwell
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Byrne
Cantwell
Carr
Chapman
Clayton
Clement
Clyburn
Coleman
Collins (IL)
Collins (MI)
Condit
Conyers
Cooper
Coppersmith
Coyne
Cramer
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
Dellums
Derrick
Deutsch
Dicks
Dingell
Dixon
Dooley
Durbin
Edwards (CA)
Edwards (TX)
Engel
English (AZ)
English (OK)
Eshoo
Evans
Farr
Fazio
Fields (LA)
Filner
Fingerhut
Flake
Foglietta
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Glickman
Gonzalez
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Harman
Hastings
Hayes
Hefner
Hilliard
Hinchey
Hoagland
Hochbrueckner
Holden
Hoyer
Hughes
Hutto
Inslee
Jefferson
Johnson (GA)
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kennedy
Kennelly
Kildee
Kleczka
Klein
Klink
Kopetski
Kreidler
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lehman
Levin
Lewis (GA)
Lipinski
Livingston
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCloskey
McCurdy
McDade
McDermott
McHale
McKinney
McNulty
Meehan
Meek
Menendez
Mfume
Miller (CA)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Morella
Murphy
Murtha
Myers
Nadler
Natcher
Neal (MA)
Neal (NC)
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Parker
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Pickle
Pomeroy
Price (NC)
Rahall
Rangel
Reed
Regula
Reynolds
Richardson
Roemer
Rogers
Rose
Rostenkowski
Rowland
Roybal-Allard
Sabo
Sanders
Sangmeister
Sarpalius
Sawyer
Schenk
Schiff
Schumer
Scott
Serrano
Sharp
Shepherd
Sisisky
Skaggs
Skeen
Skelton
Slattery
Slaughter
Smith (IA)
Smith (NJ)
Spratt
Stark
Stenholm
Stokes
Strickland
Studds
Stupak
Swett
Swift
Synar
Talent
Tanner
Taylor (MS)
Tejeda
Thompson
Thornton
Thurman
Torres
Torricelli
Traficant
Tucker
Unsoeld
Valentine
Velazquez
Vento
Visclosky
Volkmer
Washington
Waters
Watt
Waxman
Wheat
Whitten
Williams
Wilson
Wise
Wolf
Wyden
Wynn
Yates
Young (FL)

NAYS—157

Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)
Ballenger
Barrett (NE)
Bartlett
Barton
Bentley
Bereuter
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Coble
Collins (GA)
Combest
Costello
Crane
Crapo
Cunningham
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Emerson
Everett
Ewing
Fawell
Fields (TX)
Fish
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gallo
Gekas
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Grams
Grandy
Greenwood
Gunderson
Hancock
Hastert
Hefley
Herger
Hobson
Hoekstra
Hoke
Huffington
Hunter
Hutchinson
Hyde
Inglis
Inhofe
Istook
Jacobs
Johnson (CT)
Johnson, Sam
Kasich
Kim
King
Kingston
Klug
Knollenberg
Kolbe
Kyl
Lazio
Leach
Levy
Lewis (CA)
Lewis (FL)
Lightfoot
Linder
Manzullo
McCandless
McCollum
McCrery
McHugh
McInnis
McKeon
McMillan
Meyers
Mica
Michel
Miller (FL)
Molinari
Moorhead
Nussle
Packard
Paxon
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce (OH)
Quillen
Quinn
Ramstad
Ravenel
Ridge
Roberts
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Rush
Santorum
Saxton
Schaefer
Schroeder
Sensenbrenner
Shaw
Shays
Shuster
Smith (MI)
Smith (TX)
Snowe
Solomon
Spence
Stearns
Stump
Sundquist
Taylor (NC)
Thomas (CA)
Thomas (WY)
Torkildsen
Upton
Vucanovich
Walker
Walsh
Weldon
Zimmer

NOT VOTING—20

Berman
Cardin
Clay
Clinger
Cox
Hansen
Horn
Houghton
Kaptur
Machtley
Moran
Oxley
Peterson (MN)
Royce
Smith (OR)
Tauzin
Towns
Woolsey
Young (AK)
Zeliff

□ 1255

The Clerk announced the following pair:

On this vote:

Mr. Berman for, with Mr. Smith of Oregon against.

So the joint resolution was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. HOUGHTON. Mr. Speaker, I was unavoidably detained and did not vote on rollcall 536. Had I been present, I would have voted "aye."

PERSONAL EXPLANATION

Ms. WOOLSEY. Mr. Speaker, I was unavoidably detained in a committee hearing and missed rollcall vote 536, a vote on final passage for House Joint Resolution 283. Had I been present, I would have voted "aye."

LUMBEE RECOGNITION ACT

Mr. HALL of Ohio. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 286 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 286

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 1(b) of rule XXIII, declare the House resolved into the Committee of the Whole House on the State of the Union for consideration of the bill (H.R. 334) to provide for the recognition of the Lumbee Tribe of Cheraw Indians of North Carolina, and for other purposes. The first reading of the bill shall be dispensed with. Points of order against consideration of the bill for failure to comply with clause 2(1)(2)(B) of rule XI are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Natural Resources. After general debate the bill shall be considered for amendment under the five-minute rule. Each section shall be considered as read. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendment as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit.

The SPEAKER pro tempore (Mr. GLICKMAN). The gentleman from Ohio [Mr. HALL] is recognized for 1 hour.

Mr. HALL of Ohio. Mr. Speaker, I yield 30 minutes to the gentleman from Tennessee [Mr. QUILLEN], pending which I yield myself such time as I may consume. During consideration of this resolution, all time that is yielded is for the purpose of debate only.

Mr. Speaker, House Resolution 286 is an open rule providing for the consideration of H.R. 334, the Lumbee Recognition Act. The rule provides for 1 hour of general debate to be equally divided and controlled by the chairman and ranking minority member of the Committee on Natural Resources. The rule also waives all points of order against consideration of the bill for failure to comply with the provisions of clause 2(1)(2)(B) of rule XI, requiring the report to include the total number of votes cast for and against when reporting a measure by rollcall. Mr. Speaker,

this is a minor waiver to allow us to bring up the bill even though the roll-call was inadvertently omitted from the committee report.

Under the rule, the bill shall be considered for amendment under the 5-minute rule and each section shall be considered as having been read. Finally, the rule provides one motion to recommit.

Mr. Speaker, H.R. 334 is an important and long overdue bill which extends Federal recognition to the Lumbee Tribe of Cheraw Indians of North Carolina. Because the Lumbee Tribe has never received Federal recognition, the tribe and its members, are not eligible for services provided by the Bureau of Indian Affairs and the Indian Health Service. This bill simply provides that Federal laws and regulations generally applicable to Indian tribes will also apply to the Lumbee Tribe and its members. In addition, the Lumbee Tribe and its members will be eligible for the services and benefits provided to federally recognized tribes, when funds are specifically appropriated for this purpose.

Mr. Speaker, H.R. 334 is the result of hearings and many careful consultations. I am pleased that we have an open rule which was unanimously passed in the Rules Committee by a voice vote. I urge my colleagues to adopt it.

□ 1300

Mr. QUILLEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the gentleman from Ohio [Mr. HALL] has ably explained the provisions of the rule, and I support this rule. I am also a strong supporter of the Lumbee Indian Recognition Act.

Mr. Speaker, these native Americans have been denied the opportunity to apply for tribal recognition through the Bureau of Indian Affairs Federal acknowledgment process because of a provision included in a 1956 law. Some will argue that we should remove this ban rather than have the Congress grant tribal recognition. Well, Mr. Speaker, the Lumbee Indians have been waiting almost 40 years and the ban has not been removed. I do not think they should have to wait any longer.

Under this open rule, Members who have concerns over the provisions of this bill will have the opportunity to fully participate in the amendment process.

The Lumbee Indians are a group of some 40,000 native Americans. Why do we not recognize them? Recognition is long overdue.

Mr. Speaker, I handled the rule on the floor of the House in the last session, and we passed this measure overwhelmingly. But the Senate did not take it up. We are back again. I hope the House will again pass this bill.

Mr. Speaker, I urge support of the rule.

OPEN VERSUS RESTRICTIVE RULES 95TH–103D CONG.

Congress (years)	Total rules granted [1]	Open rules		Restrictive rules	
		Number	Percent [2]	Number	Percent [3]
95th (1977–78)	211	179	85	32	15
96th (1979–80)	214	161	75	53	25
97th (1981–82)	120	90	75	30	25
98th (1983–84)	155	105	68	50	32
99th (1985–86)	115	65	57	50	43
100th (1987–88)	123	66	54	57	46
101st (1989–90)	104	47	45	57	55
102d (1991–92)	109	37	34	72	66
103d (1993–94)	41	11	27	30	73

[1] Total rules counted are all order of business resolutions reported from the Rules Committee which provide for the initial consideration of legislation, except rules on appropriations bills which only waive points of order. Original jurisdiction measures reported as privileged are also not counted.

[2] Open rules are those which permit any Member to offer any germane amendment to a measure so long as it is otherwise in compliance with the rules of the House. The parenthetical percentages are open rules as a percent of total rules granted.

[3] Restrictive rules are those which limit the number of amendments which can be offered, and include so-called modified open and modified closed rules, as well as completely closed rule, and rules providing for consideration in the House as opposed to the Committee of the Whole. The parenthetical percentages are restrictive rules as a percent of total rules granted.

Sources "Rules Committee Calendars & Surveys of Activities," 95th–102d Cong.; "Notices of Action Taken," Committee on Rules, 103d Cong., through Oct. 27, 1993.

OPEN VERSUS RESTRICTIVE RULES: 103D CONG.

Rule number date and reported	Rule type	Bill number and subject	Amendments submitted	Amendments allowed	Disposition of rule and date
H. Res. 58, Feb. 2, 1993	MC	H.R. 1: Family and medical leave	30 (D–5; R–25)	3 (D–0; R–3)	PQ: 246–176. A: 259–164. (Feb. 3, 1993).
H. Res. 59, Feb. 3, 1993	MC	H.R. 2: National Voter Registration Act	19 (D–1; R–18)	1 (D–0; R–1)	PQ: 248–171. A: 249–170. (Feb. 4, 1993).
H. Res. 103, Feb. 23, 1993	C	H.R. 920: Unemployment compensation	7 (D–2; R–5)	0 (D–0; R–0)	PQ: 243–172. A: 237–178. (Feb. 24, 1993).
H. Res. 106, Mar. 2, 1993	MC	H.R. 20: Hatch Act amendments	9 (D–1; R–8)	3 (D–0; R–3)	PQ: 248–166. A: 249–163. (Mar. 3, 1993).
H. Res. 119, Mar. 9, 1993	MC	H.R. 4: NIH Revitalization Act of 1993	13 (d–4; R–9)	8 (D–3; R–5)	PQ: 247–170. A: 248–170. (Mar. 10, 1993).
H. Res. 132, Mar. 17, 1993	MC	H.R. 1335: Emergency supplemental Appropriations	37 (D–8; R–29)	1(not submitted) (D–1; R–0)	A: 240–185. (Mar. 18, 1993).
H. Res. 133, Mar. 17, 1993	MC	H. Con. Res. 64: Budget resolution	14 (D–2; R–12)	4 (1-D not submitted) (D–2; R–2)	PQ: 250–172. A: 251–172. (Mar. 18, 1993).
H. Res. 138, Mar. 23, 1993	MC	H.R. 670: Family planning amendments	20 (D–8; R–12)	9 (D–4; R–5)	PQ: 252–164. A: 247–169. (Mar. 24, 1993).
H. Res. 147, Mar. 31, 1993	C	H.R. 1430: Increase Public debt limit	6 (D–1; R–5)	0 (D–0; R–0)	PQ: 244–168. A: 242–170. (Apr. 1, 1993).
H. Res. 149 Apr. 1, 1993	MC	H.R. 1578: Expedited Rescission Act of 1993	8 (D–1; R–7)	3 (D–1; R–2)	A: 212–208. (Apr. 28, 1993).
H. Res. 164, May 4, 1993	O	H.R. 820: Nate Competitiveness Act	NA	NA	A: Voice Vote. (May 5, 1993).
H. Res. 171, May 18, 1993	O	H.R. 873: Gallatin Range Act of 1993	NA	NA	A: Voice Vote. (May 20, 1993).
H. Res. 172, May 18, 1993	O	H.R. 1159: Passenger Vessel Safety Act	NA	NA	A: 308–0 (May 24, 1993).
H. Res. 173 May 18, 1993	MC	S.J. Res. 45: United States forces in Somalia	6 (D–1; R–5)	6 (D–1; R–5)	A: Voice Vote (May 20, 1993)
H. Res. 183, May 25, 1993	O	H.R. 2244: 2d supplemental appropriations	NA	NA	A: 251–174. (May 26, 1993).
H. Res. 186, May 27, 1993	MC	H.R. 2264: Omnibus budget reconciliation	51 (D–19; R–32)	8 (D–7; R–1)	PQ: 252–178. A: 236–194 (May 27, 1993).
H. Res. 192, June 9, 1993	MC	H.R. 2348: Legislative branch appropriations	50 (D–6; R–44)	6 (D–3; R–3)	PQ: 240–177. A: 226–185. (June 10, 1993).
H. Res. 193, June 10, 1993	O	H.R. 2200: NASA authorization	NA	NA	A: Voice Vote. (June 14, 1993).
H. Res. 195, June 14, 1993	MC	H.R. 5: Striker replacement	7 (D–4; R–3)	2 (D–1; R–1)	A: 244–176.. (June 15, 1993).
H. Res. 197, June 15, 1993	MO	H.R. 2333: State Department. H.R. 2404: Foreign aid	53 (D–20; R–33)	27 (D–12; R–15)	A: 294–129. (June 16, 1993).
H. Res. 199, June 16, 1993	C	H.R. 1876: Ext. of "Fast Track"	NA	NA	A: Voice Vote. (June 22, 1993).
H. Res. 200, June 16, 1993	MC	H.R. 2295: Foreign operations appropriations	33 (D–11; R–22)	5 (D–1; R–4)	A: 263–160. (June 17, 1993).
H. Res. 201, June 17, 1993	O	H.R. 2403: Treasury-postal appropriations	NA	NA	A: Voice Vote. (June 17, 1993).
H. Res. 203, June 22, 1993	MO	H.R. 2445: Energy and Water appropriations	NA	NA	A: Voice Vote. (June 23, 1993).
H. Res. 206, June 23, 1993	O	H.R. 2150: Coast Guard authorization	NA	NA	A: 401–0. (July 30, 1993).
H. Res. 217, July 14, 1993	MO	H.R. 2010: National Service Trust Act	NA	NA	A: 261–164. (July 21, 1993).
H. Res. 218, July 20, 1993	O	H.R. 2530: BLM authorization, fiscal year 1994–95	NA	NA	
H. Res. 220, July 21, 1993	MC	H.R. 2667: Disaster assistance supplemental	14 (D–8; R–6)	2 (D–2; R–0)	PQ: 245–178. F: 205–216. (July 22, 1993).
H. Res. 226, July 23, 1993	MC	H.R. 2667: Disaster assistance supplemental	15 (D–8; R–7)	2 (D–2; R–0)	A: 224–205. (July 27, 1993).
H. Res. 229, July 28, 1993	MO	H.R. 2330: Intelligence Authority Act, fiscal year 1994	NA	NA	A: Voice Vote. (Aug. 3, 1993).
H. Res. 230, July 28, 1993	O	H.R. 1964: Maritime Administration authority	NA	NA	A: Voice Vote. (July 29, 1993).
H. Res. 246, Aug. 6, 1993	MO	H.R. 2401: National Defense authority	149 (D–109; R–40)		A: 246–172. (Sept. 8, 1993).
H. Res. 248, Sept. 9, 1993	MO	H.R. 2401: National defense authorization			PQ: 237–169. A: 234–169. (Sept. 13, 1993).
H. Res. 250, Sept. 13, 1993	MC	H.R. 1340: RTC Completion Act	12 (D–3; R–9)	1 (D–1; R–0)	A: 213–191–1. (Sept. 14, 1993).
H. Res. 254, Sept. 22, 1993	MO	H.R. 2401: National Defense authorization		91 (D–67; R–24)	A: 241–182. (Sept. 28, 1993).
H. Res. 262, Sept. 28, 1993	O	H.R. 1845: National Biological Survey Act	NA	NA	A: 238–188 (10/06/93).
H. Res. 264, Sept. 28, 1993	MC	H.R. 2351: Arts, humanities, museums	7 (D–0; R–7)	3 (D–0; R–3)	PQ: 240–185. A: 225–195. (Oct. 14, 1993).
H. Res. 265, Sept. 29, 1993	MC	H.R. 3167: Unemployment compensation amendments	3 (D–1; R–2)	2 (D–1; R–1)	A: 239–150. (Oct. 15, 1993).
H. Res. 269, Oct. 6, 1993	MO	H.R. 2739: Aviation infrastructure investment	N/A	N/A	A: Voice Vote. (Oct. 7, 1993).
H. Res. 273, Oct. 12, 1993	MC	H.R. 3167: Unemployment compensation amendments	3 (D–1; R–2)	2 (D–1; R–1)	PQ: 235–187. F: 149–254. (Oct. 14, 1993).
H. Res. 274, Oct. 12, 1993	MC	H.R. 1804: Goals 2000 Educate America Act	15 (D–7; R–7; I–1)	10 (D–7; R–3)	A: Voice Vote. (Oct. 13, 1993).
H. Res. 282, Oct. 20, 1993	C	H.J. Res. 281: Continuing appropriations through Oct. 28, 1993	N/A	N/A	A: Voice Vote. (Oct. 21, 1993).
H. Res. 286, Oct. 27, 1993	O	H.R. 334: Lumbee Recognition Act	N/A	N/A	
H. Res. 287, Oct. 27, 1993	C	H.J. Res. 283: Continuing appropriations resolution	1 (D–0; R–0)	0 (D–0; R–0)	

Note.—Code: C-Closed; MC-Modified closed; MO-Modified open; O-Open; D-Democrat; R-Republican; PQ: Previous question; A-Adopted; F-Failed.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. HALL of Ohio. Mr. Speaker, I have no requests for time, and I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore (Mr. GLICKMAN). The question is on the resolution.

The resolution was agreed to.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to House Resolution 286 and rule XXIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 334.

The Chair designates the gentleman from Florida [Mr. PETERSON] as Chairman of the Committee on the Whole, and requests the gentleman from Florida [Mr. HASTINGS] to assume the chair temporarily.

□ 1302

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 334) to provide for the recognition of the Lumbee Tribe of Cheraw Indians of North Carolina, and for other purposes, with Mr. HASTINGS (chairman pro tempore) in the chair.

The Clerk read the title of the bill.

The CHAIRMAN pro tempore. Pursuant to the rule, the bill is considered as having been read the first time.

The gentleman from New Mexico [Mr. RICHARDSON] will be recognized for 30 minutes, and the gentleman from Wyoming [Mr. THOMAS] will be recognized for 30 minutes.

The Chair recognizes the gentleman from New Mexico [Mr. RICHARDSON].

Mr. RICHARDSON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, H.R. 334 sponsored by Mr. ROSE of North Carolina extends Federal recognition to the Lumbee Band of Cheraw Indians. This recognition is a formal acknowledgment of a government-to-government relationship between the United States and an Indian tribal government.

In the history of this country, Congress has never enacted a law on how to recognize an Indian tribe. Instead, as we moved West, we entered into treaties with tribes and exchanged promises for land cessions.

However, as the 20th century draws to a close, we are looking at eastern tribes that existed before westward expansion. For survival reasons, these tribes took on the ways of non-Indians, but they maintained distinct Indian communities. Although the communities surrounding these tribes knew they were Indians, and generally the State governments recognized these groups as Indians, the Federal Government neglected to acknowledge these groups as Indian tribes.

Usually, the United States waits until these groups have some threat to hold over the Federal Government's head. For example, in the late 1970's, tribes in Maine who had not enjoyed a relationship with the Federal Government for over 100 years sued for two-thirds of Maine and won. Only then were these tribes granted a large monetary settlement and Federal recognition.

It is ironic that we only recognize Indian tribes when we need something from the tribe or we owe them something under a court order. The irony is these people have always been Indian, have suffered discrimination because their skin is dark, but they are not legally Indian until the Federal Government says they are.

The Lumbee Indians do not have a land claim, nor is there a court ordered settlement, nor do we need or want their land. So why are we seeking to extend Federal recognition today? For a reason that is unusual in this country but it is the best reason, because they are Indians.

The Lumbee have always had a distinct Indian community. The State of North Carolina acknowledged them as a tribe in 1885. In 1912, 1914, and 1933, the Interior Department concluded that the Lumbee were Indians, existing as a separate and independent community.

The Lumbee have tried to get recognized by Congress in the past. Unfortunately, at the end of the 19th century and the beginning of the 20th, congressional policy was to assimilate Indians into society and recognitions were difficult if not impossible. In the 1950's, when Congress was terminating Indian tribes, the Lumbee again sought Federal recognition. In 1956, the Lumbee recognition bill was passed by Congress but it was amended at the request of the Interior Department to prohibit Federal services to the Lumbee people. In a sense, the 1956 act recognized and terminated the Lumbee in the same legislation.

H.R. 334 corrects this historical wrong. It amends the 1956 act and grants full tribal status to the Lumbee Indians. However, under the bill the Lumbee must obtain appropriations separate from the outlays for other federally recognized tribes.

Congressional action is needed to recognize the Lumbee. The Interior Department's Solicitor concluded in 1989 that the tribe is not eligible to go through the Bureau of Indian Affairs Federal Acknowledgment Process because of the prohibitions in the 1956 act.

However, even if the Lumbee could go through the BIA's process, it would choose not to. The administrative recognition process is flawed. Over 120 requests for recognition sit at the BIA, and only 8 tribes have ever made it through the process. It has become so difficult to get through this system that it is doubtful that existing tribes could survive the BIA's recognition process.

But it should be noted that the administration has no objection to this bill and we intend to work with the Interior Department and the minority to improve the process.

We are all in agreement that we need to reform this Federal acknowledgement process. But today we have the opportunity to undo one injustice inflicted by the United States.

We can recognize these people for what they are and what they always have been—an Indian tribe. It is the duty of the Congress and the President to recognize this group and restore the government-to-government relationship.

Finally, Dr. William Sturtevant, a noted scholar and general editor of the Smithsonian Institution's "Handbook of North American Indians," has written the following:

> It is clear that the Lumbee have those characteristics that identify an Indian tribe. Certainly anthropologists who have looked into the case over the last century or so agree that they are an Indian tribe; no anthropologist has denied it.

Mr. Chairman, this is an Indian tribe. They have suffered discrimination because of being Indian. They have been denied recognition of their heritage by this Government. We must right this wrong.

I urge my colleagues to support this bill.

Mr. Chairman, I reserve the balance of my time.

Mr. THOMAS of Wyoming. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise today in strong opposition, to H.R. 334 in its present form.

H.R. 334 presents this Congress with one of the most difficult public policy issues in Indian affairs: In which cases, if any, should we exercise our authority to extend Federal recognition to a group seeking formal acknowledgements as an Indian tribe outside the established administrative process? We have been asked repeatedly to consider the issue of recognition in one form or another of the Lumbee Indians of Robeson County, NC. So far, we have declined to exercise that authority in their regard. The proponents of this bill present no compelling justification why we should depart from that well-reasoned course now.

H.R. 334 would legislatively extend Federal recognition to the Lumbee Indians of North Carolina, thereby circumventing the established Bureau of Indian Affairs administrative procedure through which all other nonrecognized Indian groups must pass. This procedure—called the Federal acknowledgment process [FAP]—was established in 1978 at the request of the American Indian Policy Review Commission, the National Congress of American Indians, and Members of both the House and Senate, all of whom decried the arbitrary and excessively political approaches to tribal recognition then prevalent in Congress and the lack of systematic and uniform set of criteria in this body to determine tribal status. Under the FAP,

tribes seeking Federal recognition must submit a detailed petition which is then evaluated by a team of Bureau of Indian Affairs [BIA] anthropologists, ethnohistorians, and other experts. The BIA subsequently establishes whether the petitioner meets seven criteria used to determine if the group is indeed an Indian tribe. This recognition of tribal status is a prerequisite to the tribe's and its members' receipt of the services offered by the BIA.

The Lumbee and their supporters, however, argue that they should be allowed to bypass these regulations and that Congress should recognize them legislatively. First, they contend that prior legislation—the 1956 Lumbee Act—both recognized the group and preclude them from applying for recognition under the FAP. Second, they maintain that they are justified in bypassing the FAP because the process is cumbersome and ineffective. Finally, they assert that passage of the bill is consistent with recent actions of Congress in enacting recognition legislation.

Their arguments, though, are tenuous at best, and actually militate against the bill and in favor of less precipitous legislative solutions. The 1956 Lumbee Act did not in any way extend Federal recognition to the Lumbee. Rather, it was merely a commemorative bill designating this group of Indians by a particular name. This interpretation is borne out by the wording of the act, itself, the legislative history, contemporary news reports, the Federal courts, and other authorities. While the act can be read as precluding the Lumbee from petitioning for recognition, the logical solution to that impediment—and one requested by past Solicitors at the Interior Department—is to amend the act to remove the bar rather than to bypass completely the FAP. I will be offering an amendment shortly to do just that.

The second argument, that the Lumbee should be allowed to bypass the FAP process because it is too cumbersome and backlogged, is equally specious. While the BIA recognition process is in need of repair, it is not as feckless as the majority would have us believe. There is only a backlog of—at most—8 petitions, not the 120 cases often cited; and while I concede that the process is imperfect, the most rational solution is to fix it. Continuously seeking to bypass the process only ignores the problem, undermines the role of the BIA, and is unfair to both the recognized and unrecognized tribes.

Finally, the Lumbee assert that approval of this bill is simply consistent with congressional precedent. The examples of legislation they cite to support this proposition, however, are either not recognition legislation or are easily distinguishable from the Lumbee case and therefore of no precedential value.

Mr. Chairman, so that the Members of the House can fully understand the magnitude of the issues presented by H.R. 334, a brief background on the importance of Federal recognition is in order. The question of whether a native American group constitutes an Indian tribe is one of immense significance in the field of Federal Indian law. Because Congress' power to legislate for the benefit of Indians is limited by the Constitution to Indian tribes, for most Federal purposes it is not enough that an individual simply be an Indian to receive the protections, services, and benefits offered to Indians; rather, the individual must also be a member of an Indian tribe. Though it might seem to the layperson that there is only one kind of Indian tribe, for purposes of American Indian law there are actually two—those that are recognized by the Federal Government and those that are not.

"Recognized" is more than a simple adjective; it is a legal term of art. It means that the Government acknowledges as a matter of law that a particular native American group is a tribe by conferring a specific legal status on that group, thus bringing it within Congress' legislative powers. This Federal recognition is no minor step. A formal, political act, it permanently establishes a government-to-government relationship between the United States and the recognized tribe as a "domestic dependent nation," and imposes on the Government a fiduciary trust relationship to the tribe and its members. Concomitantly, it institutionalizes the tribe's quasi-sovereign status, along with all the powers accompanying that status such as the power to tax, and to establish a separate judiciary. Finally, it imposes upon the Secretary of the interior specific obligations to provide a panoply of benefits and services to the tribe and its members. In other words, unequivocal Federal recognition of tribal status is a prerequisite to receiving the services provided by the Department of the Interior's Bureau of Indian Affairs [BIA], and establishes tribal status for all Federal purposes.

Prior to the 1930's Federal recognition of tribes took many forms: Congressionally sanctioned treaties, court cases, administrative decisions, and executive orders—and "was essentially sporadic, or, at best * * * plagued with all sorts of pitfalls and a lack of a systematic approach. * * *" Instead of a process based on a well-reasoned set of standardized criteria, the granting of recognition was, by all accounts, nothing better than arbitrary and excessively political. In 1871, Congress provided that no tribe could thereafter be recognized as an independent sovereign entity with which the Untied States Could conclude a treaty. Similarly, in 1919 Congress retired another method of recognizing an indigenous group as a tribe when it prohibited the President from creating reservations by Executive order. Thus, by the early 1900's, this curtailment of available avenues of dealing with the tribes, coupled with the growing involvement of the BIA in managing the daily affairs of the tribes, meant that Congress had effectively delegated—either explicitly or implicitly—much of its authority over Indian matters to the BIA.

Those agencies, however, continued to deal with the tribes in a somewhat desultory fashion. The early principles of administrative recognition were based on a Supreme Court decision which offered a rather vague guide to defining a tribe. In an effort to remedy this disorganization, in 1942 the Solicitor of the BIA, Felix Cohen, first proposed a workable set of criteria designed to provide a uniform framework for tribal recognition. The so-called Cohen criteria considered both the tribal character of the native group and any previous Federal actions treating it as a tribe. However, application of the criteria proved to be no less haphazard than the process they replaced. Besides the Cohen criteria, the BIA relied on a patchwork mixture of court opinions, limited statutory guidance, treaty law, and evolving departmental policy and practice. Thus by 1975, faced with a steadily increasing number of groups seeking recognition, the BIA held in abeyance further acknowledgement decisions pending the development of regulations for a systematic and uniform procedure to recognize Indian tribes.

About this same time the congressionally established American Indian Policy Review Commission [AIPRC] proposed the formation of a firm legal foundation for the establishment and recognition of tribal relationships with the United States, and the adoption of a "valid and consistent set of factors applied to every Indian tribal group. * * *" Joining the chorus for standardization was the National Congress of American Indians, which called for a "valid and consistent set of criteria applied to every group which petitions for recognition * * * based on ethnological, historical, legal, and political evidence." Senator James Abourezk, AIRPC's chairman, took the issue to the floor of the Senate, and introduced legislation calling for the establishment of an office in the BIA to handle recognition petitions in a uniform way.

In 1978, the Interior Department, after exhaustive consultations with Indian country, established procedures to provide a uniform approach to the recognition process. Called the Federal acknowledgement process [FAP], the regulations set forth seven criteria a petitioning group must meet to be deemed

a "recognized" tribe. The BIA FAP office is staffed by two teams of professionals including historians, genealogists, ethnologists, and anthropologists. These teams do exhaustive research on the petitions they receive, and examine such factors as Indian identity and community, as well as political and cultural cohesiveness. Once a petition is received it is reviewed for any obvious deficiencies. These are noted for the tribe, which is given the opportunity to supply additional material to supplement its petition. The petitions are then placed on active consideration in the order received. Since 1978, 8 tribes have been administratively recognized, 14 have been denied recognition, 1 has had a proposed negative finding and another a proposed positive finding of tribal status. Several others, including the Lumbee, have filed petitions which are in various stages of movement through the FAP process.

H.R. 334 seeks to legislatively extend Federal recognition to a group of Indians in North Carolina, completely bypassing the established BIA FAP process. The bill's proponents take great pains to posit that the Lumbee meet all the criteria used by the BIA in determining tribal status. However, while the proponents' remarks on this bill, as well as the majority's report, focus extensively on their highly subjective judgments about whether the Lumbee people meet these criteria, I decline to engage in debate over this emotional topic since it is largely irrelevant in terms of my position on this legislation. I do not argue that the Lumbee people are not of Indian descent; moreover, I make no judgments on the question of their tribal status, or the adequacy of their recognition petition. Rather, I believe strongly that the Members of the House are in a position to make a rational and informed decision as to whether this group constitutes a federally recognizable tribe.

Mr. Chairman, I will not repeat in extenso the chronicle of the people now called the Lumbee; it is adequately set forth in previous committee reports and accompanying appendices. However, mindful that the intricacies and peculiarities of Indian law demand an appreciation of history, I feel constrained to point out a few salient historical facts with which the majority is either unfamiliar or which it chooses to gloss over in its headlong rush toward passage of this legislation.

Foremost among these: While neither side in this debate questions the group's Indian descent, the exact origin and tribal derivation of the Lumbee has been the subject of considerable dispute and uncertainty, and since the 19th century the Lumbee and their predecessors have sought an identifying link with some historic tribe. Unlike most other tribes, it is inaccurate to refer to a continuously existing tribe of Lumbee; that name is a modern creation which was only adopted in 1956, and is the most recent in a long line of appellations belonging to this group. It is important to bear this fact in mind because proponents of the bill, as well as some contemporary commentators, tend to obscure this fact and absorb the long and complex history of Robeson County Indians into a single, supposedly Lumbee, history.

The story of how the progenitors of the Lumbee came to live in this area of North Carolina is a multifarious one. In fact, there are almost as many theories as there are theorists. Up until the 1920's, the most persistent tradition among the Indians in Robeson County was that they were descended primarily from an Iroquoian group called the Croatans. This theory, though highly conjectural, is as follows. In 1585, Sir Walter Raleigh established an English colony under Gov. John White on Roanoke Island in what later became North Carolina. In August of that year, White departed for England for supplies, but was prevented from returning to Roanoke for 2 years by a variety of circumstances. When he finally arrived at the colony, however, he found the settlement deserted; no physical trace of the colonists was found.

The only clue to their whereabouts were the letters "C.R.O." and the word "Croatoan" carved in a tree. From this it was surmised that the colonists fled Roanoke for some reason, and removed to the nearby island of Croatoan which was inhabited by a friendly Indian tribe. There, according to the theory, they intermarried with the Indians, and the tribe eventually migrated to the southwest to the area of present-day Robeson County. The theory is lent some credence by reports of early 18th century settlers in the area of the Lumber River who noted finding a large group of Indians—some with marked Caucasian features such as grey-blue eyes—speaking English, tilling the soil, and practicing the arts of civilized life. In addition, many of the surnames of Indians resident in the county match those of Roanoke colonists.

This view was the most widely accepted among both the Indians and their neighbors for more than 100 years. It was even officially echoed by the Department of the Interior, which concluded:

> [T]he Indians originally settled in Robeson and adjoining counties * * * were an amalgamation of the Hatteras Indians with [Raleigh's] lost colony; the present Indians are their descendants with a further amalgamation with the early Scotch and Scotch-Irish settlers, such amalgamation continuing down to the present time, together with a small degree of amalgamation with other races.

The Lost Colony theory has, however, since fallen into disrepute. Since the late 1930's, the most generally accepted supposition is that the ancestors of the Lumbee—

> Had many different "tribal" affiliations, originally spoke several different Indian languages, and had one common goal—to find refuge from White-introduced diseases, wars, and the settlers who were sweeping through North and South Carolina. The swamps of what was to be Robeson County combined with the county's uncertain colonial status attracted people of Indian descent with a promise of protection.
>
> There were massive dislocations of Indian populations in areas to the north and south of Robeson County. In 1711, the Tuscarora War to the north could have driven some Indians to seek refuge in the southern swamps on the border between the Carolinas. Later, in the 1730's, a smallpox epidemic raged through South Carolina and may have sent those fleeing it northward into the swamps. That Robeson [County] provided a refuge for people—Indian, White and Black—who sought to avoid highly organized government is also likely.
>
> The county is located in a section of North Carolina that was, between 1712 and 1776, involved in a border dispute between the colonies of North and South Carolina. * * * Many White colonists would have hesitated to settle there because of the confusion about which colony would be legally responsible for the region, and therefore the area would provide an ideal refuge for those seeking to avoid large all-White settlements. The remnant groups who found safety in Robeson County intermarried, amalgamating into a single people that included some non-Indian[s]. * * *

This amalgamation, which consisted of several different Siouan coastal tribes, has been accepted by the present Lumbee as the beginnings of their group. For example, in 1955 a representative of the Lumbee stated that the group is "an admixture of seven different tribes of Indians including the Cherokee, Tuscarora, Hatteras, Pamlico, and Croatan—about seven tribes were mixed with them and intermarried with the first colonists."

This change in theories over the years has resulted in a series of official name changes for the Robeson County Indians as they sought to conform legislatively to whichever view was prevalent at the time. In 1885, the State of North Carolina designated a group of Indians in and around Robeson County—the ancestors of the present Lumbee—as "Croatan Indians." By 1911, however, the designation had been popularly shortened to "Cro" and was used by non-Indians as a racial pejorative which the Indians found extremely objectionable. In addition, the term was one not recognized by historians, ethnologists, or bureaucrats in the Federal Government; it had no historical precedent and was based on the name of a place, not the name of a people. Therefore in that year, at the group's request, the State legislature changed the group's name to "Indians of Robeson County." That change, however, pleased nobody and settled nothing, since in the opinion of many Lumbee it served only to obscure further the claimed origins of the group. Consequently, in 1913, again at the

group's request and despite the vehement protests of the federally recognized Eastern Cherokee Tribe in the western part of the State, the name was changed to "Cherokee Indians of Robeson County."

From 1910 to the 1930's, supporters of the group introduced several bills in Congress to give them a Federal designation variously proposed as "Cherokee Indians of Robeson and adjoining counties," "Southeastern Cherokee," "Cheraw," and "Siouan Indians of the Lumber River." In 1953, they finally settled on adopting a derivation of the name of the Lumber (Lumbee) River, which flows through Robeson County, as their self-designation. In justification for the change, one of the group's leaders wrote:

> The first white settlers found a large tribe of Indians living on the Lumbee River in what is now Robeson County—a mixture of colonial blood with Indian blood, not only of [Raleigh's] colony; but, with other colonies following and with many tribes of Indians; hence, we haven't any right to be called any one of the various tribal names; but, should take the geographical name, which is Lumbee Indians, because we were discovered on the Lumbee River.

At no point over all these years, however, have State or Federal statutes even remotely referenced the Cheraw—note the absence of that name from the preceding list of progenitor tribes given by Dr. Lowery—but we are now told by the Lumbee, after more than 100 years of being informed otherwise, that this group is the principal historical tribe from which they really descend. However, a close examination of the issue calls this assumption into some question.

In 1914, at the direction of the Senate, the Secretary of the Interior sent Special Indian Agent O.M. McPherson to North Carolina to investigate "the condition and tribal rights of the Indians of Robeson and adjoining counties. * * *." Mr. McPherson returned his exhaustive report—including over 230 pages of exhibits—to the Senate in January 1915. The proponents of Lumbee recognition state that this report unequivocally concluded that the Lumbee are descended principally from the Cheraw Tribe. This characterization of McPherson's report, however, is not quite accurate. McPherson noted that the Cheraw, being subject to attacks from Iroquoian tribes, became incorporated with the Catawbas of South Carolina between 1726 and 1739. "The last historical notice of them was in 1768, when their remnant, reduced by war and disease, were still living with the Catawbas." These statements would seem to argue against an assumption that the report concludes that the Cheraw were the principal ancestors of the Lumbee. The closest McPherson came to establishing a Lumbee-Cheraw connection was the following: "It is not improbable, however, that there was some degree of amalgamation between the Indians residing on the Lumber River and the Cheraws, who were their nearest neighbors."

This subsummation of the Cheraw into the Catawba Nation in the early 1700's—which in my view greatly diminishes the force of the Lumbee Cheraw claim—is substantiated in a number of contemporaneous and modern sources. Among the former: James Adair, an Englishman who resided with the Catawba in 1743, stated that the Catawba consisted of up to twenty different constituent groups; among the eight tribes explicitly cited by Adair were the Cheraw. A map drawn on deerskin by a Catawba chief in 1724 shows the Charra as a group residing with the Catawba. Another map, drawn by the trader John Evans in 1756, shows the location of the Charraw town in the Catawba lands.

In addition, all of the modern treatments of the Catawbas with which I am familiar indicate that the Cheraw were one of the many tribes subsumed into the Catawba. For example, Dr. Jane Brown notes that "[o]f the twenty-two tribes which formed the Catawba Nation as early as 1743, the most important * * * were: The Catawbas proper * * * the Cheraws * * * the Sugaree * * * the Waxhaws * * * the Congarees, the Santees * * * the Pedees * * * the Waterees * * * and the Wateree-Chickanees * * *." These groups all merged with the Catawba, and "[a]s a result of these tribal mergers, the Catawba Nation became a melting pot of peoples * * *. Cheraws * * * and other migrants gradually lost their own identity and came to think of themselves as Catawbas." Secretary of the Interior Harold Ickes, citing a Smithsonian report, noted that the remnants of the Cheraw "became incorporated with the Catawbas of South Carolina" between 1726 and 1739.

I am not the first to question the validity of the Lumbee-Cheraw connection. In 1933, a bill introduced in the Senate would have provided for the enrollment of the group as Cheraw Indians. The Secretary of the Interior objected to the use of the term "Cheraw," however, and suggested that they be designated Siouan Indians instead. This change was prompted by a report from Dr. J.R. Swanton, a Smithsonian anthropologist, who concluded that the group is:

> Descended from a considerable number of small tribes, of which the Cheraw were only one, and since the greater part of these, like the Cheraw, belonged to what is called the Siouan linguistic family, it would be more nearly correct to designate them Siouan Indians of Lumber River, from this fact and the name of the stream about which the greater number of them are settled.

The bill was amended in committee to reflect that request.

The report by Swanton—often cited by the Lumbee as an authority on the subject—is instructive as to the true nature of the Lumbees' relationship of the Cheraw. It noted that the Lumbee are descended "from certain Siouan tribes of which the most prominent were the Cheraw and Keyauwee, but [] probably included as well remnants of the Eno, and Shakori, and very likely some of the coastal groups such as the Waccamaw and Cape Fear." Swanton went on to state that" [a]lthough there is some reason to think that the Keyauwee tribe actually contributed more blood to the Robeson County Indians than any other," he preferred the use of the term "Cheraw" simply because whereas the Keyauwee name was not widely known, "that of the Cheraw has been familiar to historians, geographers, and anthropologists in one form or another since the time of DeSoto * * *." In other words, the choice of the Cheraw was apparently made in large part for reasons of academic ease rather than historical reality.

In a later, seminal work, Swanton reiterated his belief that the Keyauwee, and not the Cheraw, were the main predecessors of the Robeson County Indians. He noted that between 1726 and 1739, the remnants of the Cheraw were incorporated into the Catawba Tribe, and that they still resided with the latter group as of 1768, by which time the Lumbee claim their ancestors were already established in North Carolina's Robeson County. He estimated their numbers at that time to be between 50 and 60 individuals. He went on to state that the Keyauwee, while also eventually setting with the Catawba, left descendants "among the Robeson County Indians."

In 1989, the head of the BIA's Bureau of Acknowledgement and Research questioned the adequacy of the Lumbees' proof underlying their assertion of Cheraw descent. He testified that

> [t]he Lumbee petition submitted to the BIA in 1987 claims to link the group to the Cheraw Indians. The documents presented in the petition do not support [this] theory * * *. These documents have been misinterpreted in the Lumbee petition. Their real meanings have more to do with the colonial history of North and South Carolina than with the existence of any specific tribal group in the area in which the modern Lumbee live.

Even the Lumbees' own consulting anthropologists have previously been somewhat lukewarm in their support for the proposition that the Lumbee are principally descended from the Cheraw. For example, one has stated that "the Cheraw are probable ancestors in the early 18th century. It does not really matter, however * * *." In fact, the case for Cheraw ancestry is not one of conclusion by proof, but of conclusion by supposition and process of elimination. All of these sources, from Adair onwards, cast a considerable pall over the Lumbee assertion that "the proof in this case [of descent

from the Cheraw] is supported by the fact that no disconfirming evidence exists," and over their anthropologists statements that "[t]here is no evidence to the contrary."

Given the very small numbers of Cheraws left after the ravages of disease and the early colonial Indian wars, what seems to be the prevailing view that the group was subsumed into the Catawba Nation to the south, and the lack of concrete proof, I find it difficult to fathom how the Cheraw could have been the principal forbearers of the Lumbee. In addition, this change in the asserted origins of the Lumbee over the years has not been a minor one. Since the 1860's, the group has claimed "Croatan," then Cherokee, then Cheraw descent. This progression was not one from one correlate tribe to another, such as from Mohawk to Oneida to Onondaga. Rather, these tribes are not at all related. The Croatan were Algonquian, the Cherokee Iroquoian, and the Cheraw Siouan—three completely distinct linguistic groups.

In fairness, however, I note that two anthropologists have stated that it is possible that another band of Cheraw existed, and that they could have been one of the progenitors of the Lumbee. There are some facts from which this inference could plausibly be drawn. I do not necessarily rule out the theory of Cheraw descent; records from this period are sketchy at best and, as one early explorer noted:

> In tracing the origin of a people, where there are no records of any kind, either written, or engraved, who rely solely on oral tradition for the support of their ancient usages, and have lost great part of them * * * where we have not the light of history, or records, to guide us through the dark maze of antiquity, we must endeavor to find it out by probable arguments.

Moreover, I reiterate that I do not purport to judge the merits, or lack thereof, of the Lumbee petition. Rather, I think that the descent issue, among others, points out that this is not the open and shut case its proponents would have us believe, and underscores the need for its review by objective and neutral historians, anthropologists and other scientifically-trained personnel at the BIA. It is relatively immaterial to my position that the tribe has produced experts to testify before us regarding the validity of the Lumbee claims, or that an equal number of other experts has contradicted them; it may well be that the Lumbee have a perfectly valid claim. I am simply stating that we as a body are not adequately equipped to make that determination.

True, as the gentleman from California [Mr. MILLER] has previously pointed out, "[t]his is not about us being experts. It is about weighing the evidence that the experts have given us. That is our job on this and so many other subjects." However, the "experts" disagree on many issues, and there is not one Member of this House, nor of our staffs, with the specialized educational background necessary to make an informed decision in this area. Properly done, the process of recognition requires an evaluation of complex and often ambiguous data and issues of ethnohistory, cultural anthropology, and genealogy. Not only do we lack that expertise, but there are precious few Members of this body with any more than the most superficial knowledge on the subject at all. I seriously doubt that any Member of the majority, or of their staffs, has read even the multivolume Lumbee recognition petition, let alone any anthropological, ethnohistorical or sociological treaties on the group.

This lack of knowledge is especially troubling in the case of the Lumbee. Laypersons tend to have a single, conglomerate view of what constitutes an Indian tribe, a view usually on the Great Plains model. The Lumbee, however, bear very few if any characteristics in common with that view, a fact of which I would wager most if not all of the Members of the House are unaware. The Lumbee have an Indian ancestry, but have never had treaty relations with the United States, a reservation, or a claim before the Indian Claims Commission; they do not speak an Indian language; they have had no formal political organization until recently; and they possess no autochthonous "Indian" customs or cultural appurtenances such as dances, songs, or tribal religion. One of the group's consultant anthropologists, Dr. Jack Campisi, noted this lack of Indian cultural appurtenances in a hearing colloquy with then-Congressman Ben Nighthorse Campbell:

> Mr. CAMPBELL. * * * Do [the Lumbee] have a spoken language * * * ?
>
> Dr. CAMPISI. No.
>
> Mr. CAMPBELL. Do they have distinct cultural characteristics such as songs, dances, and religious beliefs and so on? * * * Do the Lumbees have that?
>
> Dr. CAMPISI. No. Those things were gone before the end of the 18th Century.

This absence of cultural appurtenances in part identifies the Lumbee as part of what sociologist Brewton Berry has termed the "marginal Indian groups." As Berry notes:

> These are communities that hold no reservation land, speak no Indian language, and observe no distinctive Indian customs. Although it is difficult to establish a firm historical Indian ancestry for them, their members often display physical features that are decidedly Indian. Because they bear no other historic tribal names, they often emphasize a Cherokee ancestry.

These characteristics do not, in my mind, necessarily preclude Federal recognition. They do, however, point out that this is a case replete with out-of-the-ordinary complexities which require more than just a simple one-page staff memo to understand fully. Needless to say, if those of us charged with the day-to-day oversight of Indian affairs do not have the necessary expertise—or even knowledge—in this area, how will the balance of our Members appropriately exercise those judgments as they will be called upon to do when this legislation reaches the floor?

Aside from our lack of expertise, other considerations militate against removing the recognition process from the BIA in this case. Foremost among these is the fact that recognition should be based on established principles free from the eddies and currents of partisan politics and influence—this was the reason the FAP criteria were established in the first place. Congress is by nature, however, a highly partisan institution. A single, powerful Member in the majority part is perfectly capable of moving a recognition bill through this body with little reference to its actual merits. As one attorney has noted:

> Neither this Committee [Interior] nor the Senate Committee [on Indian Affairs] has adopted any self-policing criteria [to use] to judge the petitions. If has to do with the nature of the arguments that are put forward before [the Committee], the proponents of the legislation bring their historians and anthropologists and say absolutely this is a tribe. The member or sponsor of the bill lobbies the members of the Committee on behalf of his [petitioning constituent and depending on whether he's persuasive or not perhaps he is successful. Some professional staff pointed out to me one day, what happens the day that Dan Rostenkowski[, Chairman of the House Ways and Means Committee,] goes to George Miller[, Chairman of the House Natural Resources Committee,] and says the Illini tribe are alive and living in downtown Chicago. That should not be the way the federal recognition is granted. There has to be some sort of criteria and I think that is the bottom line.

The Lumbee attorney has previously acknowledged the wisdom of this view by recognizing its obverse, and has argued against leaving the process up to Congress:

> [E]xperience in the last few Congresses has also taught us that the power of a single congressman who represents a single district who is opposed to the recognition of other tribes can be very influential. That person can block a particular bill and, for all practical purposes, prevent the recognition of a tribe that should be recognized. You can create a political donnybrook by bringing it [the FAP process] all back to Congress.

In other words, while we clearly have the power to recognize a tribe, that does not mean that the wisest use of that power is its exercise. In the absence of any discernible criteria by which we judge tribal status, and of any particularized background or knowledge, the Congress should leave the decision up to those best qualified to make it: the BIA.

Mr. Chairman, despite the fact that the BIA, and not this body, is best equipped to handle the issue, the Lumbees and their supporters argue that they should be allowed to bypass the established recognition process because theirs is a unique case requiring

a legislative solution. First, they contend that prior legislation both recognized the group and precluded them from applying for recognition under the FAP. Second, they maintain that they are justified in bypassing the FAP because the process is cumbersome and ineffective. Finally, they assert that approval of the bill is consistent with recent actions of Congress in enacting recognition legislation. For the reasons set forth below, however, these contentions are without merit sufficient to warrant congressional recognition. Their arguments are tenuous at best, however, and actually mitigate against this legislation and in favor of less precipitous legislative solutions.

The Lumbees' principal contention is that the act of June 7, 1956, both served as a prior Federal recognition of the tribe and precludes their petitioning for recognition under the present regulatory scheme. As a result, they posit, they are entitled to congressional recognition. Such a position rests, however, on specious premises. The 1956 act did not in any way extend Federal recognition to the Lumbee; rather, it simply served as a formal affirmation of their status as an identifiable group named "Lumbee" descended from an admixture of Indian and other ethnic groups. Moreover, while the act may be read as precluding the Lumbee from petitioning for administrative recognition, the logical solution is to amend the act to remove the bar rather than to bypass the FAP altogether.

The proponents' position that the purpose of the 1956 Lumbee Act was the acknowledgment of the Lumbee as a federally recognized tribe is simply wrong. The purpose of the act is clear; it was merely a commemorative bill designating a group of Indians by a particular name to reflect a similar change in the group's self-designation made 3 years earlier at the State level. This is evident from the wording of the act itself, which states in pertinent part:

> That the Indians now residing in Robeson and adjoining counties of North Carolina, originally found by the first white settlers on the Lumbee River in Robeson County, and claiming joint descent from remnants of early American colonists and certain tribes of Indians originally inhabiting the coastal regions of North Carolina, shall, from and after the ratification of this Act, be known and designated as Lumbee Indians of North Carolina.

The 1956 act fails to include any of the typical indicators that would enable one properly to conclude that it is a recognition statute. In contrast to the 1956 act's language, when Congress has desired to grant Federal recognition to a tribe it has consistently done so by express and unambiguous language. For example, Public Law 95-281 states "[t]he Modoc Indian Tribe of Oklahoma is hereby recognized as a tribe * * *."; Public Law 95-195 states "recognition is hereby extended to the [Siletz] tribe * * *."; and Public Law 93-197 states "[f]ederal recognition is hereby extended to the Menominee Indian Tribe * * *." Even the majority must recognize that this is the correct formula to invoke recognition, since the bill before us—H.R. 334—contains identical language: "Federal recognition is hereby extended to the Lumbee tribe * * *." Furthermore, unlike the language in all other recognition acts—

> [t]he 1956 [Lumbee] legislation does not mention any political organization of the Lumbee or any governing body. It does not convey any land in trust, make any reference to whether state laws are to apply, or render Lumbees eligible for federal services. It, thus, would seem that there is little room for an argument that the statute was extending recognition * * *.

Moreover, the act passed with the following introductory clauses which, from the liberal use of the term "whereas," follow the usual litany of commemorative legislation:

> Whereas many Indians now living in Robeson and adjoining counties are descendants of that once large and prosperous tribe which occupied the lands along the Lumbee River at the time of the earliest white settlements in that section; and
>
> Whereas at the time of their first contacts with the colonists, these Indians were a well-established and distinctive people living in European-type houses in settled towns and communities, owning slaves and livestock, tilling the soil, and practicing many of the arts and crafts of European civilization; and
>
> Whereas by reason of tribal legend, coupled with a distinctive appearance and manner of speech and the frequent recurrence among them of family names such as Oxendine, Locklear, Chavis, Drinkwater, Bullard, Lowery, Sampson, and others found on the roster of the earliest English settlements, these Indians may, with considerable show of reason, trace their origin to an admixture of colonial blood with certain coastal tribes of Indians; and
>
> Whereas these people are naturally and understandably proud of their heritage, and desirous of establishing their social status and preserving their racial history * * *.

The last of these clauses is further evidence of the aim of the legislation: validating the "social status" of this group and preserving their "racial history." In the context of the 1956 legislation, this meant formal affirmation of them as an identifiable group descended from an admixture of Indian and other ethnic groups. This was not the first time that the Lumbee had sought a commemorative bill acknowledging their "Indian-ness." In 1932, members of the group sought passage of a bill to confer upon them the designation of "Cherokee Indians." The group's pro bono attorney at the time stated that

> [t]he chief desire of these Indians appears to be that Congress shall do something which will recognize affirmatively that they are Indians. Being myself from Georgia, I am able to appreciate the desire of these Indians for some status by which they would be, at least by their own thinking, clearly distinguished from [other ethnic groups in the area].

Even assuming arguendo that the wording of the 1956 Lumbee Act itself is somehow nebulous as to recognition, it is abundantly clear from the legislative history of the Act that it was not intended by Congress in any way to be a recognition bill. As noted by the American law Division of the Library of Congress, the committee reports accompanying the 1956 legislation indicate that the intent of the Act "was to designate a name for this group." To illustrate, House Report No. 84-1654 reads as follows: "If enacted, H.R. 4656 would permit about 4,000 Indians of mixed blood presently residing in Robeson and adjoining counties in North Carolina to become known and designated as the Lumbee Indians of North Carolina." Nowhere in the report does the term "recognition" appear; nor can a congressional desire to extend Federal recognition be inferred from the language of the report.

Additionally, the following colloquy between the sponsor of the 1956 act, Congressman Frank Carlyle, and another committee member confirms this view and belies the majority's assertion that the Lumbee understood the intent of the act to be recognition:

> Mr. CARLYLE. Now I should like for you to recall that there is nothing in this * * * that requests one penny of appropriations of any kind. There is nothing in this bill that would call for any upkeep or expenditure. It just relates to the name of these people of the county.
>
> Mr. ASPINALL. What benefits do they expect to get from this? Just purely the name "Lumbee Indian Tribe" does not appear to me to give too much importance to it, unless they expect to get some recognition later on as members of some authorized tribe, and then come before Congress asking for benefits that naturally go to recognized tribes.
>
> Mr. CARLYLE. No one has ever mentioned to me any interest in that, that they had any interest in becoming a part of a reservation or asking the federal government for anything. Their purpose in this legislation is to have a name that they think is appropriate to their group * * *.

Later, Congressman Carlyle continued:

> Mr. CARLYLE. As to any ulterior motive that might be suggested—that is, if they would come in and ask for benefits now or later—that is not in this picture at all.

Congressman Aspinall then asked this question of one of the Lumbee witnesses:

> Mr. ASPINALL. Do you or any members of your organization anticipate that, after you might receive this designation, you would come to Congress and ask for any benefits that otherwise go to Indian tribes?
>
> Rev. LOWERY. No Sir.

Finally, during consideration of the bill on the House floor, the following exchange took place:

> The SPEAKER. Is there objection to the present consideration of the bill?
>
> Mr. FORD. Mr. Speaker, reserving the right to object, I should like to ask the author of the bill, the gentleman from North Carolina [Mr. Carlyle], whether or not this bill, if enacted, would in any way whatsoever commit

the federal government in the future to the furnishing of services or monetary sums?

Mr. CARLYLE. Mr. Speaker, I am happy to say that the bill does not * * *.

Mr. FORD. There is no obligation involved, as far as the Federal Government is concerned * * *?

Mr. CARLYLE. None whatsoever.

Mr. FORD. It simply provides for the change of name?

Mr. CARLYLE. That is all.

Nowhere—in committee, on the floor, or in the act as passed—is there any statement from which one could logically construct a basis for recognition.

Not only is this position clearly supported by both the wording of the act and its legislative history, but contemporary news reports add strong evidence to the conclusion that the purpose of the 1956 act was simply to institutionalize the group's newly chosen name. For example, note the following from a North Carolina newspaper:

Senator Kerr Scott reports this week that the Lumbee Indians of Southeastern North Carolina should now have their name made official as far as the Federal Government is concerned.

"Last week the Senate Interior Committee's sub-committee on Indian affairs gave a quick okey to a bill that would make the name official. Final action will be routine," Scott said.

The North Carolina state legislature has already passed legislation doing the same thing.

Another North Carolina article notes that the Senate "had approved a bill to permit Indians of Robeson County to be designated as the Lumbee Indians of North Carolina * * *. The House and the North Carolina Assembly have already approved the name for the people." Another states that a bill "to make the name of Robeson County Indians the 'Lumbee Indians' has passed yet another hurdle in the Senate * * *. Previously the Indians had voted 2,189 to 35 for the name change in 1951, and in 1953, the North Carolina General Assembly gave the tribe its designation as Lumbee Indians." An article from the New York Times notes that the Senate voted "unanimously that some 4,000 [sic] Indians around Robeson County, NC, should be known officially as the Lumbee Indians." Another, that the "bill to rename the Indians of Robeson County the Lumbee Indians of North Carolina struck a snag in Washington last week, but will probably be signed by the President this week." Finally, the local papers reported that "President Eisenhower has received a bill to allow Indians in and around Robeson County, NC, to be known as the Lumbee Indians of North Carolina."

Of all the available news articles concerning the bill, I was only able to uncover one which arguably supports the majority's previous assertions that the legislation "was widely reported as a recognition bill * * *." It reads:

Senator W. Kerr Scott today asked a Senate sub-committee to give federal recognition to the Lumbee Indians of North Carolina. In testifying before a sub-committee of the Senate Interior Committee, Senator Scott said: "The State of North Carolina has already by state law recognized the Lumbee Indians under that tribal name." The North Carolina State Legislature gave official recognition to the Lumbee Indians while Scott was Governor of North Carolina. * * *

However, it is evident form the context of the article that the term "recognized" means cognitive, rather than jurisdictional, recognition, especially given that the article speaks in terms of the group being "recognized" by a specific name, and that the term "recognized" had not yet acquired its present legal meaning. The article's support for the majority's argument is thus highly questionable.

All the available authorities which have considered the question concur with my position that the bill is not recognition legislation. In Maynor versus Morton, the United States Court of Appeals for the District of Columbia Circuit—the highest Federal court to have addressed the issue—stated that "the limited purpose of the legislation appears to [be to] designate this group of Indians as 'Lumbee Indians.'" The court later reiterated this view, noting that the act was "a simple statute granting the name 'Lumbee Indian' to a group of Indians, which hitherto had not had such designation legally. * * *" Similarly, the American Indian Policy Review Commission agrees with this assessment of the act's intent. The Comptroller General has concluded that the Lumbee are not a federally recognized tribe, as has the Department of the Interior. In a 1988 opinion, the American Law Division of the Library of Congress concluded "that the 1956 statute does not provide recognition of Lumbee Indians as a political entity. * * *"

Even the Lumbee attorney has herself previously concluded that the act does not confer recognition on the tribe, but rather "was the culmination of many years of effort by the Lumbee Indians to be known by a name that reflected the group's unique ethno-history." Additionally, I note that nowhere in the Lumbee petition for recognition is any assertion made to the effect that the 1956 act constitutes recognition legislation. In fact, the petition makes no stronger assertion than that, in gaining passage of the act, "[t]he tribe had finally received some degree of Federal acceptance after 50 years of trying."

In its report on H.R. 1426—the identical predecessor to H.R. 334—the Democrats on the Interior Committee apparently agreed with my conclusion, explicitly stating that the purpose of the State legislation was to designate the group as "Lumbee Indians of North Carolina." Members of the Rules Committee have implicitly taken the view that the act did not serve to recognize the Lumbee; as has the Senate Committee on Indian Affairs. Perhaps more to the point, I pose the following query: If the 1956 Lumbee Act recognized the Lumbee as the majority suggests, then why do we now need H.R. 334 to accomplish that very same objective?

In spite of all this information, there are some who have argued that the State act changing the group's name to Lumbee was State recognition legislation, and that the 1956 act was meant to be identical recognition legislation on the Federal level. Others have said that the Lumbee understood the purpose of the 1956 act to be Federal recognition as we understand that term today. However, the sources I have previously cited, as well as the following chronology of article captions from the Robesonian, a local North Carolina paper, clearly belie these revisionist assertions and support the conclusion that both the State and Federal acts were both simply commemorative bills designating an existing Indian group by a new name:

Apr. 05, 1951: "'Lumbee Indians' Designated in Bill Introduced by Watts."

Apr. 12, 1951: "Indian Name Bill Hearing Attended by Both Factions."

Aug. 17, 1951: "Robeson Indians Drive Toward Vote to Decide Official Name."

Dec. 04, 1951: "Indians Can Have Election to Decide on Name of Tribe"

Jan. 23, 1952: "Indians Voice Name Change Opinions"

Feb. 01, 1952: "Robeson Indians Favor 'Lumbee' as Race Name"

Feb. 05, 1952: "Indians Vote Name Change"

Feb. 06, 1953: "Indian Asks for Teacher Support for Lumbee Name"

Feb. 12, 1953: "Senate Gets Indian Bill"

Sept. 30, 1953: "Copy of Lumbee Name Bill Presented to Indian Leader"

July. 29, 1955: "Indian Name-Change Stands Little Chance of Passing This Session"

Feb. 21, 1956: "[U.S.] House Passes Indian Name Bill"

May 16, 1956: "Indian Bill Ok'd by Senate Group"

May 22, 1956: "President Receives Lumbee Indian Bill"

The Robesonian article listed above and dated July 29, 1955, is particularly illustrative of my point:

Congressman James A. Haley * * * of the House Indian Affairs subcommittee said today he plans for further sessions on the group before Congress adjourns. * * * But Haley added that he personally could see no objection to the proposal as long as it involves strictly a name change and not the question of federal benefits.

The subcommittee had had assurance from the Rev. D.F. Lowery of Pembroke that the Indians do not want a reservation and do not want to become wards of the government. * * *

He told the congressman that the Robeson area Indians "would leave the county before they would come under a reservation or (become) anything like wards of the government."

Pending before the committee is a bill introduced by Rep. F. Ertel Carlyle of Lumberton to give the designation of Lumbee to the Indians living along the Lumbee River.

The following passage from the Lumbee petition, tracing the course of

the groups' name changes, further substantiates my position that the act simply codified a new self-designation for the group previously enacted at the State level:

[T]here was an absence of tranquility among our people on the whole [name] issue. Accordingly, a group of leaders among us joined in support of a name previously suggested—Lumbee—which would give us a well adapted legal name, geographically proper, and equally support the historical fact of our multiple tribal origins.

* * * * *

The result * * * was the completion and eventual approval of a change of name from Cherokee Indians of Robeson County to Lumbee Indians of the State of North Carolina * * *.

Following the draft of the above legislation the Commissioners of Robeson County held a duly constituted referendum and the bill was approved by a vote of some 2,000 for and 30 against. The Commissioners then unanimously concurred in the referendum result, following which the [state] legislature enacted it into law. It was then submitted to the House and Senate of the United States, passed and signed by the President of the United States, with minor amendments, as national legislation.

This passage—tracing the flow of the legislation from concept to State legislation to Federal legislation—clearly contradicts the revisionist view now put forward by the bill's proponents that the State act was recognition legislation and the 1956 act simply a Federal adoption of that recognition.

Further contradicting the erroneous view of the purpose of the State, and thus the Federal, act are statements noting that the State of North Carolina recognized the Lumbee as a political entity in 1885, and has maintained an uninterrupted government-to-government relationship with them ever since from the chairman of the board of directors of the Lumbee Regional Development Association; a member of the House Rules Committee; the chairman of the Natural Resources Committee; the sponsor of H.R. 334; Senator Terry Sanford of North Carolina; the Senate Committee on Indian Affairs; the Lieutenant Governor of North Carolina; the secretary of administration, Office of the Governor of North Carolina; the chairman of the North Carolina Commission on Indian Affairs; the Lumbee attorney; the group's own position paper; and the anthropologist who authored the Lumbee recognition petition. Even the group's petition for recognition states that "[i]n 1885, the North Carolina General Assembly passed an act recognizing the Lumbee tribe * * *." In a case such as we have here where recognition has been legislatively extended to a group by a State, and that recognition has not been withdrawn, it makes little sense to argue that the State would reextend that same recognition in a later act.

This is not the first time in the group's history that Federal legislation has been introduced on its behalf to mirror a change in name designation by the State. In 1924, the Interior Committee favorably reported to the House, H.R. 8083, a bill to change the name of the group from Croatan to Cherokee. The committee report notes the purpose of the bill:

By an act of the State of North Carolina these Indians have recently been designated as Cherokee Indians, and this legislation carries out this act and gives the Indians the same Federal status * * *.

Clearly, the 1956 act served the same purpose.

Mr. Chairman, all of this preceding information aside, the argument that the act somehow recognizes the Lumbees is especially disingenuous when examined in light of the prevailing congressional Indian policy at the time. Over the years, congressional dealings with the tribes have gone through several policy phases. Until 1887, the basic approach to dealing with the tribes was conquest and segregation to designated territories and reservations. Between 1887 and 1934, the Federal Government implemented a program directed at assimilating Indians into the dominant culture. In 1934, with the adoption of the Indian Reorganization Act, the Government began to encourage tribal sovereignty and self-governance. In 1953, Congress formally adopted a policy of "termination," its express aim being "as rapidly as possible, to make the Indians within the territorial limits of the United States subject to the same laws and entitled to the same privileges and responsibilities as are applicable to other citizens * * * and to end their status as wards of the United States. * * *" In other words, the new policy sought to force Indians into the mainstream culture by terminating their separate tribal status and the benefits they received from that status. Pursuant to this policy, during the 1950's Congress terminated the Federal recognition—and thereby the benefits—of some 110 tribes consisting of more than 13,000 individuals. They were than subject to State laws, and their lands were converted to private ownership and in most instances sold.

In the same year in which the 1956 Lumbee Act was passed, Congress terminated four tribes: the Lower Lake Ranacheria, the Wyandotte, the Peoria, and the Ottawa. To interpret the Lumbee Act as granting Federal recognition to the Lumbees during a period in which Congress was actually terminating recognized tribes is to indulge in historical revisionism at its worst and fabricates a result clearly contrary to the avowed policy and stated intent of Congress during this period.

In sum, it is clear from the wording of the 1956 act, as well as from its legislative history, that the act simply institutionalized on the Federal level a name for the group adopted by the State of North Carolina in 1953. Contemporary news reports support this conclusion, as do the opinions of the Federal courts, administrative agencies, and the Library of Congress Congressional Research Service.

The second portion of the argument regarding the 1956 Lumbee Act—that it precludes the Lumbee from petitioning for recognition—may have more merit. In response to concerns raised that the Act would somehow allow tribal members to avail themselves of Federal services even though not part of a recognized tribe, the following section was appended to the bill prior to passage to "clearly indicate that the Lumbee Indians w[ould] not be eligible for any services provided through the Bureau of Indian Affairs to other Indians":

Nothing in this Act shall make such Indians eligible for any services performed by the United States for Indians because of their status as Indians, and none of the statutes of the United States which affect Indians because of their status as Indians shall be applicable to the Lumbee Indians.

The Department of the Interior and others have concluded that this portion of the act essentially prohibits the Lumbee from petitioning for recognition under the FAP. While I do not necessarily agree with the accuracy of that conclusion, such agreement is essentially unimportant to this discussion since the present and binding position of the Bureau is that the 1956 act does constitute a bar to petitioning.

Given this stance, the logical solution is to amend the act to allow the Lumbee to petition—the solution proposed by an amendment in the nature of a substitute which I offered at subcommittee and full committee markup—and not simply to ignore the problem in the rush to circumvent the recognition process. The amendment would have directly addressed all of the Lumbee concerns. It would, inter alia, remove the 1956 Lumbee Act's statutory bar to the FAP process. In addition, it would directly remedy the most oft-cited flaw of the FAP—the time it takes to review a group's petition—by guaranteeing the Lumbee petition expedited consideration, and provide for Federal district court review of untimely or adverse determinations by the BIA without requiring resort to the administrative appeals process which any other group would have to exhaust prior to taking the matter to Federal court. I note that the Department of the Interior, which opposes H.R. 334, supports this alternative.

Mr. Chairman, the majority's next contention is that the Lumbee are justified in bypassing the FAP because the process is cumbersome and ineffective. The FAP has come under fire over the last few years. There are those who argue—correctly in some instances—that the process takes longer to complete than is provided for in the agency's regulations, costs each group financial resources they do not have, and

is subject to the whims of the BIA staff. In limited defense, I point out that because the FAP establishes a permanent government-to-government relationship with a tribe, the BIA is very cautious about its determinations. This kind of exhaustive research takes a lot of time, as does the process of preliminary review, notification to the tribe of deficiencies, and waiting for the tribe to respond to these deficiencies with a supplemental petition. In addition, the FAP teams have been historically underfunded by this Congress and there have never been more than two. Still, the process clearly has its faults.

While I have always agreed that the FAP is in need of repair, it is not as broken down as the bill's proponents would have us believe. For example, I have repeatedly heard Members state that there is a backlog of 120 cases waiting to be processed, and that only 8 tribes have made it through the process since its inception. However, those numbers—oft-parroted as the premier example of why the FAP should be bypassed—are patently spurious and unsupported by the record. There were 40 petitions on hand when the FAP office organized in October 1978, and 96 petitions or related inquiries have been filed since then for a total of 136 cases. Of these, 8 groups have been recognized; 13 have been denied recognition; 1 was determined to be part of a recognized tribe; 1 had its status clarified by legislation at the BIA's request; 1 had its previously terminated recognition restored; 3 were legislatively acknowledged; 1 withdrew its petition and merged with another petitioner; and 7, including the Lumbee, require legislative action to permit processing. This means that a total of 35 cases, no 8 as others contend, have been resolved since 1978: 23 by the BIA, 4 by Congress, 1 of its own accord, and 7 because they are precluded from petitioning.

Of the 101 remaining cases, 19 are considered inactive because the groups have not responded to BIA inquiries or cannot be contacted; 47 have submitted only letters of intent to petition informing the BIA that at some unspecified time in the future they will submit their actual petitions; and 25 groups are in the process of responding to letters of obvious deficiency from the BIA and have not filed final petitions. In simple terms, 90 percent of the petitions pending in the FAP are awaiting tribal, not BIA, action. Of the remaining 10 cases, 3 are under active consideration; 1 has been resolved with a proposed negative finding; 1 has been resolved with a proposed negative finding but the comment period has been left open at the tribe's request; 1 has been resolved with a proposed positive finding; 3 are waiting to be placed on active consideration; and 1 is awaiting review for obvious deficiencies in its petition. Even a cursory examination of these numbers shows that although the majority has claimed there is a backlog of 120 cases, the actual backlog—even counting cases presently under active review—is at the very most only 7 cases.

In any event, just as the logical solution to the problems posed by the 1956 Lumbee Act is to amend it to correct any impediment to recognition, so too is correction the proper response to allegations that the FAP process is inefficacious. Several bills have been introduced over the past few years to overhaul and streamline the process, the most recent being H.R. 3430 introduced last session by Congressman John J. Rhodes III, the then-chairman of the Republican Task Force on Indian Affairs, and reintroduced this session by Delegate FALEOMAVAEGA. Despite the chorus of Democrat complaints about the process, though, the majority has never seriously pursued any of these bills in committee, seeming to prefer instead the introduction of a string of ad hoc recognition bills designed to circumvent the process entirely.

Bypassing the process not only ignores the problem, but is unfair to all of the recognized tribes. There exists a formal government-to-government relationship between the recognized tribes and the United States. If Congress creates tribes at will, without meaningful uniform criteria or substantial corroborated evidence that the group is indeed a tribe, then we dilute and weaken that relationship. A sizable majority of tribes have objected to H.R. 334 for just this reason. We have received resolutions that support the FAP process and a strict adherence to a systematic procedure from tribes in 12 States, from regional intertribal organizations representing all the tribes of the Pacific Northwest, Montana, and Wyoming, the United South and Eastern Tribes—representing all the tribes from Maine to Florida and west to Louisiana, all of the 10 southwestern Pueblo tribes, and 25 of the 26 tribes of Arizona.

Passage of H.R. 334 is also patently unfair to all of the other petitioning groups. If the process is so ineffectual that the Lumbee should be excused from it, then what of the other 100 tribes presently in the process? What of the other 10 groups in North Carolina who have petitioned, 6 of whom are precluded from petitioning by the same 1956 act of which the Lumbee complain? If the majority decides to recognize the Lumbee in whole or in part, because they deem the FAP process to be necrotic, does not equity require that we immediately put before the House, bills to provide for the recognition of all these other groups too? It is sadly ironic that the Lumbee have stated that the process is so flawed that they should be excused from it, but that no other group should be. Finally, what about those groups that have been denied recognition under this superfluous FAP process; do we now open our doors to them and allow them another bite of the recognition apple? It would be patently unfair to require some groups to be judged under the administrative standards and allow other groups to be judged in Congress under no discernible standards simply because they are able to avail themselves of a powerful and influential sponsor. Should the majority persist in moving this and other ad hoc recognition bills through the House based on this premise, then we will be happy to accede to their argument and introduce separate bills to legislatively recognize each of the 101 groups presently in the BIA process. While dramatic, I believe that such a move would expose the majority's FAP argument for what it is—merely a convenient canard.

Finally, passage of H.R. 334 would be unfair to those North Carolina Indian groups seeking recognition such as the Hatteras Tuscarora. The expansive Lumbee membership criteria, which would be effectively codified by passage of H.R. 334, make Lumbee the descendent of anyone identified as Indian in five North Carolina counties and two South Carolina counties in either the 1900 or 1910 Federal census. But note—these census returns do not differentiate among Indian individuals by tribal affiliation; the listings simply say "Indian"—not "Cheraw" or "Croatan" or "Lumbee." Thus, any person listed as Indian in either census—even if she were a Navajo, Shoshone, Catawba, Tuscarora, or Cherokee—is considered Lumbee under this bill. Of the 10 or so tribal petitioners in North Carolina, 5 are from Robeson or surrounding counties. The language of H.R. 334 thus subsumes these groups into the Lumbee. I am not convinced of the ultimate efficacy of provisions of that bill added ostensibly to address the concerns of these groups; and in its rush toward passage I note that the majority is apparently indifferent to their plight.

Aside from the obvious inequities to other native groups, I cannot help but consider the effects of a case in which we are wrong in our assessment of a group seeking legislative recognition. As I have repeatedly stressed, we are not equipped to make an informed decision in this area. It has been estimated by one authority that at least 15 percent of groups currently seeking recognition are essentially bogus Indian groups, or Indian descendent recruitment organizations, composed of predominately non-Indian persons. If we make a mistake, and recognize a group that should not have been accorded that status, then we sully the relationship with the tribes even further.

Moreover, legislative acknowledgement of the Lumbee in the absence of any established recognition criteria raises serious constitutional questions.

Despite our plenary power over Indians, Congress may not arbitrarily confer Federal recognition as an Indian tribe on any group claiming to be a tribe. If we act to recognize the Lumbee, or any other group, in the absence of any set guidelines, then it seems to me that we act ultra vires—outside the bounds of what is constitutionally permissible.

In conclusion, while the recognition process is in need of repair, it is not as crippled as the majority would have us believe. There is only a backlog of, at the most, 8 petitions, not the 120 cases often cited. While I concede that the process is imperfect, the most rational solution is to fix it. Continually seeking to bypass it only ignores the problem and forces us to address it over and over again. In addition, it undermines the role of the BIA, is unfair to both the recognized and unrecognized tribes, and raises constitutional concerns.

Finally, Mr. Chairman, the majority's last rhetorical refuge is to assert that approval of the bill is simply consistent with congressional precedent to enact recognition legislation. Were the principles of stare decisis somehow applicable here, I would remind the majority of the legal axiom that precedent is meant to be a guide, not a straitjacket. However, principles of precedent are not involved here since each of those examples cited by the proponents is easily distinguishable from the 1956 Lumbee Act. Since 1978, the year the BIA promulgated the FAP regulations, Congress has approved 17 acts pertaining to recognition of tribal groups. More than half of the cited acts were bills restoring Federal recognition to groups that had once been officially recognized, but were terminated by legislation—a status to which the Lumbee cannot lay claim. The rest involved unique circumstances not applicable to the Lumbee.

The principal stylobate upon which the majority rests its precedent argument is fatally flawed. Attempting to draw an analogy to the Lumbee, their report states:

> Since the promulgation in 1978 of the regulations governing administrative acknowledgement, the Congress has considered the status of 10 other Indian tribes also ineligible for the administrative process. In every case, Congress enacted recognition legislation.

Yet in the very next sentence in which are cited the bills purportedly supporting that thesis, the majority guts its own argument. The legislation cited is not recognition legislation at all, but restoration legislation—the word "restoration" appears in the title of each act cited. There is a clear legal distinction between a recognition bill, which establishes the government-to-government relationship between the United States and a tribe for the very first time, and a restoration bill, which simply reinstates a relationship which once existed but was terminated by statute or treaty. No amount of obfuscation can turn one into the other. These nine bills, therefore, cannot possibly serve as precedent for the Lumbee case.

Of the eight remaining acts, four were related to the recognition of tribes in the context of eastern land claims. In these bills, Congress extended recognition to several groups as part of settlements of the tribes' legal claims to land in Maine, Connecticut, and Massachusetts. Another act pertained to a tribe that had already been recognized as part of another tribal entity; one acknowledged a band as a subgroup of another recognized tribe; and one act involved a group that was aboriginally indigenous to Mexico and thus specifically excluded from the administrative regulations.

This leaves only one act, the slightly more analogous Texas Tiwa legislation. Often cited by the Lumbee as the best parallel to their situation, the Tiwa Act differs significantly from the 1956 Lumbee Act. In 1968, Congress transferred responsibility over the Tiwa Tribe, now known as the Ysleta del Sur Pueblo, and their lands to the State of Texas, thereby terminating any Federal relationship with the tribe. The act read, in pertinent part:

> Responsibility, if any, for the Tiwa Indians of Ysleta del Sur is hereby transferred to the State of Texas. Nothing in this act shall make such tribe or its members eligible for services performed by the United States for Indians because of their status as Indians * * * and none of the statutes of the United States which affect Indians because of their status as Indians shall be applicable to [them].

Congress later reversed itself, thereby restoring recognition to the Tiwa, when informed by the State that the latter could not legally hold tribal land in trust for the tribe.

The differences between this and the 1956 Lumbee Act are readily apparent. First despite attempts to characterize the Tiwa Act as recognition legislation, it is not; the Tiwa Act was restoration legislation, a status set forth in the very name of the act itself. As I have previously noted, recognition and restoration are two completely different legal concepts, and consequently the TIWA Act—restoration—is not precedentially analogous to the Lumbee case—recognition. Furthermore, no similar transfer of responsibility has ever taken place between the United States and North Carolina with regard to the Lumbee, nor has the United States ever held land in trust for this group. Unlike the Tiwa case, there has never been any trust responsibility between the United States and the Lumbee. Moreover, the 1968 Tiwa Act specifically refers to the Tiwa as a tribe, a denomination noticeably lacking in the Lumbee Act.

In sum, the 1956 Lumbee Act did not in any way extend Federal recognition to the Lumbees. Rather, it merely designated this group of Indians by a particular name to reflect a similar designation made at the State level. This interpretation is borne out by the wording of the act itself, the legislative history, contemporary news reports, and Federal court rulings. While the act can be read as precluding the Lumbees from petitioning for recognition, the logical solution to that impediment is to amend the act to remove the bar.

Furthermore, the argument that the Lumbee should be allowed to bypass the process because it is too cumbersome and backlogged is equally specious. While the BIA recognition process is in need of repair, it is not as decrepit as the majority would have us believe. There is only a backlog of 9 petitions, not the 120 cases often cited; and while I concede that the process is imperfect, the most rational solution is to fix it. Bypassing the process only ignores the problem, undermines the role of the BIA, and is unfair to both the recognized and unrecognized tribes.

In turn, the Lumbee assertion that approval of this bill is simply consistent with congressional precedent rests upon a flawed rhetorical premise. The examples of legislation they cite to support this proposition are either not recognition legislation or are easily distinguishable from the Lumbee case and therefore are of no precedential value.

Mr. Chairman, before I close I must point out one glaring inaccuracy put forward by Members on the other side of the aisle today as a justification for passage of this bill. We have heard, and will hear I'm sure, several Members state that the Lumbee have been seeking Federal recognition since 1888. This is simply not true, and only supports my contention that most Members are woefully uninformed about the real facts of this case.

In 1888 and 1889, the Lumbee petitioned Congress not for Federal recognition as an Indian tribe, but only to have money appropriated to help pay for their school system. All congressional contacts from that time until approximately 1988 centered solely on name changes for the group, with occasional requests for monetary assistance. It was not until 1988 that a bill to recognize the Lumbee was introduced. To argue then that we should recognize the Lumbee because they have been waiting more than 100 years for recognition is completely inaccurate—they've been waiting one-twentieth of that time.

Mr. Chairman, the past two administrations opposed this bill. The BIA has always opposed this bill, and that opposition had not changed under the new administration until yesterday. A letter from the Department of the Interior dated May 3, 1993, outlines why they objected to the bill. However, as

of yesterday the administration did a 180-degree about face and now does not object to passage. Since the substance of the bill has not changed between May 3 and today, I suspect that political motives are behind the Department's sudden change of heart.

In any event, Mr. Chairman, the overwhelming number of tribes in this country oppose this bill. I strongly urge the House to do the same.

Mr. Chairman, I submit the following documents to be included in the RECORD, and reserve the balance of my time.

U.S. DEPARTMENT OF THE INTERIOR,
Washington, DC, May 3, 1993.

Hon. GEORGE MILLER,
Chairman, Committee on Natural Resources, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This responds to your request for a report on H.R. 334, a bill "To provide for the recognition of the Lumbee Tribe of Cheraw Indians of North Carolina, and for other purposes."

We oppose the bill because we believe that questions concerning the Indian ancestry and tribal affiliation of the Lumbees need to be resolved before the Department can support Federal recognition of the group. We also believe that the fairest and most expedient way to answer questions concerning Lumbee history would be for the Lumbees to go through the established administrative process (25 CFR 83) as other groups are required to do. Legislative recognition of any group avoids the rigorous and impartial standards upon which the acknowledgment process is based. It would also encourage other unacknowledged groups to avoid having to abide by those standards.

We would favor the introduction of legislation which would clarify the language of the Act of June 7, 1956 "Relating to the Lumbee Indians of North Carolina", (70 Stat. 254), so as to allow the group to petition through the acknowledgment process as any other unacknowledged group can.

We will submit very shortly a full report which sets out in detail our concerns about legislative acknowledgment of the Lumbee group.

Sincerely,

THOMAS THOMPSON,
Acting Assistant Secretary—Indian Affairs.

A MEMORIAL TO THE MEMBERS OF THE U.S. SENATE AND HOUSE OF REPRESENTATIVES ON H.R. 1426, LUMBEE RECOGNITION LEGISLATION

We, the undersigned elected officials of federally recognized Indian tribes from across the United States do hereby memorialize the House of Representatives and Senate of the United States to carefully consider our views on the legislation now pending before the Senate to grant federal recognition to the Lumbee Indians of North Carolina. It is our jointly held view that the Congress should not enact such legislation.

We join in the resolutions previously adopted by many individual tribes as well as by regional inter-tribal Indian organizations including, but not limited to, the Affiliated Tribes of Northwest Indians, the Montana-Wyoming Tribal Chairmen's Association, the Southern Pueblos Governors Council and the Eight Northern Pueblos, all of whom have opposed the enactment of this legislation and insisted that the Lumbees, together with other non-recognized groups of Indians seeking federal recognition, should go through the well established administrative process within the Interior Department known as the Federal Acknowledgement Process (FAP—25 CFR, Part 83). To allow the Lumbees to circumvent the FAP by attaining legislative recognition would be a mistake.

We feel that the FAP is the best available process whereby equitable criteria can be uniformly applied toward petitioning groups of Indians seeking federal recognition and we feel that the process of attaining recognition must be very deliberative, methodical and thorough. Federal recognition is the establishment of a permanent government-to-government relationship and that relationship is one we view as both pivotal and critical to the future well being of our tribes and citizens. The Congress of the United States has not adopted any criteria that it uses in determining the validity of a group's claim to be treated as a federally recognized tribe. If, absent a treaty, no criteria are used and the Congress simply legislatively establishes a federally-recognized tribe at will, the government-to-government relationship and the trust responsibility will be weakened for all tribes.

We feel that attempts to revise history by contending that the Lumbees were somehow previously partially recognized are disingenuous and misleading. We object to attempts to muddy the distinction between Restoration bills, which restore the federal relationship for those tribes that were unfortunately terminated; as opposed to Recognition bills, which, like HR 1426, proposed the establishment of the federal relationship for the first time. We support legislation to rectify any obstacles, such as the 1956 legislation, that would impede the processing of the Lumbees FAP petition.

We express our strong concern that HR 1426 would create the third largest tribe in the country (the Lumbees claim a membership of over 40,000 people including thousands in Detroit, Michigan and Baltimore, Maryland) which would completely over-burden existing underfunded BIA and IHS programs. While we do not object to federal services being provided to the Lumbees if they go through the FAP and meet criteria that other non-recognized have met, we strongly object to multi-million expenditures coming from federal tribal programs for a group who may not legitimately constitute a tribe.

We urge the Congress to examine the history of the FAP regulations and to realize that it was a process supported by tribes and the Congress to assure that an equitable, non-arbitrary process could be used in determining which Indian groups should be recognized. If the Congress determines that the FAP needs amending, we would support procedural amendments providing that the existing criteria are not weakened and that all groups seeking recognition be required to adhere to the FAP regulations.

We therefore urge the rejection of HR 1426 by the Senate and we ask the Members of the Senate to vote against the bill and against any attempts to invoke cloture intended to cut off debate on the bill.

COLORADO RIVER INDIAN TRIBES,
COLORADO RIVER INDIAN RESERVATION,
Parker, AZ, September 13, 1988.

Hon. DENNIS DECONCINI,
Hart Senate Office Building, Washington, DC.

DEAR SENATOR DECONCINI: The Colorado River Indian Tribes is opposed to enactment of S. 2672 which would provide for federal recognition and services to the Lumbee Tribe of North Carolina. Federal recognition of an Indian tribe should involve a detailed inquiry into the sovereign status of the group requesting recognition. Such an inquiry should ensure that all pertinent information is available for review and that all tribes seeking federal recognition are treated in an equal manner. The Bureau of Indian Affairs has established a procedure for conducting a detailed inquiry and reviewing petitions for federal acknowledgment, 28 C.F.R. Part 83. Requiring tribes to follow this procedure ensures that all those who receive federal acknowledgment are entitled to such recognition and receive equal treatment in the review process. The tribe requests that you allow the administrative process to function by opposing S. 2672 and requiring the Lumbee Tribe to utilize the administrative process.

Sincerely yours,

ANTHONY DRARNAN, SR.
Chairman, Tribal Council.

RESOLUTION NO. 88-5

Whereas, the Southern Pueblos Governors Council is comprised of the Pueblos and Acoma, Cochiti, Isleta, Ysleta Del Sur, Jemez, San Felipe, Sandia, Santa Ana, Santo Domingo, Zia, and Zuni; and,

Whereas, these Pueblos have received information that S. 2672, proposes to circumvent the Federal Acknowledge Project and would confer federal recognition upon the Lumbee Indians of North Carolina; and,

Whereas, this proposed legislation presents too many complex, unresolved issues to be rushed through Congress at this last minute and that Indian Tribes across the nation should be afforded the courtesy of sufficient time to address thee issues; and,

Whereas, the Federal Acknowledgement Project (FAP) has established certain objective criteria that must be met and the Lumbee Tribe is obligated to provide satisfactory factual evidence and to wait their turn for other Tribes who have petitioned earlier for recognition; and,

Whereas, the Pueblos are concerned with the precedent that may be established by this bill and its unfairness to other Tribes awaiting their turn seeking recognition; and,

Whereas, the Congress, the Executive Branch, and the Federal Courts have recognized that the United States has a Government-to-Government relationship with Indian Tribes and a trust obligation to them. If Congress creates Indian Tribes at will, without meaningful criteria or substantial evidence that a group is in fact a Tribe within the normal meaning of that term than the Government-to-Government relationship and the trust responsibility will be enormously weakened: Now, therefore, be it

Resolved, the Southern Pueblos Governors Council is opposed to S. 2672 which would circumvent the Federal Acknowledge Project to the Lumbee Indians of North Carolina and that Congress seek an amendment to the 1956 Lumbee Act expressly to qualify the Lumbees for eligibility under the FAP process: Be it further

resolved, That:

1. Congress appropriate more funds under New Tribes Funding and that the Bureau of Indian Affairs be mandated to include funding and data on the program requirements of newly recognized tribes, rather than taking the funding from existing BIA Programs.

2. A further deadline be established by the Congress for Tribes seeking such recognition.

3. If the Lumbees, or any other group petitioning for recognition under FAP, can meet

the established standards, the Southern Pueblos Governors Council welcomes them into the community of soverign, federally recognized Tribes.

RESOLUTION No. 89-16

Whereas: The Big Pine Tribal Council is the duly elected governing body of the Big Pine Band of Paiute/Shoshone Indians, and

Whereas: the Bureau of Indian Affairs has promulgated rules and regulations contained in 25 CFR Part 83, providing for specific procedures and criteria for Indian groups to petition for the Department of the Interior for Federal recognition, and

Whereas: a number of Indian groups have gone through the existing CFR process, of which some, having met the criteria, were recognized and others, not meeting the criteria were rejected, and

Whereas: legislation was pending in the 100th Congress, and is likely to be reintroduced in the 101st Congress, to legislatively grant federal recognition to the Lumbee Indians of North Caroline, and

Whereas: the proposed Lumbee legislation singles out one petitioning group for expeditious treatment without any true rational or unique reason for doing so and with the knowledge that several tribal groups with meritorious petitions for such recognition will be required to complete the CFR process, and

Whereas: the creation of one of the largest tribes in the United States and the concomitant fiscal outlay estimated at between $90 million to $120 million annually and the establishment of a fiduciary trust relationship with a tribe should not be made without the deliberate and careful consideration of ethnological, historical, legal and political evidence as required by the CFR process, now therefore be it

Resolved: That the Big Pine Tribal Council does hereby state it's position that groups of non-federally recognized Indians desiring federal recognition should go through the administrative process whereby a consistent set of criteria can be uniformly and deliberatively applied using ethnological, historical, legal and political evidence and does therefore call upon the Congress to reject legislation granting recognition to the Lumbee Indians of North Carolina.

Be It Further Resolved: That the Big Pine Tribal Council does hereby call on the Senate Select Committee on Indian Affairs, the House Interior and Insular Affairs Committee and the Interior Appropriations Sub-Committees to hold oversight hearings, including field hearings, in the 101st Congress, on the existing Bureau of Indian Affairs procedures (25 CFR, Part 83) including the adequacy and timeliness of the existing process as well as sufficiency of budget and staff at the Branch of Acknowledgement and Research and to make recommendations for changes to the existing process if so warranted.

Be it further resolved: That the Big Pine Tribal Council does support, at the least, the proposed $650,000 increase for FY 1990 for the Branch of Acknowledgement and Research to enable the Bureau to more expeditiously process the pending Lumbee and other Indian Groups petitioned.

RESOLUTION 89-10

Whereas, the Kaw Tribe of Oklahoma is federally recognized by the Secretary of the Interior by a Governing Resolution adopted and ratified on October 7, 1958, and

Whereas, the Kaw Tribal Business Committee is the governing body of the Kaw Tribe of Oklahoma, and

Whereas, legislation was pending in the 100th Congress, and it likely to be reintroduced in the 101st Congress, to legislatively grant federal recognition to the Lumbee Indians of North Carolina; and

Whereas, the American Indian Policy Review Commission, the Congress of United States and the National Congress of American Indians have all previously called for the establishment of a consistent set of criteria and a special office through which unrecognized groups of Indians could petition for federal recognition; and

Whereas, the Bureau of Indian Affairs has responded to such recommendations by promulgating rules and regulations contained in 25 CFR, Part 83, providing for specific procedures and criteria for Indian groups to petition the Department of the Interior for federal recognition; and

Whereas, a number of Indian groups have gone through the existing CFR process, of which some, having met the criteria, were recognized and others, not meeting the criteria were rejected; and

Whereas, the proposed Lumbee legislation singles out one petitioning group for expeditious treatment without any true rational or unique reason for doing so and with the knowledge that several tribal groups with meritorious petitions for such recognition will be required to complete the CFR process; and

Whereas, the creation of one of the largest tribes in the United States and the concomitant fiscal outlay estimated at between $90 million to $120 million annually and the establishment not be made without the deliberate and careful consideration of ethnological, historical, legal and political evidence as required by the CFR process;

Therefore be it resolved, with full authority and approval, a quorum being present, the Kaw Tribal Business Committee does hereby state its position that groups of non-federally recognized Indians desiring federal recognition should go through the administrative process whereby a consistent set of criteria can be uniformly and deliberatively applied using ethnological, historical, legal and political evidence and does therefore call upon the Congress to reject legislation granting recognition to the Lumbee Indians of North Carolina.

Be it further resolved, that the Kaw Tribal Business Committee does hereby call on the Senate Select Committee on Indian Affairs, the House Interior and Insular Affairs Committee and the Interior Appropriations Subcommittees to hold oversight hearings, including field hearings, in the 101st Congress, on the existing BIA procedures (25 CFR, Part 83) including the adequacy and timeliness of the existing process if so warranted.

Be it finally resolved that the Kaw Tribal Business Committee does support, at least, the proposed $650,000 increase for FY '90 for the Branch of Acknowledgement and Research to enable the Bureau to more expeditiously process the pending Lumbee and other Indian groups' petitions.

RALEIGH, NC,
August 17, 1988.

Hon. JESSE HELMS,
U.S. Senate,
Washington, DC.

DEAR SENATOR HELMS: The Tusacarora Indian Community of Eastern North Carolina would like to enlist your help concerning the Lumbee Recognition Act. We like other eastern Indian groups have petitions for recognition under the Federal Acknowledgement Procedure. Will we get the same treatment as the treatment and consideration as the Lumbees?

Secondly, the bill will seriously hurt our efforts for recognition because of it's wording. For years now we have been trying to get from under the 1956 Lumbee Indian Act which designated all the Indians of Robeson and surrounding Counties as Lumbee Indians. However there were and still is other Indian tribes in that specified area. They are recognized by the state of North Carolina as separate tribal entities. They are the Ocharia Indians and the Wassamaw-Souian Indians. Are they also Lumbees? By the 1956 Act, they are because they live in counties that surround Robeson County, What about our people who live in Maxton and adjoining townships of western Robeson County? Are we Lumbees? No. Yet we will all fall into the designation as Lumbees. We will never be Lumbee Indians. We would rather die then give up our tribal heritage.

So this new bill force us to deny our heritage. A heritage that is older and has more of a historical basises. We are a separate tribal entity. We are desirous of preserving and confirming our tribal heritage. We would like to ask you if you can get them to change the bill. So it will either recognize us as a separate tribal entity or put a clause in it making it not applicable to us. We would prefer the first named item. Any assistance you can give us will be deeply appreciated.

Sincerely yours,

A.J. AUSTIN.

THE SAULT STE. MARIE TRIBE
OF CHIPPEWA INDIANS,
Sault Ste. Marie, MI, February 20, 1989.

Senator DANIEL K. INOUYE,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR INOUYE: I am writing today to request that you act to insure the established criteria be followed in regards to the Lumbee recognition issue. We are very concerned with attempts by the Lumbee group to circumvent existing criteria.

It is the position of the Sault Ste. Marie Band of Chippewa Indians that all groups seeking federal recognition should follow the established guidelines for federal recognition. Furthermore should the existing guidelines need clarification all federally recognized tribes should have input into any changes in that criteria. Finally we oppose any circumvention of the existing criteria for federal recognition.

It is the position and opinion of the Sault Ste. Marie Tribe of Chippewa Indians that the existing criteria is sufficient for establishing recognition for an Indian group.

We feel the underlying reasons for the lengthy delays in the recognition process is the small operating budget the Bureau of Acknowledgement and Records has to services such claims. We feel the best way to correct the process would be more appropriations for the Bureau of Acknowledgement and Records.

We request you act to insure the established criteria is followed in the recognition of any Indian group. We ask that our views be acknowledge as part of the public input on this matter.

In closing Mr. Chairman and Distinguished Members, I would like to extend my appreciation for the opportunity to enlighten your committee on this matter.

Respectfully,

BERNARD BOUSCHOR,
Tribal Chairman.

RESOLUTION No. B-88-193

Whereas, the United South and Eastern Tribe is an inter-tribal council composed of

seventeen federally recognized tribes in the Eastern United States; and

Whereas, from time to time, various groups have approached the Board of Directors seeking support for their petitions for Federal recognition; and

Whereas, an established set of criteria exists within the Bureau of Indian Affairs to obtain said recognition.

Now, therefore, be it resolved that the Board of Directors of United South and Eastern Tribes hereby support any group that can successfully meet said criteria in their efforts to obtain Federal recognition.

RESOLUTION NO. 116

Whereas, a petition has been submitted to The United South and Eastern Tribes, Inc. (USET) for that Indian organization to support a request for recognition of the Lumbee as a Federal Indian tribe; and,

Whereas, both the Eastern Band of Cherokee Indians and USET has in the past opposed Federal recognition of the Lumbee on specific grounds; and,

Whereas, the Eastern Band memorialized its position on the Federal recognition of any Indian group by specific objective standards in resolution No. 216 (1974); and,

Whereas, the Eastern Band does not reaffirm its consistent policy in this regard and requests USET not to support a request for Federal recognition by Lumbee or any other Indian group until or unless they satisfy the previously established critiera.

Now, therefore, be it resolved, by the Tribal Council of the Eastern Band of Cherokee Indians, in Annual Council assembled, with a quorum present, that The United South and Eastern Tribes, Inc. is hereby requested not to support any request for Federal recognition for tribal status by Lumbee or any other group unless or until such group satisfies at least four of the following seven criteria for Indian tribal status:

(1) A history of entering treaties with the United States Government.

(2) Show enrollment with a Federally recognized Indian tribe.

(3) Inclusion in the most recent BIA census.

(4) Substantial evidence of Indian language, history, foods, technology and religion.

(5) Recognition by national Indian tribal organizations to be a member of the root race or aborigine.

(6) Have a claim settled by or before the United States Claims Commission.

(7) Be an offspring of sufficient blood quantum recognized by the tribe, with proof of parents qualified under any four of the above.

RESOLUTION OF THE MONTANA/WYOMING CHAIRMEN'S ASSOCIATION

Whereas, legislation has been introduced in the Congress of the United States to legislatively grant Federal recognition to the Lumbee Indians of North Carolina, and

Whereas, there exists in the Code of Federal Regulations (25 CFR Part 83) a specific procedure and criteria for Indian groups to petition the Department of the Interior for Federal recognition, and

Whereas, this section of the CFR was established pursuant to pressure on the Bureau of Indian Affairs (BIA) by tribes and Congress to establish a consistent set of criteria under which Indian groups should petition for recognition, and

Whereas, the NCAI resolution that led to the establishment of these regulations called for "A valid and consistent set of criteria applied to every group which petitions for recognition. The criteria applied to every group which petitions for recognition. The criteria must be based on ethnological, historical, legal, and political evidence, and

Whereas, a number of groups have gone through the existing CFR, some which have been successful and some who have not met the criteria, have been rejected for recognition, and

Whereas, a number of groups, including one in Montana, are presently in the midst of having their petitions reviewed, and

Whereas, there is no justifiable reason for the Lumbee to be allowed to circumvent the established process by instead seeking legislative recognition, and

Now, therefore be it resolved that the Montana/Wyoming Tribal Chairmen's Association meeting in Billings, Montana, on September 15, and 16, 1988, does hereby go on record in opposition to S. 2572 and H.R. 5042.

RESOLUTION NO. 88-219

Whereas, the above referenced legislation has been introduced in the Congress of the United States to legislatively grant federal recognition to the Lumbee Indians of North Carolina; and

Whereas, upon the recommendation of the National Congress of American Indians there were promulgated rules and regulations contained in 75 CFR, part 83 providing for specific procedures and criteria for Indian groups to petition the Department of Interior for federal recognition; and

Whereas, a number of Indian groups have gone through the existing CFR process, of which some, having met the criteria, were recognized and others not meeting the criteria were rejected; and

Whereas, the legislation singles out one Indian group for expeditious treatment in the face of a lack of any rational reason for doing so and with the knowledge that several tribal groups with meritorious petitions for such recognition, including the Little Shell Band of Montanas, will be required to complete the CFR process; and

Whereas, the creation of the second largest Indian tribe in the United States and the concomitant fiscal burden estimated in excess of One Hundred Million Dollars ($100,000,000.00) should not be made without the deliberate and careful consideration of ethnological, historical, legal and political evidence as required by the CFR process;

Now, therefore, be it resolved, that the Confederated Saliah and Kootanai Tribes of the Flathead Reservation, hereby records its opposition to the "Lumbee Recognition Act" and urges that the act be rejected, and that the Lumbee petition for recognition be allowed to take its course within the Department of Interior process set out in 25 CFR, part 83.

RESOLUTION NO. 88-58

We, the members of the Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendents-rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States and several States, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish and submit the following resolution:

Whereas, the Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

Whereas, the Affiliated Tribes of Northwest Indians is a regional organization comprised of American Indians in the states of Washington, Idaho, Montana, Oregon, Nevada, northern California, and Alaska; and

Whereas, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of Affiliated Tribes of Northwest Indians; and

Whereas, the existing tribes in the United States and the Bureau of Indian Affairs have established a Federal Acknowledgement process, known as the Bureau of Acknowledgement and Research (BAR), to review and determine the eligibility of a petitioning tribe to become a Federally Acknowledged Tribe; and

Whereas, this BAR process has established criteria that must be met to determine the validity of a petitioning tribe's status as a Federally Acknowledged tribe; and

Whereas, a number of unrecognized tribes in the United States have been denied Federal Acknowledgement through this process (BIA Bureau of Acknowledegment and Research); and

Whereas, many of these same tribes, as well as others, are attempting to become Federally Acknowledged through Congressional legislation as an alternative approach; and

Whereas, Federal Acknowledgement should be based on established research principles rather than political judgements; and

Whereas, ATNI does not believe that the Committees of Congress have the time, resources, expertise, or knowledge of this field to adequately or qualitively research the validity of the acknowledgement of a tribe and that to legislatively acknowledge a new tribe circumvents the existing Bureau of Acknowledgement and Research process; and

Whereas, ATNI is also deeply concerned that this BAR process has sufficient funding, staff, and resources to expeditiously and adequately process the number of petitions that have been submitted through this program; and

Whereas, ATNI is also concerned about the final judgement within the BAR process that makes the final determination of eligibility based on the submitted criteria and feels that the Bureau of Indian Affairs should review this step to determine if a more equitable approach could be incorporated in lieu of the existing procedural now

Therefore, be it resolved, that Affiliated Tribes of Northwest Indian does hereby urge the President, Congress, National Congress of American Indians, and other tribes in the United States to only acknowledge the existing process known as the BLA Bureau of Acknowledgement and Research as the appropriate process for an alleged Indian Tribe to become Federally Acknowledged; and

Be it further resolved, that due to the magnitude of petitions submitted through this process and the backlog that currently exists, ATNI encourages the Bureau of Indian Affairs and Congress to increase the funding, staff, and resources of the BAR program, as well as review the procedures and criteria of the process to increase the accuracy and effectiveness of the process, as well as determine the fairness of the criteria and the appropriateness of the final determination step.

RESOLUTION 3-1-89-1

Whereas: legislation was pending in the 100th Congress, and is likely to be reintroduced in the 101st Congress, to legislatively grant federal recognition to the Lumbee Indians of North Carolina; and

Whereas: the American Indian Policy Review Commission, the Congress of the United States and the National Congress of American Indians have all previously called for the establishment of a consistent set of criteria and a special office through which unrecognized groups of Indians could petition for federal recognition; and

Whereas: the Bureau of Indian Affairs has responded to such recommendations by promulgating rules and regulations contained in 25 CFR, Part 83, providing for specific procedures and criteria for Indian groups to petition the Department of the Interior for federal recognition; and

Whereas: a number of Indian groups have gone through the existing CFR process, of which some, having met the criteria, were recognized and others, not meeting the criteria were rejected; and

Whereas: the proposed Lumbee legislation singles out one petitioning group for expeditious treatment without any true rational or unique reason for doing so and with the knowledge that several tribal groups with meritorious petitions for such recognition will be required to complete the CFR process; and

Whereas: the creation of one of the largest tribes in the United States and the concomitant fiscal outlay estimated at between $90 million to $120 million annually and the establishment of a fiduciary trust relationship with a tribe should not be made without the deliberate and careful consideration of ethnological, historical, legal and political evidence as required by the CFR process;

Now therefore be it resolved that the Cabazon Band of Mission Indians does hereby state its position that groups of non-federally recognized Indians desiring federal recognition should go through an administrative process whereby a consistent set of criteria can be uniformly and deliberately applied using ethnological, historical, legal and political evidence and does therefore call upon the Congress to reject legislation granting recognition to the Lumbee Indians of North Carolina.

Be it further resolved that the Cabazon Band of Mission Indians does hereby call on the Senate Select Committee on Indian Affairs, the House Interior and Insular Affairs Committee and the Interior Appropriations Subcommittee to hold oversight hearings including field hearings, in the 101st Congress, on the existing BIA procedures (25 CFR, Part 83) including the adequacy and timeliness of the existing process as well as sufficiency of budget and staff at the Branch of Acknowledgement and Research and to make recommendations for changes to the existing process if so warranted.

Be it finally resolved that the Cabazon Band of Mission Indians does support, at the least, the proposed $650,000 increase for FY '90 for the Branch of Acknowledgement and Research to enable the Bureau to more expeditiously process the pending Lumbee and other Indian groups' petitions.

RESOLUTION NO. WR-62-89

Be it resolved by the Tribal Council of the Walker River Paiute Tribe that:

Whereas, the governing body of the Walker River Paiute Tribe is organized under the provisions of the Indian Reorganization Act of June 18, 1934 (48 Stat 984) as amended, to exercise certain rights of home rule and be responsible for the promotion of the economic and social welfare of its members, and

Whereas, legislation is now pending in the Congress to legislatively grant federal recognition to the Lumbee Indians of North Carolina and,

Whereas, the American Indian Policy Review Commission, the Congress of the United States and the National Congress of American Indians have all previously called for the establishment of a consistent set of criteria and a special office through which unrecognized groups of Indians could petition for federal recognition and,

Whereas, the Bureau of Indian Affairs has responded to such recommendations by promulgating rules and regulations contained in 25 CFR, Part 83, by providing for specific procedures and criteria for Indian groups to petition the Department of the Interior for federal recognition and,

Whereas, more than twenty Indian groups have gone through the existing CFR process, with those meeting the criteria being recognized and those not meeting the criteria being rejected and,

Whereas, the proposed Lumbee bill singles out one petitioning group for expeditious treatment without any true rationale or unique reason for doing so and with the knowledge that several tribal groups with meritorious petitions for such recognition will be required to complete the CFR process and,

Whereas, the creation of one of the largest tribes in the United States, with approximately 40,000 members and the expected fiscal outlay establishment of a fiduciary trust relationship with a tribe should not be made without the deliberate and careful consideration of ethnological, historical, legal and political evidence as required by the CFR process.

Now therefore, be it resolved, by the Tribal Council of the Walker River Paiute Tribe, that the Walker River Paiute Tribe does hereby state its position that groups of non-federally recognized Indians desiring federal recognition should go through an administrative process whereby a consistent set of criteria can be uniformly and deliberatively applied by historians and anthropologists using ethnological, historical, legal and political evidence, and the Walker River Paiute Tribe does therefore call upon the Congress to reject legislation that would grant recognition to the Lumbee Indians of North Carolina.

Be it further resolved, that the Walker River Paiute Tribe does support the proposed funding increase for FY '90 for the Branch of Acknowledgement and Research (BAR) to enable the Bureau to more expeditiously process pending petitions and does hereby call upon the Congress to support this and further increases in the BAR budget if needed.

Be it further resolved, that should the Interior Solicitor indicate that the 1956 Lumbee legislation creates an obstacle to processing the ruling on the Lumbee BAR petition, the Walker River Paiute Tribe would support an amendment to that Act clarifying that nothing in said Act should effect the ability of the BIA to process and rule on the merits of the pending Lumbee recognition petition.

Be it further resolved, that the Walker River Paiute Tribe does hereby support legislation similar to S. 912 as introduced by Senator John McCain to establish meaningful and realistic time frames for the BIA to process pending petitions for recognition and which also preserves the existing well established criteria as contained in 25 CFR, Part 78.

SUMMARY STATUS OF ACKNOWLEDGMENT CASES

Petitions pending: 35.

BAR's action items: 9.

Active consideration: 5.

Final determinations: 1—Mohegan.

Proposed findings: 4—Snoqualmie, United Houma Nation, Duwamish (under contract), Ramapough.

Waiting to be placed on active consideration: 3—Chinook Indian Tribe, Pokagon Potowatomi, MOWA Band of Choctaw.

Deficiency reviews: 1—Piro/Manso/Tiwa Indian Tribe of the Pueblo of San Juan de Guadalupe.

Petitioner's action items: 26.

Commenting on proposed finding: 1—Snohomish.

Responding to deficiencies: 25.

Letters of intent to petition: 65.

Preparing petition/in contact with BAR: 46.

Inactive/does not respond to BAR inquiries: 19.

In litigation: 3—Samish (denied acknowledgment), San Juan Paiute (acknowledged), Ione (letter of intent to petition).

Cases resolved: 28.

By department: 23.

Through acknowledgment process:

Acknowledged: 8.

Denied acknowledgment: 13.

Determined part of recog'd tribe: 1—Texas Kickapoo.

Status clarified by legislation at department's request: 1—Lac Vieux Desert.

By Congress: 4.

Legislative restoration: 1—Confederated Tribes of Coos, Lower Umpqua & Siuslaw, OR.

Legislative recognition: 3—Cow Creek Band of Umpqua, Western (Mashantucket) Pequot, Aroostook Band of Micmacs.

By Other Means: 1—Merged with another petitioner: 1.

Cases requiring legislative action (Legislation required to permit processing under 25 CFR 83): 7—Lumbee Regional Development Assn., Hatteras Tuscarora Indians, Cherokees of Robeson & Adjoining Cos., Tuscaroras, Drowning Creek, Waccamaw Siouan Devlpmt Assn., Cherokees of Hoke Co., Tuscarora Nation of NC.

DETAILED STATUS OF ACKNOWLEDGMENT CASES

PETITIONS—35

Bar's action items—9

Under Active Consideration—5

Final Determination—1:

1032: Mohegan Indian Tribe, CT (#38) (A/C 11/3/87; pending, proposed neg finding pub'd 11/9/89; comments complete 3/1/91)

Proposed Findings—4:

425: Snoqualmie Indian Tribe, WA (#20) (A/C 5/21/90; Anthro section under contract)

17657: United Houma Nation, Inc., LA (#56) (A/C 5/20/91; proposed finding due 11/20/92)

356: Duwamish Indian Tribe, WA (#25) (A/C 5/1/92 under contract)

c2500: Ramapough Mountain Indians, Inc., NJ (#58) (A/C 7/14/92)

Waiting to be Placed on Active Consideration—3:

These petitions have been reviewed for obvious deficiencies in accordance with 25 CFR 83.9(b); petitioners have corrected deficiencies and/or have stated that their petition should be considered "ready" for active consideration.

Chinook Indian Tribe, Inc., WA (#57) (doc'n recv'd 6/12/81; CD ltr 3/8/82; rspns recv'd 7/23/87; 2nd CD ltr 11/1/88; complete, "ready" 8/13/92)

c2500: Pokagon Potawatomi Indians of Indiana & Michigan, IN (#75/78 (doc'n recv'd 11/2/88; CD ltr 2/22/90; rspns recv'd 6/13 & 9/18/91; complete, "ready" 9/18/91)

3250: MOWA Band of Choctaw, AL (#86) (doc'n recv'd 4/28/88; CD ltr 2/15/90; rspns recv'd 11/8/91; complete, "ready" 11/19/91)

Deficiency Reviews ("CD")—1:

These are documented petitions which are under staff review or awaiting review for obvious deficiencies under 25 CFR 83.9(b). (*—under review) Piro/Manso Tiwa Indian Tribe of the Pueblo of San Juan de Guadalupe (formerly Tiwa Indian Tribe), NM (#5) (doc'n recv'd 3/24/92)

Petitioner's action items—26:

Commenting on Proposed Finding—1:

836: Snohamish Tribe of Indians, WA (#12) (pending; proposed negative finding pub'd 4/11/83; edited staff notes provided 3/25/91; comment period reopened 12/1/91, extended to 4/3/93 at petitioner's request)

Responding to Deficiencies—25:

These petitions have been reviewed by staff in accordance with 25 CFR 83.9(b); although petitioners have been advised both orally and in writing of obvious deficiencies ("OD letter"), the petitioner has not officially responded to the deficiencies or has responded, but only in part.

Delawares of Idaho (#55) (doc'n recv'd 6/14/79; OD ltr 9/24/79; partial respnse 12/10/79)

Georgia Tribe of Eastern Cherokees, Inc. (aka Dahlonega), GA (#41) (doc'n recv'd 2/5/80; OD ltr 8/22/80)

Seminole Nation of FL (aka Traditional Seminole) (#89) (doc'n recv'd 11/10/82; OD ltr 10/5/83, lacks genealogy; partial rspns 12/7/83)

Jena Band of Choctaws, LA (#45) (doc'n recv'd 5/2/85; OD ltr 9/11/86; response 11/25/86; 2nd OD ltr 10/1/87)

Huron Potawatomi Band (#9) (doc'n recv'd 2/3/87; OD ltr 10/13/87)

Shasta Nation, CA (#83) (doc'n recv'd 7/24/84; OD ltr 5/30/85; response 6/8/86; 2nd OD ltr 10/22/87)

Little Shell Tribe of Chippewa Indians of MT ($31) (OD ltr 4/18/85; partial response 11/2/87, 10/26/89; "not ready" 8/17/90)

Steilacoom Tribe (#11) (doc'n recv'd 10/27/86; OD ltr 11/30/87)

Nipmuc Tribal Council of MA (#69) (doc'n recv'd 7/20/84; OD ltr 3/1/85; response 6/12/87; 2nd OD ltr 2/5/88)

Tolowa Nation, CA (#85) (doc'n recv'd 5/12/86; OD ltr 4/6/88)

American Indian Council of Mariposa County (aka Yosemite), CA (#82) (doc'n recv'd 4/19/84; OD ltr 5/1/85; rsp 12/12/86; 2nd OD ltr 4/11/88)

Yokayo, CA (#104) (doc'n recv'd 3/9/87; OD ltr 4/25/88)

Cowlitz Tribe of Indians, WA (#16) (doc'n recv'd 2/1/83; OD ltr 6/15/83; response 2/10/87; 2nd OD ltr 10/21/88)

Juaneno Band of Mission Indians, CA (#84) (doc'n recv'd 2/24/88; OD ltr 1/25/90)

Hayfork Band of Nor-El-Muk Wintu Indians, CA (#93) (doc'n recv'd 9/27/88; OD ltr 2/26/90)

Eastern Pequot Indians of Connecticut, CT (#35) (doc'n recv'd 5/5/89; OD ltr 3/13/90)

Haliwa-Saponi, NC (#63) (doc'n recv'd 10/19/89; OD ltr 4/20/90)

Oklewaha Band of Seminole Indians, FL (#117) (doc'n complete 2/12/90; OD ltr 4/24/90)

St. Francis/Sokoki Band of Abenakis of VT (#68) ("not ready" 9/18/90)

Mashpee Wampanoag, MA (#15) (doc'n recv'd 8/16/90; OD ltr 7/30/91)

Clifton Choctaw, LA (#30) (ltr/doc'n recv'd c.9/28/90; OD ltr 8/13/91)

Indian Canyon Band of Coastanoan/Mutsun Indians of CA (#112, 6/9/89) (doc'n recv'd 7/27/90; OD ltr 8/23/91)

North Fork Band of Mono Indians, CA (#90) (doc'n recv'd 5/15/90; OD ltr 10/28/91)

Snoqualmoo of Whidbey Island, WA (#108) (doc'n recv'd 4/16/91; OD Ltr 8/13/92)

Yuchi Tribal Organization, OK (#121) (doc'n recv'd 9/9/91; OD ltr 9/14/92)

LETTERS OF INTENT TO PETITION—65

These are typically undocumented letter petitions which state that the group is currently working on the petition and will submit the required documentation at a later date. No action can be taken by staff until a documented petition is received. Petitioners are grouped below by status based on the most recent information available.

Preparing Petition/In Contact with BAR—46:

Ione Band of Miwok Indians, CA (#2, 1916)

Shinnecock Tribe, NY (#4, 2/8/78)

Mono Lake Indian Community, CA (#21, 7/9/76)

Washoe/Paiute of Antelope Valley, CA (#22, 7/9/76)

Antalope Valley Paiute Tribe, CA (#22a, 7/9/76)

Maidu Nation, CA (#24, 1/6/77)

Piscataway-Concy Confederacy & Sub-Tribes, Inc., MD (#28, 2/22/78)

Florida Tribe of Eastern Creek Indians, FL (#32, 6/2/78)

Tsimshian Tribal Council, AK (#36, 7/2/78)

Choctaw-Apache Community of Ebarb, LA (#37, 7/2/78)

Nanticoke Indian Association, DE (#40, 8/8/78)

Cane Break Band of Eastern Cherokees, GA (#41a, 1/9/79)

Tuscola United Cherokee Tribe of FL & AL, Inc., FL (#43, 1/19/79)

Kern Valley Indian Community, CA (#27, 2/27/79)

Hattadare Indian Nation, NC (#49, 3/16/79)

Brotherton Indians of Wisconsin, WI (#67, 4/15/80)

Coharie Intra-Tribal Council, Inc., NC (#74, 3/13/81)

Schaghticoke Indian Tribe, CT (#79, 12/14/81)

Coastal Band of Chumash Indians, CA (#80, 3/25/82)

Golden Hill Paugussett Tribe, CT (#81, 4/13/82)

Dunlap Band of Mono Indians, CA (#92, 1/4/84)

San Luis Rey Band of Mission Indians, CA (#96, 10/18/84)

Wintu Indians of Central Valley, California, CA (#97, 10/26/84)

Northern Cherokee Tribe of Indians, MO (#100, 7/26/85)

Burt Lake Band of Ottawa & Chippewa Indians, Inc., MI (#101, 9/12/85)

Pahrump Band of Paiutes, NV (#105, 11/9/87)

Wukchumni Council, CA (#106, 2/22/88)

Choinumni Council, CA (#109, 7/14/88)

Coastanoan Band of Carmel Mission Indians, CA (#110, 9/16/88)

Ohlone/Coastanoan Muwekma Tribe, CA (#111, 5/9/89)

Paucatuck Eastern Pequot Indians of CT (#113, 6/20/89)

Canoncito Band of Navajos, NM (#114, 7/31/89)

Little Traverse Bay Bands of Odawa Indians, MI (#115, 9/27/89)

Salinan Nation, CA (#116, 10/10/89)

Revived Ouachita Indians of AR & America (#118, 4/25/90)

Meherrin Indian Tribe, NC (#119, 8/2/90)

Amah Band of Ohlone/Coastanoan Indians, CA (#120, 9/18/90)

Etowah Cherokee Nation, TN (#122, 1/2/91)

Upper Kispoko Band of the Shawnee Nation, IN (#123, 4/10/91)

Piqua Sept of Phio Shawnee Indians, OH (#124, 4/16/91)

Little River Band of Ottawa Indians, MI (#125, 6/4/91)

Chickamauga Cherokee Indian Nation of AR & MO (#100a, 9/5/91)

Lake Superior Chippewa of Marquette, Inc., MI (#126, 12/31/91)

Nanticoke Lenni-Lenape Indians, NJ (#127, 1/3/92)

Northern Cherokee Nation of Old Louisiana Terr, MO (#100b, 2/19/92) GunLake Village Band & Ottawa Colony Bard of Grand River Ottawa Indians, MI (#128, 6/24/92)

Inactive/Does not respond to BAR inquires—19:

Group has not responded to written inquires—(14):

Little Shell Band of North Dakota, ND (#18, 11/11/75)

Four Hole Indian Orgn/Edisto Tribe, SC (#23, 12/30/76)

Delaware-Muncie, KS (#33, 6/19/78)

Coree [formerly Faircloth] Indians, NC (#39, 8/5/78)

Shawnee Nation U.K.B., IN [formerly Shawnee Nation, United Remnant Band, OH] (#48, 3/13/79)

North Eastern U.S. Miami Inter-Tribal Council, OH (#50, 4/9/79)

Santee Tribe, White Oak Indian Community, SC (#53, 6/4/79)

Alleghenny Nation (Ohio Band), OH (#60, 11/3/79)

United Rappahannock Tribe, Inc., VA (#61 11/16/79)

Charokees of Jackson County, Alabama, AL (#77, 9/23/81)

Christian Pembina Chippewa Indians, ND (#94, 6/26/84)

Cherokee-Powhattan Indian Association, NC (#95, 9/7/84)

Wintoon Indians, CA (#98, 10/26/84)

Cherokees of SE Alabama, AL (#107, 5/27/88)

Efforts to contact have been unsuccessful—(5):

Cherokee Indians of Georgia, Inc., GA (#27, 8/8/77)

Kah-Bay-Kah-Nong (Warroad Chippewa), MN (#46, 2/12/79)

Upper Mattaponi Indian Tribal Association, Inc., VA (#62, 11/26/79)

Consolidated Bahwetig Ojibwas and Mackinac Tribe, MI (#64, 12/4/79)

Chuckchansi Yokotch Tribe, CA (#99, 5/9/85)

CASES IN LITIGATION—3

Samish (Denied Acknowledgment 5/6/87)

San Juan Paiute (Acknowledged 3/28/90)

Ione (Letter of Intent to Petition, 1916)

CASES RESOLVED—28

Resolved by Department—(23)

Acknowledged through 25 CFR 83—8:

297: Grand Traverse Band of Ottawa & Chippewa, MI (#3) (effective 5/27/80)

175: Jamestown Clallam Tribe, WA (#19) (eff. 2/10/81)

200: Tunica-Biloxi Indian Tribe, LA (#1) (eff. 9/25/81)

199: Death Valley Timbi-Sha Shoeshone Bank, CA (#51) (eff. 1/3/83)

1170: Narragansett Indian Tribe, RI (#59) (eff. 4/11/83)

1470: Poarch Band of Creeks, AL (#13) (eff. 8/10/84)

521: Wampanoag Tribal Council of Gay Head, MA (#76) (eff. 4/11/87)

188: San Juan Southern Paiute Tribe, AZ (#71) (eff. 3/28/90)

Denied acknowledgment through 25 CFR 83—13:

1041: Lower Muskogee Creek Tribe-East of the Mississippi, GA (#8) (effective 12/21/81)

2696: Creeks East of the Mississippi, FL (#10) (eff. 12/21/81)

34: Munsee—Thames River Delaware, CO (#26) (eff. 1/3/83)

1321: United Lumbee Nation of North Carolina and America, CA (#70) (eff. 7/2/85)

1530: Kaweah Indian Nation, CA (#70a) (eff. 6/10/85)

324: Principal Creek Indian Nation, AL (#7) (eff. 6/10/85)

823: Southeastern Cherokee Confederacy (SECC), GA (#29) (eff. 11/25/85)

609: Northwest Cherokee Wolf Band, SECC, OR (#29a) (eff. 11/25/85)

87: Red Clay Inter-tribal Indian Band, SECC, TN (#29b) (eff. 11/25/85)

304: Tchinouck Indians, OR (#52) (eff. 3/17/86)

590: Samish Indian Tribe, Inc., WA (#14) (eff. 5/6/87)

275: MaChis Lower AL Creek Indian Tribe, Al (#87) (eff. 8/22/88)

4381: Miami Nation of Indians of State of IN, Inc., IN (#66) (eff. 8/17/92)

Determined Part of Recognized Tribe—1

650: Texas Band of Traditional Kickapocs, TX (#54) (Determined part of recognized tribe 9/14/81; petition withdrawn)

Status Clarified by Legislation at Department's Request—1

c224: Lac Vieux Desert Band of Lake Superior Chippewa Indians, MI (#6) (legis clarification of recog'n status 9/8/88)

Resolved by Congress—(4)

Legislative Restoration—1

328: Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians, OR (#17) (legis restoration 10/17/84)

Legislative Recognition—3

651: Cow Creek Band of Umpqua Indians, OR (#72) (legis recognition 12/29/82)

55: Western (Mashantucket) Pequot Tribe, CT (#42) (legis recog'n 10/18/83 in association with eastern land claims suit)

611: Aroostock Band of Micmacs, ME (#103) (legis recog'n 11/26/91)

Resolved by other means—(1)

Petition withdrawn (merged with another petition)—1:

Potawatomi Indians of IN & MI, Inc., MI (#75) and Potawatomi Indian Nation, Inc. (Pokagon), MI (#78) merged; now Pokagon (#75/78)

CASES REQUIRING LEGISLATIVE ACTION—7

Cases requiring legislation to permit processing under 25 CFR 83—7:

Lumbee Regional Development Association (LRDA/Lumbee) (#65)

Hatteras Tuscarora Indians, NC (#34)

Cherokee Indians of Robeson and Adjoining Counties, NC (#44)

Tuscarora Indian Tribe, Drowning Creek Res. NC (#73)

Waccamaw Siouan Development Association, Inc., NC (#88)

Cherokee Indians of Hoke County, Inc., NC (#91)

Tuscarora Nation of North Carolina, NC (#102)

Note

Petitioners on hand with Acknowledgment staff organized Oct. 1978: 40.

New petitioners since Oct. 1978: 95.

Total Petitions: 135.

135 total petitioners, includes 8 groups that initially petitioned as part of other groups, but have since split off to petition independently.

□ 1310

Mr. RICHARDSON. Mr. Chairman, I yield 2 minutes to the gentlewoman from North Carolina [Mrs. CLAYTON].

Mrs. CLAYTON. Mr. Chairman, I stand to express my support for the passage of H.R. 334, the Lumbee Recognition Act.

The State of North Carolina formally recognized the Lumbee Indians in 1885. Under legislation passed in 1956, Congress lamely recognized them as an Indian tribe—in name only—but denied them services due all recognized Indians through the Bureau of Indian Affairs. They are an independent Indian community residing in eastern North Carolina, predominently in Robeson County, but spreading into surrounding counties, including Cumberland and Bladen Counties, which are in my congressional district. They host a membership of over 40,000. The Lumbees are proud people—proud of their heritage and of their community. They teach their children this heritage and raise them to be proud to be Lumbee and proud to be citizens of the United States.

This tribe has been seeking Federal recognition since 1899, yet the Department of the Interior has consistently denied them tribal status. Finally in 1956, Congress did recognize the Lumbee Tribe; however, precluding these people from the Federal services to which other Indian tribes are entitled. It is time to rectify this situation and make the Lumbees a nationally recognized tribe and treat them with the same respect other tribes across the Nation are treated.

It is a travesty that the Lumbee is being prevented from full recognition just because there are other tribes who fear their own Federal funding will be effected.

I oppose the amendment offered by Representative THOMAS of Wyoming. He would have the tribe go back through the Bureau of Indian Affairs when, in fact, this has been tried many times in the past. The tribe has been turned away in large part due to the population which officials in the Interior Department believe could restrict funding to other tribes. They should be recognized solely because they are a proven Indian tribe and should not be denied due to the fiscal situation of the Bureau of Indian Affairs.

Mr. Chairman, I include the following material on the Lumbee Recognition Act, H.R. 334:

OBJECTIONS AND RESPONSES—LUMBEE RECOGNITION ACT, H.R. 334

THERE IS ALREADY AN ADMINISTRATIVE PROCESS AT BIA, WHY AREN'T THE LUMBEE USING IT?

The Associate Solicitor at the Interior Department ruled in October of 1989, that the Lumbee Tribe was ineligible to proceed through the BIA process, due to a statutory bar in the 1956 Lumbee Act (copy of opinion is attached). The 1956 Lumbee Act recognized the Lumbees by name, but prohibited them from receiving any benefits or services from the federal government.

Aside from present ineligibility, the historic bias of the BIA against Lumbee will preclude any favorable administrative action. In 1991, BIA officials testified in opposition to the bill at a recent joint hearing with the House Committee on Interior and Insular Affairs and the Senate Select Committee on Indian Affairs. During that hearing, present Branch of Acknowledgement and Research personnel made it clear that they intend to deny the Lumbee petition under current regulations despite the recommendations of other academic scholars.

WHY NOT REPEAL THE 1956 LEGISLATION, THEN REQUIRE THE LUMBEES TO PROCEED THROUGH THE BIA PROCESS?

Congress has never required any Indian group to obtain both legislation and administrative action to become recognized. Over the fifteen years that the Department's acknowledgement process has been in place, Congress has considered the status of ten other tribes subject to statutes that barred them from the administrative process. In each case, Congress enacted comprehensive recognition legislation. One of these situations, that the Ysleta del Sur (formerly Tiwa) of Texas, is very similar to the Lumbee situation in that the tribe had no relationship with the federal government before the enactment of termination-type legislation that precluded administrative acknowledgment. The language in the Tiwa bill was modeled after the Lumbee bill and Congress has since restored their recognition rights. The Lumbee Tribe is simply asking Congress to follow through with its past practice in these situations.

HAS THE LUMBEES' NATIVE AMERICAN IDENTITY BEEN FIRMLY ESTABLISHED?

The Committee's hearing record contains testimony from leading anthropologists and historians, notably Dr. William Sturtevant of the Smithsonian Institution, who has concluded that the Lumbee Tribe meet all the criteria for federal recognition. The Lumbees were recognized by the State of North Carolina in 1885, and began seeking federal recognition in 1888. In response to federal bills, Congress asked the Interior Department to investigate the Tribe's history and condition. On three separate occasions, in 1912, 1915, and 1933, the Department concluded that the Lumbees were indeed Indians, existing as a separate and independent community. The most comprehensive study, done in 1914, traced their origin to Cheraw and other coastal tribes. This study far exceeds in length and detail these presently done by the BIA on petitions for recognition.

IF THE RECORD IS CLEAR, WHY HAVEN'T THEY ALREADY BEEN RECOGNIZED?

Each time a bill was introduced to recognize the Lumbee Tribe, the Department of the Interior testified in opposition, generally because of the size and consequent cost of recognizing the tribe. Recent history also reflects this concern on the part of the BIA. The Bureau's objections about the size of the Lumbee has come up repeatedly in off-the-record discussions between members of the Lumbee Tribe and some BIA officials. BIA officials often privately acknowledge that, had it not been for the size of the tribe, the Lumbee Tribe would have been recognized long ago. Secretary Babitt, of the Department of the Interior, supports H.R. 334 and the Administration has recently stated that

they have no longer have any opposition to the bill.

IS THE TRIBE'S ENROLLMENT PROCESS LEGITIMATE SO THAT ONLY LUMBEE INDIANS ARE ENROLLED?

The Lumbee Tribe requires documentation to prove eligibility for every individual that applies. An applicant must be a descendant of an ancestor that appeared on the 1890 and 1900 census. Of the 40,000 enrolled members, approximately 90% reside in Robeson and adjoining counties. All of the members have proven Lumbee ancestry and maintain close ties to the tribe and community. In addition, H.R. 334 authorizes the Secretary of the Interior to verify the validity of the Lumbee roll.

WOULDN'T LUMBEE RECOGNITION OPEN THE FLOODGATES FOR OTHER TRIBES SEEKING RECOGNITION?

There will always be tribes who seek recognition legislatively, but most of these tribes are eligible for the BIA process. The '56 Act is the only remaining termination era statute that bars administrative action on tribal status according to the Department of Interior. Earlier this month, Congress passed a bill which finalized a land claims settlement as well as federal recognition for the Catawba Tribe in South Carolina. Therefore, Lumbee is the only remaining tribe to be dealt with. The Committee would be following precedent by recognizing the Lumbee legislatively and would not establish a precedent for any other tribe to do the same.

DO OTHER TRIBES SUPPORT THE LUMBEE BILL?

Most of the tribes that have been willing to meet with Lumbee leaders support the legislative efforts of the tribe. However, there are tribes, especially those in the western states who are not as familiar with Lumbee and their special eastern heritage. Other tribes mistakenly think the Lumbee would be receiving preferential treatment if they were recognized legislatively. There is some concern that they will receive fewer benefits if the Lumbees are brought into the picture. HR 334 addresses these concerns by stating that Lumbee is not eligible for services until additional funds are appropriated specifically for the tribe.

WHAT ABOUT THE BUDGETARY IMPACT OF LUMBEE RECOGNITION ON THE NEEDS OF OTHER TRIBES?

Several provisions are included to give the Appropriations Committee flexibility to address the needs of the Lumbee people, without threatening the budgets of other federally recognized tribes. This legislation requires that any BIA funding for the Lumbee must come through a separate appropriation, separate from outlays for other federally recognized tribes. This funding mechanism has been endorsed by a former Assistant Secretary for the Department of Interior during the Reagan Administration.

If H.R. 334 was passed, it would be three to four more years before the Department of Interior and the Department of Health and Human Services completed its evaluation of the Tribe's membership rolls and budgetary needs. The CBO has stated that this bill is not subject to pay-as-you-go procedures because it would not affect direct spending or receipts.

DO THE LUMBEE PLAN TO OPEN GAMING OPERATIONS OR CASINOS?

No. In fact, the current tribal government has passed a resolution which states that it is not their intention now or in the future to engage in Indian gaming activity.

Mr. RICHARDSON. Mr. Chairman, I yield 5 minutes to the gentleman from American Samoa [Mr. FALEOMAVAEGA].

Mr. FALEOMAVAEGA. Mr. Chairman, I want to first commend our subcommittee chairman, the gentleman from New Mexico [Mr. RICHARDSON] for his leadership and hard work, and whereby this bill is now before us for consideration. Also I want to thank our full committee chairman, GEORGE MILLER, for his guidance and support throughout the hearings process, and the approval of the members of the Committee on Natural Resources.

Mr. Chairman, I want to especially recognize the gentleman from North Carolina [Mr. ROSE] as the chief sponsor of H.R. 334—this bill simply will provide that the Lumbee Indian Tribe of North Carolina will be given Federal recognition.

Mr. Chairman, I have the highest regard for any colleague and friend from Wyoming [Mr. THOMAS], the ranking minority member on our Subcommittee on Indian Affairs. I respect his opinions and in some instances we have agreed on policies and legislation brought before the committee. I regret, however, that we have an honest disagreement concerning the provisions of this bill.

Our critics have emphasized the importance of process, that is, the recognition process that was established Federal regulations since 1978.

Mr. Chairman, the Lumbee Tribe went through the process—7 more years of haggling with the Federal bureaucracy and costing the tribe over $500,000 for the process.

Mr. Chairman, the Lumbee people have been subjected to 110 years of cruel and demeaning processes imposed upon them by our own national Government. And I submit, Mr. Speaker, this institution—the Congress of the United States—has to take full responsibility for this tragic episode of our dealings with native Americans.

Mr. Chairman, throughout the 110-year period these noble people have been subjected to several processes instituted by our own Federal Government. First, our national process was to exterminate the native Americans. Then, our next national policy was to forcibly remove the native Americans from their homelands, and as evidenced by trails of many tears and trails of broken treaties and promises. Our third national policy or process then was to assimilate native Americans into the mainstream of American life—make them all Americans—bury their culture and desecrate the graves of the millions who have passed on. Still yet, Mr. Chairman, our fourth national process toward native Americans was most of termination, that is, do not even call them tribes or Americans Indians anymore. Then under the circumstances, another national process that has evolved was to divide and divide again the native Americans, that is, have the tribes fight among themselves given the limited resources they have to live under most unfavorable living conditions.

Mr. Chairman, again I plead with my colleagues of the House. The Lumbees do not want handouts and they are not begging for Federal recognition. In the almost 5 years that to have served as a member of this committees that handles native American issues—the hearings and testimonies that I have listened to concerning the Lumbee Tribe of North Carolina, I have never witnessed a record as clear on how the Federal Government—and specifically this institution, the Congress of the United States, with a specific and clear mandate from the Federal Constitution—that we have failed miserably to provide the Lumbee Tribe proper recognition.

I commend the gentleman from Tennessee [Mr. QUILLEN], the ranking minority member of the Rules Committee for his support of this legislation.

Mr. Chairman, let us all do the right thing. I urge my colleagues to support H.R. 334.

□ 1320

Mr. RICHARDSON. Mr. Chairman, I yield 3 minutes to the gentleman from North Carolina [Mr. ROSE], the author of the bill.

Mr. ROSE. Mr. Chairman, last year the House passed the Lumbee Recognition Act, and I am pleased that this body has an opportunity today to once again take the first step toward the recognition of a group of native Americans which I have been fortunate to represent during my time in Congress. The Lumbee Tribe of Cheraw Indians have maintained a distinct community in southeastern North Carolina for hundreds of years. This alone is impressive, considering early European settlement in this region and numerous attempts to drive these native Americans out of the area.

The Lumbee have been active and respected members of the national native American community for many years. The tribe was recognized by the State of North Carolina in 1885. In fact, it seems that the Federal Government is the only entity which has failed to recognize the Lumbee and its special heritage. On June 7, 1956, Congress passed a bill which left their status as recognized native Americans in limbo. Thirty-seven years have passed and the Lumbee's status is still unresolved.

Mr. Chairman, there are three important points that I would like to make so that Members can understand why the Lumbee's situation is unique and deserves special attention.

First, the Associate Solicitor of Indian Affairs for the Department of the Interior ruled in 1989 that the 1956 act precluded the tribe from proceeding through the administrative process for recognition. This ruling came 2 years after the tribe had submitted their painstakingly prepared petition to the

BIA. In fact, the tribe spent 10 years assembling documentation for its petition and raising funds for legal costs. Obviously, the Lumbee have made every effort to comply with the BIA's recognition process. That process has failed them, and now they are placed in a position where legislative action is not a choice, but a necessity.

Second, eight other tribes have also been ruled to be ineligible for the Federal acknowledgment process since 1980. The Catawba Tribe's situation was recently resolved through legislation, and that bill is expected to be signed into law in the near future. Ladies and gentlemen, the Lumbee is the last tribe to find itself in this predicament. Congress has dealt with the other ineligible tribes through legislation, and no other tribe has been asked to go through, back through the BIA process in order to be recognized. Congress has established a precedent, and it is only fair that it be applied equitably in this case as well.

Third, I am aware that some Members are frustrated with the Federal acknowledgment process and would like to see it changed. I certainly support the idea that the process needs to be reformed. But the Lumbee is the only remaining tribe with circumstances that set them apart from all others, and they should be dealt with first. This tribe has been studied by the Department of the Interior on three separate occasions, in 1912, 1915, and 1933, and it was concluded each time that the Lumbee were Indians with a separate and independent community. They do not need to be examined again by the BIA and the staff of the Bureau of Acknowledgment and Recognition. It is time for the Congress to right the injustice which it created in 1956.

Because of their status as a State recognized tribe, the tribe already receives some Federal services from the Office of Indian Education and the Administration for native Americans. The Indian Health Service allows Lumbee to receive scholarships but will not give medical services to the members of the tribe. Clearly, one hand of the Federal Government recognizes the tribe as Indian people while the other hand does not. This tribe deserves the same rights and privileges that other native Americans have across the land. The current system of federally recognized tribes versus non-federally-recognized tribes creates unnecessary friction amongst these people. It makes the non-federally-recognized people feel like second-class citizens.

Finally, there are other Indian groups in my congressional district that are adversely affected by the Lumbee Recognition Act of 1956. The 1956 act gave the Lumbee name to all Indians in Robeson and adjoining counties. However, there are Indians in this area who identify themselves as a separate group other than Lumbee. This bill would allow those groups to petition separately for recognition. Without this legislation, they are deemed ineligible for the same reason that the Lumbee are restricted.

Mr. Chairman, I urge the House to oppose the substitute which will be offered and pass the Lumbee Recognition Act so that the history books can be corrected and human dignity can be restored to these people and their culture.

Mr. RICHARDSON. Mr. Chairman, I yield 4 minutes to the gentleman from California [Mr. MILLER], the chairman of the Committee on Natural Resources.

Mr. MILLER of California. Mr. Chairman, Members of the House, I rise in strong support of this legislation. Unfortunately we are once again considering this legislation, a bill that has been around this Congress, as many have said already, in one form or another for the last 100 years.

I want to thank the subcommittee of the Committee on Natural Resources, its chairman, the gentleman from New Mexico [Mr. RICHARDSON], and the gentleman from Wyoming [Mr. THOMAS], for their work on this legislation. While we do not have complete agreement among the members of the committee, I do think we have a bill that addresses a very important problem, a problem that, again, has been highlighted for this committee, and for the House, and for this country by the gentleman from North Carolina [Mr. ROSE], who is insistent upon our committee meeting its obligations and reporting out this legislation.

Mr. Chairman, we have had numerous hearings on this legislation, have taken testimony and evidence. Our good colleague, the gentleman from American Samoa [Mr. FALEOMAVAEGA], has chaired these hearings, has listened to the witnesses, and I think we are in complete agreement that this bill gives us an opportunity to correct a very serious injustice in that nobody can deny that the Lumbee are Indians, and it is very clear that they do, in fact, deserve immediate recognition.

There are some who would like to believe that the Lumbee could go through the Federal administration recognition process, but at the same time all recognize that that process has broken down, it is not working, and in fact it may be more designed to prevent justified recognition than it is to help those tribes who can prove their case. I think it is clear that this bill provides the Lumbee what they should have, and that is government-to-government relations between the United States and the Lumbee, and the official recognition of the Indian heritage of the Lumbee people, and to forestall this legislation any longer would be to continue one of the longer running injustices in the long history of this Government's relationship with the Indian nations, with the Indian nations of this country.

I would hope that my colleagues would support this legislation, that we would pass it again, as we have in the past, and that the Senate would address this problem immediately, and we would have an opportunity to right this wrong, and again I want to thank our colleague, the gentleman from North Carolina [Mr. ROSE], for his help in working this issue to get it to the floor and to get our attention, and my thanks again to the subcommittee, and I ask for support of this legislation.

Mr. THOMAS of Wyoming. Mr. Chairman, I yield 5 minutes to the gentleman from North Carolina [Mr. TAYLOR].

Mr. TAYLOR of North Carolina. Mr. Chairman, I first want to take this opportunity to commend my colleague from North Carolina, Congressman ROSE, for his effort on behalf of the Indians of Robeson County and in all of North Carolina. However, I rise today to oppose this bill.

I represent a district which encompasses the area of the eastern band of the Cherokee Indians. In the early history of our Nation, Congress and the administration often abused the American Indians of this Nation. In my district, Andrew Jackson tried to move the entire Cherokee Nation to Oklahoma. Many died while walking the Trail of Tears, which many people have heard about. They are remembered in a drama on the Cherokee reservation by those that stayed—that is, those that evaded capture by the soldiers—and those that returned back to western North Carolina.

As we have heard before, the bulk of Indian tribes were established by treaty, many of them following wars in this country. What does it mean to be a federally recognized tribe? It is a formal act that establishes a government-to-government relationship between the United States and the recognized tribe. It institutionalizes the tribe's quasi-sovereign status, giving it the power to tax and to establish a judiciary and it gives the tribe the right to treatment as a sovereign nation.

This relationship is unique in the world. Tribes view it as almost sacred. Many American Indians died for this right. It must be taken seriously and protected.

The history of Federal recognition of Indian tribes has been plagued with pitfalls and perceived as arbitrary and excessively political. In 1978, the Interior Department, after exhaustive consultations with Indians, established procedures to provide a uniform approach to the recognition process. Called the Federal Acknowledgement Process [FAP], the regulations set forth seven criteria a petitioning group must meet to be deemed a recognized tribe, including a historical, genealogical and cultural background.

What we would be doing today with this bill is to replace that orderly process and again return to a method where recognition is granted for arbitrary and political reasons. This would be done contrary to the wishes of the majority of the American Indians.

Let there be no mistake about this vote. This is a vote against the American Indians, not for them. The Cherokee Nation, the Eastern band of which are located in my district, strongly opposes this bill. The Hatteras Tuscarora, located among the Lumbees in Robeson County, have stated that they oppose this bill. Under H.R. 334, they will be subsumed, but they want to apply for tribal recognition through the FAP process. I have received letters that support the FAP process and a strict adherence to a systemic recognition process from various tribes in Arizona, California, Nevada, North Carolina, Oklahoma, Michigan, Washington, Oregon, Idaho, Montana, California, Minnesota, New Mexico.

What I am saying to you is that the American Indian has an established process for tribal recognition. They want to keep this orderly process, and not return to a political logrolling process.

Do the Lumbees deserve Federal recognition? I cannot answer that question and Congress should not determine it. If we do this, what do we do with the numerous other groups across this Nation who want to be recognized? Do we immediately put bills before this body to consider these groups?

And what about those groups who were turned down through the FAP process? Can we say that those who were turned down should not be allowed to come back through the legislative process, and, if they can, find a legislator here with enough power that they become federally recognized as a tribe of American Indians?

Let me emphasize that what the American Indians and certainly the Cherokee in my district have expressed eloquently to me is that they do not object and question this bill based on whether or not there will be a financial loss to one tribe versus another tribe. They are not considering this from a monetary standpoint. We appropriate precious little now to support the tribes of this country. The tribes that I have met with have expressed to me their concern that we will dilute a very sacred recognition process, and they consider it most serious. They feel it will return tribal recognition to a political process that will depend more on political power rather than true Indian heritage.

I urge my colleagues to do the right thing. Support the American Indians of this country and vote against this bill.

□ 1330

Mr. RICHARDSON. Mr. Chairman, I yield 2 minutes to the gentleman from North Carolina [Mr. LANCASTER].

Mr. LANCASTER. Mr. Chairman, I commend Chairman ROSE for bringing this important piece of legislation to the floor once again and Chairman RICHARDSON and the others who have worked so hard with Chairman ROSE to see that justice long denied is finally granted to the Lumbee Indians of North Carolina. Though most of those Indians live within the constituency of the gentleman from North Carolina [Mr. ROSE], a number of them live in my district, and I know them well. It has certainly been my pleasure to get to know the Lumbee Indians in my district and to learn of their long traditions and their proud and unique heritage.

Mr. Chairman, another thing that happens to have occurred in my district was the first English colony was established on the coast of North Carolina in my district. It disappeared from the face of the Earth, and is now known as the Lost Colony. An outstanding outdoor drama is presented each year on it. It is interesting to note that in the oral tradition of the Lumbee Indians, it is passed down through the years that it was the Lumbee Indians who befriended these English colonists. Who, when they fled the island off the coast of North Carolina, the Outer Banks, and went inland, they befriended them, took them under their wing and under their care, and ultimately absorbed them into their tribe.

Mr. Chairman, it is that kind of hospitality that one feels whenever they are with the Lumbee Indians, because they are a warm and hospitable people who do in fact deserve the recognition that this legislation would give.

They have maintained a strong oral tradition that carries back hundreds of years to their forbearers, that does reflect the kind of uniqueness as an Indian nation that should be required for recognition.

Mr. Chairman, I urge my colleagues to vote for this legislation and to reject weakening amendments, so that at long last the Lumbee Indians of North Carolina will receive the justice they so richly deserve.

Mr. THOMAS of Wyoming. Mr. Chairman, I yield 1 minute to the gentleman from California [Mr. CUNNINGHAM].

Mr. CUNNINGHAM. Mr. Chairman, I have colleagues on both sides of the aisle that stand up on every bill and try to cut $1 million for this or $1 million for that. This program, if enacted, would cost taxpayers $100 million per year forever, just for the Lumbees.

Mr. Chairman, you talk about a budget buster, $100 million per year, forever, just for this one tribe.

There is a normal process that one should go through to determine if they deserve that or note. This body should not be that place.

Those that are trying to prove that they are fiscally conservative need to take a look at just the cost of this process and make sure that the process is done properly, instead of us getting involved.

The other native Americans that deserve it, yes, if they are deserving, then let them go through the normal process that it takes.

Mr. RICHARDSON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, as we conclude this debate, let me just first of all state that my good friend, the gentleman from California [Mr. CUNNINGHAM], is not correct. This does not cost the taxpayers $100 million per year.

Let me be very precise. The Congressional Budget Office estimates that the Lumbee Tribe would cost the Government $80 to $100 million "only if the necessary funds are appropriated."

In other words, what we would have to have is line items specifically for the Lumbees in the pot of money that goes toward Indian tribes. I repeat, in the pot of money that goes to Indian tribes, there is no allocation for the Lumbees.

Let us say there is going to be a need for a special program relating to the needs of the Lumbee Tribe. There would have to be a line item. Because of the unique status the Lumbees will have, it is impossible to estimate the cost. The cost would be zero, zero, if the Appropriations Committee does not choose to provide funds to the Lumbees.

Mr. Chairman, the Lumbees choose this as a compromise. They did not want to take money from the family of tribes. They mainly want their heritage recognized.

This debate is not about money. There is no money in this bill. There has to be a specific line item.

Mr. FALEOMAVAEGA. Mr. Chairman, will the gentleman yield?

Mr. RICHARDSON. I yield to the gentleman from American Samoa.

Mr. FALEOMAVAEGA. Mr. Chairman, I want to echo the sentiments expressed by the chairman of our subcommittee with reference to comments made earlier by our good friend, the gentleman from California [Mr. CUNNINGHAM], that at this point we are quantifying 40,000 Americans, of whom over 400 fought and died in our wars.

Mr. Chairman, we gave $5 billion to Iraq. Nobody seems to be paying any attention to that amount of money. Here we are talking about $100 million, if it ever comes to that amount, to Americans who fought and died for this country. Why are we putting money values on the lives of these people who have been asking for just recognition? And that is all this legislation provides.

Mr. Chairman, we are not talking about money. We are talking about giving these people what is rightfully theirs, full recognition. I think it is overdue.

Mr. RICHARDSON. Mr. Chairman, I yield 1 minute to my friend, the gentleman from California [Mr. CUNNINGHAM].

Mr. CUNNINGHAM. Mr. Chairman, I thank my good friend for yielding.

Mr. Chairman, my point is that, first of all, if the money is not there, then the other tribes will suffer. I think that is why some of the other tribes are maybe against this, if we do not get line items.

If this tribe wanted just recognition and would waive all the other rights, I would support it, just to recognize their heritage. But we are trying to eliminate welfare states. As a native American you qualify for special benefits. We are trying to do away with the welfare state in this country, instead of creating one.

Mr. Chairman, another thing, not in my district, but just outside, we have a real problem on the Barona Indian Reservation and some other reservations of gambling. We have 3,000 slot machines coming in. We have no idea concerning this. The sheriff cannot get involved with it. I just see the problem that could come out if we give full recognition and the rights that these tribes would have.

Mr. Chairman, if they want to have just recognition as a tribe and waive all the other rights, I will support the gentleman from New Mexico [Mr. RICHARDSON].

□ 1340

Mr. THOMAS of Wyoming. Mr. Chairman, I yield 3 minutes to the gentleman from Connecticut [Mr. SHAYS].

Mr. SHAYS. Mr. Chairman, I hope we tread very carefully on this issue. It is not just a matter of recognition. It is a matter of funds being appropriated. It is also a matter of whether this tribe can have a gaming casino.

There is a process to be followed. It is a process that requires one to go before the Bureau of Indian Affairs. There are seven criteria.

That is an effort to protect legitimate tribes, and it is also a recognition that when we recognize a tribe, it is not just full recognition. It means they have a right to a reservation. It means they have a right to sovereignty, a nation within a nation.

We cannot do this lightly. We have got to recognize that we have to have some process. If we set the precedent that we are doing today, I fear that we have just basically taken away the argument that tribes should go before the Bureau of Indian Affairs. And if we take that away, then every decision will be a political decision.

It will be, does the gentleman from North Carolina [Mr. ROSE] have the votes to get it through, because he is a powerful Member of Congress, or does someone else have the power. It becomes a matter of individuals and not a question of whether the merit justifies it.

Mr. ROSE. Mr. Chairman, will the gentleman yield?

Mr. SHAYS. I yield to the gentleman from North Carolina.

Mr. ROSE. Mr. Chairman, the Lumbees do not want, and I will never agree to, a separate reservation. They have specifically said that there is no land for a reservation. They want to live in their community, abide by the laws of North Carolina, abide by the local authority. And the tribal council has signed a very broad agreement that they will never ask for gaming rights.

Mr. Chairman, I thank the gentleman for yielding to me.

Mr. SHAYS. Mr. Chairman, I thank the gentleman for making those comments.

The bottom line is that they have the legal right to, if they are given full recognition. And that is what troubles me.

We know, for instance, in the State of Connecticut, there is a tribe that we think has a net profit of $400 million a year; $400 million a year can get people to decide to change what they thought was what they wanted in the past.

I have tremendous concern about the precedent we are establishing here. There is a criteria. We have the Bureau of Indian Affairs, and we are just circumventing that process.

I fear the day that we vote this out and Members then have an argument that is, maybe we should go before the Bureau of Indian Affairs, and the argument is, but we did not do it for the Lumbees or we did not do it for this group.

This is a big mistake. I urge my colleagues to support the amendment that will be brought forward by the gentleman from Wyoming [Mr. THOMAS] that will say, go before the Bureau of Indian Affairs. If they succeed in meeting those seven criteria, then they will have my full support without question.

Mr. RICHARDSON. Mr. Chairman, I yield 3 minutes to the gentleman from North Carolina [Mr. PRICE].

Mr. PRICE of North Carolina. Mr. Chairman, I rise today in support of H.R. 334, the Lumbee Indian Recognition Act. This legislation marks the culmination of more than 100 years of effort by the Lumbee Indians to receive Federal recognition.

In the first part of this century, Congress directed the Department of the Interior to investigate the history and status of the Lumbee Indian tribe. Although these studies, and two consequent studies conducted by the Department of the Interior, concluded that the Lumbees met the qualifications for identification as a native American Indian tribe, the department continually opposed congressional attempts to recognize the Lumbees because of the tribe's relatively large size and the possible cost of Federal recognition.

Finally, in 1956 Congress passed the Lumbee Act, which confirmed the tribe's status as a legitimate Indian tribe. However, it did not provide Federal recognition. This was in keeping with the politics of the time, when the Federal Government severed relationships with native American Indian tribes which had been formally recognized.

In 1978, the Bureau of Indian Affairs [BIA] established a formal process by which a native American Indian tribe could petition for formal Federal recognition, and the Lumbee Indians submitted a petition to the BIA. In 1989, the associate solicitor of Indian Affairs for the Department of Interior ruled that the 1956 Lumbee Act precludes the tribe from proceeding through the administrative recognition process at BIA. As a result, the only recourse available to the Lumbee Indians is congressional action. Interior Secretary Babbitt supports this legislation and the Office of Management and Budget [OMB] has no objections to it.

Representative THOMAS has put forth a substitute measure which would amend the 1956 Lumbee Act to allow a Federal relationship with the Lumbee Indians and would provide expedited consideration for the Lumbee recognition petition before the BIA.

While I appreciate the intent of the substitute measure, I do not believe it is an effective way to deal with the Lumbee case. The Interior Department's 1989 ruling that administrative action by the BIA was not possible for the Lumbee has left congressional action the only recourse. Even if administrative action was a possibility, it is simply unrealistic to believe that a staff of 10 at the BIA could meet the deadlines for expedited review set forth by Representative THOMAS' amendment. The substitute measure also would be unfair to the other tribes which have submitted petitions to the BIA. Representative THOMAS' substitute would effectively put their applications on hold for 18 months while the full BIA staff was devoted to the Lumbee petition.

Mr. Chairman, the Lumbee Indians clearly meet the BIA criteria for Federal recognition. They have been working for such recognition since 1888, and it is simply unfair to ask these proud people to wait any longer. I urge my colleagues to support the Lumbee Indian Recognition Act and vote to defeat the substitute measure.

Mr. THOMAS of Wyoming. Mr. Chairman, I yield myself the balance of my time.

Let me just comment on the remarks of the gentleman from North Carolina who indicated there is no alternative. There is an alternative, of course. They would be put at the first of the line. And to indicate that that would be unfair, it seems to me, is a little bit of a paradox when you are bringing them up over the others. If there is anything that is unfair, this is unfair.

In closing, Mr. Chairman, this House must decide if it will continue to support the utilization of an equitable and standardized method of determining which Indian groups should be recognized by the Federal Government, or if it will return us to the pre-1978 days of piecemeal and arbitrary recognition through individual bills such as H.R. 334. While it is clearly within our power to recognize Indian tribes, we have tried our hand at it before. Because we did it so badly and so politically, however, leaders from both parties on this committee and from throughout Indian country insisted on a better way—the administrative FAP process of the BIA. Passage of H.R. 334 in its present form is contrary to the recommendations of the American Indian Policy Review Commission, opposed by the Department of the Interior, opposed by the overwhelming majority of tribes, and contrary to logic. It can only serve to undermine further an already beleaguered recognition process, to encourage other groups to circumvent that process, and to place recognition in an arena where emotional arguments, influential sponsors, and the partisan nature of Congress replace merit and fact. For these reasons, I join the Department of the Interior and the overwhelming majority of Indian tribes in strongly opposing H.R. 334.

Mr. Chairman, I yield back the balance of my time.

Mr. RICHARDSON. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, in closing, let me just make the following points:

First, the administration, the Office of Management and Budget, has no objection to this bill. They support this bill.

Second, this is a bill that is identical to one that we passed in the last session of Congress.

Third, we intend to fix the Federal acknowledgement process. We are going to do that. There are some 135 tribes that have gone through the acknowledgement process. And because of bureaucracy and redtape and inefficiency, the BIA has not moved. And this is why we have this movement to do some of these acknowledgement bills through the Congress.

The new Assistant Secretary of BIA, Ada Deer, has said there are two ways one can get recognized: through the Federal acknowledgement process, which she acknowledges is flawed and needs to be revised, and through acts of Congress.

We have done acts of Congress before, extending recognition. The gentleman is correct. We need to revive and better the processes that exist.

What we need to do, though, because of the special status, because for 100 years we have asked the Lumbees to wait, when they are native Americans, we should pass this bill.

Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Pursuant to the rule, the bill shall be considered under the 5-minute rule by sections, and each section shall be considered as read.

The Clerk will designate section 1.

The text of section 1 is as follows:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Lumbee Recognition Act".

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. THOMAS OF WYOMING

Mr. THOMAS of Wyoming. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN. The Clerk will report the amendment.

The Clerk read as follows:

Amendment in the nature of a substitute offered by Mr. THOMAS of Wyoming: Strike all after the enacting clause and insert in lieu thereof the following:

SECTION 1. AUTHORITY TO PETITION FOR FEDERAL RECOGNITION.

(a) CONSIDERATION OF LUMBEE PETITION.—The Act of June 7, 1956 (70 Stat. 254), shall not be construed to constitute a bar to the consideration by the Secretary of the Interior of a petition of a group or organization representing the Lumbee Indians of Robeson and adjoining counties of North Carolina.

(b) CONSIDERATION OF OTHER PETITIONS.—The Act of June 7, 1956, shall not be construed to constitute a bar to the consideration by the Secretary of a petition of a group or organization representing any Indians in Robeson or any other county of North Carolina other than the Lumbee Indians.

(c) RECOGNIZED GROUPS.—The Act of June 7, 1956, shall not be construed to operate to deny any group or organization whose petition is approved by the Secretary on or after the date of the enactment of this Act any of the special programs or services provided by the United States to Indian tribes and their members because of their status as Indians.

SEC. 2. CONSIDERATION OF PETITION REQUIRING RECOGNITION AS AN INDIAN TRIBE.

(a) PROPOSED FINDING.—The Assistant Secretary of the Interior for Indian Affairs shall publish a proposed finding with respect to the petition for Federal recognition as an Indian tribe by the Secretary of the Interior pursuant to part 83 of title 25, Code of Federal Regulations, submitted by the Lumbee Regional Development Association on December 17, 1987, and subsequently supplemented, not later than 18 months after the date on which the petitioner has fully responded to the notice of obvious deficiencies regarding that petition.

(b) NUMBER OF MEMBERS NOT A FACTOR.—The number of persons listed on the membership roll contained in the petition referred to in subsection (a) shall not be taken into account in considering such petition except that the Assistant Secretary may review the eligibility of individual members or groups listed in such petition in accordance with the provisions of part 83 of title 25, Code of Federal Regulations.

(c) REVIEW.—(1) If the Assistant Secretary fails to publish the proposed finding referred to in subsection (a) within the 18-month period referred to in such subsection, the petitioner may treat such failure as final agency action refusing to recognize the petitioner as an Indian tribe and seek in federal district court a determination of whether the petitioner should be recognized as an Indian tribe in accordance with the criteria specified in section 83.7 of title 25, Code of Federal Regulations.

(2) If the Assistant Secretary publishes a final decision refusing to recognize the Indians seeking recognition under the petition referred to in subsection (a), the petitioner may, not later than one year after the date on which the final decision is published, seek in Federal district court a review of the decision, notwithstanding the availability of other administrative remedies.

SEC. 3. CRIMINAL AND CIVIL JURISDICTION.

(a) STATE.—In the event that an Indian tribe is recognized pursuant to the petition referred to in section 2(a), the State of North Carolina shall exercise jurisdiction over all criminal offenses that are committed and all civil causes of action that arise, on lands located within the State that are owned by, or held in trust by the United States for, such tribe or any member of such tribe, or on lands within any dependent community of such tribe, to the same extent that the State has jurisdiction over any such offense committed elsewhere in the State or over other civil causes of action.

(b) TRANSFER TO THE UNITED STATES.—The Secretary may accept on behalf of the United States, after consultation with the Attorney General of the United States, any transfer by the State of North Carolina to the United States of any portion of the jurisdiction of the State described in subsection (a).

SEC. 4. NO DELAY FOR PETITIONS AWAITING ACTIVE CONSIDERATION.

It is the sense of the Congress that the review of the petition referred to in section 2(a) should not unnecessarily delay the review of the pending full documented petitions for recognition as an Indian tribe awaiting active consideration as of the date of enactment of this Act.

Mr. THOMAS of Wyoming (during the reading). Mr. Chairman, I ask unanimous consent that the amendment in the nature of a substitute be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from Wyoming?

There was no objection.

□ 1350

Mr. THOMAS of Wyoming. Mr. Chairman, let me briefly outline the purpose of this amendment. It addresses each of the Lumbee concerns, short of recognition. It would remove the 1966 Lumbee Act statutory bar to the FAP process. In addition, it would directly remedy the most often-cited flaw of the FAP process, the time it takes to review a group's petition, by guaranteeing that the Lumbee petition will receive expedited consideration, and provide the Federal court review of untimely and adverse determinations by the BIA without requiring resort to the administrative appeals process, which any other group would have to exhaust prior to taking the matter to the Federal court.

I note that, again, prior to yesterday, the Department of Interior, which opposes the bill, had opposed the bill, supports this alternative.

Unfortunately, it appears the Lumbee and the bill's proponents want

to have their cake and eat it, too. Rather than constructively addressing the issue, they prefer the bar to remain in place as justification for legislative recognition. This is highly troublesome for several reasons.

Principally, the same amendment was offered in the 101st Congress and was supported by then-Chairman Udall and a 3-to-1 majority of the committee members, both Democrats and Republicans. The full committee later voted to accept the substitute 25 to 8. However, in the last Congress the same amendment, when offered by a Republican, was defeated on a partisan vote of 26 to 18, even though none of the underlying facts had changed.

Another reason I find the offhand rejection of this substitute troubling is the effect it has on the Lumbee. The committee's hearing records describe in detail the numerous unsuccessful attempts the Lumbee have made since 1988, not 1888, to persuade either the executive branch or the Congress to extend Federal recognition to the group. In its present form, H.R. 3334 is, as was its immediate predecessor, unacceptable to the other body.

Given the ultimate legislative death we all know awaits the bill, it is highly regrettable that the bill's proponents are willing to stubbornly stick to their guns and let another Congress, another 2 years, elapse without passage of a bill; that, rather than join in a reasonable and workable compromise solution. It is especially ironic in light of the fact that the opponents of this amendment consistently urge its defeat on the grounds that it would delay a long-overdue recognition of the tribe.

Nothing will do more to assure that delay, however, than the passage of H.R. 334 in its present form. If the House had accepted this substitute 4 years ago, or even in the last Congress, the Lumbee would have been through the process already.

Mr. Chairman, this amendment provides a certainty for the Lumbee people. This bill provides, on the other hand, nothing but false hope, nothing but more delay. It also opens the door to a flood of legislative recognition requests, a path down which we should be very wary of treading.

Mr. Chairman, I urge adoption of the amendment in the nature of a substitute.

Mr. RICHARDSON. Mr. Chairman, I rise in opposition to the amendment offered by the gentleman from Wyoming [Mr. THOMAS].

Mr. Chairman, let me just say that the gentleman from Wyoming has been extremely constructive throughout the entire proceedings of this Subcommittee on Native American Affairs of the Committee on Natural Resources, but this amendment would basically kill the bill. This amendment would allow the Lumbee tribe to go through the Federal acknowledgement process, which has been the problem; again, I repeat, over 150 applications, only 8 to 12 have been acted on; over 100 assays into red tape and bureaucracy and the maze of red tape known as the Bureau of Indian Affairs, without any action.

There are native Americans, Americans they went to war, sitting out there waiting for the bureaucracy to acknowledge that they are Indian tribes. The tribe does not want to go through this ordeal. The tribe deserves immediate recognition. They tried to go through the process in 1987. They supplied volumes of data supporting their claim, and they were declared ineligible to go through the process. This is a process that is fatally flawed. The gentleman from American Samoa [Mr. FALEOMAVAEGA] and the former Representative from Arizona, Mr. Rhodes, are trying to change the acknowledgement process. There are bills that we are going to take up to do this.

The new Assistant Secretary for Indian Affairs, Ada Deer, has said that the administration has a strong desire to fix the process. The Committee on Natural Resources, headed by the gentleman from California [Mr. MILLER], as well as our minority Members, recognize we have to improve the acknowledgement process.

The department is now recognizing that there are two ways to recognize a tribe. First, we do it through the Congress. Second is through the Federal acknowledgement process. Most tribes, a majority of tribes, have gone this route through congressional recognition.

The clearest statement that we are doing the right thing is the statement of administrative policy which says that the administration has no objection to this legislation. Today we can decide whether or not the Lumbees will get recognized during this Congress, or they will then, again, languish for another year, as they have for the last 100 years.

Mr. Speaker, we are the Subcommittee on Native American Affairs of the Committee on Natural Resources, the Indian subcommittee. This is an Indian tribe. They deserve this immediate recognition. There is no cost to this legislation. If they are going to get any funds, they have to get a line item appropriation.

Mr. Speaker, we promised to fix this process, but let us not delay the Lumbees from getting the due recognition as a Indian tribe that they deserve. Regrettably, the amendment of the gentleman from Wyoming [Mr. THOMAS] does not achieve that goal. In fact, it kills the bill.

Mr. ROSE. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I will be brief.

Mr. Chairman, the sponsors of this substitute say that the Lumbee should have to go through the BIA's acknowledgment process like other tribes seeking recognition. Well, let me assure my colleagues that the Lumbee have already tried to comply with this request.

In fact, the Lumbee spent 7 long years putting together a petition for the BIA, and submitted in to the Department in 1987. Two years later, they got a letter from the Associate Solicitor at Interior informing them that they had been ruled ineligible to participate in the Federal acknowledgment process. You know why? Because of a bill Congress had passed in 1956 which in effect said: "You are indeed native Americans but we don't want to treat you like native Americans." For anyone familiar with Government policy toward native Americans during the 1950's, this is no surprise. This was the period known as the "termination period" when the Federal Government was trying to distance itself from commitments made to native Americans.

Supporters of the substitute have also suggested that acknowledging the Lumbee legislatively would open the floodgates for other groups seeking recognition. Members of the House, the only new precedent which would be established here is a failure to recognize this tribe legislatively. The Lumbee are not the first tribe who have found themselves in this predicament over the years, but they are the last. Since 1980, eight tribes have been declared ineligible for the process because of prior legislation passed by Congress. In every case, Congress has resolved the matter with legislation. In fact, the Lumbee are the only tribe remaining which fall into this category.

Righting this injustice for the Lumbee does not set any new precedent. It is totally consistent with past congressional action, and to suggest otherwise is to withhold the fairness for the Lumbee which my colleagues seem to suggest is reserved for other tribes.

Mr. CUNNINGHAM. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, if the gentleman from New Mexico [Mr. RICHARDSON] would enter into a colloquy with me, I have a question for my friend.

To my knowledge, the members of this tribe are American citizens; is that correct?

Mr. RICHARDSON. Mr. Chairman, will the gentleman yield?

Mr. CUNNINGHAM. I yield to the gentleman from New Mexico.

Mr. RICHARDSON. That is correct.

Mr. CUNNINGHAM. Another gentleman mentioned that they have gone and fought in wars. They fought as American citizens when they went to war; is that correct?

Mr. RICHARDSON. If the gentleman will continue to yield, that is correct.

Mr. CUNNINGHAM. And they receive funds and benefits as American citizens, as any citizen would; is that correct?

Mr. RICHARDSON. That is correct.

Mr. CUNNINGHAM. Mr. Chairman, my point is that when we have a welfare state as expansive as it is, if this tribe wants recognition for their heritage, I will be more than happy to support the gentleman. My concern, and I do believe that there will be funds that we will have to come up with. If there are not line items in there, the gentleman knows how this Congress works. It will add funds, because there will not be enough for all the other native Americans.

I would say to the gentleman that these are American citizens. They went to war as American citizens. They have the rights and benefits as any American citizens, Irish, Indian, or whatever nationality or ethnic group.

Mr. RICHARDSON. If the gentleman will continue to yield, I want my friend to read section 3 of the bill. What that subsection does is conditions the eligibility of the Lumbee for any kind of services for tribal members, any kind of funds are conditioned specifically on an appropriation. In other words, they cannot go after the pot that exists for other native American tribes that the gentleman knows has been cut. The gentleman knows there is a special relationship between the Federal Government and the tribes based on treaty and sovereignty.

I would disagree with my friend, who has characterized the tribes as welfare states. I do not think that is the case. I know that is not the case. Perhaps the gentleman did not fully intend that.

Mr. CUNNINGHAM. Reclaiming my time, Mr. Chairman, and I thank the gentleman for the clarification, however, I do know there would be special rights and services as a native American offered. That would be my concern in this thing.

No, I would say to the gentleman, I do not apply the term "welfare state" to all Indian tribes. However, this would cost additional money. The gentleman and I both know how this body operates when it comes to spending. When there needs to be more money appropriated for these types of special services, it will come, and it will come out of taxpayers' money. I would be willing to bet large sums of money that that would happen.

Mr. WILLIAMS. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, as a member of the subcommittee with jurisdiction now over these matters, and as one who has been involved in supporting the request of the Lumbee people here in the Congress, I want to be certain that my colleagues understand the process.

□ 1400

Terminated tribes, of which the Lumbee are one, have to come to Congress to get recognition. They cannot go through the regular process. Not just the Lumbees cannot go through it, no tribe that has been terminated can go through the regular process. They have to do it the way we are doing it today.

What the gentleman's amendment would say is let us create a separate process for the Lumbee, even though they are a terminated tribe. Let us grant them under this act the right to go downtown and go through the normal process. That is different. What the gentleman's amendment would do is put the Lumbee again on a different track than other tribes have been required to entertain.

Having said that, let me just make a general statement. My colleagues notice of course that there are a lot of Members rising suddenly on an issue of native Americans, more than we have seen in a good many years. I have deep respect for all of my colleagues. I like this place. But the hard fact is that Americans, native Americans get scant attention until the time comes when money is involved, or out West at least water is involved. At that point the Congress begins to pay attention to the American Indian, because the American Indian once again becomes a threat.

How is money involved? Not necessarily because the Lumbees are asking for an appropriation here. In fact they are not. A lot of my colleagues are suddenly interested in native Americans because gambling on reservations has become an issue in their districts.

Now we welcome you all. We are glad that the House has suddenly and once again become aware that there are Indian people in America. I just encourage Members to all be aware of it all of the time, not just when Indians become a threat because of money or because they are making legitimate water claims.

Mr. TAYLOR of North Carolina. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I yield to the gentleman from Wyoming [Mr. THOMAS].

Mr. THOMAS of Wyoming. Mr. Chairman, I had hoped to have a chance to visit with my friend from Montana. The fact is this tribe has never been terminated because they have never been recognized, so that is not an accurate observation.

Mr. TAYLOR of North Carolina. The gentleman has spoken eloquently on the fact that we overlook the native Americans, American Indians. Let me just tell the gentleman that I am here speaking for the Eastern Band of the Cherokees. The chief was in my office this morning. The tribal council has met. They are very much opposed to this legislation. They are a recognized Indian tribe.

As I mentioned earlier, there are numerous tribes that oppose this legislation. These are native Americans, these are organized tribes.

The great list that is waiting to come in through the legislative process because they either will not come before the Federal process, or they cannot be approved that way, are not necessarily, and I say that restriction, they are not necessarily native Americans. They may be or they may not be. We do not know. Many people who will be making applications will be people who will not be able to show in any way that they are native Americans.

Now I think the Lumbees have a good, strong case. That is why I support the gentleman's amendment. This removes any of the impediments that the Lumbees have for applying through the Federal process, and I think that is what we need to do.

The gentleman from New Mexico I am sure is earnest in his desire to see that fair treatment is given to native Americans. But what criteria does the gentleman from New Mexico use for determining a tribe?

Mr. RICHARDSON. Mr. Chairman, will the gentleman yield?

Mr. TAYLOR of North Carolina. I am glad to yield to the gentleman from New Mexico.

Mr. RICHARDSON. Mr. Chairman, first of all, historical documents, archaeological documents, words from noted scholars that the subcommittee has amassed, that the Bureau of Indian Affairs has amassed.

The gentleman stated something that I want to correct. In 1956 the tribe was recognized and derecognized in one act, was recognized and derecognized by the Interior Department in one act, so it has been recognized. It so happened that it was terminated in the same initiative, a very flawed process.

Mr. TAYLOR of North Carolina. Reclaiming my time, I would say that what Congress was doing in the 1950's does not come close to the process that we have today, a process which was created so that we could give fair, equitable treatment, stating the geological, historical, all of the records the gentleman mentioned. If the Lumbees have those records and can make that case, they can come through the proper process, especially if this amendment passes.

If we do not pass this amendment, if we do as we have done in many Congresses, we send this over to the Senate, and the Senate kills it, as it likely will, then 2 years from now they will be sitting here again making this case and not getting proper recognition for the Lumbees.

Mr. THOMAS of Wyoming. Mr. Chairman, will the gentleman yield?

Mr. TAYLOR of North Carolina. I yield to the gentleman from Wyoming.

Mr. THOMAS of Wyoming. Mr. Chairman, just one point. If the gentleman is correct, then this bill is wrong, because we would not be recognizing

them then, we would be restoring, and that would be the legal term. So I question the historic benefit.

Mr. DE LUGO. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise today to join my colleagues, the gentleman from North Carolina, in enthusiastic support for H.R. 334, the Lumbee Recognition Act of 1993.

Our colleague, Mr. ROSE, has worked tirelessly on this legislation for several years now and I pleased once again to join with him as one of the cosponsors of the bill.

As my colleagues well know, the Lumbee Indians have been recognized by the State of North Carolina since 1885, and have been seeking Federal recognition ever since then. The Department of the Interior has continuously opposed legislative efforts to recognize the Lumbee Tribe, either because recognition conflicted with prevailing Federal policies toward Indians or because of concern that providing services to the Lumbees would be too costly.

Because the Lumbee Tribe does not have Federal recognition, they receive some Federal services but they are ineligible for services provided to Indian Tribes by the Bureau of Indian Affairs and the Indian Health Service.

Mr. Chairman, it is time that we right this wrong that has been inflicted upon the Lumbee Tribe for over 100 years. I urge my colleagues to resist any amendments to the bill and pass it as it is presented today.

In conclusion, I want to take a moment to commend my colleague on the Natural Resources Committee, the chairman of the Subcommittee on Native American Affairs, BILL RICHARDSON, for his strong leadership on this issue and for bringing this bill to the floor today. I want to also thank the chairman of the full Natural Resources Committee, the gentleman from California [Mr. MILLER], for his support and leadership on this issue as well. And I urge my colleagues to vote "yes" on H.R. 334.

The CHAIRMAN. The question is on the amendment in the nature of a substitute offered by the gentleman from Wyoming [Mr. THOMAS].

The question was taken; and the Chairman announced that the ayes appeared to have it.

RECORDED VOTE

Mr. THOMAS of Wyoming. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 178, noes 238, not voting 22, as follows:

[Roll No. 537]

AYES—178

Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)
Ballenger
Barrett (NE)
Bartlett
Barton
Bentley
Bereuter
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Brewster
Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Collins (GA)
Combest
Crane
Crapo
Cunningham
DeLauro
DeLay
Diaz-Balart
Dickey
Dingell
Doolittle
Dreier
Duncan
Dunn
Edwards (CA)
Emerson
English (OK)
Everett
Ewing
Fawell
Fields (TX)
Fish
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gallo
Gekas
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Grams
Grandy
Greenwood
Gunderson
Hall (TX)
Hancock
Hansen
Hastert
Hefley
Herger
Hobson
Hoekstra
Hoke
Horn
Houghton
Huffington
Hunter
Hutchinson
Hyde
Inhofe
Inslee
Istook
Johnson (CT)
Johnson (SD)
Johnson, Sam
Kennelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
Kyl
LaFalce
Lazio
Leach
Lehman
Levy
Lewis (CA)
Lewis (FL)
Lightfoot
Linder
Livingston
Machtley
Manzullo
McCandless
McCollum
McCrery
McCurdy
McDade
McHugh
McInnis
McKeon
Menendez
Meyers
Mica
Michel
Miller (FL)
Molinari
Moorhead
Morella
Myers
Nussle
Orton
Oxley
Packard
Paxon
Petri
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Quinn
Ramstad
Regula
Ridge
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Santorum
Saxton
Schaefer
Schiff
Sensenbrenner
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Spence
Stearns
Stump
Sundquist
Swift
Synar
Talent
Taylor (NC)
Thomas (CA)
Thomas (WY)
Torkildsen
Torricelli
Upton
Walker
Walsh
Weldon
Wolf
Young (FL)
Zeliff
Zimmer

NOES—238

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barcia
Barlow
Barrett (WI)
Becerra
Beilenson
Bevill
Bilbray
Bishop
Blackwell
Bonior
Borski
Boucher
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Byrne
Cantwell
Carr
Chapman
Clay
Clayton
Clement
Clyburn
Coble
Coleman
Collins (IL)
Collins (MI)
Condit
Cooper
Coppersmith
Costello
Coyne
Cramer
Danner
Darden
de la Garza
de Lugo (VI)
Deal
DeFazio
Dellums
Derrick
Deutsch
Dicks
Dixon
Dooley
Durbin
Edwards (TX)
Engel
English (AZ)
Eshoo
Evans
Faleomavaega (AS)
Farr
Fazio
Fields (LA)
Filner
Fingerhut
Flake
Foglietta
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Glickman
Gonzalez
Gordon
Gutierrez
Hall (OH)
Hamburg
Hamilton
Harman
Hastings
Hayes
Hefner
Hilliard
Hinchey
Hoagland
Hochbrueckner
Holden
Hoyer
Hughes
Hutto
Jacobs
Jefferson
Johnson (GA)
Johnson, E. B.
Kanjorski
Kaptur
Kennedy
Kildee
Kleczka
Klein
Klink
Kopetski
Kreidler
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Levin
Lewis (GA)
Lipinski
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCloskey
McDermott
McHale
McKinney
McMillan
Meehan
Meek
Mfume
Miller (CA)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Murphy
Murtha
Nadler
Natcher
Neal (MA)
Neal (NC)
Norton (DC)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Parker
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pickle
Poshard
Price (NC)
Quillen
Rahall
Ravenel
Reed
Reynolds
Richardson
Roemer
Rose
Rostenkowski
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Sarpalius
Sawyer
Schenk
Schroeder
Schumer
Scott
Serrano
Sharp
Shepherd
Sisisky
Skaggs
Skelton
Slattery
Slaughter
Smith (IA)
Snowe
Spratt
Stark
Stenholm
Stokes
Strickland
Studds
Stupak
Swett
Tanner
Tejeda
Thompson
Thornton
Thurman
Torres
Traficant
Tucker
Underwood (GU)
Unsoeld
Valentine
Velazquez
Vento
Visclosky
Volkmer
Washington
Waters
Watt
Waxman
Wheat
Whitten
Williams
Wilson
Wise
Woolsey
Wyden
Wynn
Yates

NOT VOTING—22

Bateman
Berman
Cardin
Clinger
Conyers
Cox
Dornan
Green
Inglis
Johnston
Kasich
McNulty
Penny
Rangel
Romero-Barcelo (PR)
Royce
Smith (OR)
Tauzin
Taylor (MS)
Towns
Vucanovich
Young (AK)

□ 1420

The Clerk announced the following pair:

On this vote:

Mr. Smith of Oregon for, with Mr. Rangel against.

Mrs. UNSOELD, Ms. SHEPHERD, Mr. KENNEDY, and Mr. OBEY changed their vote from "aye" to "no."

Mr. BLUTE, Mr. ENGLISH of Oklahoma, and Mrs. ROUKEMA changed their vote from "no" to "aye."

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

□ 1430

The CHAIRMAN. The Clerk will designate section 2.

The text of section 2 is as follows:

SEC. 2. PREAMBLE.

The preamble to the Act of June 7, 1956 (70 Stat. 254), is amended—

(1) by striking out "and" at the end of each of the first three clauses;

(2) by striking out ": Now therefore," at the end of the last clause and inserting in lieu thereof a semicolon; and

(3) by adding at the end thereof the following new clauses:

"Whereas the Lumbee Indians of Robeson and adjoining counties in North Carolina are

descendants of coastal North Carolina Indian tribes, principally Cheraw, and have remained a distinct Indian community since the time of contact with white settlers;

"Whereas the Lumbee Indians have been recognized by the State of North Carolina as an Indian tribe since 1885;

"Whereas the Lumbee Indians have sought Federal recognition as an Indian tribe since 1888; and

"Whereas the Lumbee Indians are entitled to Federal recognition of their status as an Indian tribe and the benefits, privileges, and immunities that accompany such status: Now, therefore,".

The CHAIRMAN. Are there amendments to section 2?

The Clerk will designate section 3.

The text of section 3 is as follows:

SEC. 3. FEDERAL RECOGNITION.

The Act of June 7, 1956 (70 Stat. 254), is amended—

(1) by striking out the last sentence of the first section; and

(2) by striking out section 2 and inserting in lieu thereof the following:

"FEDERAL RECOGNITION; ACKNOWLEDGMENT

"SEC. 2. (a) Federal recognition is hereby extended to the Lumbee Tribe of Cheraw Indians of North Carolina. All laws and regulations of the United States of general application to Indians and Indian tribes shall apply to the Lumbee Tribe of Cheraw Indians of North Carolina and its members.

"(b) Notwithstanding the first section of this Act, any group of Indians in Robeson or adjoining counties whose members are not enrolled in the Lumbee Tribe of Cheraw Indians of North Carolina, as determined under section 4(b), may petition under part 83 of title 25 of the Code of Federal Regulations for acknowledgment of tribal existence.

"SERVICES

"SEC. 3. (a) The Lumbee Tribe of Cheraw Indians of North Carolina and its members shall be eligible for all services and benefits provided to Indians because of their status as federally recognized Indians, except that members of the tribe shall not be entitled to such services until the appropriation of funds for these purposes. For the purposes of the delivery of such services, those members of the tribe residing in Robeson and adjoining counties, North Carolina, shall be deemed to be resident on or near an Indian reservation.

"(b) Upon verification of a tribal roll under section 4 by the Secretary of the Interior, the Secretary of the Interior and the Secretary of Health and Human Services shall develop, in consultation with the Lumbee Tribe of Cheraw Indians of North Carolina, a determination of needs and a budget required to provide services to which the members of the tribe are eligible. The Secretary of the Interior and the Secretary of Health and Human Services shall each submit a written statement of such needs and budget with the first budget request submitted to the Congress after the fiscal year in which the tribal roll is verified.

"(c)(1) The Lumbee Tribe of Cheraw Indians of North Carolina is authorized to plan, conduct, consolidate, and administer programs, services, and functions authorized under the Act of April 16, 1934 (48 Stat. 596; 25 U.S.C. 452, et seq.), and the Act of November 2, 1921 (42 Stat. 208; 25 U.S.C. 13), popularly known as the Snyder Act, pursuant to an annual written funding agreement among the Lumbee Tribe of Cheraw Indians of North Carolina, the Secretary of the Interior, and the Secretary of Health and Human Services, which shall specify—

"(A) the services to be provided, the functions to be performed, and the procedures to be used to reallocate funds or modify budget allocations, within any fiscal year; and

"(B) the responsibility of the Secretary of the Interior for, and the procedure to be used in, auditing the expenditures of the tribe.

"(2) The authority provided under this subsection shall be in lieu of the authority provided under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450, et seq.).

"(3) Nothing in this subsection shall be construed as affecting, modifying, diminishing, or otherwise impairing the sovereign immunity from lawsuit enjoyed by the Lumbee Tribe of Cheraw Indians of North Carolina or authorizing or requiring the termination of any trust responsibility of the United States with respect to the tribe.

"CONSTITUTION AND MEMBERSHIP

"SEC. 4. (a) The Lumbee Tribe of Cheraw Indians of North Carolina shall organize for its common welfare and adopt a constitution and bylaws. Any constitution, bylaws, or amendments to the constitution or bylaws that are adopted by the tribe must be consistent with the terms of this Act and shall take effect only after such documents are filed with the Secretary of the Interior. The Secretary shall assist the tribe in the drafting of a constitution and bylaws, the conduct of an election with respect to such constitution, and the reorganization of the government of the tribe under any such constitution and bylaws.

"(b)(1) Until the Lumbee Tribe of Cheraw Indians of North Carolina adopts a constitution and except as provided in paragraph (2), the membership of the tribe shall, subject to review by the Secretary, consist of every individual who is named in the tribal membership roll that is in effect on the date of enactment of this Act.

"(2)(A) Before adopting a constitution, the roll of the tribe shall be open for a 180-day period to allow the enrollment of any individual previously enrolled in another Indian group or tribe in Robeson or adjoining counties, North Carolina, who demonstrates that—

"(i) the individual is eligible for enrollment in the Lumbee Tribe of Cheraw Indians; and

"(ii) the individual has abandoned membership in any other Indian group or tribe.

"(B) The Lumbee Tribe of Cheraw Indians of North Carolina shall advertise in newspapers of general distribution in Robeson and adjoining counties, North Carolina, the opening of the tribal roll for the purposes of subparagraph (A). The advertisement shall specify the enrollment criteria and the deadline for enrollment.

"(3) The review of the tribal roll of the Lumbee Tribe of Cheraw Indians of North Carolina shall be limited to verification of compliance with the membership criteria of the tribe as stated in the Lumbee Petition for Federal Acknowledgment filed with the Secretary by the tribe on December 17, 1987. The Secretary shall complete his review and verification of the tribal roll within the 12-month period beginning on the date on which the tribal roll is closed under paragraph (2).

"JURISDICTION

"SEC. 5. (a)(1) The State of North Carolina shall exercise jurisdiction over—

"(A) all criminal offenses that are committed on, and

"(B) all civil actions that arise on, lands located within the State of North Carolina that are owned by, or held in trust by the United States for, the Lumbee Tribe of Cheraw Indians of North Carolina, any member of the Lumbee Tribe of Cheraw Indians of North Carolina, or any dependent Indian community of the Lumbee Tribe of Cheraw Indians of North Carolina.

"(2) The Secretary of the Interior is authorized to accept on behalf of the United States, after consulting with the Attorney General of the United States, any transfer by the State of North Carolina to the United States of any portion of the jurisdiction of the State of North Carolina described in paragraph (1) pursuant to an agreement between the Lumbee Tribe of Cheraw Indians and the State North Carolina. Such transfer of jurisdiction may not take effect until two years after the effective date of such agreement.

"(3) The provisions of this subsection shall not affect the application of section 109 of the Indian Child Welfare Act of 1978 (25 U.S.C. 1919).

"(b) Section 5 of the Act of June 18, 1934 (Chapter 576; 25 U.S.C. 465), and the Act of April 11, 1970 (84 Stat. 120; 25 U.S.C. 488 et seq.), shall apply to the Lumbee Tribe of Cheraw Indians of North Carolina with respect to lands within the exterior boundaries of Robeson and adjoining counties, North Carolina.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 6. (a) There are authorized to be appropriated such funds as may be necessary to carry out this Act.

"(b) In the first fiscal year in which funds are appropriated under this Act, the tribe's proposals for expenditures of such funds shall be submitted to the Select Committees on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives 60 calendar days prior to any expenditure of such funds by the tribe.".

The CHAIRMAN. Are there further amendments to the bill?

Under the rule, the Committee rises.

Accordingly the Committee rose; and the Speaker pro tempore [Mr. DURBIN] having assumed the chair, Mr. PETERSON of Florida, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 334) to provide for the recognition of the Lumbee Tribe of Cheraw Indians of North Carolina, and for other purposes, pursuant to House Resolution 286, he reported the bill back to the House.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. RICHARDSON. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 228, noes 184, not voting 21, as follows:

[Roll No. 538]

AYES—228

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barcia
Barlow
Barrett (WI)
Becerra
Beilenson
Bevill
Bilbray
Bishop
Blackwell
Blute
Bonior
Borski
Boucher
Brewster
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Byrne
Cantwell
Carr
Chapman
Clay
Clayton
Clement
Clyburn
Coble
Coleman
Collins (IL)
Collins (MI)
Cooper
Coppersmith
Costello
Coyne
Cramer
Danner
Darden
de la Garza
Deal
DeFazio
Dellums
Derrick
Deutsch
Dicks
Dixon
Dooley
Durbin
Edwards (CA)
Edwards (TX)
Engel
English (AZ)
Eshoo
Evans
Farr
Fazio
Fields (LA)
Filner
Fingerhut
Flake
Foglietta
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Gilman
Glickman
Gonzalez
Gordon
Gutierrez
Hall (OH)
Hamburg
Hamilton
Harman
Hastings
Hefner
Hilliard
Hinchey
Hochbrueckner
Holden
Horn
Hoyer
Jacobs
Jefferson
Johnson (GA)
Johnson, E. B.
Kanjorski
Kaptur
Kennedy
Kildee
Kleczka
Klein
Klink
Kopetski
Lambert
Lancaster
Lantos
LaRocco
Leach
Lehman
Levin
Lewis (GA)
Lipinski
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Martinez
Matsui
Mazzoli
McCloskey
McDermott
McHale
McKinney
McMillan
Meehan
Meek
Mfume
Miller (CA)
Mineta
Mink
Moakley
Mollohan
Moran
Murphy
Murtha
Nadler
Natcher
Neal (MA)
Neal (NC)
Obey
Olver
Ortiz
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pickle
Poshard
Price (NC)
Rahall
Rangel
Ravenel
Reynolds
Richardson
Ridge
Roemer
Rose
Rostenkowski
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Sarpalius
Sawyer
Schenk
Schroeder
Schumer
Scott
Serrano
Sharp
Shepherd
Sisisky
Skaggs
Skelton
Slattery
Slaughter
Smith (IA)
Snowe
Spratt
Stark
Stokes
Strickland
Studds
Stupak
Swett
Tejeda
Thompson
Thornton
Thurman
Torkildsen
Torres
Traficant
Tucker
Unsoeld
Upton
Valentine
Velazquez
Vento
Visclosky
Volkmer
Washington
Waters
Watt
Waxman
Wheat
Whitten
Williams
Wilson
Wise
Woolsey
Wyden
Wynn
Yates

NOES—184

Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)
Ballenger
Barrett (NE)
Bartlett
Barton
Bateman
Bentley
Bereuter
Bilirakis
Bliley
Boehlert
Boehner
Bonilla
Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Collins (GA)
Combest
Condit
Crane
Crapo
Cunningham
DeLauro
DeLay
Diaz-Balart
Dickey
Dingell
Doolittle
Dornan
Dreier
Duncan
Dunn
Emerson
English (OK)
Everett
Ewing
Fawell
Fields (TX)
Fish
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gallo
Gekas
Gilchrest
Gillmor
Gingrich
Goodlatte
Goodling
Goss
Grams
Grandy
Greenwood
Gunderson
Hall (TX)
Hancock
Hansen
Hastert
Hayes
Hefley
Herger
Hoagland
Hobson
Hoekstra
Hoke
Houghton
Huffington
Hughes
Hunter
Hutchinson
Hutto
Hyde
Inhofe
Inslee
Istook
Johnson (CT)
Johnson (SD)
Johnson, Sam
Kasich
Kennelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
Kreidler
Kyl
LaFalce
Laughlin
Lazio
Levy
Lewis (CA)
Lewis (FL)
Lightfoot
Linder
Livingston
Machtley
Manzullo
McCandless
McCollum
McCrery
McCurdy
McInnis
McKeon
Menendez
Meyers
Mica
Michel
Miller (FL)
Minge
Molinari
Montgomery
Moorhead
Morella
Myers
Nussle
Oberstar
Orton
Oxley
Packard
Parker
Paxon
Penny
Petri
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Quinn
Ramstad
Reed
Regula
Roberts
Rogers
Rohrabacher
Roth
Roukema
Santorum
Saxton
Schaefer
Schiff
Sensenbrenner
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Spence
Stearns
Stenholm
Stump
Sundquist
Swift
Synar
Talent
Tanner
Taylor (MS)
Taylor (NC)
Thomas (CA)
Thomas (WY)
Torricelli
Vucanovich
Walker
Weldon
Wolf
Young (FL)
Zeliff
Zimmer

NOT VOTING—21

Berman
Brooks
Cardin
Clinger
Conyers
Cox
Green
Inglis
Johnston
Markey
McDade
McHugh
McNulty
Quillen
Ros-Lehtinen
Royce
Smith (OR)
Tauzin
Towns
Walsh
Young (AK)

□ 1450

The Clerk announced the following pairs:

On this vote:

Mr. Johnston of Florida for, with Mr. Cox against.

Mr. Conyers for, with Mr. Smith of Oregon against.

Mr. McCURDY changed his vote from "aye" to "no."

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. CLINGER. Mr. Speaker, I was unavoidably absent on Thursday, October 28. Had I been present, I would have voted "no" on rollcall 535; "no" on rollcall 536; "yes" on rollcall 537; and "no" on rollcall 538.

GENERAL LEAVE

Mr. RICHARDSON. Mr. Chairman, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous matter on H.R. 334, the bill just passed.

The CHAIRMAN pro tempore. Is there objection to the request of the gentleman from New Mexico?

There was no objection.

LEGISLATIVE PROGRAM

(Mr. MICHEL asked and was given permission to address the House for one minute.)

Mr. MICHEL. Mr. Speaker, I have asked unanimous consent to speak for 1 moment in order that I might inquire of the distinguished majority leader the program for next week.

I yield to the gentleman from Missouri [Mr. GEPHARDT].

Mr. GEPHARDT. Mr. Speaker, I think the gentleman for yielding to me.

There will very likely be no more votes today. The only reason I do not state it unequivocally is that the other body still has to deal with the continuing resolution. We have no reason to believe that they will not pass the continuing resolution that was passed here earlier today, but I wanted Members to be aware that if for any reason that did not happen, we might have to take some further action today or tomorrow. So we are not anticipating votes later today or tomorrow.

On Monday, November 1, the House will meet at noon, but there will not be legislative business and there will not be votes.

Tuesday, November 2, the House will meet at noon to consider eight bills on suspension, but recorded votes on suspensions will be postponed until Wednesday, November 3, toward the end of the day. And the reason for that, of course, is that Tuesday, November 2, is an election day in a number of States.

We will be taking up the eight suspension bills on Tuesday that are noted on the schedule. However, again, the votes will be held until Wednesday.

On Wednesday, November 3, and the balance of the week, the House will meet at noon on Wednesday and at 10 a.m. on Thursday, and, if needed, on Friday. We will be taking up H.R. 2151, the Maritime Security and Competitiveness Act of 1993, subject to a rule.

There could be possible further action on H.R. 3167, the Unemployment Compensation Extension. We will be taking up H.R. 1036, to amend the Employee Retirement Income Security Act of 1974, subject to a rule, and H.R. 3116, the Defense Appropriations Conference Report, again, subject to a rule.

Conference reports can be brought up at any time and any further program will be announced later.

Mr. MICHEL. Mr. Speaker, would the gentleman venture a guess as to when those votes might begin on Wednesday? What hour of the day?

Mr. GEPHARDT. Mr. Speaker, if the gentleman will continue to yield, I would say that there would not be any votes before 1 o'clock on that day.

Mr. MICHEL. Mr. Speaker, the gentleman and I have had little, informal conversations, looking toward Thanksgiving. From what I understand, we are still reaching for adjournment before Thanksgiving.

Mr. GEPHARDT. Mr. Speaker, still targeting it November 22, and we would reiterate to Members that it may be necessary, to reach that goal, to have votes through the weekend of November 19, 20, and 21.

Mr. UPTON. Mr. Speaker, will the gentleman yield?

Mr. MICHEL. I yield to the gentleman from Michigan.

Mr. UPTON. Mr. Speaker, if I might just ask the gentleman, his staff has been very good about talking about votes for next week, particularly on Friday. I noted in the gentleman's remarks, he indicated that we would meet at 10 on Friday, if necessary.

Do we have a 60-percent chance, perhaps, of not having votes, 70 percent?

I know the gentleman does not want to give it away yet.

Mr. GEPHARDT. Mr. Speaker, if the gentleman will continue to yield, the reason we are unable to be definitive is two things: One is the defense bill and, therefore, the continuing appropriation. We need to know if those two are moving properly, and it may be necessary to be here to deal with them on Friday. But we just cannot tell Members at this point.

Mr. UPTON. Mr. Speaker, I thank the gentleman for yielding to me.

Mr. MICHEL. Mr. Speaker, I thank the distinguished gentleman.

HOUR OF MEETING ON WEDNESDAY, NOVEMBER 3, 1993

Mr. GEPHARDT. Mr. Speaker, I ask unanimous consent that when the House adjourns on Tuesday, November 2, 1993, it adjourn to meet at noon on Wednesday, November 3, 1993.

The SPEAKER pro tempore (Mr. ANDREWS of Maine). Is there objection to the request of the gentleman from Missouri?

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY NEXT

Mr. GEPHARDT. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday Rule be dispensed with on Wednesday next.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Missouri?

There was no objection.

ADJOURNMENT TO MONDAY, NOVEMBER 1, 1993

Mr. GEPHARDT. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at noon on Monday next.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Missouri?

There was no objection.

ANNOUNCEMENT REGARDING SUBMISSION OF AMENDMENTS TO H.R. 796, THE FREEDOM OF ACCESS TO CLINIC ENTRANCES ACT OF 1993

(Mr. MOAKLEY asked and was given permission to address the House for 1 minute.)

Mr. MOAKLEY. Mr. Speaker, the Rules Committee is planning on meeting the week of November 1, 1993, on H.R. 796, the Freedom of Access to Clinic Entrances Act of 1993.

In order to provide for an orderly process in the consideration of this matter, the Rules Committee is requesting that Members submit 55 copies of their amendments to the bill, together with a brief explanation of the amendment, to the Rules Committee office at H-312, the Capitol, by 5 p.m., Wednesday, November 3, 1993.

Copies of the text of the bill and the report are available in the House Document Room.

Again, the committee would urge Members to submit any amendments to the Rules Committee at the earliest possible time but in no case later than 5 p.m. on November 3, 1993. I thank the Members for their consideration on this matter.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 2151, MARITIME SECURITY AND COMPETITIVENESS ACT OF 1993

Mr. MOAKLEY, from the Committee on Rules, submitted a privileged report (Rept. No. 103-311) on the resolution (H. Res. 289) providing for consideration of the bill (H.R. 2151) to amend the Merchant Marine Act, 1936, to establish the Maritime Security Fleet Program, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REMARKS OF PRESIDENT CLINTON

(Mr. DORNAN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DORNAN. Mr. Speaker, on September 23 President Clinton, who loves to campaign more than anything else, held a townhall meeting in Tampa, FL, to discuss his proposed healthcare plan.

In response to a woman who voiced her strong opposition to having her tax money fund abortions, the President completely ignored her concerns and said something so outrageous, so ignorant, that I had to get the transcript of that event to satisfy myself that I had not misunderstood him. I hadn't. It was as bad as I thought. Here is exactly what President Clinton said about the prolife movement:

> I believe we need an aggressive plan to promote adoptions in this country. If every prolife advocate in America adopted a child, this world would be a better place.

This statement is shocking and offensive in the extreme. Perhaps the President should do some research before he opens his mouth.

□ 1500

Every year there are 1,500,000 couples who want to adopt a child. Yet each year, while 1.6 million children are being killed by abortion, only 50,000 new children are available for adoption. This means that for every new adoptable child, 30 others are killed. For every couple that adopts, another 40 wait in line.

So what was he saying, with my new healthcare plan the Government will pay to kill your unborn children and hopefully the prolifers can adopt the few that manage to escape? Disgraceful.

Mr. Speaker, I include in the RECORD the excerpt of the Tampa townhall meeting which includes the Clinton remarks I quoted:

> The PRESIDENT: Well, let me ask you—we are also personally and morally improving preventive and primary health services, and we'll actually stop some abortions from occurring with the kind of preventive services that we're going to cover for the first time in the history of this country.
>
> This could be a subject for a whole other program. I have a difference of opinion from you about whether all abortions should be illegal. I do agree that there are way too many in the United States. I believe we need an aggressive plan to reduce teen pregnancy, to reduce unwanted pregnancies. One of the reasons I named the Surgeon General I did, my health department director, is because I'm committed to that. I believe we need an aggressive plan to promote adoptions in this country. If every prolife advocate in America adopted a child, this world would be a better place.
>
> I want this issue to be debated, and I haven't hedged with you. Most people will get this service covered because most private plans do it. And we propose for the first time ever to put Medicaid people in the big private plans to get the economies of scale. Not for the purpose of doing that, but basically to end this two-tiered system we've had. So most will be covered. But some won't if they choose to join plans that don't cover them. Most plans do today.

COMMUNICATION FROM THE CHAIRMAN OF THE COMMITTEE ON HOUSE ADMINISTRATION

Mr. SPEAKER pro tempore (Mr. ANDREWS of Maine) laid before the House the following communication from the

Honorable CHARLIE ROSE, chairman of the Committee on House Administration:

COMMITTEE ON HOUSE ADMINISTRATION,
Washington, DC, October 26, 1993.

Hon. TOM S. FOLEY,
Speaker of the House, the Capitol, Washington, DC.

DEAR MR. SPEAKER: This is to formally notify you pursuant to Rule L (50) of the Rules of the House that an employee of the Committee on House Administration has been served with a subpoena issued by the United States District Court for the District of Columbia.

After consultation with the General Counsel, I have determined that compliance with the subpoena is consistent with the privileges and precedents of the House.

Sincerely,

CHARLIE ROSE,
Chairman.

COMMUNICATION FROM THE HONORABLE JANE HARMAN, MEMBER OF CONGRESS

The SPEAKER pro tempore laid before the House the following communication from the Honorable JANE HARMAN, a Member of Congress:

HOUSE OF REPRESENTATIVES,
Washington, DC, October 25, 1993.

Hon. THOMAS S. FOLEY,
Speaker, House of Representatives, Washington, DC.

DEAR MR. SPEAKER: This is to inform you, pursuant to Rule L (50) of the Rules of the House, that I have been served with a subpoena issued in a civil case pending in the Superior Court of Torrance, California.

After consultation with the General Counsel, I will make the determinations required by the rule.

Regards,

JANE HARMAN,
Member of Congress.

VACATING SPECIAL ORDER AND GRANTING SPECIAL ORDER

Mr. KOLBE. Mr. Speaker, I ask unanimous consent that the gentleman from California [Mr. DREIER] be granted a 5-minute special order today, in lieu of the 60-minute special order previously agreed to.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arizona?

There was no objection.

GENERAL LEAVE

Mr. SANDERS. Mr. Speaker, I ask unanimous consent that all Members may be permitted to extend their remarks, and to include extraneous material, on the special order of the gentleman from Michigan [Mr. FORD] today.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Vermont?

There was no objection.

REALLOCATION OF SPECIAL ORDER TIME

Mr. SANDERS. Mr. Speaker, I ask unanimous consent that the special order of the gentleman from Michigan [Mr. BONIOR] on November 15, 1993, be allocated to the gentleman from Massachusetts [Mr. NEAL].

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Vermont?

There was no objection.

A NEW PLAYGROUND FOR THE CHILDREN OF THE DISTRICT OF COLUMBIA

(Mr. SWETT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SWETT. Mr. Speaker, Henry David Thoreau said, "If you have built castles in the air, your work need not be lost; that is where they should be. Now put the foundations under them." For the last 2 years, some of us in Congress have been working on our dream of building castles—a playground—for the children of Washington, DC, and we now have finally put in the foundation and built that dream.

My colleagues, Representative ELEANOR HOLMES NORTON, Senator ORRIN HATCH, and then-Senator AL GORE, helped me in spearheading a joint project to build a playground for the children at the Montana Terrace housing development in the District of Columbia. Mayor Sharon Pratt Kelly and the D.C. government joined with other national and local officials to make this project happen. The children who live in this housing development designed the playground themselves with the help of volunteer architects from the American Institute of Architects, who translated the children's dreams and drawings into an elaborate design for a wooden volcano, a stepped pyramid, and a tower designed to resemble a tree house or fort. More than 100 Members of the Senate and House contributed personal cash donations, many businesses provided materials, and local residents and numerous volunteers from the community and Capitol Hill helped to build it.

Mr. Speaker, the District of Columbia is a second home for all of us, who commute between our congressional districts and our Nation's capital. Many of us have long felt the need to give something back to our second home. The freshman class of the 102d Congress felt that this project could help to do that in at least some small way, and many of those Members were very helpful and supportive of this project. I want to thank them and all of the other people and organizations who have helped to make the children of D.C.'s dream, become a reality.

First, the sponsoring organizations—The American Architectural Foundation, The American Institute of Architects, The Washington Chapter of the American Institute of Architects, and the D.C. Department of Public and Assisted Housing; second, my co-chairs in the House and Senate, Representative ELEANOR HOLMES NORTON, Senator ORRIN HATCH, and Vice President GORE; third, the Architecture Firms of Hellmuth, Obata and Kassabaum, PC, as well as Brenda Sanchez Architects; fourth, the construction coordinators Larry Pericolosi of Jefferson Millwork and Design, Valerie Warshaw of the D.C. Jewish Community Center Behrend Shelter Repair and Construction Program, Dom Vokic and Shirli Sensenbrenner of Lehman [Smith] Wiseman and Associates, and Chuck Lovett and Susan A. Retz of the American Institute of Architects; fifth, congressional spouse fundraisers Suzie Brewster and Linda Dooley; and sixth, corporate contributors the Hechinger Co., The American Institute of Architects, The American Consulting Engineers Council, Landscape Architects Daniel Castle Turner and Associates, Reprographic Technologies, Inc., Smoot Lumber Company, Safeway, National Capital Parks—Central, and Giant Food.

There are many others who deserve special credit for their tireless work over the last 2 years—Michele Booth, office of Representative ELEANOR HOLMES NORTON; Bryant and Bryant Architects; Representative DAVE CAMP; Eve Grossman, of my office; Representative DAVE HOBSON; Independent Church of God; Kay Atkinson King, my chief of staff; Jennifer Knott, Cannon Architects; Chris LaRocco, wife of Representative LARRY LAROCCO; Ann Looper, The American Institute of Architects; Martin Moeller, Washington Chapter of the American Institute of Architects; Steve Rentner, The American Institute of Architects; Susan A. Retz, AIA, Washington Chapter of the American Institute of Architects; Brenda Sanchez, Brenda Sanchez Architects; Suzette Voline, Hellmuth, Obata and Kassabaum, PC; Woody Woodrich, Executive Office of the Mayor, and the residents of Montana Terrace.

I also am grateful to those Members of Congress who gave their personal cash donations to build this playground:

INDIVIDUAL CONTRIBUTORS

Vice President Albert Gore, Jr., Treasury Secretary Lloyd Bentsen, Senator Brock Adams, Senator Robert Byrd, Senator Kent Conrad, Senator John Danforth, Senator Dennis DeConcini, Senator Bob Dole, Senator Wendell Ford, Senator Orrin Hatch, Senator Ernest F. Hollings, Senator James Jeffords, Senator Edward M. Kennedy, Senator John Kerry, Senator Herbert Kohl, Senator Carl Levin, Senator Richard Lugar, Senator Howard Metzenbaum, Senator Sam Nunn, Senator Charles Robb, Senator Terry Sanford, Senator Ted Stevens, Senator Strom Thurmond, Representative George

Allen, Representative Robert Andrews, Representative Thomas Andrews, Representative Jim Bacchus, Representative Cass Ballenger, Representative Bill Barrett.

Representative Lucien Blackwell, Representative John Boehner, Representative Bill Brewster, Representative Dave Camp, Representative Bill Clinger, Representative Barbara Rose Collins, Representative Antonio Colorado, Representative John Cox, Representative Bud Cramer, Representative Randy Duke Cunningham, Representative Rosa DeLauro, Representative Cal Dooley, Representative John Doolittle, Representative Thomas Ewing, Representative Barney Frank, Representative Wayne Gilchrest, Representative Pete Geren, Representative David Hobson, Representative Joan Kelly Horn, Representative Jay Inslee, Representative Bill Jefferson, Representative Sam Johnson, Representative Jim Jontz, Representative Joe Kennedy, Representative Herb Klein, Representative Mike Kopetski, Representative Larry LaRocco, Representative Tom Lantos.

Representative John Linder, Representative Tom Luken, Representative Buck McKeon, Representative David Minge, Representative Jim Moran, Representative Dick Nichols, Representative Eleanor Holmes Norton, Representative John Olver, Representative Bill Orton, Representative Ed Pastor, Representative L.F. Payne, Representative Collin Peterson, Representative Pete Peterson, Representative Earl Pomeroy, Representative Jim Ramstad, Representative Jack Reed, Representative Frank Riggs, Representative Tim Roemer, Representative George Sangmeister, Representative Nick Smith, Representative Dick Swett, AlA, Representative John Tanner, Representative Ray Thornton, Representative Maxine Waters, Representative Mel Watt, Representative Bill Zeliff, Ms. Ellen R. Shaffer, and anonymous contributors.

CONSUMER PRICE INDEX FOR GOVERNMENT USE

(Mr. SMITH of Michigan asked and was given permission to address the House for 1 minute and to revise and extend his remarks and include extraneous matter.)

Mr. SMITH of Michigan. Mr. Speaker, my son, Brad, called to my attention the other day a problem related to the Consumer Price Index that doesn't seem to make sense and costs billions of dollars.

Mr. Speaker, I rise today to call to the attention of my colleagues what I consider a bureaucratic absurdity. Let me ask you a question: Did you know that we increase Government payments to Social Security retirees, the physically impaired, and others, just because the cost of tobacco products increase, from taxes or anything else?

Today, I am introducing bipartisan legislation to remove tobacco products from the so-called "market basket of goods" used by the Department of Labor to determine the Consumer Price Index used to increase Government payments.

Currently, tobacco products make up about 2 percent of the consumer price index used to inflate Government benefits. The Government should not increase Government payments to individuals as a result of rising prices for a product that may be harmful, and is not used by most of those individuals having their benefits increased.

Specifically, I am concerned that the proposed 75 cent or $1 increase in the tax on cigarettes will inadvertently result in an increase in the CPI, and thus, substantially increase Government payments.

From my discussions with the U.S. Department of Labor, CBO, and CRS, it is estimated that an increase in the tax on cigarettes of 75 cents will increase the average price of a pack of cigarettes to $2.65 from the current average cost of $1.90. The cigarette tax increase alone will increase the CPI 7 percent, and thus increase Government outlays $4 billion, annually. Most every State is also considering increased taxes on tobacco, which could add additional billions of dollars of cost to the Federal Government. The cost to local and State government, because of increased payouts based on a CPI, skewed by tobacco, adds additional billions of dollars in cost to those governments.

Mr. Speaker, in order to keep Federal spending down, and not provide a windfall increase for recipients of Federal benefits, I am introducing legislation to create a separate consumer price index for Government use, the CPI–G. It is good legislation and I urge my colleagues to support this change.

FUNDING FOR THE CVN–76 AIRCRAFT CARRIER

(Mrs. CLAYTON asked and was given permission to address the House for 1 minute and to revise and extend her remarks and include extraneous matter.)

Mrs. CLAYTON. Mr. Speaker, there has been a great deal of debate over the issue of funding a new aircraft carrier. Despite the procedural and jurisdictional problems we have encountered here in Congress, this is an issue of great importance to our national security.

This matter was considered as a part of President Clinton's Bottom-Up Review of our Defense strategy. The conclusion of that study was that a new carrier needs to be built, and that funds for this purpose should be made available in the next budget submission. This carrier issue is not new to Congress, for it was only last year that the House and Senate authorized and appropriated $832 million to begin construction on a new carrier to replace one built in the 1950's. The question now before us is whether or not we will make final payment on the carrier. In the long run, estimates show that we can save the American taxpayers at least $200 million by efficiently beginning CVN–76 on the heels of the carrier now being completed.

Mr. Speaker, earlier this week, Chairman INOUYE made a statement on the floor of the other body making a powerful case for funding CVN–76 in this year's Defense appropriations bill. I ask unanimous consent that his remarks be printed in the RECORD at the conclusion of my remarks, and I implore my colleagues to read this powerful argument. I also ask that a brief executive summary of a recent study on the role of aircraft carriers in the 21st century by printed in the RECORD at the conclusion of my remarks.

Let's do the right thing and fund CVN–76.

[From the Congressional Record, Oct. 26, 1993]

AIRCRAFT CARRIER FUNDING

Mr. INOUYE. Mr. President, during the debate on the fiscal year 1994 Defense appropriations bill certain statements were made which gave an unfavorable characterization to the committee's decision to provide funding for a new aircraft carrier. I believe it would be useful to examine these comments in their proper context.

The committee-reported bill recommended $3.4 billion to complete—and here. I would underscore the word complete—the financing of the CVN–76, the next nuclear aircraft carrier. The House Appropriations Committee had recommended an appropriation of $1 billion to partially finance the remaining balance of the carrier. Specific authorization for this action was denied on the House floor, Nonetheless, the House-passed bill still provides $1 billion in undesignated shipbuilding funds, presumably, for this purpose.

Unfortunately, Mr. President, some have argued that the carrier is a new start which is both unauthorized and unrequested. Mr. President, I want the record to be clear. This is not a new start. The administration requested, and the Congress authorized and appropriated, $832 million in fiscal year 1993 to begin work on this aircraft carrier. These funds paid for the purchase of nuclear components for the ship. The Navy began spending these funds last fall. Work has already begun on the carrier. All of these funds have been obligated. So, regardless of what others may argue, through these actions, the Congress has already made the decision to buy the carrier; now the question is when should the remaining funds be provided.

My colleagues should understand that DOD planned to request funds to complete payment for the aircraft carrier in 1995. While this would allow for the carrier to be built with few perturbations in the shipyard work force, it is not the most cost effective method to purchase the carrier.

President Clinton's budget for fiscal year 1994 took no decisive action on the aircraft carrier. Instead, the decision to continue to purchase the carrier was to be reassessed in the Bottom-Up Review—in conjunction with an analysis and formulation of overall carrier force structure levels. The Bottom-Up Review process carried out this in-depth analysis of the requirement for aircraft carriers. The review determined that the Navy must have 12 aircraft carriers to meet force structure requirements. With that decision, the DOD validated the need to build the next carrier.

So, the question recurs: When should the carrier be funded? The Appropriations Committee reviewed this matter and determined it would be appropriate to finance the balance of the ship's costs in 1994. There are several budgetary reasons for this. First and

foremost, by funding the carrier in 1994 instead of 1995, the Congress can save $200 million—6 percent of the remaining requirement. This is not a trivial sum.

Second, in conducting its review of the budget requirements for DOD the committee was able to identify sufficient funds to pay for the remaining balance in 1994.

With the conclusion of the Bottom-Up Review in August, many changes were made in the financial requirements for DOD programs. In most cases this information was not available to the authorizing committees until their review of program requirements had already been virtually completed. Because we came later in the process, the Senate Appropriations Committee was able to tailor its recommendations to these results.

The Bottom-Up Review also established several basic tenets for future defense requirements. The committee adopted many of the underlying premises of the Bottom-Up Review in making its adjustments. As a result, the committee's recommendations freed up $3.4 billion in budget authority and $170 million in outlays, sufficient funding to cover the costs of the aircraft carrier in 1994. For good and sufficient reasons, the committee chose to allocate these funds to complete—again, underscore complete—the purchase of the CVN-76.

Mr. President, reaching the budget targets in 1994 has not been easy. It should be made clear to all Senators that 1995 will be a more difficult budget year than 1994. The Appropriations Committee will be required to cut $24.7 billion below the CBO baseline in 1995. In addition, DOD has identified a short-fall of $13 billion in achieving its budgetary goals over the next 4 years. Providing $3.4 billion for the carrier in 1994, instead of 1995, helps alleviate these problems. And, as I noted, we also save $200 million in total costs for construction of the carrier.

Mr. President, it has been falsely suggested that the committee cut research and development funds in order to pay for the carrier. That is not correct and those who have made this unfounded charge should know better. The subcommittee reviewed research and development funding requested by the President and reduced the request based on the merit of individual programs. The savings identified helped the committee reach its overall outlay target. Coincidentally, it also freed up budget authority which could be allocated for the carrier.

In debate on the Senate floor it was said that the outlay impact from this decision to fund the carrier in fiscal year 1994 will exacerbate an assumed outlay shortfall in 1995. This is also incorrect. The outlay impact from financing the carrier in 1994 in $442 million in 1995. Had the committee spent the $3.4 billion on research programs, the outlay impact in 1995 from those programs would have been in excess of $1.15 billion—and the Congress would be faced with the unhappy prospect of providing $3.4 billion in budget authority in 1995 for the carrier. The committee's recommendation will actually lower outlays in 1995 by more than $870 million.

Mr. President, the decision to complete the financing of the CVN-76 in 1994 instead of 1995 makes good business sense. I would not want to be in the position of trying to explain to the American taxpayer that, when the Congress provided $832 million in fiscal year 1993 for advance procurement of items which can only be used in a nuclear carrier, it really had not authorized the new carrier. That does not make any sense to me and would not make any sense to the taxpayers.

I am prepared to explain the decision to complete financing of the carrier in fiscal year 1994. We will find it easier to stay on the path to a declining defense budget, if we finance the $3.4 billion in remaining costs this year. This decision reduces outlays in 1996 compared to spending the funds on research. And, best of all, it saves $200 million in the total cost of the ship. I hope all members now understand the committee's recommendations and support this approach and I urge the conferees on the Defense authorization bill to adopt it as well.

AIRCRAFT CARRIERS AND THE ROLE OF NAVAL POWER IN THE 21ST CENTURY

(By Jacquelyn K. Davis)

The defining events of the 1990s—the end of the Cold War, the war in the Gulf, and the dismantling of the Soviet empire—have had a profound effect upon U.S. security planning. Reflected in the Defense Department's "Bottom-Up Review," the Clinton administration is undertaking a major reassessment of defense force structure and logistical support networks designed to meet the challenges of the post-Cold War world, while taking into account public sentiment for greater defense economies now that the Soviet threat has dissipated.

NEW RISKS

But the breakup of the Soviet Union does not mean that U.S. interests are free from risks. There have emerged new risks in the global security environment—risks that may require the employment of U.S. forces. As the one nation that remains uniquely capable of projecting substantial power beyond its shores—and, hence, having at least some impact on the shape of the post-Cold War world—the United States may find it necessary to deploy its forces to regions where vital U.S. interests may not be at stake, but in which broader humanitarian and democratic values are being challenged. Indeed, the deployment of U.S. contingents to such widely varied crisis settings as Somalia, Northern Iraq, Liberia, and recently Macedonia, has already demonstrated the importance of maintaining flexible forces able to respond to a variety of requirements. As peacekeeping and peace-making operations assume a greater priority in U.S. foreign policy planning, and missions of humanitarian relief and disaster assistance—both at home (as in the case of clean-up operations after Hurricanes Andrew and Iniki) and overseas as well—become the norm rather than the exception in the employment of U.S. forces, civilian and military planners will be compelled to find imaginative solutions to the problem of developing a range of force packages for use in multiple contingencies.

THE AIRCRAFT CARRIER'S ENABLING CAPABILITIES

Inevitably, the challenges of security in the 1990s will place greater emphasis on "jointness," both among the U.S. Services and in connection with allied and coalition planning. Because the aircraft carrier platform is large enough to integrate a mix of Marine, Army and Air Force assets with its own considerable striking power, it will be central to U.S. joint planning in the future—both for peacetime forward presence missions and wartime operations. By virtue of its geography, the United States is a maritime nation whose welfare and global role depends on unimpeded access to the world's sea lines of communication (SLOCs). Even though there may be relatively little direct threat to U.S. navigation on the open seas (now that the Soviet Union has been dismantled), the potential for conflict in key regional theaters is very real—conflicts that could escalate into open warfare either involving the engagement of U.S. forces, or posing a threat to U.S. (and allied) commercial and strategic interests, or both. With the proliferation of weapons technologies and the growing lethality of the forces of potential regional adversaries, the capability of the aircraft carrier battle group will provide to a joint commander or theater CINC an important enabling force of facilitate crisis response, sustained military operations, conflict escalation, and war termination.

In future theater contingencies—the primary planning focus of the new strategic guidance that is emerging from the Pentagon—there is likely to be a premium placed on those U.S. and allied forces that can:

deploy to a theater of operations in a timely fashion;

prevent minefields from being laid in the sea approaches to the area;

protect sea-lift assets en route and at the point of arrival and departure;

deliver firepower against an array of targets whose interdiction would give the adversary's leadership pause to reflect on utility of proceeding further with its warfare objectives; and,

offer a range of flexible options, in terms of strike planning, escalation control, and war termination.

Against any range of theater scenarios, the aircraft carrier and its associated systems' assets (including its battle-group combatants, but also its deployment of long-range precision-guided missiles and new generation sensor-fuzed munitions) contribute an unparalleled capability to meet any of these objectives, while providing a tangible demonstration of U.S. capability and will—thereby offering U.S. policymakers a unique crisis management and deterrent tool.

Pressured by defense budget cuts, which could be even more severe in the out years, the number of aircraft carrier platforms in the active inventory of the Navy is likely to be a subject of contentious debate. As a capability that could aptly be described as a moveable piece of "sovereign America," the aircraft carrier can steam to a crisis location without raising tensions in countries that are not involved. Operationally, it would also not be encumbered by the political debate that often accompanies requests for the overflight of national territory, or that is inherent in requests for access to local basing facilities. The aircraft carrier platform, moreover, can bring to the scene of a crisis tangible evidence of U.S. resolve, and provide the basis for coordinating joint and combined operations if a given situation warrants the use of military force.

CARRIER FORCE LEVELS

For all these reasons, it would be foolhardy for the United States to reduce its carrier force to a level that could not provide for a flexible forward presence policy. In view of the political-psychological mindset that forms a central aspect of national security decision-making, it may be more difficult to commit (and mobilize) U.S.-based forces for regional crisis deployment missions than it would be to put carrier-based assets already near or in the area in question on alert status. Planning a force structure to fight in two major regional contingencies "nearly simultaneously" (to use Secretary Aspin's recent formulation) requires a prudent planner to retain the Navy's preferred minimum number of twelve carriers in the force structure. Reducing the number of carriers in the U.S. fleet to ten would result in significant deployment gaps, increased time at sea for sailors, and an inability to react to crises

with the flexibility that is necessary to ensure a timely and effective response. Even with a twelve-carrier force, key regions-notably the Mediterranean, Persian Gulf, and the Western Pacific-could only be covered about eighty percent of the time.

In its search to make prudent decisions about force structure (while recognizing the need to achieve some, reasonable defense economies), the Clinton administration needs to appreciate the risks associated with a decision to reduce the number of carrier platforms below twelve. The costs to the nation of doing so will in the long run far outweigh any near-term defense savings that some think can be so derived. By themselves the intangibles associated with the deployment of a credible forward presence posture centered around twelve carrier battle groups by far exceed (in value) the hoped-for defense economies of cutting the carrier program—and this includes the costs of building a new carrier, CVN-76, to being to nine the number of Nimitiz-class carriers.

DEFENSE INDUSTRIAL BASE ISSUES

CVN-76 construction carries profound and far-reaching implications for the ability of the United States to sustain a nuclear shipbuilding industry. Construction of a nuclear-powered aircraft carrier entails special skills and a comprehensive base of second- and third-tier suppliers—all of whom are not common to the construction of a nuclear-powered submarine. A decision not to fund the new carrier, or to push off its funding until after fiscal year 1995, will likely result in the disappearance of critical job skills that are crucial to the nuclear carrier shipbuilding industry. If new carrier construction were delayed, or stretched out—an alternative that is apparently being considered—the result is likely to be a far more expensive program, due to the need to accommodate the loss of key suppliers and to recreate and qualify skilled teams to do the work. Overhaul and refueling work on existing carriers simply would not provide enough work for major component suppliers in the industry to justify their staying in business. Thus, any decision delaying or canceling the construction of CVN-76 will have major implications for both the domestic economy and the defense industrial skill base. Moreover, such a step would affect adversely our ability to reconstitute and mobilize forces if confronted with a major global contingency or the need to fight in two theaters simultaneously.

One option that might be pursued is an incremental funding strategy for CVN-76. Under such an arrangement, the critical vendor base could be sustained through the authorization of funding on three or four "ship sets" of highly specialized equipment for the carrier (e.g., nuclear cores, special reactor pumps, and hydraulic plants). Such funding, in the form of another year of advanced procurement funding for CVN-76, would be a second-best means of preserving the vendor base; yet it would maintain the option to build the tenth nuclear carrier, and would moreover be consistent with the administration's domestic and global priorities.

BOTTOM-LINE ASSESSMENT

Viewed in this context, the carrier emerges as central to sustaining an adequate forward presence capability, and assuring a flexible maritime instrument for responding to the variety of potential local conflicts and crisis situations—ranging from humanitarian assistance to peacekeeping, conflict management, and war termination. Clearly, the preferred option would be maintaining twelve carriers in the Navy's force structure—with earlier rather than later investment in CVN-76 production and development. At the very least, it is necessary to secure and sustain a degree of incremental funding sufficient to maintain the vendor base critical to future U.S. carrier construction. If CVN-76 is not funded, the United States may be forfeiting its future ability to build aircraft carriers in a cost-effective and timely manner. The operational implications of failing to move ahead with CVN-76 will undermine the Navy's ability to maintain adequate global presence, and could well hamper any President's ability to respond to unfolding crises swiftly and in an appropriate manner.

THE FAMILY VIOLENCE PREVENTION ACT

(Ms. VELÁZQUEZ asked and was given permission to address the House for 1 minute and to revise and extend her remarks and include extraneous matter.)

Ms. VELÁZQUEZ. Mr. Speaker, today I have the privilege of being joined by 27 of my colleagues in introducing the Family Violence Prevention Act, which provides family violence prevention services to underserved populations regardless of race, culture, language, or geography. The measure also establishes model programs to educate young people about domestic violence and violence against intimate partners. The bill will equally distribute family violence prevention services to all populations, and makes it possible for young people to learn about the atrocities of domestic violence at an early age.

Domestic violence is a major contributor to the escalating level of violence in America. It is the leading cause of injury to women aged 15 to 44, more common than muggings and car crashes combined. And children who live in abusive households are four times more likely to become juvenile delinquents than those raised in a violence-free environment. More than one in three Americans report witnessing an incident of domestic violence, and 14 percent of women admit that their husband or boyfriend has violently abused them. In a recent national survey conducted by the Family Violence Prevention Fund, 87 percent of those polled said that they would support legislation to increase funding for battered women's programs.

These figures paint a sad portrait of an America in turmoil. For far too many women and children in our society, the home is not a place of comfort, security, and shelter, but, instead, a den of despair and violence. Americans are in desperate need of family violence prevention services that promote prevention through education and instruction. In light of this, there is no reason why my colleagues should not support the Family Violence Prevention Act.

The act consists of two sections. Section 1 amends the Family Violence Prevention and Services Act to require that applications for State grants include a plan to address the needs of underserved populations, including populations underserved because of ethnic, racial, cultural, language diversity, or geographic isolation. This important provision will assure an equitable distribution of grants and grant funds within all populations in the State, and is crucial because poor communities and communities of color that are usually overlooked, will receive funds for education on family violence. In addition, upon completion of activities funded, the State grantee must file a performance report explaining the activities carried out together with an assessment of the effectiveness of such activities. This would be required from all grantees.

Section 2 amends the Family Violence Prevention and Services Act to direct the Secretary of Education to select, implement, and evaluate four model programs for the education of young people about domestic violence and violence among intimate partners, with one program for each of primary, middle, and secondary schools, and institutions of higher education. The model programs shall be selected, implemented, and evaluated in light of the comments of a multicultural panel of educational experts on battering, and victim advocate organizations such as battered women's shelters, State coalitions, and resource centers. This section seeks $400,000 for these programs.

Mr. Speaker, I urge my colleagues to join my efforts to ensure that family violence prevention services and education on domestic violence is available to all Americans, regardless of their race, culture, ethnicity, or language. The patterns of violence that plague our country must be broken, and the only way to achieve this goal is by educating our young about the atrocities committed by those who resort to domestic violence.

The following is a text of my legislation and a list of original cosponsors.

H.R. —

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE, REFERENCE.

(a) SHORT TITLE.—This Act may be cited as the "Family Violence Prevention Act".

(b) REFERENCE.—Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Family Violence Prevention and Services Act.

SEC. 2. GRANTEE REPORTING.

(a) PLAN TO SERVE UNDERSERVED POPULATIONS.—Section 303(a)(2)(C) (42 U.S.C. 10402(a)(2)(C)) is amended by inserting "and a plan to address the needs of underserved populations, including populations underserved because of ethnic, racial, cultural, language diversity or geographic isolation" after "such State".

(b) PERFORMANCE REPORT.—Section 303(a) (42 U.S.C. 10402(a)) is amended by adding at the end the following new paragraph:

"(4) Upon completion of the activities funded by a grant under this subpart, the State grantee shall file a performance report with the Director explaining the activities carried out together with an assessment of the effectiveness of those activities in achieving the purposes of this subpart. A section of this performance report shall be completed by each grantee or subgrantee that performed the direct services contemplated in the application certifying performance of direct services under the grant. The Director shall suspend funding for an approved application if an applicant fails to submit an annual performance report or if the funds are expended for purposes other than those set forth under this subpart, after following the procedures set forth in paragraph (3). Federal funds may be used only to supplement, not supplant, State funds.".

SEC. 3. EDUCATING YOUTH ABOUT DOMESTIC VIOLENCE.

The Family Violence Prevention and Services Act (42 U.S.C. 10401 et seq.) is amended by adding at the end the following new section:

"SEC. 318. EDUCATING YOUTH ABOUT DOMESTIC VIOLENCE.

"(a) GENERAL PURPOSE.—For purposes of this section, the Secretary shall delegate the Secretary's powers to the Secretary of Education (hereafter in this section referred to as the "Secretary"). The Secretary shall select, implement and evaluate 4 model programs for education of young people about domestic violence and violence among intimate partners.

"(b) NATURE OF PROGRAM.—The Secretary shall select, implement and evaluate separate model programs for 4 different audiences: primary schools, middle schools, secondary schools, and institutions of higher education. The model programs shall be selected, implemented, and evaluated in the light of the comments of a multi-cultural panel of educational experts, legal and psychological experts on battering, and victim advocate organizations such as battered women's shelters, State coalitions and resource centers. The participation of each of those groups or individual consultants from such groups is essential to the selection, implementation, and evaluation of programs that meet both the needs of educational institutions and the needs of the domestic violence problem.

"(c) REVIEW AND DISSEMINATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall transmit the design and evaluation of the model programs, along with a plan and cost estimate for nationwide distribution, to the relevant committees of Congress for review.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $400,000 for fiscal year 1994.".

COSPONSORS OF THE FAMILY VIOLENCE PREVENTION ACT

Patsy Mink.
Louise McIntosh Slaughter.
Bob Filner.
Carrie Meek.
Cynthia McKinney.
Connie Morella.
Maxine Waters.
Eleanor Holmes Norton.
Jim McDermott.
Jolene Unsoeld.
Charles Rangel.
Luis Gutierrez.
Edolphus Towns.
Lucille Roybal-Allard.
George Miller.
Marcy Kaptur.
José Serrano.
Elizabeth Furse.
Sanford Bishop, Jr.
Patricia Schroeder.
Kweisi Mfume.
Xavier Becerra.
Karan English.
Bill Richardson.
Lynn Woolsey.
Carlos Romero-Barceló.
Barbara-Rose Collins.

COMMUNICATION FROM THE CHAIRMAN OF THE COMMITTEE ON THE BUDGET REGARDING CURRENT LEVELS OF SPENDING AND REVENUES FOR FISCAL YEARS 1994–98

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota [Mr. SABO] is recognized for 5 minutes.

Mr. SABO. Mr. Speaker, on behalf of the Committee on the Budget and pursuant to sections 302 and 311 of the Congressional Budget Act, I am submitting for printing in the CONGRESSIONAL RECORD an updated report on the current levels of on-budget spending and revenues for fiscal year 1994 and for the 5-year period fiscal year 1994 through fiscal year 1998.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC, October 28, 1993.

Hon. THOMAS S. FOLEY,
Speaker, U.S. House of Representatives, Washington, DC.

DEAR MR. SPEAKER: To facilitate application of sections 302 and 311 of the Congressional Budget Act, I am transmitting an updated status report on the current levels of on-budget spending and revenues for FY 1994 and for the 5-year period FY 1994 through FY 1998.

The term "current level" refers to the amounts of spending and revenues estimated for each fiscal year based on laws enacted or cleared for the President as of October 26, 1993.

The first table in the report compares the current levels of total budget authority, outlays, and revenues with the overall limits set in H. Con. Res. 64, the concurrent resolution on the budget for FY 1994. This comparison is needed to implement section 311(a) of the Budget Act, which creates a point of order against measures that would breach the budget resolution's overall limits. The table does not show budget authority and outlays for years after FY 1994 because appropriations for those years will not be considered until future sessions of Congress.

The second table compares the current levels of budget authority, outlays, and new entitlement authority for each direct spending committee with the "section 602(a)" allocations made under H. Con. Res. 64 for FY 1994 and for FY 1994 through FY 1998. This comparison is needed to implement section 302(f) of the Budget Act, which creates a point of order against measures that would breach the section 602(a) allocation of new discretionary budget authority or new entitlement authority for the committee that reported the measure. It is also needed to implement section 311(b), which exempts committees that comply with their allocations from the point of order under section 311(a). The section 602(a) allocations were printed in the CONGRESSIONAL RECORD for March 31, 1993 on pages H. 1784–87.

The third table compares the current levels of discretionary appropriations for FY 1994 with the revised "section 602(b)" suballocations of discretionary budget authority and outlays among Appropriations subcommittees. This comparison is also needed to implement section 302(f) of the Budget Act, since the point of order under that section also applies to measures that would breach the applicable section 602(b) suballocation. The revised section 602(b) suballocations were filed by the Appropriations Committee on September 30, 1993 (H. Rept. 103–271).

Sincerely,

MARTIN OLAV SABO,
Chairman.

REPORT TO THE SPEAKER FROM THE COMMITTEE ON THE BUDGET ON THE STATUS OF THE FISCAL YEAR 1994 CONGRESSIONAL BUDGET ADOPTED IN HOUSE CONCURRENT RESOLUTION 64

REFLECTING ACTION COMPLETED AS OF OCTOBER 26, 1993

[On-budget amounts, in millions of dollars]

	Fiscal year 1994	Fiscal years 1994–1998
Appropriate level (as set by H. Con. Res. 64):		
Budget authority	1,223,400	6,744,900
Outlays	1,218,300	6,629,300
Revenues	905,500	5,153,400
Current level:		
Budget authority	1,210,171	(1)
Outlays	1,215,097	(1)
Revenues	905,579	5,106,141
Current level over(+)/under (−) appropriate level:		
Budget authority	−13,229	(1)
Outlays	−3,203	(1)
Revenues	+79	−47,259

[1] Not applicable because annual appropriations acts for fiscal years 1995 through 1998 will not be considered until future sessions of Congress.

BUDGET AUTHORITY

Enactment of measures providing more than $13,229 billion in new budget authority for FY 1994 (if not already included in the current level estimate) would cause FY 1994 budget authority to exceed the appropriate level set by H. Con. Res. 64.

OUTLAYS

Enactment of measures providing new budget or entitlement authority with FY 1994 outlay effects of more than $3,203 billion (if not already included in the current level estimate) would cause FY 1994 outlays to exceed the appropriate level set by H. Con. Res. 64.

REVENUES

Enactment of measures producing a revenue loss of more than $79 million in FY 1994 (if not already included in the current level estimate) would cause FY 1994 revenues to fall below the appropriate level set by H. Con. Res. 64.

Enactment of any measure producing any net revenue loss for the period FY 1994 through FY 1998 (if not already included in the current level estimate) would cause revenues for that period to fall below the appropriate level set by H. Con. Res. 64.

DIRECT SPENDING LEGISLATION—COMPARISON OF CURRENT LEVEL WITH COMMITTEE ALLOCATIONS PURSUANT TO BUDGET ACT SECTION 602(a)

[Fiscal years, in millions of dollars]

	1994			1994–1998		
	Budget authority	Outlays	New entitlement authority	Budget authority	Outlays	New entitlement authority
House committee:						
Agriculture:						
Allocation	−65	−66	−60	−2,725	−2,727	888
Current level	−99	−106	−402	−2,216	−2,411	−3,559
Difference	−34	−40	−342	509	316	−4,447
Armed Services:						
Allocation	−128	−128	−128	−2,365	−2,357	−2,357
Current level	−176	−176	−180	−2,310	−2,310	−2,357
Difference	−48	−48	−52	55	47	0
Banking, Finance and Urban Affairs:						
Allocation	0	−338	0	0	−2,792	0
Current level	0	−498	0	0	−2,831	0
Difference	0	−160	0	0	−39	0
District of Columbia:						
Allocation	0	0	0	0	0	0
Current level	0	0	0	0	0	0
Difference	0	0	0	0	0	0
Education and Labor:						
Allocation	0	0	118	0	0	−4,048
Current level	−150	−158	−795	−150	−150	−5,180
Difference	−150	−158	−913	−150	−150	−1,132
Energy and Commerce:						
Allocation	0	−1,700	−180	−1,169	−8,369	−7,798
Current level	2	−2,398	42	−1,159	−11,359	−7,059
Difference	2	−698	222	10	−2,990	739
Foreign Affairs:						
Allocation	0	0	0	−5	−5	−5
Current level	−6	−6	−3	−75	−75	−60
Difference	−6	−6	−3	−70	−70	−55
Government Operations:						
Allocation	0	0	0	0	0	0
Current level	0	0	0	0	0	0
Difference	0	0	0	0	0	0
House Administration:						
Allocation	0	0	0	0	0	0
Current level	1	1	0	8	8	0
Difference	1	1	0	8	8	0
Judiciary:						
Allocation	0	0	0	0	−472	0
Current level	0	0	0	0	−345	0
Difference	0	0	0	0	127	0
Merchant Marine and Fisheries:						
Allocation	0	0	0	−205	−205	−4
Current level	0	0	0	−205	−205	0
Difference	0	0	0	0	0	4
Natural Resources:						
Allocation	−117	−112	0	−709	−693	0
Current level	−74	−78	0	−478	−481	0
Difference	43	34	0	231	212	0
Post Office and Civil Service:						
Allocation	−66	−66	−77	−10,199	−10,547	−9,597
Current level	−266	−266	−266	−10,258	−10,606	−9,451
Difference	−200	−200	−189	−59	−59	146
Public Works and Transportation:						
Allocation	2,092	−13	0	37,458	−85	0
Current level	−13	−13	0	−85	−85	0
Difference	−2,105	0	0	−37,543	0	0
Science, Space, and Technology:						
Allocation	0	0	0	0	0	0
Current level	0	0	0	0	0	0
Difference	0	0	0	0	0	0
Small Business:						
Allocation	0	0	0	0	0	0
Current level	0	0	0	0	0	0
Difference	0	0	0	0	0	0
Veterans' Affairs:						
Allocation	−11	−11	70	−1,356	−1,352	3,447
Current level	−11	−11	−233	−1,356	−1,352	−1,880

DIRECT SPENDING LEGISLATION—COMPARISON OF CURRENT LEVEL WITH COMMITTEE ALLOCATIONS PURSUANT TO BUDGET ACT SECTION 602(a)—Continued

[Fiscal years, in millions of dollars]

	1994			1994–1998		
	Budget authority	Outlays	New entitlement authority	Budget authority	Outlays	New entitlement authority
Difference	0	0	−303	0	0	−5,327
Ways and Means:						
Allocation	−2,876	−2,054	−2,036	−29,669	−24,422	−12,596
Current level	−2,134	−1,742	−755	−41,279	−38,945	−34,917
Difference	742	312	1,281	−11,610	−14,523	−23,321
Permanent Select Committee on Intelligence:						
Allocation	0	0	0	0	0	0
Current level	7	7	7	15	15	15
Difference	7	7	7	15	15	15

DISCRETIONARY APPROPRIATIONS FOR FISCAL YEAR 1994—COMPARISON OF CURRENT LEVEL WITH SUBALLOCATIONS PURSUANT TO BUDGET ACT SECTION 602(b)

[In millions of dollars]

	Revised filed 602(b) suballocations (Sept. 30, 1993)		Current level		Difference	
	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays
Agriculture, rural development	14,819	14,317	14,799	14,297	−20	−20
Commerce, State, Judiciary	23,119	23,231	22,838	23,221	−281	−10
Defense	240,446	255,465	232,363	255,668	−8,083	203
District of Columbia	700	698	677	677	−23	−21
Energy and water development	22,017	21,702	20,585	20,407	−1,432	−1,295
Foreign Operations	13,444	13,918	12,939	13,916	−505	−2
Interior	13,736	13,731	12,610	13,060	−1,126	−671
Labor, Health and Human Services, and Education	67,283	68,140	67,230	68,089	−53	−51
Legislative	2,270	2,267	2,270	2,267	0	0
Military construction	10,066	8,784	10,065	8,783	−1	1
Transportation	13,284	34,889	13,283	34,889	−1	0
Treasury-Postal Service	11,469	11,642	11,439	11,642	−30	0
VA–HUD–Independent agencies	68,311	69,973	68,303	69,973	−8	0
Grand total	500,964	538,757	489,401	536,889	−11,563	−1,868

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 27, 1993.

Hon. MARTIN O. SABO,
Chairman, Committee on the Budget, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Pursuant to section 308(b) and in aid of section 311 of the Congressional Budget Act, as amended, this letter and supporting detail provide an up-to-date tabulation of the on-budget current levels of new budget authority, estimated outlays, and estimated revenues for fiscal year 1994 in comparison with the appropriate levels for those items contained in the 1994 Concurrent Resolution on the Budget (H. Con. Res. 64), and is current October 26, 1993. A summary of this tabulation follows:

[In millions of dollars]

	House current level	Budget resolution (H. Con. Res. 64)	Current level +/− resolution
Budget authority	1,210,171	1,223,400	−13,229
Outlays	1,215,097	1,218,300	−3,203
Revenues			
1994	905,579	905,500	+79
1994–98	5,106,141	5,153,400	−47,259

Since my last report, dated September 22, 1993, the President has signed the National Service Trust Act (Public Law 103–82) and the following appropriation bills: Agriculture (Public Law 103–111), Foreign Operations (Public Law 103–87), Labor, HHS, Education (Public Law 103–112), Military Construction (Public Law 103–110) and the continuing resolution for fiscal year 1994 (Public Law 103–113). The Congress also cleared for the President's signature a bill extending most favored nation status to Romania (H.J. Res. 228), and appropriation bills for Commerce, Justice, State (H.R. 2519), Transportation (H.R. 2750), Treasury, Postal Service (H.R. 2403) and Veterans, Housing and Urban Development (H.R. 2491). These actions changed the current level of budget authority, outlays, and revenues.

Sincerely,

ROBERT D. REISCHAUER,
Director.

PARLIAMENTARIAN STATUS REPORT 103D CONG., 1ST SESS.—HOUSE ON-BUDGET SUPPORTING DETAIL FOR FISCAL YEAR 1994 AS OF CLOSE OF BUSINESS OCT. 26, 1993

[In millions of dollars]

	Budget authority	Outlays	Revenues
ENACTED IN PREVIOUS SESSIONS			
Revenues			878,100
Permanents and other spending legislation	740,893	699,501	
Appropriation legislation		241,770	
Offsetting receipts	(183,477)	(183,477)	
Total previously enacted	557,415	757,794	878,100
ACTION THIS SESSION SIGNED INTO LAW			
Appropriation legislation:			
1993 spring supplemental (Public Law 103–50)	10	(292)	
Agriculture (Public Law 103–111)	70,561	42,579	
Foreign operations (Public Law 103–87)	12,983	5,869	
Offsetting receipts	(44)	(44)	
Labor, HHS, Education (Public Law 103–112)	223,497	183,014	
Offsetting receipts	(46,061)	(46,061)	
Legislative branch (Public Law 103–69)	2,270	2,063	
Military construction (Public Law 103–110)	10,065	2,403	
Authorizing legislation:			
Authorize construction of World War II memorial (Public Law 103–32)	1	1	
CIA Voluntary Separation Incentive Act (Public Law 103–36)	7	7	
Unclaimed Deposit Amendments Act (Public Law 103–44)		17	
Transfer naval vessels to foreign countries (Public Law 103–54)	(3)	(3)	

PARLIAMENTARIAN STATUS REPORT 103D CONG., 1ST SESS.—HOUSE ON-BUDGET SUPPORTING DETAIL FOR FISCAL YEAR 1994 AS OF CLOSE OF BUSINESS OCT. 26, 1993—Continued

[In millions of dollars]

	Budget authority	Outlays	Revenues
Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66)[1]	(2,944)	(5,478)	27,489
Extending Chapter 12 of Bankruptcy Code (Public Law 103–65)			(1)
National Service Trust Act (Public Law 103–82)	20	12	
Total signed into law	270,360	184,086	27,488
PENDING SIGNATURE			
Appropriaton legislation:			
Commerce, Justice, State (H.R. 2519)	23,273	17,255	
Offsetting receipts	(146)	(146)	
Transportation (H.R. 2750)	13,884	12,636	
Treasury, Postal Service (H.R. 2403)	22,352	19,811	
Offsetting receipts	(7,063)	(7,063)	
Veterans, HUD (H.R. 2491)	87,035	47,961	
Authorizing legislation:			
Extending MFN status to Romania (H.J. Res.228)			(9)
Total pending signature	139,335	90,454	(9)
CONTINUING RESOLUTION			
Continuing appropriations for Defense, District of Columbia, Energy and Water, and Interior	266,061	181,892	
Total action this session	675,757	456,433	27,479
ENTITLEMENTS AND MANDATORIES			
Budget resolution baseline estimates of appropriated entitlements and other mandatory programs not yet enacted[2]	(23,001)	871	
Total current level[3 4]	1,210,171	1,215,097	905,579
Total budget resolution	1,223,400	1,218,300	905,500
Amount remaining:			
Under budget resolution	13,229	3,203	

PARLIAMENTARIAN STATUS REPORT 103D CONG., 1ST SESS.—HOUSE ON-BUDGET SUPPORTING DETAIL FOR FISCAL YEAR 1994 AS OF CLOSE OF BUSINESS OCT. 26, 1993—Continued

[In millions of dollars]

	Budget authority	Outlays	Revenues
Over budget resolution			79

[1] Includes Budget Committee estimate of $2.4 billion in outlay savings for FCC spectrum license fees.

[2] Includes changes to baseline estimates of appropriated mandatories due to enactment of Public Law 103–66.

[3] In accordance with the Budget Enforcement Act, the total does not include $3,252 million in budget authority and $5,661 million in outlays in emergency funding.

[4] At the request of committee staff, current level does not include scoring of section 601 of Public Law 102–391.

Notes: Amounts in parentheses are negative. Detail may not add due to rounding.

POVERTY IN AMERICA

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York [Mr. HINCHEY] is recognized for 5 minutes.

Mr. HINCHEY. Mr. Speaker, I do not think that there is a single day, probably not even a single house, when we here in Washington are not deluged with another desk full of statistics generated by commissions or researchers.

This is not a complaint, just an observation. Because those statistics contain the raw information we need to make informed decisions about where our country needs to go and how we can best serve our constituents.

But by themselves, those graphs and numbers rarely command more than a brief focus of attention unless they are particularly compelling to someone with the media's ear: either horrific, inspiring, or, most commonly, politically useful, because numbers, however logically compelling, do not seem to touch most people's lives.

Today I want to talk about some recent statistics that are all too immediate. All too real. All too easy to turn away from because they pose hard questions without easy answers, because they do not offer quick advantages for anyone.

Nearly 37 million Americans are living in poverty today. Not simply laboring to make ends meet, but struggling with nearly insurmountable barriers of need.

And if you exclude Government assistance in the form of Social Security, unemployment insurance and the like from the reckoning, the number would jump to more than 57 million poor: individuals making less than $7,143 a year, families of four surviving on less than $14,435.

Just another number, and, the Census Bureau adds, it is not even a statistically significant increase from last year's figures.

Yet more Americans are poor today than they have been since 1962. And 40 percent of them are children.

More than one in five American children lives in poverty, another statistic that has been firmly entrenched in yearly reports since the early 1980's.

These are not simply numbers. They are a searing indictment of the decisions and priorities we've adopted as business-as-usual practices in our Government and society.

Thirty-seven million Americans in poverty aren't numbers in an annual report. They are children whose futures are handcuffed to the limited horizons of violence and dependency.

They are families where there is no American dream, only a continuing daily struggle to survive. People are being forced into a permanent underclass on the edge of society.

These are numbers we cannot put aside when we go about the day-to-day considerations of Government and personal existence.

These are statistics we cannot accept as simple descriptions of a stabilizing social snapshot.

Because these are not numbers, but people—and so many of them are children unable to defend themselves from the assaults to their dignity, their hopes, and—all too often, their very lives, that poverty inflicts.

Here in Washington it can be all too easy to move on to the next report, focus on the constant stream of topics demanding our immediate attention.

Together, as a nation, we are facing an unparalleled series of social changes and tests. Our ability to retain and nurture America as a place where hope and opportunity are every citizen's birthright is in question.

The changing realities of the global political and economic map, coupled with the reordering of the workplace as the technological revolution rolls onward, present enormous challenge and opportunity.

As we consider how to shape our responses to health care, NAFTA and every other issue, we cannot ignore the 37 million Americans living in poverty.

We can't let that number remain statistically unchanged.

We must keep it burning so fiercely in our conscience that its light illuminates every decision we make. Or else the darkness of poverty will enfold all of our spirits as surely as it does the everyday lives of so many of our fellow Americans.

RETIREMENT PROTECTION ACT OF 1993

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan [Mr. FORD] is recognized for 5 minutes.

Mr. FORD of Michigan. Mr. Speaker, I am very pleased to introduce, with my good friend and colleague, Chairman DAN ROSTENKOWSKI, the Retirement Protection Act of 1993. This bill is the administration's proposal to reform the Pension Benefit Guaranty Corporation [PBGC] to strengthen and insure the pension benefit security for millions of workers and retirees in underfunded defined benefit pension plans.

I applaud the administration, the Secretaries of Labor, Commerce and Treasury and their staffs for their efforts to produce this product. The Congress has expressed growing concern over the perceived risk to the PBGC of several large unfunded plans. The administration, on taking the reigns of government, asked for time to review pension benefit security and the long-term stability of the PBGC, to project the extent of its exposure, and to recommend a thoughtful solution if needed. The administration has met its timetable and the bill reflects several months of hard work by the interagency task force.

The proposal provides for a number of reforms to increase pension funding for certain underfunded plans, attaining full funding of nonforfeitable benefits within 15 years. It is expected that these reforms will stabilize the financial condition of the PBGC for the long run. The administration further projects that the PBGC's deficit will be eliminated within 10 years. The bill would also enhance the PBGC's compliance tools so as to assure that employers remain responsible for their plans. Of particular importance to workers and retirees is the requirement that participants in underfunded plans be given an annual, plain-language explanation of their plan's funding status as well as the limits on the PBGC's guarantee. I include at the conclusion of my remarks a brief explanatory statement prepared by the PBGC that outlines the bill's major provisions.

Mr. Speaker, while I introduced this bill by request, I want my colleagues to know that I am committed to ensuring the long-term financial soundness of this program. When we passed the Employee Retirement Income Security Act of 1974, we promised our workers that their pensions would be secure and available upon retirement. Securing the financial soundness of the PBGC will reaffirm that promise. We can do no less for our workers and retirees. I wish, as well, to express my hope that as we approach this very complicated area of the law that we proceed with great care to measure the effects that these funding requirements will have on particular sectors of our economy. Surely we do not want, in the name of reform, to destroy jobs or threaten the well being of whole industries. We need to proceed with caution and with the help of the companies that have underfunded plans. And we need always to remember our ERISA promise to our workers and retirees.

RETIREMENT PROTECTION ACT OF 1993

As a whole, the defined benefit pension system insured by the Pension Benefit Guaranty Corporation (PBGC) is strong and well-funded. There is, however, persistent pension underfunding in some single-employer plans. Underfunding in single-employer plans grew from $27 billion in 1987 to $38 billion in 1991 and is expected to grow much more for 1992. At the end of 1991, about $12 billion in underfunding was in plans sponsored by troubled companies. The PBGC is in no immediate danger and will be able to pay benefits well into the foreseeable future, but there are substantial long-term risks to participants, the PBGC, and the retirement plan system, which must be squarely addressed now.

Given the current funding rules, the level of underfunding in plans of troubled companies and the PBGC's $2.7 billion deficit in the single-employer program are likely to increase in the coming years.

The legislation has four major areas of reform: plan funding rules, compliance, premiums, and participant services.

Funding. The bill strengthens the funding requirements for underfunded plans. The deficit reduction contribution (DRC), which was enacted in 1987 to increase funding of underfunded plans, has not accomplished its goal. The DRC was flawed in several ways. The legislation will correct these flaws by: eliminating the double counting of gains that significantly weaken the DRC under current law; specifying interest and mortality assumptions and requiring IRS approval of changes in other assumptions in certain underfunded plans; and accelerating the DRC funding schedule. Under the accelerated funding schedule, new liability would be amortized at 30% per year if the plan's funding ratio is 60% or less (versus a 35% or less funding ratio under current law.) Plans that are fully funded for current benefit promises would not be affected by these rules.

Further, for plan years beginning after 1994, the bill requires sponsors to begin funding immediately for negotiated benefit increases that will become effective in the future.

As an extra safeguard, plans at risk of not being able to pay benefits in the short term, are required to have on hand enough liquid assets to cover three years' benefit payments. The provision is designed to reduce the possibility that these plans will run out of money.

The bill includes a transition rule to ease the impact of the new funding requirements. Under the transition rule, funding percentages would increase in a measured way by 2–3 percentage points per year for the first five years and slightly higher percentages in the next two years.

The bill also deals with three issues of concern to employers that want to fund their pension plans or that have well-funded plans. The bill repeals the quarterly contribution requirement for fully funded plans. The bill eliminates the current 10% excise tax on certain nondeductible contributions for combined contributions to a company's defined benefit and defined contribution plans that exceed 25% of payroll. It also eliminates the 10% excise tax on nondeductible contributions for plans with fewer than 100 participants that fully fund all benefit liabilities upon plan termination. (Plans with more than 100 participants may deduct this contribution under current law.) Deductibility rules would not change.

Compliance. Certain corporate transactions, such as break up of a controlled group, threaten funding of pension plans and increase the risk that participants in an underfunded plan will lose benefits. The only current remedy is for the PBGC to petition the court to terminate the plan before the transaction. Other remedies are needed because plan termination can have harsh effects on plan participants and their employers. The bill would enable PBGC to seek judicial relief short of plan termination, such as a court order requiring that departing controlled group members remain responsible for pension underfunding for a period of time or provide security for part of the pension liabilities. Controlled groups with over $50 million in their underfunded plans, outstanding liens for missed contributions, or outstanding funding waivers of more than $1 million would be required to give PBGC 30 days' advance notice of certain events.

Other compliance changes would require sponsors with over $50 million in underfunding (or outstanding liens or funding waivers) to provide PBGC with better actuarial and financial information; grant ongoing plans a claim for pension underfunding against liquidating sponsors or controlled group members; prohibit employers from increasing benefits in underfunded plans during bankruptcy proceedings; and give PBGC concurrent authority with the Department of Labor to enforce minimum funding requirements when missed contributions exceed $1 million.

Premiums. The bill increases for plans that pose the greatest risk by phasing out the $53 per participant cap on the variable rate premium. The premium cap will be phased out over three years, starting with plan years beginning on or after July 1, 1994—20% the first year, 60% the second year, and 100% the third year. Because of the cap, plans with the greatest amount of underfunding pay no additional premiums for increased underfunding. In fact, plans at the cap account for 80% of all single-employer plan underfunding, but pay only about 25% of PBGC's total premium revenues. The flat rate premium of $19 per participant paid by all plans is not changed.

Participant Protection. In addition to protections provided by the enhanced funding and compliance, the bill contains other important participant protections. Too often, workers and retirees do not know the risks to their benefits posed by underfunding until after their pension plan has been terminated. The bill requires employers to provide participants in underfunded plans a simplified, understandable explanation of the plan's underfunded status and the limits of PBGC's guarantee. The PBGC will provide a model notice for use by employers.

The bill also contains provisions to protect participants who are "missing" when their fully funded plans terminate. Employers would be required to transfer adequate assets to PBGC to pay for missing participants. PBGC would pay the benefit to the participant when the participant contacts PBGC or is otherwise located.

Other Changes. The bill specifies the interest rate and mortality assumptions that may be used to calculate a lump sum distribution, provides rounding rules for certain tax code cost-of-living increases that affect benefit plans, and eliminates "age-weighted" profit-sharing plans and similar cross-tested defined contribution plans.

Effect of Reforms. The Administration expects the reforms to eliminate PBGC's deficit within 10 years and, based on an initial analysis, to improve funding of underfunded plans from the current average of 55% to 90% of all benefits, and from an average of 60% to 100% of vested benefits, within 15 years. The legislative package is budget neutral.

Mr. ROSTENKOWSKI. Mr. Speaker, I rise to announce introduction, by request, of the Retirement Protection Act of 1993. My colleague, the honorable WILLIAM FORD of Michigan, Chairman of the Committee on Education and Labor, and I have introduced this legislation at the request of the administration.

This bill reflects the administration's proposals to the Congress for reform of the significant and chronic underfunding of certain federally insured pension plans. These underfunded plans have a direct impact on the financial solvency of the Pension Benefit Guaranty Corporation [PBGC] as well as the security of millions of workers.

The issues surrounding underfunded defined-benefit pension plans have been the focus of a series of hearings before the Committee on Ways and Means over the past 2 years. During this time, the Committee has received reports from various governmental agencies and private entities on these issues. Those reports concluded that underfunding is a serious problem that will only worsen unless legislative reforms are enacted.

I think it is unfortunate that nearly 20 years after the passage of the Employee Retirement Income Security Act [ERISA], approximately 20 percent of all pension plans are still underfunded. Some of these underfunded plans have assets worth less than half of their current liabilities. In addition, some plans are underfunded by billions of dollars. To date, the unfunded liabilities insured by the PBGC exceed $50 billion. In such cases, the workers and retirees of these plans are at risk of losing benefits they have earned, and which they believe are guaranteed. In addition, underfunded pension plans pose great financial risk to the Government.

Mr. Speaker, I share the concerns of the administration and my colleagues on these issues, and believe that failure to act now will present us with greater problems in the future. If we enact legislative reforms now, we can prevent the need for the Federal Government to bail out the PBGC. If we delay, the bailout may be inevitable.

The legislation Chairman FORD and I are introducing for the administration today strengthens the funding rules for underfunded plans and increases the insurance premiums charged to severely underfunded plans. In addition, the bill increases PBGC's ability to enforce the minimum-funding requirements and to hold large groups of commonly controlled corporations accountable for the pension commitments of their corporate members. Finally, the bill requires that each participant in an underfunded plan receive a written explanation of the plan's financial condition and the limits of the PBGC's guarantee of their promised benefits.

Mr. Speaker, let me conclude by saying that I look forward to working with the administration and my colleagues on these issues. Many of my colleagues will agree that the bill before us is not perfect in every detail. Concerns about certain provisions contained in the bill have been brought to my attention. These concerns include the ability of significantly underfunded plans to continue to provide additional pension benefits. In addition, concerns may also be raised over some of the financing provisions contained in the bill. I would request that the administration remain open to working with the Congress to analyze the financing sources contained in the bill.

The legislation we are introducing today, by request, reflects some meaningful reform proposals. The financial security of many of our retired workers will remain at risk until we address these issues. It is my hope that the legislation will be taken up as soon as possible.

ISSUES THIS CONGRESS MUST ATTEND TO

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Vermont [Mr. SANDERS] is recognized for 5 minutes.

Mr. SANDERS. Mr. Speaker, as the only Independent in the House, my perspective on some of the issues of the day is a little bit different on occasion than my friends in the Democratic and

Republican Parties. What concerns me very much is that as we debate very, very important issues here on the floor of the House, sometimes we have a tendency to forget what are some of the most important issues facing our country. We slough over them. We do not debate them. We do not talk about the possible solutions.

Mr. Speaker, what I want to do now is just touch on some issues that I think do not get the attention they are due. The first point I want to make is, I wonder how many Americans today know that over a 20-year period, the United States of America went from No. 1 in the world in terms of the wages and benefits our workers receive, to No. 12 in the world. When we hear people up here saying, "We are the wealthiest country in the world," it isn't true anymore. It once was.

There is a reason why German companies are now coming to the United States of America to manufacture their products. That is, the German workers now make 25-percent higher wages than our manufacturing workers.

And if you look at other social indices, if you look at the health care situation in Europe or in Scandinavia, the parental leave situation, the unemployment compensation, pensions for the elderly, in many, many instances people of Europe and Scandinavia now do better than we do.

□ 1510

So my first thought is, we have got to examine how does that happen. How do we go from No. 1 in the world to No. 12 in the world? I think clearly one of the reasons has to do with the decline in manufacturing in America.

As it happens, I have many, many disagreements with Ross Perot, and I am offended that somebody who has billions of dollars can suddenly become a political leader because he has billions of dollars. But we must congratulate Mr. Perot in making a very important point, and that is if we continue to lose our manufacturing base, if we continue to convert our jobs from decent paying manufacturing jobs that pay workers $15, $10 an hour to flipping hamburgers at McDonald's for $4.25 or $5, we will continue to see a decline in our standard of living. And that is what is happening in a very, very rapid way, and that is what the NAFTA agreement is about.

Over the last 20 years the wages that our production workers have earned has declined by 20 percent. And it is even worse for the young workers. They are making nowhere near what young workers made 20 years ago. So we have to reverse that. We need a new industrial policy in America which rebuilds our manufacturing base. That is an issue that we are not discussing anywhere near enough, but we have got to pay attention to it.

The second point I want to make, which is talked about very, very rarely here on the floor of the House, is the growing gap between the rich and the poor and what we call class issues. There is a mythology that some people out there have that gee, we are a classless society, we are all in this thing together, and that is absolute nonsense. What has been going on over the last 12, 15 years is the gap between the rich and the poor has grown wider.

How many Americans know that the wealthiest 1 percent of our population now own more wealth than the bottom 90 percent? That is called, my friends, oligarchy. When we were kids in school we used to learn about that existing in Latin American countries. What do you think is happing in America today? The rich are getting much richer. The working people are seeing a decline in their standard of living and the poor are now sleeping out on the street. And we have 5 million children who are hungry.

Now, you do not hear this too often, but how do the American people feel about the fact that the chief executive officers of the largest corporations in America now earn 157 times what the workers in those corporations earn, 157 times? Their incomes are soaring. Last year the incomes of the top chief executive officers in America went up by 56 percent. Not too bad. For workers, we continue to see a decline in our standard of living.

Now how does this go on? Well, I will tell you how it goes on. What goes on is that ordinary American people are extremely frustrated at the two-party system, they are extremely frustrated with what is going on in terms of politics as usual, and they do not vote, they give up. In terms of NAFTA, we give up things where we should have hundreds and hundreds and thousands of people rising up and saying do not send our jobs to Mexico. We demand that American corporations reinvest in this country, not in Malaysia. The truth is we are not hearing that.

So what I would say is that if we are going to turn this country around, what I beg is that ordinary American working people, family farmers, those people who are working longer hours for less pay, those people who want to see their kids get a college education, that they begin to stand up and fight back, and demand that the U.S. Congress act for ordinary people and not just the wealthy and the powerful.

HEALTH CARE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan [Mr. BONIOR] is recognized for 60 minutes.

Mr. BONIOR. Mr. Speaker, I am here today once again to talk about an issue that all America is talking about today, an issue that touches the lives of more Americans in a more personal way than any other, and that issue of course is health care.

Mr. Speaker, 1 month ago yesterday the eyes of the Nation were focused on this Chamber as the President of the United States challenged Congress to take up the task of health care reform. He unveiled his plan to fix what is wrong with our health care system while preserving what is good, what is working, and what is right with it, a plan that builds upon and improves the system we have now to make it fairer, to make it better, and to make everyone responsible, and above all, above all, Mr. Speaker, a plan to guarantee each American comprehensive benefits that can never be taken away, never be taken away.

It has been nearly 50 years since Harry Truman first proposed comprehensive health care reform, 50 years. And yesterday an American President finally delivered on that promise. Yesterday the President presented his bill for health care reform to Congress in Statuary Hall, which is right in front of me. It is the old Chamber in which the House of Representatives used to meet.

What he presented is the most detailed, the most comprehensive, the most responsible health care reform plan ever introduced in the history of America. Working on this bill will likely be the highlight of each of our careers, because it will benefit Americans of all ages for generations to come.

Mr. Speaker, when Franklin Delano Roosevelt introduced Social Security back in 1935 he called it a sacred trust between the Government and its people that could never be broken, and that trust was symbolized by the Social Security card that we all have, and many of us probably carry it in our wallets and in our purses.

I think the same can be said about the President's health care plan. If you remember during the speech, the President held up this card, a health security card, a card that guarantees to each American a comprehensive package of benefits equal to, or better than, the benefits provided by the Fortune 500 companies. This card too represents a sacred trust between the Government and the people. And as the President said in his speech, with this card if you lose your job, or if you switch your job, you are covered. If you leave your job to start a small business, you are covered. If you retire early, you are covered. If you or someone in your family has a preexisting medical condition, you are covered. If you get sick, or a member of your family gets sick, even if it is a life-threatening illness, you are covered. And if an insurance company tries to drop you for any reason, you will still be covered, because that will be illegal.

The President's health care plan guarantees a comprehensive package of

benefits, and with this card you will never leave home without it. That, Mr. Speaker, is the ultimate goal of health care reform, to give all Americans the peace of mind to know that no matter what happens, health care will always be there for them.

The First Lady, of course, joined us yesterday in the unveiling of this proposal, and she said not long ago, "I hope we can agree on one thing from the outset, that when our work is done, every American will receive a health security card guaranteeing a comprehensive package of benefits that can never be taken away under any circumstances," because we all know that is certainly not the case today. Every single month, every month in America, nearly 2 million people who work hard, who play by the rules, lose their coverage. And over the next 2 years one out of every four Americans is expected to be without health insurance at some point.

This problem is unraveling the social, and I might also add the economic fabric of our society. It is reducing productivity, it is affecting our competitiveness, it is draining our Federal and State budgets, it is driving down the wages and living standards of our work force. This problem affects all of us, and each of us, Independent, Democrat, Republican, have got to work together to solve it.

A national consensus for health care is forming now for the first time ever. Leaders in both the Republican and Democratic Parties have embraced comprehensive reform. But of course, now the hard work begins, really begins. The question we will spend the coming months trying to answer is simply this: What is the best way to get there from here?

□ 1520

It is not an easy question. As someone said, "Gravity isn't easy, but it's the law." Well, health care reform will not be easy, but it is the law that will most profoundly affect the future of America. We must all work together, Democrat, Independent, Republican, to make it happen.

We have a unique opportunity as people who have been given the privilege to serve our constituents in this great Nation to provide perhaps one of the most significant pieces of legislation in the entire history of this great Nation of ours.

In the coming months we in Congress are going to work with the White House and the public to hammer out all of the choices that confront us. But there are a lot of issues before us. It is not simple, it is not just a matter of one or two things. This involves a lot of issues that affect every segment of our society.

But I hope when we engage in this debate we can put aside our partisan and ideological differences and have a constructive debate in order to come up with a final plan that is fair, compassionate, and that works, a plan that remains wedded to the six basic principles, the principles of health care reform that the President outlined again yesterday morning.

And they are: security, simplicity, savings, choice, quality, and responsibility. And I think they bear repeating this afternoon.

I want to talk about them very briefly. First, security: To provide all Americans the security of knowing that, as I said, no matter what happens, whether you switch your job, you get laid off from your job, lose your job, you have a preexisting condition, you and your family will never lose your health care coverage.

Second, savings: To control the cost of health care that is crippling the American business community, hurting American families, and exploding our deficit, the plan will stop the escalating costs of health care premiums and provide discounts to small businesses so they can afford health care for their employees and their families.

Simplicity: to reduce the paperwork. We all have horror stories about having to fill out insurance forms. All our medical doctors and nurses know of the plethora of paperwork that encumbers an office trying to provide medical services. Cut the redtape, reduce the regulations that are keeping our doctors, our nurses, from giving you the health care you need. They should not be spending an inordinate amount of their time doing paperwork when they were trained to provide services to people that affect their medical health.

Today there are 1,500 insurance companies all with a form of their own. Under the President's plan, there will be only one form.

Fourth, choice: We have heard a lot about choice over the last several months. We want to preserve your right to choose your doctor and your health plan so that we can, above all, have a doctor that our family has confidence in and a plan that we have confidence in. And this plan that the President is proposing will give you your choice of the type of doctor you want or the type of plans you want, much more choice, I might add, than the American people have now.

Many of our people who work in our economy today and whose employer provides health insurance for them are limited in the scope in which they get to choose their doctor and their plan. This will broaden that considerably and give the consumer and the worker more choice.

Fifth, quality: To make what is best about America's health care system even better, the plan would provide free preventive care, invest in training more family doctors and make medical research a priority.

For seniors, it will preserve Medicare and cover prescription drugs and expanded long-term care for the first time. There is one issue that we have heard consistently from our senior constituents, and even our nonsenior constituents who have parents who are in that age bracket, they want to know what we are going to do about long-term care. They want to know what we are going to do about the escalating cost of prescription drugs which is eating away at the meager savings of many of our seniors today. It is not unusual to find many of our seniors taking one of the pills that they are ordered to take instead of the four because they cannot afford it. It is not unusual to find them paying 30 and 40 percent of their monthly incomes just on prescription drugs.

We will deal with those problems in this comprehensive reform bill. We will move in the long-term care to home health care where people will be able to get care in their homes when they are elderly.

We must also insure that America continues to have the best doctors and the most advanced treatment in the world.

Now, the sixth is responsibility: To make sure that everybody is in this together, everybody pays their part and contributes to health care.

Right now we all pay for those who do not take responsibility. Everybody knows the stories of the folks, the 2 million a month who lose insurance, or the permanents who do not have insurance or will not have insurance; when they get ill, they get cared for usually. They end up going to the emergency room, which is very inefficient. But that cost is passed on to the rest of us. And everybody knows that employers who do not provide health insurance for their employees, other employers have to pick up that added cost that is passed on to the insurance bills that those of us who have insurance have to pay.

That is why, often, when you get a bill from the hospital, you will see an exorbitant amount for an aspirin or for this or that; usually buried in that cost is the cost to service people who do not have health insurance.

Responsibility also means changing behavior that drives up our costs and causes suffering, like the violence from handguns in our society, smoking, excessive drinking. These issues we are beginning to address and to tackle in American society today. There is a raging debate, obviously, over violence in our communities all across America and what causes that violence. There has been a campaign against smoking that has raged now for a couple of decades in this country, and smoking is down considerably. Of course, there is education, more and more education about excessive alcohol intake.

We need to do more on preventive medicine, we need to do more about making sure that people take care of

their own bodies, the temple of who they are, to make sure that costs do not continue to rise.

We need to restore the sense that we are all in this together, that behavior by one group or one segment of our society affects not only the health of others but the costs that we all pay to tackle this health care problem.

Mr. Speaker, through it all there will be those who will say we cannot afford change, that the present system, you know, is working fine, just tinker there and tinker there and that will take care of it, that the insurance companies and the drug companies will make changes on their own. Well, we cannot let the special interests dictate this debate. That is what you are getting on a lot of TV commercials running today, it is the special interest campaign to dictate this debate, to make you worry that your elected Representatives will not act in your best interests.

We have a system that is bankrupting this country today. We can fix it. If we do not fix it, it will drift, and the way it is continuing to drift, the cost of health care will rise to $14,000 a year for a family of four by the end of the decade. It is about $5,500 now: it was about $2,500 in 1980. It is out of control. It needs to be reined in, it needs to be tightened, it needs to be polished so the quality is better than ever, and we can do that.

Amerca has been at the mercy of some of the special interests too long. It is time we recognize in this country that health care is a right and not a privilege. If every other major industrial country in the world can provide health coverage for all of its people, we ought to be able to do it too. After all we have 200 years of existence as a Nation, and its seems to us it is about time we did it.

In the months to come we are going to hear a lot of statistics and numbers to dramatize the crisis in health care; but we have to remember that health care is more than just numbers and statistics and theory; it is the real lives of real people.

We have to be able to put ourselves into the stories of the people we hear from to give this debate real meaning, people like the man from my district whom I met who told me, "Congressman, I am in my late fifties, I worked 40 years in the plant, and I am now retired. I go to the mailbox every month to get my retirement check. I went last month and there was a check for $32, and a note that said, 'that's all you're going to get from now on because we are deducting from your retirement your accelerated and increasing health care costs' ", which was part of his contract.

□ 1530

A man's life and dreams shattered, 40 years, and this guy was not working in a soft job. It was a factory job, a job where he went in, did a hard day's work, came out, grimy from the work, his muscles tired and sore and all he wanted to do was go home and let some time drift by him as he relaxed. He did that for 40 years, felt he had a pension coming to him and then had it ripped off because of this escalating health care crisis in this country.

People like the women who visited me in my office who were working in nursing homes, I had five of them visit me. They said to me, "Congressman, we take care of your parents and your grandparents, yet we make $6 an hour and we don't even have health insurance ourselves."

This one woman almost broke down and cried. She told me, "I say a prayer every night that my son doesn't get sick, because I don't know what I would do."

Women who are working in nursing homes, taking care our own, and yet have no insurance for their own families.

Or like that man from Michigan who wrote to say that 14 years go he was diagnosed with Hodgkins disease. With the help of a strong will and some good doctors, he fought it and by 1985 he was pronounced cured, cured by everybody but his employer's insurance company who refused to cover him because it was a bad risk. So after 15 years on the job, his boss was forced to lay him off just because the insurance company would not cover him. Now he has no job. He and his wife and his two children have no health insurance.

Mr. Speaker, we have all heard these stories. There are tens of thousands of them out there. Each of us in our own constituencies goes home and hears them on a daily and weekly basis. They come from people who are frustrated, who are frightened, who are fed up with a system that makes no sense, that provides no coverage at crucial times when they expect it, when it is their right to have it, and that does nothing to protect them from price gouging and risk and the rising cost of health care.

They come from people whose very idea of security is being shattered, like the man I mentioned earlier, shattered right before their eyes.

It is time that we provide people with the security and the peace of mind to know that no matter where they go or when they go, their health care will always be there for them.

Our ultimate goal then is this: Health care security for all Americans, and the only way to get there is to keep what is right with our system, the best doctors, the best medical technologies, the best medical research, while fixing what is wrong, and there is a lot wrong.

Nothing we do in this Congress will be as important. Nothing we do will be as long lasting. Nothing we do will touch the lives of more people than health care reform.

The President's plan, Mr. Speaker, is before us. The hard work is just beginning.

The eyes of the Nation are watching us today. Health care reform has got to be our top priority. It will not be easy, but I hope we all have the courage in this Chamber to do what is right, because the future of our children and the future of our country depends upon it.

Mr. Speaker, this is a very, very tough debate we will enter into in the coming months. I just want also to add for my colleagues who may be listening, I hope we do not dilly and we do not dally. This debate has been going on for 50 years. We cannot in all good conscience suggest that it is just beginning. We cannot do that. This debate has been going on since Harry Truman called for it 50 years ago.

There have been peaks and there have been valleys in which it has raged. We are now at a peak and it is important for us to embrace it, to accept it and to do it. Just like the Nike ad says, "Just do it," and do it right. Consider it, have the proper hearings, the input from the American people, but do it, and not under the illusion that we will get it a hundred percent right on the first try.

All one has to do is look at Germany, England, and Canada, and all our other Western democratic neighbors who have national health care. The Germans have had it since 1870.

If you look every year at one of the major, if not the major, item in their legislative and parliamentary agenda, it is health care reform. They are constantly refining it, improving it, tinkering with it, making it work better for the people, because the society in which it functions changes. People change and times change. Technology changes. So we have to evolve and change with it.

We have got to develop the mainframe. We have got to develop the plan in which we encompass health care, because it is not something that once we do is going to go away. It will be with us constantly throughout our lives and certainly our political lives.

But let us first begin. Let us take the plunge to do something about a problem that has plagued this country and has not been properly addressed by this Nation.

I want to commend the President and Mrs. Clinton for having the courage to come forward, the first people since Harry Truman to come forward with a comprehensive plan to get this done. All the other Presidents, Republican and Democratic alike, failed to do that. The most advance we have made during that 50-year period was in 1964–65, 1965 specifically, when we did the Medicare reforms in this country, which provided Medicare for the elderly.

It was a big advance. There was Social Security in the midthirties. Medicare in the midsixties, and now we are going to wrap up health care in the early 1990's, another 30-year period.

But the country is ready. You can sense it. You can feel it, with the different players involved here, the doctors, the nurses, the people who are involved in the business side of medicine and the hospitals, even some of the interest groups are ready to come to the table and bargain and try to put together a plan that makes sense, not only for them but for their employees and the rest of American society.

So I am just very pleased that the President came. He spoke with emotion. If you listened to him yesterday, you heard him talk about the fact that we went through a wrenching 6 months in this Chamber of deficit reduction. We passed the deficit reduction bill of half a trillion, $500 billion in deficit reduction. We won it by one vote here, one vote in the U.S. Senate, and that vote was cast by the Vice President who broke the tie and it was signed by the President.

It was difficult because it encompassed everything we do in our Government today. It affected everybody's life in America, and it was tough because it involved raising some revenues, taxes if you will. Mostly 99 percent of that was on the very upper income people who make $140,000 a year or more; but nonetheless, we had to raise some revenues and we also had to cut a lot, but we need to be fiscally solvent.

One of the biggest parts of our budget problem is the rising health care costs. They are rising three and four times the rate of inflation. Medicaid, Medicare, VA health care, health care for our military personnel, all are rising at an astronomical rate.

We will have lost the budget battle, lost it entirely, all the blood, the sweat, the tears, the votes we cast over this past year to get that budget down, we will lose that if we do not supplement it with health care reform.

I might tell my fiscally conservative friends out there and colleagues, this health care reform package will be the biggest deficit reduction bill and budget package that you will pass probably in your entire history in the U.S. Congress. That is my guess, because it will restrict the amount of spending on programs that are out of control already in America today.

So Mr. Speaker, I just want to conclude by thanking my colleagues for attending the event yesterday and watching and listening intently to Mrs. Clinton, who has been just such a champion on this issue. She is knowledgeable. She is bright. She cares with a passion that is almost beyond belief about the health of this country. She is a tremendous asset to this administration and to the American people.

Then listening to the President outline his passion and the need, this will be the issue that we focus on more than anything else in the coming year.

We began yesterday with the presentation of the bill. I entered it into the RECORD this afternoon. Hearings will commence very shortly on the specifics of it, and then, of course, the debate begins again. It begins in earnest as we move forward to provide health care for all Americans.

□ 1540

GUN CONTROL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Mexico [Mr. SCHIFF] is recognized for 60 minutes.

Mr. SCHIFF. Mr. Speaker, I ask unanimous consent to yield 10 minutes of my time to the gentleman from North Dakota [Mr. POMEROY].

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Mexico?

There was no objection.

HEALTH CARE

Mr. POMEROY. Mr. Speaker, I thank the gentleman from New Mexico [Mr. SCHIFF]. I want to speak for a few minutes about the health care debate and, in particular, talk about problems that require Congress to take the action for enactment of meaningful reform and meaningful reform this session.

I say to my colleagues, You don't have to be a public policy genius to understand that dramatic changes are needed with our health care system. We have got a system that is broken. We have got problems that are bad and getting worse every single week.

Mr. Speaker, for me the most powerful indicators that I have seen about the deteriorating condition and the fatal problems in the present system have come to me from personal examples of family threatening problems called to my attention by individuals during the years I have been in public service to the citizens of North Dakota. Prior to being a Member of Congress, Mr. Speaker, I served for 8 years as a State insurance commissioner, and in the years as a State insurance commissioner and in the last several months as a Member of Congress I have had some truly heart-wrenching situations called to my attention.

For example, one evening at home I received a call while I was insurance commission. It was a gentleman who had been out in the field for an entire day putting in his crop. He came home, opened his mail and saw his Blue Cross/Blue Shield premium. It indicated a rate increase that, in fact, exceeded his ability to continue in place that needed coverage for his family.

Mr. Speaker, this individual asked me time and time again, "What am I going to do? I cannot afford this insurance rate increase, and Lord knows my family needs health insurance. What am I going to do?"

I was the State's insurance commissioner, but I did not have any advice for that farmer, and I expect that today he and his family are without the coverage they need to access health insurance services.

I traveled throughout North Dakota holding senior citizen forums, trying to address questions about health care and health insurance coverage issues. Sometimes to these forums some senior citizen constituents of mine will bring small boxes literally full of correspondence they have received from insurance companies or health care providers, billings, notices of payment, and goodness knows what all, but it is so indicative of the paperwork clogging our present system.

Third, Mr. Speaker, I had a circumstance where a young couple took me aside at a public event. I noticed the individual, the fellow, had a slight limp, and in fact, as they told their story to me, he had lost his leg in a work-related accident working for stockyards up in northwestern North Dakota. He was employed at the time of this accident, and the insurance covered his medical bills, but in fact the premiums paid by that small employer had risen 200 percent since that accident, and they were facing dropping of coverage even though he needed additional medical attention because they could not keep up with the premium increases.

And finally I have received calls over the years from people in stages of cancer treatment, people who barely have any hope left of being able to receive the medical care that they need, people whose only hope of beating this dreadful disease is a bone marrow transplant prescribed by their physician. In a couple of instances these individuals were unable to access the bone marrow treatment prescribed by their physician because their insurance company deemed this to be an experimental procedure, something they would not cover even though it was literally a matter of life and death to these people.

Now these are all problems that have a very personal character and represent, I think, in terribly personal ways problems we have with our present health care system.

For example, Mr. Speaker, the cost issue, the ongoing, unrelenting cost inflation we see in our system evidenced by the farmer who called me with his premium increase. We have a situation where national health care spending, the amount spent on health care in this country has doubled since 1985. It will nearly double in the next 7 years, by the turn of the century. We will have a situation where, without change, one dollar out of five goes for health care services.

The past statistics bear witness to what is taking place. Per capita we spent in this country on health care a

little over $1,000 in 1980; by 1990, 2½ times that amount, a little over $2500; by 1993, a little over $3,000, and by the year 2000, if we do nothing, every man, woman, and child in this country will spend, on average, $6,000 on health care services. We cannot continue this per capita rate of increase.

The cost for individuals, as my colleagues know, is reflected in premium increases having gone from a hundred dollars a month from merely a few years ago to routinely over $500 a month. We have seen the cost of insurance represent a little less than the cost of one's car payment. Now it exceeds the cost of the mortgage, and there is no end in sight.

The cost for business is just as severe. It is a significant factor behind suppressed wage growth. It is a significant factor behind the reluctance of employers to hire more people back to work. It is a significant factor, in fact, in global competitiveness where we have $1,200 representing the sticker price of a United States-manufactured car compared to less than half that amount for a Japanese-manufactured automobile. How can we compete internationally when we carry a price tag on health benefits that is more than double our international competitors, and, as a percentage cost of the gross national product of this company, 9 percent of the gross national product in 1980 went to health care services, 14 percent in 1993, and we are heading for 19 percent by the year 2000, nearly one dollar out of five.

We have got to deal with cost. Health reform that does not deal with reining in cost is no meaningful health care reform at all. It is beyond what it is doing to families, beyond what it is doing to business. It is crippling the solvency of the Government itself. It is the biggest reason for the rising cost for Federal Government. The Federal Government spent $72 billion on health care services in 1980, $223 billion in 1991, $259 billion in 1992, heading for $600 billion in 10 years if we do nothing, and we cannot keep up with that kind of growth in Government. It is absolutely killing taxpayers across this country. We have got to do something about reining in costs.

For the individual with the amputated leg that found himself unable to obtain alternative coverage we see demonstrated a very sad aspect of what costs have done to insurance practices by some companies in my States.

□ 1550

Rather than take the steps necessary to contain medical costs, they have instead spent their energies trying to figure out how to uninsure those running up the bills for them and how to keep away from insuring those that most need it, the people with health conditions in this country. We have seen medical underwriting screen out anyone with the slightest hint of medical troubles. Even more insidiously, we have seen rating schemes, that in your group, if you have a health care problem, as your claims come in, your premiums go up. Insurance we think of as spreading the costs out over a large body. This is keeping costs right on the group itself, until the premiums get to a point where they have to drop the coverage. This type of insurance practice has left even those with insurance today with no security that they will actually have the coverage when they need it. Demonstrated by the senior citizens bringing their bills to these forums in box loads, we have a demonstration of a system of paperwork that is completely out of control. We are strangling in paperwork with our present system.

I am absolutely confident that we can cut down on this paperwork. How many of you have received billing notices from insurance companies, you open them up, and the thing reads, "This is not a bill"? If it is not a bill, why are they sending it out for heaven's sake? There is an expense involved in that. We can cut down costs by eliminating paperwork that is only confusing the public and adding expense, time, and bother to the medical providers of this country.

Mr. Speaker, I have tried in the last few minutes to point out the breadth of problems in our existing system of health care and to challenge this body to address these problems. This is a terribly difficult issue, and I am not sure I am for everything in the President's 1,600-page bill. I have certainly got more study before I conclude it. But I will give him credit for facing up to the issue and advancing a program that meaningfully addresses these problems. We have got to in our own response make sure we deal with costs, and make sure we deal with coverage, if we are to enact meaningful health care reform this session.

GUN CONTROL

Mr. SCHIFF. Mr. Speaker, I have not very often come out here to present a special order. Those few times that I have, have invariably been met by a few letters from around the country that basically say to me, and I am sure my colleagues have the same experience, "Why on Earth do you Members of the House of Representatives do these special orders? As anyone can see, the Chamber is virtually empty." It is not completely empty.

There are actually two reasons in my judgment for doing special orders. The first is we do communicate with our colleagues this way. During most of the day, during any portion of the session, all of us have televisions tuned to C-SPAN next to our desks. I have heard it argued that maybe C-SPAN was a bad idea in that sense because more Members of the House of Representatives and perhaps the other body, too, came to their Chambers to hear debates in person when there was no C-SPAN.

I cannot say for sure, except that I can say that Members do follow the debate in their office while they are doing other work.

Second, of all, however if C-SPAN has caused less Members to come to the House floor, whether it is now or earlier during the various debates, it has presented a wonderful opportunity to invite the public into the Chamber.

C-SPAN provides an unparalleled historic opportunity for the public in the United States not only to see the votes as they take place, but to see the different individuals, hear the different arguments, and make up their own minds.

So I believe that these special orders, even if no other Members are listening, achieve a great purpose and are presenting to the public various information and arguments that we think are not presented any other way.

Mr. Speaker, that is why I am out here today. I am out here to talk about the proposed Brady bill, the proposed waiting period and background check before an individual can purchase a handgun.

I want to say that I am taking this time somewhat reluctantly, because although I do not support this bill, for reasons which I will explain, neither is it some type of holy crusade on my part to see it defeated.

For example, if the Brady bill does pass, and I think the odds very much favor that at some point during this Congress, based on previous votes, that it will and if it, for example, were included in a larger crime bill and not by itself, I would not vote against an entire crime bill that I otherwise agreed with because this provision might be there.

Nevertheless, the reason that I am taking the floor today is that I am very concerned that information through the normal media channels about what is and what is not in this bill, I do not think, has been adequately presented, and I desire the time here today to make that kind of presentation.

Mr. Speaker, today in the Committee on the Judiciary we were supposed to take up the entire proposed administration's crime bill. Also introduced was another proposed alternative bill, generally from Republican members of the House on the Committee on the Judiciary, as well as another proposed bill from other Democratic members of the Committee on the Judiciary.

Our chairman decided, because there were a number of different bills, that most of the proposed crime legislation would be referred back to the subcommittees from the Committee on the Judiciary for further consideration. I understand that decision because the fact is there is nobody for crime. There

is nobody out there arguing that we ought to have crime. But it is a very complex and difficult subject, and there is a variety of legitimate disagreement on how to approach the subject of crime.

Although perhaps we could have taken up more in the full Committee on the Judiciary without referring it to the subcommittee, I understand that there is significant debate that the chairman wished to have further pursued.

Well, I am also, in addition to being a member of the Committee on the Judiciary, a member of the Subcommittee on Crime and Criminal Justice. The chairman of our committee has called for a vote first thing tomorrow morning on the Brady bill. So we will have an independent vote in the Subcommittee on Crime and Criminal Justice tomorrow morning on that bill. It is important for that reason, the fact that we are having this vote tomorrow and the fact that I do not think there has been an adequate explanation of the bill, that I am here right now.

Now, when I say I do not think there has been an adequate explanation of the bill, what I mean is that its proponents, in my judgment deliberately, because they have been a great deal of headway with this, have said we have to pass the Brady bill because we have to teach a lesson to the National Rifle Association. And whenever I see various news commentaries, it is usually revolving around, if not directly, the National Rifle Association. Certainly those who say we should not have any kind of gun control or oppose generally gun control.

My feeling is that we should pass legislation that is good for the country and we should reject legislation that is bad for the country. We do that by looking at the specific legislation and examining how it is proposed to benefit, in this case, law enforcement, or how it might actually be counterproductive to law enforcement.

In my judgment, whether the National Rifle Association or any other organization supports a bill or objects to a bill, they are entitled to their input in our democracy, of course, but that is not a reason to pass or reject legislation. We should pass or reject legislation strictly on its merits.

I think that the use of "We are going to teach the National Rifle Association something," is a diversion in my opinion to keep from looking exactly at what is in this bill and what it hopes to provide and why it does not provide that.

To go into the bill now, the Brady bill contains three basic parts. The first is it contains a waiting period before one can purchase, in this case, a handgun. The waiting period is for the purpose of doing a background check by law enforcement on the proposed purchaser, to try to be certain that it is not illegal for the proposed purchaser to receive or possess a firearm under Federal law.

□ 1600

There are various categories of individuals who are not permitted, under Federal law, to legally possess firearms. Probably the most significant in these terms are those who are convicted felons, but there is also others on the list, including those who have been adjudicated mentally incompetent and so forth. So the first provision in the Brady bill is, there is going to be a waiting period for the purpose of a background check.

The second provision is that the background check will be conducted, it is mandatory in the bill that it be conducted by local law enforcement. That is, the local sheriff or local chief of police from county to county and city to city will be required to perform this background check. And third and finally, the bill provides for adoption of a national instant check, computer check, for purchasers of handguns by utilizing a direct computer connection between retail firearms merchants and law enforcement agencies to get a quick yes or no, when someone applies for a firearm.

That bill has been presented before. It is now part and parcel of the Brady bill. In fact, the bill itself, the Brady bill says that once we have a national records check, once this is available for the entire Nation, then the waiting period and the background check go away. So actually, the national background, direct computer check will actually take the place of the waiting period at some day in the future.

Now, let me go back over those three parts. First of all, the background check, the waiting period for a background check.

The idea of a waiting period for a background check is that it gives law enforcement the time to check out the background of a purchaser to see if that purchaser is eligible, or not eligible, to possess a firearm, in this case, again, a handgun, and if not, to say, no, you cannot get that handgun. And the object behind it, because this is called, I believe, the Brady Violence Control Act, words to that effect, Handgun Violence Control Act, so clearly the reason here for all of these provisions is to have a system where the waiting period will deny a handgun to those who are about to use it to commit the next violent felony. That is the purpose here.

Just stopping there for a moment, is that likely to work? I submit that that is not the case.

I have a background in law enforcement. I was a criminal prosecutor, including an elected district attorney for 8 years, and a criminal prosecutor for a total of 14 years. For 2 additional years, I was also a defense attorney. So I have seen that side of the system. And I can say that those criminals who are going to commit the next felony are not expected to buy their firearms at a licensed, reputable dealer. I think it will be found that they buy them on the black market or, more likely, they just steal them from those licensed establishments. After all, if you are a thief, why do you buy anything? You just break in and take it with you. So I submit to my colleagues that there is no reason to think that; that the criminals we are talking about are the people who are purchasing firearms from legitimate gun dealers.

Now, the proponents cite those States which have State background checks right now, and they cite figures to prove their point. They will say that in various States that have a background check, in a certain number of cases, whatever number they can cite, during a year guns were denied to people who were not eligible to own those firearms. And they cite that as proof of the fact that these waiting periods and background checks actually accomplish what they are, in fact, supposed to accomplish, that they are supposed to keep guns out of the hands of criminals. And they say it is done.

But I think a closer look at the statistics that are presented, if you can get this information, which I have found it very difficult, if not impossible, to do, at least from the State I have dealt with, I think would not support that claim.

First of all, I suggest that on those persons who attempt to purchase who are rejected, they may, in fact, be rejected for legitimate reasons, but I suspect that at the same time they are not your next criminal. What I am talking about is, I suspect that in many cases, there was someone who convicted of a felony, perhaps an embezzlement 20 years ago, and today, now, they are interested in personal protection, as many people are. Well, it is still technically illegal for them to purchase a firearm, including a handgun, of course. Therefore, they are lawfully denied the right to buy this particular handgun.

But to suggest that these individuals are the same individuals who are getting a firearm for the purpose of robbing the next convenience store, I suggest, challenges the mind. I think further evidence of that is to take the terms that I have heard to the effect of, we kept, we being the waiting periods in the States, we kept so many criminals from getting firearms, that cannot be backed up no matter what the criminals were, no matter whether they were, as I have suggested, nonviolent criminals from years or decades ago who may not have even known that they could not buy a firearm, who even if they are the most violent criminal ready to commit the next crime, there is no evidence, no credible evidence that State background checks have actually kept firearms out of their hands.

I mean the potentially most violent people, if, in fact, that is who we are talking about. Here is how I come to that conclusion. Once again, the statistics out there are almost nonexistent in any State that I have been dealing with with respect to having waiting periods and background checks.

But the question is, What happens to those individuals who are not eligible to purchase a handgun and try to purchase a handgun, once they are rejected? Again, no matter what kind of former felons they are, there is very little evidence that those people are rapidly arrested and prosecuted. There is little evidence that the States and localities make a serious effort, once they know somebody has tried to purchase a firearm, to say, we have to go out and arrest that person. They have tried to illegally purchase a firearm, and we are afraid they are intent on robbing a store or committing another violent crime. We have to take them off the streets now.

That just does not happen. So what the best evidence shows is that those States with background checks today deny a certain number of purchases, but the individuals who are denied that purchase are free, free to then go down the street and try again or go to the black market or steal one and so forth. The only statistics I have seen on prosecution are based upon prosecutions that may have occurred anyway and elsewhere. There is nothing to indicate that there is, in all the States that do a background check, that there is an organized system to say, we are going to get these people off the street now. And if you do not get the person off the street, assuming this is the kind of person you want off the street, you have not stopped them from getting a handgun. You have only stopped them for that moment.

I would respectfully ask, to those who live in States where there is a background check right now of people who wish to purchase a handgun, ask your State government or ask your local government, what do you do? What do you do when somebody is turned down? What effort do you make to take them off the street immediately? See what kind of answer you get, especially over, say, the last 12 months.

But it is often suggested that if, despite its deficiencies, if a bill like this can prevent even one crime, is it not worth it? In other words, even if it is not perfect, even if it will not catch every crime, if a 5-day waiting period and a background check will, in fact, prevent a violent felony, is that not reason to proceed anyway? To put it another way, what is the harm?

The answer is, there is an argument on the other side. There is an argument, and I would have to concede that it is possible in some cases one could argue that the waiting period and the background check mean that a crime had been prevented. I cannot argue that it is impossible anywhere. Quite possibly, that is the case.

The idea that even at best it is any number that would make any noticeable difference in the crime rate, I think, is not supported. But why not do an act like this, if it could stop any number of violent crimes, even one? The answer is that it can be argued that a waiting period can also cause crime.

How can a waiting period cause crime?

□ 1610

There are two reasons. No. 1, we do know that most of the individuals who attempt to buy handguns at legitimate gun dealers are honest citizens. That is a given to everybody. We can argue about how many criminals are trying to buy that way and what kind of criminals they are, but the truth is most individuals who are trying to buy are honest citizens. Yet we are taking police officers or police personnel, but certainly police dollars, off of the street to check out numbers of buyers who are legitimate citizens.

One has to ask how many criminals could be taken off the street if we took the money that is devoted to investigating backgrounds of honest citizens and used that specifically to investigate and prosecute criminals. The argument can be made that the resources lost checking out honest citizens are permitting criminals to continue to commit crimes.

Second of all, waiting periods are a two-edged sword. A waiting period by itself is a waiting period. A waiting period can apply just as easily to an individual who is threatened by a criminal and wishes a firearm for personal protection.

I am well aware there are normally escape hatches in bills like this, and there is here, that allow the discretion to chiefs of police and so forth to allow the immediate purchase of a firearm for self-defense, but this requires somebody who believes they are a victim, a woman, for example, being stalked by an ex-boyfriend, to convince someone else, "I need to buy a firearm for self-defense." It at least raises a question that somebody has to make an evaluation for somebody else, whether they need to defend themselves and in what manner.

I think what this all comes down to is the fact that the people who are sponsoring this bill, H.R. 1025, by official name, have not, as of thus far, been willing to do the background check themselves, either through use of a Federal agency or through reimbursing the local government to do the check.

Mr. Speaker, I would point out again that the first part of H.R. 1025, the Brady bill, is a waiting period for the purpose of a background check. The second part is to require a background check by local law enforcement. There is no provision that the Federal Bureau of Investigation do the background check, although we have the power to mandate that, since they are a Federal law enforcement agency. There is no reimbursement for the localities to do it if we want to use them.

What is the reason for not having the Federal Bureau of Investigation do the background check? The proponents give this reason. They say that local police know their cities better than the FBI agents would know a city, and might know something about a potential purchaser that would come to mind faster than would come to mind with a Federal official.

First of all, I submit that that is not going to be true in any major metropolitan area. The person working in records in a city and the person working in the FBI office in the same metropolitan area probably know the same amount of personal information.

More significantly, though, that argument is only true as far as it goes. It is true that the local police or sheriff might have some local records that are not available anywhere else except in that local police or sheriff's office. It is also true that the local police and local sheriff might not know of any arrest, any arrest at all, that has occurred in the next State or even in the next county, because they do not necessarily keep those records.

I can say that any kind of reasonable check, background check by local or by FBI officials, requires at least two stops. It is absolutely necessary to check with the local police department. It is absolutely necessary to check with the FBI, because the FBI is the repository of our national records system.

There is absolutely no reason why local police officers can make these two checks better than an FBI agent can make these two checks. They can both do both checks equally. I submit that the real reason why there is not a provision in this bill to make the Federal Bureau of Investigation do the check, which I think would improve the bill from the point of view of the supporters, they are complaining that the reason we need a national bill is some States have background checks and some do not, and that is a hodgepodge. The bill on its face really does not improve that. It says, "local law enforcement agencies are required to make every reasonable effort at a check."

What does that mean? That is still going to mean a hodgepodge of how well the checks are done in some places versus other places. If the Federal Bureau of Investigation were used to do the check nationally, you would have a common quality standard on doing the checks.

It makes more sense from a supporter's point of view. I think the reason it is not here is that the Department of Justice, which has been appearing regularly testifying in favor of the Brady bill, would go crazy if they thought they had to actually use their manpower and their resources to do the background check. In other words, the Department of Justice today thinks that the Brady bill is a wonderful idea, provided only they do not have to do any work about it.

I think if we really made the decision, given the debate which is arguable on both sides, that a background check is a worthwhile use of law enforcement resources, we should use our own agency.

Tomorrow I intend to offer an amendment at the subcommittee that will say that. If that amendment fails, I intend to offer an amendment that would require the Federal Government to pay the local police officials for doing this check. If we insist that local police officials can do a better job than the FBI can of doing a background check, then it seems to me we ought to be willing to pay the local police officials to do this background check.

By the way, if that amendment fails, I am going to offer a third amendment that says the local police may do the check but are not required to do it. It seems to me that if we are not going to use a Federal police agency to do the check, if we are not willing to pay local law enforcement to do the check, I do not think we should make it mandatory on another agency.

I want to stress that I think that if any individual State wants to pass a waiting period and a background check, I am not here to object to it. What I am objecting to is Congress telling the local agencies, "We think this is such a great idea, you ought to do it." That is the law enforcement equivalent of "let's you and him fight." "We think it is a wonderful idea, but we are not going to touch it." I think that is what is chiefly wrong with the bill.

Mr. Speaker, I might add that another argument that has been made in favor of this bill, H.R. 1025, is the cooling-off period; that if a certain number of days existed between the desire to purchase a weapon and the actual receipt of that weapon, that would cause individuals who are bent on committing murder to not commit murder, because they would think about it and be dissuaded from the crime. This assumes, among other things, that they would not get mad 5 days later and go ahead and do it anyway. I suggest that anyone who is mad enough to commit murder right at a moment is going to find a way to commit murder.

However, I would point out that the third provision of the Brady bill, after the waiting period and after the requirement that law enforcement do the check, the third provision of the Brady bill is adoption of the national instant computer check as a substitute for the waiting period and background check. That means no waiting period. The waiting period goes away. That is what this bill says today. That is how it is written today. That is what we are going to vote on tomorrow.

For those who believe this cooling-off period would be beneficial in and of itself, without any reference to a background check, I would point out that the waiting period goes away under the bill, so that is not a particular reason to support it.

Mr. Speaker, I would like to take just a couple more minutes to just go into some of the things that I think should be done. I have stood here and criticized the proposal and given the reasons for it, and given the reasons that I think what I have said has not normally been reported, I think, in the conventional media, which is why I am here.

What would I propose? First of all, I am not adverse to gun control by that name. In other words, I am willing to consider any proposal on its merits, and vote for it or against it, depending on whether I think it is best for the country. In fact, I support the instant check system. That is the way the Brady bill says the Nation is going to go. I have to say that it has been 5 years since I was elected to Congress and left law enforcement, and the improvement in the record system around the country has been enormous in the last several years.

I personally credit Sara and Jim Brady, even though I have disagreed with their bill, for putting the emphasis on this issue that I think has led to the improvement of the records, because it was a real mess for a number of years, not just to determine who can purchase a firearm, but for such things as determining if you have a given defendant in a given case, do you have a first-time offender or do you have a multiple offender. We could not tell. We could not get what is called a rapid sheet from the Federal Bureau of Investigation, which is supposed to be a complete criminal history, and most likely it would show an arrest in a given State on a given date for a given offense, and no disposition.

□ 1620

So you then have to go to that State and ask them to search through their archives to determine whether this person was convicted of an offense say several years ago in another State. It was not a good system. It was improved dramatically, and I think to the credit of the Bradys. But I support the national instant check system.

Second of all, I want to point out that one of the most important anticrime laws on the books today is gun control. That is, the crime I have referred to that says it is a crime for a convicted felon to be in possession of a firearm. We are concerned that a convicted felon would have a propensity to use a firearm to commit the next offense. I think it is a legitimate concern in many cases. We already have a law against that. We already have a law that says it is against the law for a convicted felon to possess a firearm. It is Federal legislation today. It has been for many, many years.

I have tried to get statistics from the Justice Department for weeks on end about how much enforcement they are doing of that law, how many cases have they prosecuted, how many cases have they rejected, how many cases have they prosecuted where the individual has not yet committed another crime. In other words, using this law to prevent another crime rather than just using it as an added charge to someone who has committed a new crime and has a prior record. I have no objection to that use, but if we are talking about using laws to prevent crime, this is a major piece of legislation that could be used. Thus far the Department of Justice has not responded.

At such time as they do respond, I will in fairness make their response a part of the RECORD, but thus far they do not have those statistics. I assume they are compiling them now. From what I know of the situation in the last 2 years, there has been some improvement over the use of this law by the Department of Justice in a program called Trigger Lock initiated by the Bush administration and I think continued by the Clinton administration. But it seems inconsistent to me, and I think I am being kind in the use of that word, that the Justice Department testifies in favor of new gun control legislation, the Brady bill, that they do not have to enforce, while at the same time, at least up until now, they have not been able to show what they are doing in enforcing the Federal gun control statute they have at their disposal. It seems to me if they were not just being politically correct, and they really believed this was effective legislation, not only would they be willing to do the check themselves through the FBI, as I have indicated before, but in addition they would have immediately available to us here how many prosecutions of convicted felons in possession of a firearm that we have done already.

Now I think that tackling crime is going to be an extremely difficult issue. I think the causes of crime are very complex and the solutions will be complex. I would say that of all of the collective proposals, and I am not necessarily rejecting many different proposals, I would center on two ideas. If we are going to reduce violent crime in this country, we have to first keep young people from turning into violent criminals, and second, we have to do

something about the violent criminals that regretfully we already have.

On the first, the Judiciary Committee today under the chairmanship of Chairman BROOKS is expected to pass several bills that deal with grants for the States that will help them try to dissuade young people from becoming violent criminals, and I support those bills. I regret to say, though, there is absolutely nothing on the horizon to do something about the here and now.

I believe the leading immediate cause of violent crime is the revolving door of violent criminals in our prisons where convicted violent criminals get a substantial portion off of their sentences from prison, and then are allowed back out on the street. And we all know what happens then. I regret to say that my own State of New Mexico is a leading offender, giving their violent criminals up to 50 percent off of their prison sentences.

Now I am not calling for specific sentences. That is up to a jury or a judge in accordance with the laws of the State. What I am calling for is truth in sentencing. I believe that when a convicted criminal is convicted through due process, and is sentenced by a jury or a judge, depending on that State's rules, to a prison term, that convicted criminal should serve at least 85 percent of their term as imposed before they can be released by good-time credit or parole or anything else. I am convinced that we can take any other action that we can envision on immediate law enforcement, including more police on the street, or passage of the Brady bill, and by itself it will not have any meaning if we cannot keep off of the street those violent criminals that are causing this mayhem in our society, and I think that ought to be our primary goal in terms of immediately assisting law enforcement.

Mr. Speaker, in conclusion, I want to say that the Republican members of the Judiciary Committee, under the leadership of my colleague, BILL MCCOLLUM from Florida, and under the Research Committee Task Force on Crime, of which I am chairman, will have a public hearing at 11 a.m. tomorrow, actually following the Brady bill vote, in which experts from the field of law enforcement will testify as to their ideas as to what should be in crime legislation. I want to stress that although this is a Republican-sponsored hearing I think crime is not a partisan issue. Crime prevention is not a partisan issue. And I look forward to taking the ideas we get from this hearing and joining with my Democratic and independent colleagues to pass the best legislation we can to protect the American people, because in the words of President Clinton, keeping people safe is the first responsibility of Government.

SOUTHERN CALIFORNIA FIRES

The SPEAKER pro tempore (Mr. ANDREWS of Maine). Under a previous order of the House, the gentleman from California [Mr. DREIER] is recognized for 60 minutes.

Mr. DREIER. Mr. Speaker, under normal circumstances I would be taking this time to talk about what I clearly believe is the single most important domestic and international vote that we will cast in the 103d Congress, and I am referring to the urgent need to pass the North American Free-Trade Agreement. But because of the fact that I represent parts of Pasadena, CA, and other areas of southern California that have been devastated over the past 48 hours by the fires which we have all seen, I would like to take a few minutes to talk about that, and then I am going to yield the balance of my time to my very good friend from Selah, WA, Mr. INSLEE, who is going to carry the day on the North American Free-Trade Agreement.

We have all seen that over the past few days southern California has been devastated due to the Santa Ana winds which created the climate for these fires. Many people know that over the past several years California has suffered a very serious drought. And then last year we had tremendous rains, and those rains caused very lush growth. As we saw that take place, we saw great benefits to southern California.

But as we got toward late spring, and through the summer, things dried out, and it created the situation that developed within the past couple of days. And that is of course the climate which was very inducive to these tragic fires.

There are about 15 fires that have taken place from Ventura County all the way south to the Mexican border. And as the world knows, this is one of the most populous parts of the entire Nation and the entire world. Millions of people live in this area. And I happen to represent 18 cities or parts of cities in the eastern suburbs of Los Angeles County. I share the city of Pasadena with my good friend, Mr. MOORHEAD.

What has become known as the Altadena fire has had a particularly devastating effect on the area which Mr. MOORHEAD and I represent. Fifty to one hundred homes have been lost, and of course we do not have a final count yet because people are still working on it. There are between 8,000 and 10,000 acres that have been destroyed.

The northern portion of the city of Sierra Madre, a beautiful small city right at the base of the San Gabriel Mountains, the northern portion of it was evacuated last night. And I am very gratified at the fact that there was no structural damage in the city of Sierra Madre.

St. Luke Hospital, which is located in Pasadena, has seen, through some tremendous work by volunteers, local officials, Los Angeles County firefighters, the Forest Service, 170 people evacuated from St. Luke Hospital. The elderly in the Park Marino and Marlinda convalescent homes in Pasadena were also evacuated yesterday. Private and public schools in Pasadena and Sierra Madre were evacuated as well.

The Eaton Nature Center, which is operated by the Los Angeles County and located near Kinneloa, was destroyed by fire.

The Forest Service and the Pasadena, Sierra Madre, and Los Angeles County fire departments joined forces, and we have heard cases of great heroism that have come forward in this cause.

Other heroes included the Los Angeles County Fire Department, and included the helicopter pilots who flew into the very smoky areas that were affected next to the canyon walls to drop water and chemicals on the forest fire.

□ 1630

They also, I am very happy to report, were able to save some homes by dropping water on them. There were, as I said, other key assistants that came from neighboring communities who provide fire trucks and firefighters. Unfortunately, in the Eaton Canyon area, which I am privileged to represent, there were a number of homes that were lost. And due to the number of meetings here, I have been delayed, but the first thing tomorrow morning I will be going to southern California and I will be touring with local officials in this area.

I have underscored to those in the media with whom I have spoken that I am very sensitive to the fact that when those of us who are elected officials come into these areas, we do not want to in any way detract from those who are trying to provide immediate assistance to the victims. I am hoping by tomorrow afternoon, if it is convenient for the Fire Service in Los Angeles County and Pasadena and Sierra Madre city officials, I look forward to joining them in looking at this area.

I want to thank President Clinton for recognizing the need for designation of a natural disaster. This, of course, is one of the worst natural disasters to hit California. As I said at the opening of the session this morning here in the well, California has suffered greatly over the past several years.

I used to represent the city of Whittier, where we suffered a very devastating earthquake in 1987. We have had the Loma Prieta earthquake in 1989 and other earthquakes since which have taken place.

We all know in the wake of the Rodney King verdict we had fires and devastating riots that hit south central Los Angeles and other parts, including parts of the city of Pomona, which I represent.

Then, of course, we have seen over the past few years, due to cuts in the defense and aerospace industries, economic devastation which has hit the largest State in the Union; an unemployment rate that has hovered around 9 percent, in Los Angeles County double-digit, 10 percent; and just within the last couple of days these fires, which as I said extend from Ventura County all the way to the Mexican border.

My colleague, CHRIS COX, represents Laguna Beach. That city was evacuated. 310 homes at least were lost in that fire.

One of the things I think is very important for us to underscore is the fact that we want those who are responsible—and there is a wide range of reports that the Altadena fire reportedly came from a homeless person who started a fire to keep warm and that got out of control.

But in cases of arson, I think we need to look at the arson laws. I am told that the Federal penalty for arson is simply 5 years. I think it is important for us to intensify that because the tragic loss which has taken place in southern California can never be recouped for many of these people who have lost so much.

I hope that those who are responsible for these crimes are prosecuted to the full extent of the law, and I think that law should be toughened.

Mr. Speaker, I want to thank my colleagues, obviously not many of them here. I appreciate my friend, the gentleman from Washington [Mr. INSLEE], being here to listen to this. I will say that when I return next week I will be reporting to the House the findings that we have. Again I thank my colleagues here for understanding the necessity to deal with this very, very devastating natural disaster that has hit southern California.

At this point, Mr. Speaker, I would like to yield the balance of my time to my good friend, the gentleman from Selah, WA, Mr. INSLEE, who is going to talk about the issue which I wish I could discuss here, and will look forward to discussing as we approach that November 17 vote, and that is the North American Free-Trade Agreement.

I yield the balance of my time to Mr. INSLEE.

NORTH AMERICAN FREE-TRADE AGREEMENT

The SPEAKER pro tempore (Mr. ANDREWS of Maine). The Chair recognizes the gentleman from Washington [Mr. INSLEE].

Mr. INSLEE. I thank my friend from California, and I am sorry that he has to attend to that emergency. I hope things turn out.

Mr. Speaker, I would like to talk about the NAFTA agreement that is going to be before us in a few weeks. But before I do, I want to talk about something very nice which happened at our Capitol last weekend. It got me to thinking, what happened this last weekend, that we finally got the Statue of Freedom back up on top of the Capitol dome. As you know, we had taken it down by helicopter to refurbish it. It had taken a lot of bruises and lightning strikes since it went up in 1863—1985. We finally got it back up.

It got me to thinking about what it represents, and what it represents is the freedom which have been protected in this Chamber over the centuries of existence. I got to thinking about those freedoms.

One of them was the freedom of speech, which is difficult for people in Congress to defend sometimes because of the passions of the moment and people's instincts which sometimes indicate we should give up the freedom of speech.

I got to thinking about the freedom of religion, which is difficult sometimes to defend because of the passion of the moment and people's instincts that suggest that freedom should be abrogated.

Then I got to thinking about another freedom that America has historically tried to preserve, and that is the freedom of trade, the freedom of people to trade with one another across political boundaries free of governmental taxation, something that the NAFTA agreement, the North American Free-Trade Agreement, is designed to preserve and protect.

This is an agreement that at its heart is designed to preserve a freedom that America has historically tried to preserve. This is a freedom that I think is in jeopardy now because of the passions and perhaps the instincts driven by those passions, that we need to protect and defend the NAFTA agreement.

Let me tell you what I mean by that in the American tradition: Throughout history, the 20th-century history, there have been two driving forces in international economics. One is what I believe is the narrow-minded, shortsighted passion and instincts of protectionism. The other is the farsighted and, I believe, reasonable approach of free trade.

America historically has been the protector, the defender, the advocate for free trade internationally. But there was a time when we shirked that duty and that responsibility. We did that in the early 1930's. Those of us who may have lived through that time know what happened. We adopted, the people in this House voted for the instinct and the passion of the moment, and they adopted the Smoot-Hawley Tariff Protection Act designed to protect American workers, protect American jobs; "don't let our jobs go overseas." The same arguments that we have heard in the last few months in this Chamber were heard in the 1930's, that if we only adopted the Smoot-Hawley Act, we would preserve and protect American jobs.

What happened? We got the Depression, we got the loss of American jobs, because for the moment the people in this Chamber broke down and followed the herd instinct and passion of a shortsighted policy. Heaven help us if we adopt that instinct right now.

Let me tell you why I think that instinct is wrong and let me tell you why I think instinct can be wrong.

I was talking to another Member the other day, and he told me he believed NAFTA was going to create more jobs in this country; it was going to open up new markets in Mexico; it was going to give us an advantage in Mexico against Japan because we would have a free market in Mexico; and Japan would not be able to sell their products there. We would have a free market in Mexico and Germany would be shut out.

He told me he knew in his heart that this was going to be good for America because it helped create jobs. But he said that the instinct of some folks in his district was that it would cost jobs. Parenthetically I note instinct, you know—the hippopotamus has a good instinct, the zebra has good instinct, the ostrich has an instinct, and this leads to it sticking its head in the ground and trying to hide from problems.

For us, our responsibility in this Chamber is to exercise the common sense that says we should pass NAFTA. And I will tell you why. It is very, very simple.

What this Member told me he understood, and he told me he was still trying to decide whether he was going to vote for this, but what he understood was that Mexico has a 10 percent average tax on American workers. Mr. Speaker, most Americans do not know that. The Mexican Government imposes a 10-percent tax, a tariff on everything Americans make and ship to Mexico. It is a 10-foot-high wall we have to jump over in order to create a job in our country to ship to Mexico.

We only have a lousy 4-percent tariff in return. This is basically unfair to American workers. We have the short end of the stick, and common sense tells me, and told that Member, common sense is that if we knock down that trade barrier we even the playing field. We get rid of this unfair Mexican tax on our people that I represent, and we are going to be better off. We are simply going to be better off.

But having concluded that, the issue remains, can we come up with a better NAFTA? Can we come up with a better NAFTA that would force the things that we love, the freedoms that we enjoy now on Mexico, to force them to accept some of the things all of us would like them to have, better environmental protection, better protection for workers.

President Clinton, to his credit, has negotiated for the first time ever protection for people overseas, two side bar agreements, one which gives us a

lever to force Mexico to abide by their own environmental regulations, the second a lever to force them to abide by their own labor regulations on minimum wage laws and child labor standard laws. We have never had that kind of lever in Mexico before.

But nonetheless, I have to tell the people that I represent that if I was the czar, if we abandoned democracy and I ran Mexico, the United States and Canada, I would have a different collective bargaining system in Mexico that was better and that was like ours.

But the question people ask is, why can we not do a better one? I asked someone who is very familiar with Mexican politics and he gave me the answer why. What he explained to me is that you have to look at the relationship between Mexico and America historically. Historically Mexican politicians got elected by bashing Yankee Imperialism. They got elected by saying, "Let's have protectionism. Let's throw up walls against American imports to protect Mexican jobs," and for 50, 60, 70 years they got elected doing that. For that reason, Mexico had high walls to keep our exports away from the Mexican workers; but in the last few years a new voice has emerged in Mexico. That voice has said, "Let's break with the past. Let's break with protection. Let's break with that old feudal system. Let's move towards the democratic tradition."

That is fairly bold in Mexican politics.

This person explained to me that if we reject NAFTA, this is what is going to happen. The people in Mexico are going to say, "You see what happens when you trust the Yankees? You see what happens when we reach an agreement with them to lower trade barriers? It doesn't work."

The forces in Mexico will emerge who believe in protectionism, who believe in segregating themselves from America, who believe in having less to do with America than more, who believe in the old style of Mexican politics.

History, Mr. Speaker, does not always go forward. It can go backwards. A rejection of NAFTA at this time means that the Mexican Democratic Congress that has been made in the last 6 years will go backward. NAFTA may be renegotiated, as I asked someone in Mexico sometime ago, but it will be in about 50 years.

We need to seize the moment right now where progress in Mexico has been made, where we can honor that progress and realize there is more progress to be made and recognize something that I think we have forgotten in America. When we mix with people, when we have a relationship with them, Americans rub off on other people. We have rubbed off on Russia. We have rubbed off on a lot of countries.

When they get exposed to us, our democracy is catching. It is a virus that no one has been able to stop unless we stop it ourselves.

Let us give Mexico the virus of democracy. Let us mix up with them. Let us trade with them.

I am convinced that when we pass NAFTA, we are going to do just that. We are going to do what is happening on the border where the opposition party has won races along the border because we trade with them along the border.

Mr. Speaker, I believe very strongly we are going to protect American jobs by passing NAFTA. If we refuse and kill NAFTA, we are going to cost American jobs.

In my district, my neighbors sell products to Mexico right now because we have lowered trade barriers. Those trade barriers are going to go back up if we reject NAFTA.

Let us strike a vote for more democracy. Let us strike a vote for more jobs. Let us strike a vote for keeping the jobs we have in this country, Mr. Speaker. Let us pass NAFTA and continue the American tradition of free trade and all the other freedoms we have always protected.

RECESS

The SPEAKER pro tempore (Mr. ANDREWS of Maine). The House is now awaiting action on the continuing resolution.

Pursuant to clause 12, rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 4 o'clock and 45 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 1822

AFTER RECESS

The recess having expired, the House was called to order by the Speaker at 6 o'clock and 22 minutes p.m.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Hallen, one of its clerks, announced that the Senate had passed without amendment a joint resolution of the House of the following title.

H.J. Res. 283. Joint resolution making further continuing appropriations for the fiscal year 1994, and for other purposes.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. CLINGER (at the request of Mr. MICHEL), for today, on account of attending a funeral.

Mr. ROYCE (at the request of Mr. MICHEL), for today, on account of illness.

Mr. ROMERO-BARCELÓ (at the request of Mr. GEPHARDT), for today and the balance of the week, on account of official business.

Mr. MCNULTY (at the request of Mr. GEPHARDT), for today after 2 p.m.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Member (at the request of Mr. KOLBE), to revise and extend his remarks and include extraneous material:)

Mr. SCHIFF, for 60 minutes, today.

(The following Members (at the request of Mr. SANDERS) to revise and extend their remarks and include extraneous material:)

Mr. FORD of Michigan, for 5 minutes, today.

Mr. SANDERS, for 5 minutes, today.

Mr. UNDERWOOD, for 30 minutes, today.

Mr. LIPINSKI, for 60 minutes, each day, on November 10 and 15.

Mr. POSHARD, for 60 minutes, each day, on November 10 and 15.

Mr. SWETT, for 60 minutes, each day, on November 3 and 4.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

Mr. BONIOR, and to include therein extraneous material, notwithstanding the fact that it exceeds 2 pages of the RECORD and is estimated by the Public Printer to cost $45,090.

(The following Members (at the request of Mr. KOLBE) and to include extraneous matter:)

Mr. CRANE in two instances.
Mr. ROTH.
Mr. GOODLING.
Mr. FIELDS of Texas.
Mrs. JOHNSON of Connecticut.
Mr. LEWIS of California.
Mr. WOLF of Virginia.
Mr. BATEMAN.

(The following Members (at the request of Mr. SANDERS) and to include extraneous matter:)

Ms. ROYBAL-ALLARD.
Mr. BONIOR in four instances.
Mr. CARDIN.
Mr. SYNAR.
Ms. LONG in two instances.
Mr. PETERSON of Florida.
Mr. HOAGLAND.
Mr. FINGERHUT.
Mr. PAYNE of New Jersey.

(The following Members (at the request of Mr. INSLEE) and to include extraneous matter:)

Mr. MFUME.
Mr. GEPHARDT.
Mr. NEAL of Massachusetts.
Ms. ESHOO.
Mr. WAXMAN.
Mrs. SCHROEDER.
Mr. GILLMOR.

Mr. SOLOMON.
Mrs. MORELLA.

ENROLLED BILLS AND JOINT RESOLUTION SIGNED

Mr. ROSE, from the Committee on House Administration, reported that that committee had examined and found truly enrolled bills and a joint resolution of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 927. An act to designate the Pittsburgh Aviary in Pittsburgh, PA, as the National Aviary in Pittsburgh;

H.R. 2445. An act making appropriations for energy and water development for the fiscal year ending September 30, 1994, and for other purposes;

H.R. 2492. An act making appropriations for the government of the District of Columbia and other activities chargeable in whole or in part against the revenues of said District for the fiscal year ending September 30, 1994, and for other purposes;

H.R. 2824. An act to modify the project for flood control, James River Basin, Richmond, VA; and

H.J. Res. 283. Joint resolution making further continuing appropriations for the fiscal year 1994, and for other purposes.

ADJOURNMENT

Mr. ANDREWS of Maine. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 6 o'clock and 23 minutes p.m.) under its previous order, the House adjourned until Monday, November 1, 1993, at noon.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

2064. A letter from the President and Chairman, Export-Import Bank of the United States, transmitting a report involving United States exports to the Republic of Korea, pursuant to U.S.C. 635(b)(3)(i); to the Committee on Banking, Finance and Urban Affairs.

2065. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 10-118, "John A. Wilson Designation Act of 1993," pursuant to D.C. Code, section 1-233(c)(1); to the Committee on the District of Columbia.

2066. A letter from the Secretary of Education, transmitting final regulations for the Jacob K. Javits Fellowship Program, pursuant to 20 U.S.C. 1232(d)(1); to the Committee on Education and Labor.

2067. A letter from the Secretary, Department of Health and Human Services, transmitting a report on the progress of implementing the Breast and Cervical Cancer Mortality Prevention Act of 1990, pursuant to Public Law 101-354, section 2 (104 Stat. 415); to the Committee on Energy and Commerce.

2068. A letter from the Administrator, Environmental Protection Agency, transmitting a report on methane emissions associated with natural gas extraction, transportation, distribution, storage, and use, pursuant to Public Law 101-549, section 603(b)(1) (104 Stat. 2670); to the Committee on Energy and Commerce.

2069. A letter from the Administrator, Environmental Protection Agency, transmitting a report on methane emissions from countries other than the United States, pursuant to Public Law 101-549, section 603(c)(1) (104 Stat. 2671); to the Committee on Energy and Commerce.

2070. A letter from the Acting Director, Defense Security Assistance Agency, transmitting, notification of the Department of the Army's proposed letter(s) of offer and acceptance [LOA] to Germany for defense articles and services (Transmittal No. 94-01), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

2071. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a copy of Presidential Determination No. 93-43: Presidential Waiver Furnishing Assistance to the United Nations to Support the Reestablishment of Police Forces in Somalia, pursuant to 22 U.S.C. 2348a(c)(2) and 2364(a)(1); to the Committee on Foreign Affairs.

2072. A letter from the Assistant Secretary of State for Legislative Affairs, transmitting copies of the report of political contributions by Sandra L. Vogelesang of Ohio, to be Ambassador to the Kingdom of Nepal, and members of her family, pursuant to 22 U.S.C. 3944(b)(2); to the Committee on Foreign Affairs.

2073. A letter from the Assistant Secretary of State for Legislative Affairs, transmitting copies of the report of political contributions by M. Larry Lawrence of California, to be Ambassador to Switzerland, and members of his family, pursuant to 22 U.S.C. 3944(b)(2); to the Committee on Foreign Affairs.

2074. A letter from the Director, Office of Management and Budget, transmitting OMB's estimate of the amount of discretionary new budget authority and outlays for the current year (if any) and the budget year provided by H.R. 2446, H.R. 2493, and H.R. 2518, pursuant to Public Law 101-508, section 13101(a) (104 Stat. 1388-578); to the Committee on Government Operations.

2075. A letter from the Deputy Executive Director, Office of Navajo and Hopi Indian Relocation, transmitting the fiscal year 1993 annual report as required by the Inspector General Act Amendments of 1988, pursuant to Public Law 95-452, section 5(b) (102 Stat. 2526); to the Committee on Government Operations.

2076. A letter from the Executive Director, National Commission on Libraries and Information Science, transmitting the annual report under the Federal Managers' Financial Integrity Act for fiscal year 1993, pursuant to 31 U.S.C. 3512(c)(3); to the Committee on Government Operations.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. DINGELL: Committee on Energy and Commerce. H.R. 1257. A bill to reconstitute the Federal Insurance Administration as an independent agency within the executive branch, provide for minimum standards applicable to foreign insurers and reinsurers providing insurance in the United States, make liquidity assistance available to well-capitalized insurance companies, and provide for public access to information regarding the availability of insurance, and for other purposes; with amendments (Rept. 103-302, Pt. 2). Referred to the Committee of the Whole House on the State of the Union.

Mr. MOAKLEY: Committee on Rules. House Resolution 289. Resolution providing for consideration of the bill (H.R. 2151) to amend the Merchant Marine Act, 1936, to establish the Maritime Security Fleet Program, and for other purposes (Rept. 103-311). Referred to the House Calendar.

Mr. MONTGOMERY: Committee on Veterans' Affairs. H.R. 3340. A bill to amend title 38, United States Code, to provide a cost-of-living adjustment in the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for survivors of such veterans, and for other purposes; with amendments (Rept. 103-312). Referred to the Committee of the Whole House on the State of the Union.

Mr. MONTGOMERY: Committee on Veterans' Affairs. H.R. 3341. A bill to amend title 38, United States Code, to increase the rate of special pension payable to persons who have received the Congressional Medal of Honor (Rept. 103-313). Referred to the Committee of the Whole House on the State of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 5 of rule X and clause 4 of rule XXII, public bills and resolutions were introduced and severally referred as follows:

By Mr. FORD of Michigan (for himself and Mr. ROSTENKOWSKI) (both by request):

H.R. 3396. A bill to amend the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to provide security for workers, to improve pension plan funding, to limit growth in insurance exposure, to protect the single-employer plan termination insurance program, and for other purposes; jointly, to the Committees on Education and Labor and Ways and Means.

By Mr. ANDREWS of New Jersey (for himself, Mr. HOYER, and Mr. WELDON):

H.R. 3397. A bill to direct the President to establish a Commission for making recommendations to improve the Federal emergency management system; jointly, to the Committees on Public Works and Transportation and Armed Services.

By Mr. BARRETT of Wisconsin (for himself and Mr. SCHUMER):

H.R. 3398. A bill to amend title 18, United States Code, to regulate the manufacture, importation, and sale of certain particularly dangerous bullets; to the Committee on the Judiciary.

By Mr. BORSKI:

H.R. 3399. A bill to improve the ability of the Federal Government to prepare for and respond to major disasters, and for other purposes; jointly, to the Committees on Public Works and Transportation and Armed Services.

By Mr. GEPHARDT:

H.R. 3400. A bill to provide a more effective, efficient, and responsive government; referred to the following committees for a period ending not later than November 15, 1993: Agriculture, Armed Services, Banking, Finance and Urban Affairs, Education and

Labor, Energy and Commerce, Foreign Affairs, Government Operations, House Administration, the Judiciary, Merchant Marine and Fisheries, Natural Resources, Intelligence (Permanent Select), Post Office and Civil Service, Public Works and Transportation, Science, Space, and Technology, Veterans' Affairs, and Ways and Means.

By Mr. COYNE:

H.R. 3401. A bill to amend section 105(a)(8) of the Housing and Community Development Act of 1974 to increase the percentage limitation on the amount of community development block grant assistance that may be expended for public services activities; to the Committee on Banking, Finance and Urban Affairs.

By Mr. FIELDS of Texas:

H.R. 3402. A bill to establish a foundation darter captive propagation research program; to the Committee on Merchant Marine and Fisheries.

By Mr. GOODLING (for himself, Mr. GUNDERSON, and Mr. CASTLE):

H.R. 3403. A bill to appoint a Director of Educational Technology in the Department of Education and provide grants to States to improve the incorporation of technology in education; to the Committee on Education and Labor.

By Mr. GUTIERREZ (for himself, Mr. MCDERMOTT, Mr. ACKERMAN, and Mr. KENNEDY):

H.R. 3404. A bill to amend the Elementary and Secondary Education Act of 1965 to require the Secretary of Education to provide demonstration grants to local educational agencies for the purpose of providing instruction and training in cardiopulmonary resuscitation and first aid to secondary school students; to the Committee on Education and Labor.

By Mr. HAMILTON (for himself, Mr. GILMAN, Mr. LANTOS, Mr. BEREUTER, Mr. GEJDENSON, Mr. JOHNSTON of Florida, and Mr. DELLUMS):

H.R. 3405. A bill to establish a standing consultative group within the Congress to facilitate consultations between the Congress and the executive branch with respect to the use of U.S. military force abroad; to the Committee on Rules.

By Mr. HOAGLAND:

H.R. 3406. A bill to amend title 18, United States Code, to clarify the scope of the Gun-Free School Zones Act of 1990 and to prohibit the possession of a handgun or handgun ammunition by, or the private transfer of a handgun or handgun ammunition to, a juvenile; to the Committee on the Judiciary.

By Mr. HOAGLAND (for himself, Mrs. JOHNSON of Connecticut, Mr. LEWIS of Georgia, Mr. CRANE, Mr. MFUME, Mr. SANTORUM, and Mr. KOPETSKI):

H.R. 3407. A bill to amend the Internal Revenue Code of 1986 to provide clarification for the deductibility of expenses incurred by a taxpayer in connection with the business use of the home; to the Committee on Ways and Means.

By Mr. JEFFERSON (for himself, Mr. FIELDS of Louisiana, Mr. HAYES, Mr. LIVINGSTON, and Mr. TAUZIN):

H.R. 3408. A bill to establish the New Orleans Jazz National Historical Park in the State of Louisiana, and for other purposes; to the Committee on Natural Resources.

By Ms. LONG (for herself, Mr. BARCA of Wisconsin, and Mr. JACOBS):

H.R. 3409. A bill to amend the Social Security Act to exclude the unemployment trust fund from the budget of the U.S. Government; jointly, to the Committees on Ways and Means, Government Operations, and Rules.

By Mr. OBEY:

H.R. 3410. A bill to amend the Dairy Production Stabilization Act of 1983 to ensure that all persons who benefit from the dairy promotion and research program contribute to the cost of the program, to terminate the program on December 31, 1996, and to prohibit bloc voting by cooperative associations of milk producers in connection with the program, and for other purposes; to the Committee on Agriculture.

H.R. 3411. A bill to amend the Dairy Production Stabilization Act of 1983 to require that members of the National Dairy Promotion and Research Board be elected by milk producers and to prohibit bloc voting by cooperative associations of milk producers in the election of the producers, and for other purposes; to the Committee on Agriculture.

By Mr. ROTH (for himself and Mr. OBERSTAR):

H.R. 3412. A bill to provide fundamental reform of the system and authority to regulate commercial exports, to enhance the effectiveness of export controls, to strengthen multilateral export control regimes, and to improve the efficiency of export regulation; jointly, to the Committees on Foreign Affairs, Ways and Means, and Rules.

By Mr. SANTORUM (for himself, Mr. KASICH, Mr. JACOBS, Mr. LEWIS of Florida, Mr. BUNNING, Mr. CAMP, Mr. HANCOCK, Mr. ZIMMER, Mr. GALLEGLY, Mr. ARMEY, Mr. HUNTER, Mr. DELAY, Mr. STUMP, Mr. TAYLOR of North Carolina, Mr. HASTERT, Mr. FIELDS of Texas, Mr. BOEHNER, Mrs. JOHNSON of Connecticut, Mr. PORTER, Mr. ROBERTS, Mr. BAKER of Louisiana, and Mr. SENSENBRENNER):

H.R. 3413. A bill to amend the Internal Revenue Code of 1986 to allow a deduction for contributions to a medical savings account, and for other purposes; jointly, to the Committees on Ways and Means and Energy and Commerce.

By Mr. SAXTON:

H.R. 3414. A bill to amend title 39, United States Code, to grant State governments the discretion to assign mailing addresses to sites within their jurisdiction; to the Committee on Post Office and Civil Service.

By Ms. VELÁZQUEZ (for herself, Mrs. MINK, Ms. SLAUGHTER, Mr. FILNER, Mrs. MEEK, Ms. MCKINNEY, Mrs. MORELLA, Ms. WATERS, Ms. NORTON, Mr. MCDERMOTT, Mrs. UNSOELD, Mr. RANGEL, Mr. GUTIERREZ, Mr. TOWNS, Ms. ROYBAL-ALLARD, Mr. MILLER of California, Ms. KAPTUR, Mr. SERRANO, Ms. FURSE, Mr. BISHOP, Mrs. SCHROEDER, Mr. MFUME, Mr. BECERRA, Ms. ENGLISH of Arizona, Mr. RICHARDSON, Ms. WOOLSEY, Mr. ROMERO-BARCELÓ, and Miss COLLINS of Michigan):

H.R. 3415. A bill to amend the Family Violence Prevention and Services Act to require services for underserved populations, to require performance reporting by grantees, and to provide for the selection of model programs for education of young people about domestic violence and violence among intimate partners; to the Committee on Education and Labor.

By Mr. WOLF (for himself and Mr. BLILEY):

H.R. 3416. A bill to establish a commission to consider the closing and relocation of the Lorton Correctional Complex; jointly, to the Committees on the District of Columbia and the Judiciary.

By Mr. ALLARD:

H.R. 3417. A bill to provide for a voluntary national insurance program to protect the owners of domesticated cervidae against losses incurred as result of destroying animals or herds infected with, or exposed to, tuberculosis; to the Committee on Agriculture.

By Mr. VALENTINE (for himself, Mr. LEWIS of Florida, Mr. FRANKS of New Jersey, and Mr. MEEHAN):

H.J. Res. 285. Joint resolution to designate the week beginning March 13, 1994, as "National Manufacturing Week"; to the Committee on Post Office and Civil Service.

By Mr. JOHNSON of South Dakota (for himself, Mr. WILLIAMS, Mr. ROSE, Mr. SARPALIUS, Mr. COMBEST, Mr. EMERSON, Mr. ALLARD, Mr. MINGE, Mr. LAROCCO, Mr. SLATTERY, Mr. GLICKMAN, Mr. ENGLISH of Oklahoma, Mr. INSLEE, and Mr. POMEROY):

H. Con. Res. 172. Concurrent resolution to recognize the importance of promoting fair trade in wheat; to the Committee on Ways and Means.

By Mr. COOPER:

H. Res. 290. Resolution providing that the House may not adjourn to end this session of Congress until it receives the report of the Joint Committee on the Organization of the Congress and votes upon its recommendations; to the Committee on Rules.

By Mr. DOOLITTLE:

H. Res. 291. Resolution expressing the sense of the House of Representatives that a Presidential Commission should be established to investigate whether there has been any measurable depletion of stratospheric ozone beyond that caused by natural phenomena, whether it has been proven that the use of chloroflourocarbons damages stratospheric ozone, and whether the phaseout of chloroflourocarbons will have any effect on stratospheric ozone; to the Committee on Energy and Commerce.

MEMORIALS

Under clause 4 of rule XXII,

264. The SPEAKER presented a memorial of the House of Representatives of the State of Illinois, relative to designating the cemetery at Fort Sheridan a national cemetery for use by all veterans; to the Committee on Veterans' Affairs.

PRIVATE BILLS AND RESOLUTIONS

Under clause 1 of rule XXII,

By Ms. BYRNE:

H.R. 3418. A bill to authorize the Secretary of Transportation to issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade of the United States for the vessel *Sea Mistress;* which was referred to the Committee on Merchant Marine and Fisheries.

ADDITIONAL SPONSORS

Under clause 4 of rule XXII, sponsors were added to public bills and resolutions as follows:

H.R. 3: Mr. JOHNSTON of Florida.

H.R. 68: Ms. BROWN of Florida.

H.R. 291: Mr. PARKER, Mr. SAXTON, Mr. OXLEY, Ms. LOWEY, Mr. WISE, Mr. REGULA, Mr. PALLONE, and Mr. BONIOR.

H.R. 302: Mr. GALLEGLY.

H.R. 303: Ms. PRYCE of Ohio and Ms. BROWN of Florida.

H.R. 322: Mr. NADLER and Mr. MCDERMOTT.

H.R. 349: Mr. MARTINEZ and Mr. COSTELLO.
H.R. 462: Mr. CALVERT.
H.R. 466: Mr. GALLO and Mr. SENSENBRENNER.
H.R. 558: Mr. KREIDLER.
H.R. 702: Mr. NEAL of North Carolina, Ms. MOLINARI, Mr. BAKER of California, Mr. EDWARDS of Texas, Mr. SPENCE, Mr. PARKER, Mr. BAKER of Louisiana, and Mr. WILLIAMS.
H.R. 828: Mr. HALL of Ohio.
H.R. 830: Ms. FURSE and Mr. ROWLAND.
H.R. 894: Mr. GUNDERSON.
H.R. 1168: Mr. FIELDS of Texas.
H.R. 1212: Mr. UNDERWOOD and Mr. WILSON.
H.R. 1295: Mr. SHAYS, Mr. BARRETT of Wisconsin, Mr. KOLBE, Mr. MICA, Mr. FAWELL, Mr. FISH, Mr. UPTON, Mr. KASICH, Mr. LEACH, Ms. BROWN of Florida, Mrs. LLOYD, Mr. PALLONE, and Mrs. CLAYTON.
H.R. 1442: Ms. BROWN of Florida.
H.R. 1938: Mr. BLUTE.
H.R. 1952: Mr. BROWN of Ohio, Mr. CONYERS, Ms. FURSE, Mr. HUGHES, Mrs. LLOYD, Mr. MCCURDY, and Mr. FARR.
H.R. 2012: Mr. MCNULTY, Mr. NEAL of North Carolina, Mr. WILSON, Mr. BATEMAN, and Mr. MCDERMOTT.
H.R. 2042: Mr. SMITH of Oregon and Mr. BEREUTER.
H.R. 2066: Ms. SLAUGHTER.
H.R. 2109: Mr. SCOTT, Mr. FROST, Mr. THOMPSON, Mr. SHAYS, Mr. WYNN, Mr. LEWIS of Florida, and Mrs. MEEK.
H.R. 2154: Mr. ENGLISH of Oklahoma.
H.R. 2227: Mr. JACOBS, Mrs. MALONEY, and Mr. LIPINSKI.
H.R. 2250: Ms. ESHOO and Mr. FROST.
H.R. 2308: Ms. BYRNE, Mrs. UNSOELD, Mrs. MINK, Mrs. MORELLA, Mrs. LLOYD, and Mrs. CLAYTON.
H.R. 2394: Ms. BYRNE, Mr. NEAL of North Carolina, Mr. LAZIO, Mr. REGULA, Mr. SAWYER, and Mr. EVANS.
H.R. 2395: Ms. BYRNE, Mr. NEAL of North Carolina, Mr. LAZIO, Mr. REGULA, Mr. SAWYER, and Mr. EVANS.
H.R. 2444: Mr. TORKILDSEN.
H.R. 2556: Mr. WALSH.
H.R. 2591: Mr. FISH, Ms. NORTON, and Mr. SYNAR.
H.R. 2602: Mr. TAYLOR of Mississippi.
H.R. 2787: Mr. TUCKER and Mr. MARTINEZ.
H.R. 2803: Mr. BACCHUS of Florida, Mr. DICKS, Mr. ACKERMAN, Mr. ENGEL, and Mr. MANTON.
H.R. 2826: Mrs. LOWEY, Mr. GEKAS, Mr. FRANK of Massachusetts, Mr. DELLUMS, Mrs. MALONEY, Mr. FAZIO, Mr. HOKE, Mr. MANTON, Mr. BILIRAKIS, Mr. MCNULTY, Ms. SNOWE, Mr. NEAL of North Carolina, Mr. MACHTLEY, Mr. ANDREWS of New Jersey, Mr. GILMAN, Mr. GILCHREST, Mr. LIPINSKI, Mr. HUGHES, Mr. TORRICELLI, Mr. KNOLLENBERG, Mr. HASTINGS, Mr. PALLONE, Mr. HUTTO, Mrs. BENTLEY, Mr. VISCLOSKY, Mr. CLAY, Mr. STUPAK, Mr. MENENDEZ, and Mr. PENNY.
H.R. 2884: Mr. FORD of Tennessee.
H.R. 2921: Mr. DELLUMS.
H.R. 2957: Mr. COLLINS of Georgia, Mr. MCKEON, and Mr. KING.
H.R. 2983: Mr. FRANK of Massachusetts.
H.R. 3030: Mr. BALLENGER.
H.R. 3041: Mr. NEAL of North Carolina.
H.R. 3080: Mr. SCHIFF.
H.R. 3087: Mr. RAMSTAD and Mr. PICKETT.
H.R. 3146: Mr. TALENT.
H.R. 3183: Mr. WELDON.
H.R. 3203: Mr. HINCHEY and Mr. EVANS.
H.R. 3224: Mr. BEILENSON, Mr. CALVERT, Mr. MCKEON, Mr. ROHRABACHER, Mr. WELDON, Mr. MOORHEAD, and Mr. DOOLITTLE.
H.R. 3234: Mr. KLEIN and Ms. VELÁZQUEZ.
H.R. 3261: Mr. DOOLITTLE, Mr. BAKER of California, and Mr. BARLOW.
H.R. 3266: Mr. ARMEY, Mr. BACHUS of Alabama, Mr. BAKER of Louisiana, Mr. BAKER of California, Mr. BARTLETT of Maryland, Mr. BILIRAKIS, Mr. BLUTE, Mr. BOEHNER, Mr. BONILLA, Mr. BURTON of Indiana, Mr. BUYER, Mr. CALVERT, Mr. CANADY, Mr. CASTLE, Mr. COLLINS of Georgia, Mr. COMBEST, Mr. CRANE, Mr. CRAPO, Mr. DUNCAN, Ms. DUNN, Mr. EMERSON, Mr. EVERETT, Mr. EWING, Mr. FAWELL, Mrs. FOWLER, Mr. FRANKS of Connecticut, Mr. FRANKS of New Jersey, Mr. GOODLATTE, Mr. GOSS, Mr. GREENWOOD, Mr. GUNDERSON, Mr. HEFLEY, Mr. HERGER, Mr. HOEKSTRA, Mr. HORN, Mr. HOUGHTON, Mr. HUFFINGTON, Mr. HUTCHINSON, Mr. INGLIS of South Carolina, Mr. INHOFE, Mr. ISTOOK, Mrs. JOHNSON of Connecticut, Mr. KIM, Mr. KING, Mr. KINGSTON, Mr. KNOLLENBERG, Mr. LINDER, Mr. MACHTLEY, Mr. MANZULLO, Mr. MCHUGH, Mr. MCINNIS, Mr. MCKEON, Mr. MICA, Mr. MILLER of Florida, Mr. PAXON, Mr. POMBO, Mr. PORTER, Ms. PRYCE of Ohio, Mr. QUINN, Mr. RAMSTAD, Mr. RIDGE, Mr. ROYCE, Mr. SHAYS, Mr. SMITH of Michigan, Mr. STEARNS, Mr. SOLOMON, Mr. SUNDQUIST, Mr. TALENT, Mr. THOMAS of Wyoming, Mr. TORKILDSEN, Mr. ZIMMER, Mr. WELDON, Mr. HASTERT, Mr. DORNAN, Mr. BROWN of Ohio, Mr. CONDIT, Mr. DEUTSCH, Mr. DOOLEY, Mr. FINGERHUT, Mr. HOLDEN, Mrs. MALONEY, Mr. MCHALE, Mr. MURPHY, Mr. PENNY, Mr. POSHARD, Mr. ROEMER, Mr. SWETT, Mr. COOPER, and Mr. PORTMAN.
H.R. 3283: Mr. MINGE.
H.R. 3301: Mr. DEUTSCH, Mr. BONIOR, and Ms. PELOSI.
H.R. 3320: Mr. WILSON.
H.R. 3340: Ms. BROWN of Florida, Mr. RIDGE, Mr. HEFNER, Mr. RICHARDSON, Mr. STENHOLM, Mr. PAYNE of Virginia, Mr. PARKER, and Mr. ORTIZ.
H.R. 3341: Ms. BROWN of Florida, Mr. RIDGE, Mr. HEFNER, Mr. RICHARDSON, Mr. STENHOLM, Mr. PAYNE of Virginia, and Mr. PARKER.
H.R. 3348: Mr. WALSH and Mr. MANTON.
H.R. 3365: Ms. BROWN of Florida, Mr. KLECZKA, Mr. QUINN, Mr. MARKEY, Mr. REGULA, Mr. GONZALEZ, Mr. APPLEGATE, Mr. POSHARD, and Mr. BARRETT of Wisconsin.
H.R. 3366: Mr. JEFFERSON, Mr. CRAMER, Mr. DELLUMS, and Mrs. LLOYD.
H.R. 3370: Miss COLLINS of Michigan.
H.R. 3372: Mr. ROMERO-BARCELÓ, Mr. TOWNS, Mr. YOUNG of Alaska, Mrs. BENTLEY, Mr. BLACKWELL, Mr. MILLER of California, Mr. MONTGOMERY, Mrs. VUCANOVICH, Mr. TEJEDA, Mr. HOCHBRUECKNER, Ms. HARMAN, Mr. BAESLER, Mr. PETE GEREN of Texas, Mr. BECERRA, Mr. MENENDEZ, Ms. ROYBAL-ALLARD, Mr. EDWARDS of Texas, Mr. BONIOR, Mr. DIAZ-BALART, Ms. VELÁZQUEZ, Mr. GUTIERREZ, Mr. DARDEN, Mr. MCHALE, Mr. TUCKER, Mr. HINCHEY, Mr. FARR, Mr. VENTO, Mr. ANDREWS of Maine, Mr. CAMP, and Mr. WYNN.
H.R. 3385: Mr. GONZALEZ.
H.R. 3389: Mr. MACHTLEY.
H.R. 3392: Mr. SMITH of Iowa, Mr. YATES, and Mr. HOEKSTRA.
H.J. Res. 79: Mr. DELLUMS, Mr. PETE GEREN of Texas, Mr. LIGHTFOOT, and Mrs. LLOYD.
H.J. Res. 106: Ms. WATERS.
H.J. Res. 113: Mr. STENHOLM, Mr. PAXON, and Mr. FIELDS of Texas.
H.J. Res 165: Mr. TORKILDSEN, Mr. TALENT, Mr. FIELDS of Texas, Mr. STEARNS, Mr. HALL of Texas, Mr. JACOBS, Mr. LEACH, Mr. GRANDY, Mr. BURTON of Indiana, Mr. SUNDQUIST, Mr. BUYER, Mr. MILLER of Florida, Mr. PORTMAN and, Ms. PRYCE of Ohio.
H.J. Res. 212: Mr. BROWN of California, Mr. BURTON of Indiana, Mr. HALL of Ohio, Mr. HAYES, Mr. LEACH, Mr. ROWLAND, Ms. ENGLISH of Arizona, Mr. BARTLETT of Maryland, Mr. CALLAHAN, Mr. EWING, Mr. GILLMOR, Mr. HANSEN, Mr. LEHMAN, Mr. MCCRERY, Mr. UPTON, Mr. WYDEN, Mr. EDWARDS of Texas, and Mr. CHAPMAN.
H.J. Res. 226: Mr. RAHALL, Mr. WASHINGTON, Mr. PETERSON of Florida, Mr. GEKAS, Mrs. KENNELLY, Mr. PICKETT, Mr. BEILENSON, Mr. BLUTE, Mr. KING, Mr. BEVILL, Mr. WATT, Mr. BATEMAN, Mr. BROWN of California, Mr. DICKS, Mr. BECERRA, Mr. CRANE, Mr. CARR, Mr. OXLEY, Mr. GONZALEZ, Mr. FILNER, Mr. HAYES, Mr. LEWIS of California, Mr. DORNAN, Mr. SMITH of Texas, Mr. PAYNE of Virginia, Ms. WOOLSEY, Mr. BROOKS, Mr. HORN, Mr. SYNAR, Mr. ROYCE, Mr. NEAL of North Carolina, Mr. ENGLISH of Oklahoma, Mr. SWIFT, Mr. HANSEN, Mr. FIELDS of Texas, Mr. HOLDEN, Mr. CAMP, Mr. PETE GEREN of Texas, Mr. MCHALE, Mr. KLUG, Mr. BROWDER, Mr. GEPHARDT, Mr. HALL of Ohio, Mr. MENENDEZ, Mr. STARK, Mr. SHARP, Mr. PACKARD, Ms. DELAURO, Mr. TEJEDA, Mrs. UNSOELD, Mr. INHOFE, Mrs. COLLINS of Illinois, Ms. FURSE, Mr. ANDREWS of Texas, Mr. WHITTEN, Mr. HINCHEY, and Mr. GEJDENSON.
H.J. Res. 271: Mr. APPLEGATE, Mr. BACCHUS of Florida, Mr. BAKER of Louisiana, Mr. BALLENGER, Mr. BARCA of Wisconsin, Mr. BECERRA, Mr. BEILENSON, Mr. BEVILL, Mr. BILBRAY, Mr. BISHOP, Mr. BLACKWELL, Mr. BONILLA, Mr. BOUCHER, Mr. BROOKS, Mr. BROWDER, Ms. BROWN of Florida, Mr. BROWN of California, Mr. BROWN of Ohio, Mr. BRYANT, Mr. BUNNING, Mr. BURTON of Indiana, Ms. BYRNE, Ms. CANTWELL, Mr. CARR, Mr. CLAY, Mrs. CLAYTON, Mr. COLEMAN, Miss COLLINS of Michigan, Mrs. COLLINS of Illinois, Mr. COPPERSMITH, Mr. COSTELLO, Mr. COX, Mr. COYNE, Mr. CRANE, Mr. DARDEN, Mr. DEUTSCH, Mr. DIAZ-BALART, Mr. DICKS, Mr. DIXON, Mr. DOOLEY, Mr. DORNAN, Mr. DREIER, Mr. DUNCAN, Mr. EDWARDS of California, Mr. ENGEL, Mr. EVANS, Mr. FIELDS of Louisiana, Mr. FILNER, Mr. FINGERHUT, Mr. FISH, Mr. FLAKE, Mr. FOGLIETTA, Mr. FORD of Tennessee, Mr. FORD of Michigan, Mr. FRANK of Massachusetts, Mr. GALLEGLY, Mr. GEJDENSON, Mr. PETE GEREN of Texas, Mr. GILMAN, Mr. GLICKMAN, Mr. GONZALEZ, Mr. GENE GREEN of Texas, Mr. GREENWOOD, Mr. GUNDERSON, Mr. HALL of Ohio, Mr. HAMILTON, Mr. HANSEN, Mr. HASTERT, Mr. HAYES, Mr. HEFNER, Mr. HOCHBRUECKNER, Mr. HOLDEN, Mr. HORN, Mr. HOYER, Mr. HYDE, Mr. INSLEE, Mr. JACOBS, Mr. KASICH, Mrs. KENNELLY, Mr. KIM, Mr. KLINK, Mr. KOLBE, Ms. LAMBERT, Mr. LANCASTER, Mr. LAROCCO, Mr. LAUGHLIN, Mr. LEHMAN, Mr. LEVIN, Mr. LEWIS of Georgia, Mr. LIGHTFOOT, Mr. LIVINGSTON, Mrs. LOWEY, Mr. MCCLOSKEY, Mr. MCKEON, Ms. MCKINNEY, Mr. MCNULTY, Mr. MANTON, Mr. MARKEY, Mr. MARTINEZ, Mr. MATSUI, Mr. MAZZOLI, Mrs. MEEK, Mr. MENENDEZ, Mrs. MEYERS of Kansas, Mr. MFUME, Mr. MOAKLEY, Mr. MONTGOMERY, Mr. MORAN, Mrs. MORELLA, Mr. MURPHY, Mr. MYERS of Indiana, Mr. NADLER, Mr. NEAL of Massachusetts, Mr. ORTIZ, Mr. ORTON, Mr. PALLONE, Mr. PAYNE of New Jersey, Mr. PAYNE of Virginia, Mr. PETERSON of Florida, Mr. PICKLE, Mr. PORTER, Mr. PRICE of North Carolina, Mr. RANGEL, Mr. RAVENEL, Mr. REED, Mr. REYNOLDS, Mr. ROBERTS, Mr. ROEMER, Mr. ROGERS, Mr. ROHRABACHER, Mr. SANGMEISTER, Mr. SARPALIUS, Mr. SCOTT, Mr. SERRANO, Mr. SHAYS, Mr. SKELTON, Mr. SLATTERY, Mr. SMITH of New Jersey, Mr. SMITH of Iowa, Mr. SOLOMON, Mr. SPENCE, Mr. SPRATT, Mr. STARK, Mr. STENHOLM, Mr. STUDDS, Mr. SWETT, Mr. TAUZIN, Mr. TAYLOR of Mississippi, Mr. TEJEDA, Mr. TORRES, Mr. TORRICELLI, Mr. TRAFICANT, Mrs. UNSOELD, Mr. VENTO, Mr. VISCLOSKY, Mr. VOLKMER, Mr. WASHINGTON, Ms. WATERS, Mr. WATT, Mr.

WELDON, Mr. WHEAT, Mr. WHITTEN, Mr. WILSON, Mr. WISE, Mr. WOLF, Ms. WOOLSEY, Mr. WYDEN, Mr. WYNN, and Mr. YATES.

H.J. Res. 275: Mr. TRAFICANT, Mr. ROHRABACHER, Mr. SENSENBRENNER, Mr. STUMP, Mr. PETRI, Mr. GALLEGLY, Mr. ALLARD, Mr. SOLOMON, Mr. WALSH, Mr. LEVY, Mr. EWING, Mr. MANZULLO, Mr. GENE GREEN of Texas, and Mr. FIELDS of Texas.

H.J. Res. 278: Mr. BISHOP, Mr. MYERS of Indiana, Mrs. LLOYD, and Mr. WALSH.

H. Con. Res. 100: Mr. BISHOP and Mr. FORD of Tennessee.

H. Con. Res. 107: Mr. GENE GREEN of Texas, Mr. YATES, Mr. HOEKSTRA, Mr. GOSS, and Mr. SLATTERY.

H. Con. Res. 131: Mrs. MEYERS of Kansas, Mr. BEREUTER, Mr. HINCHEY, Mr. BLACKWELL, Mr. WATT, Mrs. MORELLA, Mr. COX, Mr. PORTER, Mr. MCNULTY, Ms. SLAUGHTER, Mr. WALSH, Mr. SCHIFF, Mr. HASTERT, Mr. SHAYS, Mr. HUGHES, Mr. KOPETSKI, Mr. PETERSON of Minnesota, Ms. NORTON, Mr. HOCHBRUECKNER, and Mr. CONYERS.

H. Res. 38: Mr. DELLUMS.

H. Res. 227: Mr. RAMSTAD.

H. Res. 237: Mr. HANSEN, Mrs. MORELLA, Mr. SMITH of Oregon, Mr. DUNCAN, Mr. GALLEGLY, and Mr. MCKEON.

H. Res. 285: Mr. DEAL, Mrs. KENNELLY, Ms. ROYBAL-ALLARD, Mrs. MEYERS of Kansas, Ms. BROWN of Florida, Ms. MOLINARI, Mr. ENGLISH of Oklahoma, Mr. STENHOLM, Mr. COPPERSMITH, Mr. TORRES, Ms. ESHOO, Mrs. MALONEY, Mrs. LOWEY, Mrs. ROUKEMA, Mrs. MINK, Mr. HAMBURG, Ms. BYRNE, Mr. SCHUMER, Mr. FORD of Michigan, Mr. FALEOMAVAEGA, Mr. BAESLER, Mr. SAWYER, Mr. FARR, Mr. MINGE, Ms. CANTWELL, Ms. MARGOLIES-MEZVINSKY, Mr. BORSKI, Mr. DURBIN, Mrs. MEEK, Ms. NORTON, Ms. SLAUGHTER, Ms. WATERS, Ms. SNOWE, Mrs. CLAYTON, Ms. MCKINNEY, Mrs. SCHROEDER, Mrs. COLLINS of Illinois, Ms. EDDIE BERNICE JOHNSON of Texas, Miss COLLINS of Michigan, Mr. MCNULTY, Mr. BARRETT of Wisconsin, Mr. CONYERS, Mr. NADLER, and Mr. HORN.

DISCHARGE PETITIONS—ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petitions:

Petition 1 by Mr. SOLOMON on H.R. 493: Scott McInnis.

Petition 5 by Mr. STEARNS on House Resolution 156: Scott McInnis.

Petition 9 by Mr. WELDON on House Resolution 227: Sam Johnson, John T. Doolittle, Jon Kyl, Dan Schaefer, Stephen Horn, Wally Herger, Rob Portman, Thomas E. Petri, and Bill Paxon.

SENATE—*Thursday, October 28, 1993*

(Legislative day of Wednesday, October 13, 1993)

The Senate met at 9 a.m., on the expiration of recess, and was called to order by the Honorable BYRON L. DORGAN, a Senator from the State of North Dakota.

PRAYER

The Chaplain, the Reverend Richard C. Halverson, D.D., offered the following prayer:

Let us pray:

Let us have a moment of silence, remembering the Vice President's mother; Senator RIEGLE's 11-month-old grandson; Mrs. Koutsoumpas, who works at the doors; and Shirley Herath, who works in the reception room. All of them need a prayer for healing.

(Moment of silence.)

Our help is in the name of the Lord, who made heaven and earth.—Psalm 124:8.

Eternal God, this truth we desperately need to learn. Forgive us for our indifference to Your availability at any time, in any circumstance. You know us in the totality of our lives, in microscopic detail—past, present, and future. We have no secrets from You. Nothing is hidden from You. You know our thoughts before we think them, our words before we say them, our actions before we take them. It is delusion to believe we do not need You.

Sovereign Lord, help us to see that we are most independent as persons when we live in dependence on Thee. Give us grace to submit to You, to commit to You, to allow You to govern our lives, that we may walk in the wisdom and the strength of the Lord.

In the name of Him who is the Way, the Truth, and the Life. Amen.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore [Mr. BYRD].

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, October 28, 1993.

To the Senate:

Under the provisions of rule I, section 3, of the Standing Rules of the Senate, I hereby appoint the Honorable BYRON L. DORGAN, a Senator from the State of North Dakota, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. DORGAN thereupon assumed the chair as Acting President pro tempore.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 11 a.m., with Senators permitted to speak therein for up to 5 minutes each.

The time until 9:30 a.m. shall be under the control of the Senator from Missouri [Mr. BOND] or his designee.

Mr. BOND addressed the Chair.

The ACTING PRESIDENT pro tempore. The Senator from Missouri.

HEALTH CARE

Mr. BOND. I thank the Chair, and I thank especially the majority leader, Senator MITCHELL, and Senator DOLE for permitting us to spend this time to discuss the vitally important issue of health care which is before this body, but is also very much on the minds of all of the people of America today.

To the extent required, I yield myself such time as required.

What we hope to do today, Mr. President, is to carry on and begin, in a full-blown fashion, the discussion begun yesterday by President Clinton and the First Lady, Mrs. Clinton, who has devoted so much time to the issue of health care.

President Clinton, as I understood it, yesterday said there were four main principles which he felt were essential. No. 1, assuring universal health care to every American; giving every American the security to know that health care cannot be taken away; changing a system of a blizzard of paperwork to electronic data filing, so that we may emphasize efficiencies in health care, as well as get better information on health care in terms of what works and what does not work. Finally, he laid the challenge before us to complete all of this by the end of this current legislative session, concluding next fall.

Mr. President, there are quite a few of us in this body, particularly on our side of the aisle, who would like to see all of those objectives accomplished.

We will be hearing today from a number of Members on our side, and then, from 9:30 to 10, from Members on the other side, who have worked long and hard on this health care issue.

I can tell you that it is not a simple one. We have spent, in a health task force established by the Republican leader, some 3 years working on health care and we have found it to be extremely complex. There are many, many different questions that need to be resolved and, frankly, there are no simple, single answers that are going to solve all problems.

We also are working on a bipartisan basis with Members on the other side of the aisle in this body and Members from both sides of the aisle in the House of Representatives, because we think that this measure is so important to the Nation's health and well-being, as well as to the individual health of our citizens, our constituents, the people of America, that we must carry out health care reform on a bipartisan basis.

Having said that, let me outline today to begin some of the principles that have been developed through the task force that are in the plan designated often as the Dole-Chafee-Bond plan or, more likely, the Dole-Chafee plan.

In any event, we realize that, even though we put a great deal of work into it, we still need to hear comments and views from people who are affected by health care, who have had problems with this system and who are involved in the system.

But let me outline for you today some of the basic principles that we think are needed in health care reform.

To set the stage, America has the finest health care system in the world today. Every day thousands of people all across the world vote with their feet—they come to America for health care. If you are sick, really sick, you want to come to the United States, because we not only have the finest technology, we have the finest health care providers—physicians, nurses, specialists, and hospital facilities—that can take care of the most pressing problems that any individual could face.

Having said that, however, we all recognize that there are problems with the system. There are problems that must be fixed.

Now, I think the first rule of health care is, first, do no harm. We could translate that into language that we use in our everyday work around here to say, If it ain't broke, don't fix it.

We do have a fine health care system. We need to focus on changing the things that are wrong, but we should not mess up the things that are good, the high quality health care that we receive.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

The problems we face are several. There are some 37 million uninsured. The figure fluctuates and the composition of those uninsured change as people go into and out of the workplace, pick up health insurance, drop health insurance, get health insurance, or health coverage again.

These people who are not covered, very often they are healthy young people who think they do not need health care. But if they are struck by a bus or have a sudden illness and wind up with very expensive care or very expensive needs, they will probably get that care.

But too often they get that care too late in their illness or in their injury. They do not get good preventive care. As a result, they wind up sicker and they require much more expensive health care. And if they do not have the funds to pay for it, then those costs are shifted to private payers, and those of us who pay our health insurance premiums regularly have to pay additionally for the uncompensated care.

Now I have to be frank about it. The Federal Government has been one of the most guilty parties in this cost shifting. We have made savings or claimed savings in Medicare, particularly, and in Medicaid by simply ratcheting down the amount of money that we pay for health coverage for those who are covered under Federal health care plans.

I read an estimate recently that the cost of that health care shifted onto the private sector about $15 billion a year. We need to get everybody covered. We need to have everybody in the system so they get the proper care at the proper time which saves them in terms of human suffering and human capacity but also which avoids cost shifting.

Second, we have a paperwork blizzard. Most of us, as consumers, have to fill out very complicated forms every time we go to a doctor or go to a hospital. If your family is like mine, we usually make errors in the first submission. We send it in and get it back and have to fill it out again. The health care payers have to process all this paperwork. Estimates of cost range from $50 to $80 to $130 billion a year just shuffling paper. It is a 19th century quill-and-scroll type of processing when we have the means of electronic processing of data, of information, that is the 21st century technology. And we are not using it.

Malpractice litigation, excessive litigation, costs $15 billion a year plus, perhaps, much more in terms of defensive medicine—procedures undertaken by doctors, unnecessary tests just to make sure they can defend themselves if they are sued because of a bad outcome, not because of negligence.

Finally, we have spiraling costs of health care; 14 percent of our gross domestic product or $900 billion is spent this year on health care. The projections are it will go to 20 percent of our gross domestic product.

In addition, I ought to say that insurance practices developing in recent years—cherry picking—have caused many people in my State, and I am sure in every State in the Nation, tremendous problems and hardship. The offer of low-price health insurance premiums to healthy groups and when somebody gets sick they have their insurance canceled or their premiums jacked up—I know at least three cases in my State. A family with insurance coverage, they thought, has had the birth of a child with significant health care problems, birth defects or other substantial problems in the family, and the insurance got canceled because they got sick. The families have gone bankrupt. Each one of us who have listened to people from his or her home State could say the same problem has occurred. We need to deal with this cherry picking and make sure insurance plans or health plans share the risk, spread the risk, not avoid the risk. We commend President Clinton and Mrs. Clinton for beginning the debate on how we reform health care and what we do about it.

Under the plan, the Dole-Chafee plan I mentioned before, we believe we must have universal coverage with individual responsibility for each individual to get insurance, not an employer mandate. We believe there must be administrative electronic data reform, malpractice reform, antitrust reform, reform of the insurance market to stop cherry picking, and using the marketplace to get the best price and the best quality for health care, and to do that through voluntary purchasing co-ops.

We looked at an employer mandate. Some say a lot of people get their health insurance through their employer. Why do we not require everybody to do it?

There are a couple of problems with that.

No. 1, imposing a mandate on employers, particularly small businesses with low-paid workers, requiring them to provide an expensive benefit, will cost jobs. Economists may disagree whether it will cost 600,000 jobs or 3 million jobs. In any event, when we are trying to get people working and we are debating an unemployment bill today, we do not need to cause more unemployment. That is the ultimate catch-22 for a worker who has no health insurance, to say we are going to give that worker health insurance, but it will cost him or her a job.

We believe tax fairness, treating everybody equally, giving them full deductibility up to the cost of a standard benefit plan—but not allowing deductions for the provision of much more expensive plans—can get a lot of people back in. Making sure that you have 100 percent deductibility rather than 25 percent deductibility if you are a farmer, a rancher, or a truck driver, other self-employed people—that can get many people in the system.

We also want to have vouchers for the low-income poor, 100 percent vouchers, for the cost of the standard minimum benefit package for poor people who do not receive Medicaid. For people above 100 percent of poverty, up to 200 to 240 percent, we would phase in, as we make savings in health care, the plans for partial vouchers for those plans.

Impose the responsibility on the individual so we do not cost jobs, so we do not wind up with a jury-rigged system of partial subsidies with limits and caps so confusing that nobody can understand them. We believe that providing employer mandates merely hides the costs and shifts the costs to the private sector, shifting costs that the Federal Government has had or has pretended to assume the responsibility for. We do not think that is an honest approach to health care reform.

We believe with the standards included in the measure that I presented with the Senator from Michigan [Mr. RIEGLE], and a bipartisan group on the House, we can achieve electronic data information systems with standard language and standard requirements and strong requirements for privacy and confidentiality. These measures can allow us to save billfons of dollars in administrative costs and also give us information on what works in health care and what does not. Administrative reform and electronic filing is an important part.

Insurance reform: We want to cut out cherry picking, limit preexisting condition exclusions, and stop the practice of canceling policies if you get sick. We say you have to pay the premiums or you are going to lose the coverage. Otherwise, we would invite people not to pay the premiums and force the plans to provide them coverage when they are cheating the system. We also believe malpractice reform is absolutely essential. And we feel this service can be provided through voluntary purchasing co-ops who have to compete on the basis of service to offer the plans to the small businesses and individuals who need health care coverage.

These are just the outlines of some of the things we want to provide and we believe can be very helpful in assurance of universal coverage in dealing with the problems I have outlined.

I will now yield 5 minutes to my distinguished colleague from Delaware, Senator ROTH.

The ACTING PRESIDENT pro tempore. The Senator from Delaware is recognized for 5 minutes.

Mr. ROTH. I thank the Chair.

(The remarks of Mr. ROTH pertaining to the introduction of S. 1598 are located in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

Mr. ROTH. I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Missouri.

HEALTH CARE

Mr. BOND. Mr. President, I thank the Senator from Delaware. I wish to reclaim the time to continue the discussion of health care which we began earlier this hour. One of the key elements in health care reform is to realize some of the mistakes we have made in the past. We cannot promise what we cannot pay for. We have had problems in the past, Mr. President, estimating the costs of Government health care programs, which we have missed badly.

In the 1990 budget summit, we told everybody that we were going to achieve a $45 billion savings over 5 years in Medicare and Medicaid. It is only 3 years past that time and there have been some nine different technical readjustments. For people who may be watching, the best way to explain it is that is a Federal way of saying, "Oops, we missed it," but after nine technical readjustments, the cost of Medicare and Medicaid over this 5-year period is not going to be $45 billion less, it is going to be $120 billion more, a $165 billion swing in the costs of the program.

That is one of the reasons that, in the Dole-Chafee plan and the other plans which we have discussed and which have been put forward by people in the mainstream Democratic and Republican efforts, we ought to achieve savings first before we promise benefits. There are some who say, "Let us promise the benefits and then, if they are too generous, we can just take them away."

When, Mr. President, has this body ever shown the willingness to take away a benefit once it is provided? That has been the problem: We cannot say no. Once some program gets started, it keeps going and it is added to the deficit or, alternatively, it might increase taxes.

In any event, our ability to cut back on spending programs once instituted has not been good. We have found out that increased utilization comes about when you expand health care coverage. That is why there was an excellent article in the Washington Post of October 17, 1993. I want to share some excerpts with you from it.

They talk about the Clinton promise of health security, and many economists view a darker reality behind it, saying they are potential fiscal time bombs. They quote distinguished Members of this body, Democratic leaders, who commend President Clinton for trying to make an accurate cost estimate but saying, "I would still bet a dime to a dollar they're wrong."

An economist at Salomon Brothers says:

> Make no mistake about it, President Clinton is proposing an entitlement program and, if its substance survives, it will inevitably expand in budget and regulatory control.

Another Member on the opposite side of the aisle—a very thoughtful Member who has been concerned about curbing costs—said:

> It is hard to make the case that our Government can be entrusted with a new entitlement program when we have let the old ones get so far out of control.

Economists of both liberal and conservative stripe have raised questions that we should take to heart as we move into this process. For example, Henry Aaron, a health economist said:

> I don't know of any good numbers out there for estimating the cost on corporate subsidies.

Former Bush economic adviser Michael Boskin said:

> A lot of seeds are being planted here for programs almost certain to grow exponentially over time. I think the conclusion is that we'll just have to force up taxes in the future.

Barry Bosworth, an economist at the Brookings Institution said:

> This is about the most complicated piece of policy I've ever heard of.

He goes on to estimate the program could just as easily be understated by $300 billion as achieving a savings.

Probably my favorite quote from Mr. Bosworth is:

> I don't think we got a chance in hell of knowing how much we will end up spending on health care 7 years out.

For those reasons, Mr. President, I believe the approach we take in our measure to pay as you save makes far more sense. Let us not embark on a very gold-plated, expensive program, new entitlements, four new entitlements without knowing that we have the costs under control and that we are able and willing to demonstrate a reasonable ability to control those costs.

Mr. President, I believe the hour of 9:30 is approaching. At that time, the time is supposed to be under the control of the other side of the aisle. I will yield the floor. I note my colleague from Utah is prepared to speak, and in the absence of another speaker, I might suggest he ask unanimous consent to proceed.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Utah.

Mr. BENNETT. I ask unanimous consent that I be allowed to speak for 7 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered. The Senator from Utah is recognized for 7 minutes.

Mr. BENNETT. I thank the Chair.

We are embarking, Mr. President, on a journey that has historic consequences as we address the issue of health care.

The comments made by the Senator from Missouri are appropriate in that they point out there are many pitfalls and difficulties ahead of us in this journey and we must proceed very carefully.

I do not rise to bash the President or Mrs. Clinton. Quite to the contrary. I think they have made a tremendous contribution to this debate. I have been impressed with Mrs. Clinton's ability to get her arms around the scope of this problem. My one concern is that as she does so, she may have a little more confidence in her ability to solve the problem than I think might be warranted under the circumstances.

There is a little bit of history that will help us. We have two medical programs already on the books, Medicare and Medicaid. They came in that order. Both of them were accompanied with forecasts of certain levels of expenditure. Both of them have so exceeded those forecasts that it is almost laughable to go back and look at what was told the Congress and what has happened in the Congress.

In each case, there was no bad faith. There was no attempt to deceive. There were no smoke and mirrors. There was the very best of faith and the best of efforts. But in each case reality caught up with the forecasts and left us in a circumstance that is now straining to break the budget.

Let us make no mistake; it is the entitlement programs that are breaking the budget and causing the budget deficit, and we are on the threshold of creating a new entitlement—indeed, the largest new entitlement in the history of the country.

This is what disturbs me as we go about this.

Secretary Shalala has been quoted in the popular press that in her testimony before the House she said in effect it does not really matter what the details of the plan are; the important thing is to get a plan in place, and then we can fix it later.

I would introduce Secretary Shalala to a previous Secretary of Health, Education, and Welfare, Mr. Joe Califano. Some people have referred to him as the father of Medicare and Medicaid, because he was on Lyndon Johnson's staff when Medicare was created and he was Secretary of HEW when Medicaid was created. He made the point that when Lyndon Johnson realized Medicare costs were going out of control and the program needed to be fixed, they could not fix it. They came to the Congress 2 years later. Things were locked in concrete at that point. People were satisfied with the entitlement that had been created and politically it was virtually impossible to fix it.

So the first message I hope we would adopt here as we start down this road is that it is more important to get it right than to get it now. I hope Mrs. Clinton and those who are embracing her program will recognize the past history which tells us the validity of that comment and would listen to Mr.

Califano, who says if you do not do it right the first time, you cannot change it, rather than adopt the attitude which Mrs. Shalala has adopted, which is, as I say, it does not really matter the details of the plan, just get one in place and we can fix it later. I consider that a very dangerous direction to go.

Second, I think we should understand we are talking about reengineering one-seventh of the total economy. We are talking about the greatest social reengineering enterprise in which this country has ever engaged. Not only should we do it right, but we should understand that a reengineering of this kind should not take place without a large and growing national consensus behind the way it is done. This is something that should not be done the way the budget was done, with 50 votes plus the Vice President breaking the tie. This is something we should have a large national consensus behind.

I salute Mrs. Clinton for reaching out to Republicans and others outside of her tight little group which put the health care plan together in the first place, to try to achieve that consensus. But as we proceed, perhaps we could understand the importance of building that consensus by slowing down a little and realizing a consensus can be gathered for a number of ideas that can be held together as we move to the more difficult ideas.

Let me give you an example the President himself has referred to, as he stood on the White House lawn and talked about the ancient rivals of Yitzhak Rabin and Yasser Arafat getting together and shaking hands, saying if these two can get together and solve these problems, surely the Republicans and Democrats in Congress can get together to solve the health care problem.

That is true, but Yitzhak Rabin and Yasser Arafat have not gotten together to solve their problems. The details of their agreement are that they have gotten together to agree to agree. They have created the framework of negotiation. They have not tried to tackle all of their problems at once because they realize how difficult those problems are. So they are putting the more difficult problems off as they work through the areas where they can agree.

Following up on the President's analogy, that is what we ought to do on health care, start with the areas where we can get 80, 90 votes in the Senate and say we will agree not to tackle the more contentious ones until we have built a consensus brick by brick, so that the more contentious issues of employer mandates and taxes can come after we have created a basis of agreement on the less contentious issues of, say, antitrust reform and common insurance practices.

Mr. President, I ask unanimous consent that I be allowed to continue for another 3 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BENNETT. I thank the Chair.

I am talking, I would hope, about a sense of cooperation and consensus in the Senate and the House to solve this problem in such a way that we do not look back on it with the same sense some of us now look back on the creation of Medicare and Medicaid and say what kind of a mess did we make, but that we build the bricks very carefully and together, in such fashion that when it is over we do not say, gee, President Clinton had his way with a narrow victory or, gee, the Republicans succeeded in rolling President Clinton on their plan and picked up enough Democratic support to create a 51-vote majority to get their plan; that we look back on this in future years and say the Congress and the executive branch, working together carefully and perhaps slowly but very accurately over time built a health care reform system that enjoyed the support of 75, 80 Senators of both parties and all political persuasions.

Are there deal breakers as we go about this process? For me there are. I do not want to see health alliances that are monopolies that have regulatory powers. But I am willing to put that off while we deal with some of the other issues on which I think we can reach agreement.

Mr. President, I offer congratulations to the Clintons for their initiative in bringing this issue to us, and I hope they will, in the spirit that has marked the conversations up to this point, be willing to back away from a sense of great haste and urgency and come to the notion with which I began my comments, that it is far more important for us to do it right than it is to do it now.

Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The Senator from Utah has suggested the absence of a quorum. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. DODD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

ORDER OF PROCEDURE

Mr. DODD. Mr. President, as on behalf of the majority leader, I ask unanimous consent that relative to the cloture vote at 1 p.m. today the mandatory live quorum be waived.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. DODD. Mr. President, may I inquire as to whether or not the Senate is now in morning business.

The ACTING PRESIDENT pro tempore. The Senator is correct.

THE HEALTH SECURITY ACT

Mr. DODD. Mr. President, I would like to take a couple of minutes, if I could, to express my immediate thoughts on the historic announcement that occurred yesterday. The President of the United States and the First Lady presented to a significant number of Members of the House and Senate their national health reform effort, the Health Security Act, as it is called. I am very proud that I will be a cosponsor of the proposal.

I would like to take just a couple of minutes this morning to express my thoughts as we begin what I think will be one of the most historic debates in the 20th century. As we close out this century, we will address something that has plagued and defied previous Congresses and administrations going back to the earlier part of this century. We are on the brink, in this Congress, of achieving something that others have wrestled with for decades and have been unable to achieve.

I begin the process by believing we will achieve national health care reform. We will have a Health Security Act, after long-awaited efforts that will give people security about their health care and relieve their fear that health care will bankrupt their families. I believe this will become a reality before this Congress adjourns next year.

Mr. President, the bill will be as I said a moment ago one of the most important pieces of legislation considered by Congress in the 20th century. That is my firm view. It will appear alongside the Social Security legislation of the 1930's and the civil rights legislation of the 1960's on the pages of future American history books. It will appear alongside the great vehicles of social reform not only because of its monumental impact but also because of the principles of security and justice on which it is based. Like the Social Security Act, the Health Security Act will provide a new and desperately needed guarantee for Americans. Just as Americans now do not have to fear old age without a pension, they will no longer have to fear illness without treatment.

Like our civil rights laws, the Health Security Act will make our society more just and more equitable. Just as Americans no longer have to fear State sanctioned discrimination based on race, they will no longer have to fear health care discrimination based on health status or ability to pay.

We have arrived, Mr. President, at one of those unique junctures in American history when there is nearly universal agreement on the need for change. Not everyone, obviously, agrees on the form this change should

take. There is a great deal of disagreement on this point. But I have yet to meet anyone in the halls of Congress or outside of this Chamber who feels that the status quo is preferable to real reform, and that we can continue down the road that we are now on, without change.

Republicans and Democrats, doctors and patients, small businesses and large corporations, consumers and insurance companies, all agree that reform is imperative. I hope we will seize this opportunity, Mr. President, to form a broad-based consensus about the shape of reform and give the American people what they deserve and have been asking for for decades: A health care system that works for everyone in this country, but does not bankrupt the Nation as well.

While the introduction of this bill has great significance for all of us, I know it has special significance for our colleague Senator KENNEDY of Massachusetts, who has been toiling away for health care reform for the last quarter of a century as a Member of this body. I want to commend, if I can, the distinguished chairman of the Labor and Human Resources Committee for his work in this area. He has been a champion of it for years.

The case for reform is clear and compelling. Our health care system is in desperate need of repair; it must be fixed. The system is too expensive, and it leaves far too many people without coverage. I see the President's plan as our best hope, and that is why I have become an original cosponsor of the Health Security Act.

I prefer President Clinton's proposal because it is based on six critical principles, which he articulated in a joint session of Congress a few weeks ago and reiterated again yesterday. Those six principles deserve being repeated over and over again, because they are the principles which Americans have talked about and cared about for such a long period of time.

The first is security; the second is savings; then quality, choice, simplicity, and finally, responsibility. Other plans, Mr. President, while they have merit and good points, fall short on one or another of these most important standards.

I am enthusiastic, Mr. President, about being part of this effort, because of the tone that the administration has set. The President and the First Lady have demonstrated, I think, a sincere willingness to listen to criticism and suggestions and to take them into account. The President has also sought to form a bipartisan coalition to support health care reform. I believe there have been more meetings and more consultations prior to yesterday's introduction than at any other time in my memory on almost any other piece of legislation—certainly any other piece of legislation of this significance. The President and the First Lady know that health care should not be a partisan cause, but an American cause; not an issue that divides us, but one that unites us; not a source of recrimination, but one of reconciliation.

Mr. President it would be naive to suggest that every part of a sweeping effort to reform one-seventh of our economy would be supported unanimously. There are certainly aspects of this health care plan that I would have written differently. I am sure that can be said of almost every single Member in this body. But we cannot allow specific objections to some parts of the plan to derail the entire effort. I am sure that will not occur.

The fact is that introduction of the Health Security Act represents not the end of this process, but rather the very beginning of this process. In the months ahead, we will be working together with those who have introduced other plans, with those who have other ideas, working together to shape this legislation, to make sure that it meets the needs of our constituents, and that it is consistent with the principles established by the President.

During this process, Mr. President, I plan to focus on preventive care and the unique needs of pregnant women and children. We can no longer afford to neglect prenatal care, and we can no longer afford to neglect child immunizations. We can no longer afford to neglect the health of adolescents. I want to work toward a reform plan that provides solid benefits in these areas and contains provisions to make sure the benefits reach those who need them.

Mr. President, I also want to make sure that the reform plan is friendly to small business, which contributes so much to job creation in this country. As the First Lady told me during her appearance before the Labor and Human Resources Committee in September, "It would be difficult to create a health care system more antibusiness than the one we currently have." I hope that the new system we design will achieve the goal of health security for all Americans, without burdening small business.

Some people might be surprised that a Senator from Connecticut, home of some of our Nation's major health insurance companies, is cosponsoring legislation to overhaul the health care system. There is a perception that all insurance companies are adamantly opposed to change and that they are conspiring to undermine the reform process. In fact, a Herblock cartoon in this morning's Washington Post lumps all of these industries together.

I suggest to my colleagues that nothing could be further from the truth. The insurance industry, of which we are very proud in my State, and which employs more than 50,000 people, is not a unified monolith that speaks in one voice. Many insurance companies strongly support reform. There has been much misinformation on these points.

For instance, last week, there was a flurry of media accounts about the Coalition for Health Insurance Choices, a group established largely by the Health Insurance Association of America, to weigh in on the health care debate. You may have seen their ads on television. The existence of this group was pointed out as evidence of a grand conspiracy on the part of all health insurance companies to derail reform.

What was left out of this discussion was the fact that the health insurance association of America does not represent the entire insurance industry. In fact, three of the largest health insurance companies in the United States located in Connecticut—Aetna Life and Casualty, Cigna, and the Travelers—do not belong to this organization and disassociate themselves from their media efforts and their propaganda.

These companies are all committed, I point out, to health care reform. Not only do they support many of the principles outlined by the President, but in a number of instances they have already achieved on a small scale what we hope to achieve nationwide through health care reform—namely, cost reduction and quality control.

Here is an example, Mr. President: Cigna Healthcare's Arizona health plan has developed an innovative way to manage pediatric asthma cases. It has improved diagnosis of the problem, implemented education programs, and provided medical equipment for children to use in their own homes. These steps have already saved $1.3 million and made treatment more comfortable for many children.

Cigna also developed a new biopsy procedure to detect breast cancer. This reliable procedure saves patients the inconvenience and discomfort of major surgery, and it costs only one-third the costs of traditional surgical biopsies.

Mr. President, we simply cannot allow this opportunity to reform the Nation's health care system to slip away. We must act now to provide the American people with the health care system they need and the health care system that they deserve. I commend the President and the First Lady for the efforts they have already undertaken in this regard. We would not be here today, we would not be at the point in our history, were it not for their efforts. As I mentioned, there are many fine ideas that have been presented by other Members of this body and other members of the other Chamber. At the end of the day, I suspect we are going to come together on a health care proposal that reflects the best ideas of all of these plans. But when that day arrives, let us not forget that if not for President Clinton and Mrs. Clinton, we would not have arrived at that moment.

In these years, 1993 and 1994, for the first time in decades, we are going to finally debate and have a health care proposal that gives people a sense of security, and a basic benefits package that would be available to all Americans. And on that point, I hope there is no disagreement in this body. A plan that is not comprehensive and does not cover all Americans does not deserve to be called health care reform. On that point, I think all of us ought to come together. I commend my colleagues for their efforts and look forward to working with them.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Chair recognizes the Senator from Massachusetts. But let the Chair advise the Senator there is 1 minute remaining in this 30-minute block scheduled for the majority side. The Chair will further advise Senators that during this 30-minute block the Senator from Missouri asked unanimous consent that the Senator from Utah, Mr. BENNETT, be allowed to speak. He consumed 10 minutes of his time because no one on the majority side was present.

Mr. KENNEDY. Obviously, I want to accommodate. I was on the floor when Senator BENNETT was making his comments. I would hope we might be able to be extended time—I know Senator BOXER and I want to speak briefly—and to ask whether we could use that 10 minutes and then go back to the earlier order.

Mr. BOND. Mr. President, this is a very important subject. Unfortunately, we have several speakers on our side who have markups and had planned to be here.

Senator CHAFEE agreed that we should extend 2 minutes of our time to the Senator from West Virginia. Then I would like to yield to him. I would also then like to yield to Senator CHAFEE so that he may go on to a markup.

I would note to the Chair that I did not yield to the Senator from Utah, a mere technicality. We want to have everybody heard. We have morning business until 10 o'clock.

Mr. CHAFEE. Mr. President, as far as I am concerned, if it is 10 minutes, fair enough, but I would hope they limit it to 10 minutes because each of us are waiting to get to committees. If that would be satisfactory, that is fine with me if they want to go.

The ACTING PRESIDENT pro tempore. That would have to be done by unanimous consent.

Mr. KENNEDY. Mr. President, if the Senator from Missouri has reservations about that then I would not offer it. But otherwise I ask unanimous consent we be able to have 10 minutes.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. BOND. Mr. President, I would concur in that and am happy to agree to the unanimous-consent request that there be 10 additional minutes on that side to be controlled by Senator KENNEDY.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts is recognized for 10 minutes.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the Republican time be extended 10 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. KENNEDY. I thank the Chair.

I yield to the Senator from California briefly.

Mrs. BOXER. I thank my friend from Massachusetts and I thank my Republican colleagues for being so accommodating.

Mr. President, I planned to be here to speak about my support for the proposal by the President in terms of his health care plan, which is something this country is crying out for. But rather than do that, because of the time limitation the Senator from Massachusetts [Mr. KENNEDY] gave me permission to speak for about 1 minute or 2 to fill the Senate in on what is happening in California with our devastating fires.

FIRES IN CALIFORNIA

Mrs. BOXER. Mr. President, the devastation continues. The Santa Ana winds continue, fortunately at a little lesser speed than they were yesterday, but predictions are they will pick up tomorrow.

We have this window when our brave firefighting men and women can get out there and get some of these fires under control. We had as many as 14 fires. My understanding is that four have been put out. There are several counties, including Ventura, Los Angeles, and others, that have been declared emergencies, and the Governor is acting to ask the President for help.

Our President will be addressing the Nation at a press conference. I believe he is going to have a statement about the fires. I just wanted to report to the Senate—because I see here my colleagues who experienced these problems in their own States—that the head of FEMA, the new head of FEMA, James Witt has been just extraordinary. Usually I have had the experience of having to beg for information, having to beg to be informed. He was on the phone to both Senator FEINSTEIN and me. He said to the people of California, do not wait until it is too late. We want to help. We want to swing people into action, the Forest Service, the Department of Defense. We want to help.

So I just again thank my colleagues for this moment. Senator FEINSTEIN and I are going to act as a team. One of us is going to go to California. One of us will stay here to inform the Senate of what is happening and do the work that needs to be done.

I say to the people of California: Our hearts are with you. We are thousands of miles away but we see the devastation you are going through.

We are very grateful that there are no deaths, Mr. President, no deaths at all, although we have had at least 30,000 people who had to flee their homes, and estimates range from 50,000 to 80,000 acres burning.

So we will pray and we will swing into action, and we will be reporting to the Senate as the day goes on.

HEALTH CARE REFORM

Mrs. BOXER. Mr. President, I am proud to rise today as an original cosponsor of the administration's health care reform bill. Yesterday's unveiling of the Health Security Act was a historic moment. After years of political neglect and denial, years of watching the number of uninsured Americans skyrocket, and years of seeing our people pay more and get less, we finally have a comprehensive plan to reform our health care system.

The Health Security Act lives up to its title. This is a bill to give all Americans security and choice, improve the quality of care, reduce costs and paperwork and make everyone responsible for health care. This bill is good for America and good for California.

We need to look at the human faces behind this issue. We need to think about the millions of Americans who work hard, play by the rules, and are unable to afford even the most basic care for themselves and their families.

One of those Americans is Donald Greenberg of San Diego, CA. In a recent letter to me, he wrote:

> Something very terrible happened to my family today. Something that made me very angry. My ten year old son Benjamin was refused medical care by a physician because we don't have health insurance. * * * My son doesn't understand why dad, who works full-time at a very respectable company, can't get health insurance, and frankly neither do I.
>
> I had health insurance once, but when the company I was working for went under, I lost my insurance as well as my job. I haven't had insurance since 1990, even though I have [been] employed all along. * * * When I moved to San Diego in 1980 health insurance was $7 every two weeks, no deductible. Now they want $400 per month.

In the months ahead, we know it's going to be tough—change and leadership are never easy. We know we are going to be asked to make some difficult decisions. But, we need to look at this program in its entirety, examine its underlying objectives and then work to make them a reality.

1. SECURITY

The President's bill provides universal coverage and gives all Americans the health care security that they deserve. It guarantees all Americans insurance coverage for a comprehensive set of benefits whether they become

sick, lose or change their jobs, or have a preexisting medical condition.

We know the statistics. In this, the greatest Nation in the world, we have the unfortunate distinction of being one of only two Western industrial countries who do not guarantee affordable health care for their citizens. The other nation? South Africa.

In this, the greatest Nation in the world, we have a situation where 37 million people live without health insurance. More than 85 percent of them are working people with families. Almost 6 million of them live in my home State of California.

In this, the greatest Nation in the world, we have a situation where an American loses his or her health insurance every 30 seconds, where 25 percent of our work force is afraid to change jobs because they fear they will lose their health insurance.

In this the greatest Nation in the world, we need to do better. The American people understand this and they elected us to get the job done. The Health Security Act guarantees all Americans insurance coverage for a comprehensive set of benefits.

None of the Republican alternative plans introduced in the Senate provide this type of security.

In fact, one plan hardly changes our current system. Senator GRAMM's bill doesn't include protections against insurance companies raising their rates or dropping individuals. And, Senator GRAMM's bill officially sanctions the current practice of raising rates for people with preexisting medical conditions by forcing them to pay 150 percent of the average premium.

2. SAVINGS

The President's plan will help businesses, consumers and our Nation by controlling our skyrocketing health care costs. Right now, we spend more money on health care than any other industrialized Nation that provides access to their citizens.

Consumers and businesses in California have been hit hard by out-of-control costs and understand the importance of these controls. In 1992, an average family living in Los Angeles, without employer provided health insurance, paid $7,296 for a health insurance plan.

During the last decade, a typical California family's health payments rose 6 percent faster than its wages. For California businesses, the current trends are equally poor. Between 1980 and 1991, spending by California businesses on health insurance increased 294 percent and reached $35 billion.

Right now, the rate of growth for our health care spending exceeds that of the overall economy. Right now, health care spending represents one in every seven dollars spent in our economy.

Unless we dramatically alter this course, within 7 years, health care costs will consume 20 percent of Federal dollars and more than 25 percent of State and local budgets. Our deficit will continue to soar, businesses will be hurt, and every American's pocketbook will suffer.

The Health Security Act establishes an overarching health care budget for the Nation, reforms workers compensation, caps the growth in health care premiums, and limits out-of-pocket costs for Americans.

It even eliminates copayments and deductibles for a critical set of preventive services, from prenatal care to immunizations and from pap smears to mammograms.

The emphasis on primary, preventive care is crucial. When our health care system fails to provide adequate primary care, we waste precious dollars treating preventable illnesses like measles and tuberculosis, which we thought we had conquered long ago. Alternative plans often fail to recognize this important point.

For example, with the medical savings account established by Senator GRAMM's bill, every time you see the doctor you pay for it out of your own savings. This would act as an incentive to avoid preventive care and to wait to seek medical attention until you are very sick, when care is more expensive.

3. SIMPLICITY

True savings are only possible when we cut the red-tape and reduce the administrative costs of health care. Every one of our health care dollars is precious.

But right now, 25 cents of every dollar goes to pay for bureaucracy and paperwork. According to Consumer Reports, Americans pay $163 billion a year for health care administrative costs. This means that we spend $447 million a day and $19 million an hour to feed an increasingly hungry bureaucracy. For our small businesses, the backbone of our economy, administrative costs consume 40 cents of every health care dollar.

Look around at the diseases claiming the lives of our people, young and old: AIDS, breast cancer, heart disease, and Alzheimers. With these tremendous challenges before us, our Nation, our businesses and our consumers cannot afford to waste one extra cent on bureaucratic redtape.

The President's bill reduces administrative costs and helps us put health care dollars where they belong.

It establishes a single insurance claim form, encourages automation, and reduces the paperwork that too often consumes our doctors and nurses and keeps them from doing the jobs they were trained to do.

4. CHOICE

The Clinton plan empowers our consumers by increasing choices. Health care is something that affects each and every one of us; it is something that everyone has a stake in—no matter where you live or how you live.

When it comes to health care, Americans know what they want. The President's bill recognizes this. It realizes that consumers make their most cost-effective choices when they understand their options and have enough knowledge to choose between them. This bill will give everyone a choice of health care plans and the option to choose their own doctor. And, everyone will have information comparing the health care plans and consumer satisfaction with them so that we can make informed choices.

5. QUALITY

The President understands the meaning of quality health care and his bill includes an expansive benefits package to guarantee it. What does quality care mean under the Clinton plan? It means that everyone will receive coverage for hospice, for home care, and for prescription drugs in the benefits package. It means that a new long-term care block grant program will provide expanded home and community-based services to all Americans, regardless of age. It means the expansion of public health and prevention programs and investments in health care training and education.

One alternative plan actually encourage bare bones coverage. Senator GRAMM's bill encourages individuals to purchase health insurance policies that cover only catastrophic health care costs. No coverage for preventive care, long-term care or prescription drugs.

Under the Clinton bill, quality care means that every retired person between the ages of 55 and 65 will receive coverage through the health alliances.

It means protection for those workers whose benefits have been cut back or terminated, and it means relief for our businesses who need to scramble to afford even the most basic retirement health plan. This is good news for California. This provision will offer a helping hand to California workers, like those at McDonnell Douglas, who have watched their health benefits altered or terminated this year.

Finally, if it is to mean anything at all, quality means comprehensive care for this Nation's women.

The President understands this and the benefits package in his plan includes the full range of family-planning and pregnancy-related services—including abortion.

When we talk about including abortion in our health care package, we need to be clear. We are not talking about providing women with a new benefit. We are not talking about providing them with additional coverage. We are talking about offering women the same coverage and benefits that they already receive from most private health insurers.

I am so proud to serve under a President who understands the meaning of reform, the meaning of fairness, and the meaning of quality care. This is a

President who understands that private health care decisions should be made in the doctor's office, not in the Halls of Congress. Because, when we infuse politics into our medical decisions, it is the health of the people that suffers.

I plan to fight with the President to make sure that Congress approves a health care plan that guarantees women the full range of reproductive services, a plan that doesn't leave half our population out in the cold.

6. RESPONSIBILITY

The President's bill asks everyone to contribute to and take responsibility for the choices and costs associated with health care. We need to take responsibility for our own health by using preventive health services, and for the health of our Nation by working to decrease violence.

The President asks everyone to contribute to health care—asks employers to pay 80 percent and employees to contribute 20 percent. But, it also establishes subsidies for small businesses and low-income individuals to make sure that these costs are not burdensome.

This plan is about all of us—from the uninsured single mother to the CEO of a large corporation. It's about coming together to make life better for all of our people.

As I said at the start, it is not going to be easy. All of us have concerns about the President's bill. I'm concerned about California continuing to get stuck with the bill for illegal immigrant emergency care. Although the administration has proposed a pool of $1 billion in fiscal year 1995 to pay for these services, the State of California estimates that such care currently costs the State's Medicaid program over $750 million in this fiscal year alone.

I am worried that new drug policies could curtail private investment for innovative research and development and hurt California's biotechnology industry, an industry that, over the past four years, has created 10 percent of the new jobs in California.

I want to examine how the cuts in Medicare and Medicaid will be administered to make sure that reform doesn't come at the price of decreasing vital services to our poor and elderly.

Finally, I have a few concerns about the treatment of women's health issues in the comprehensive benefits package. In the package, pap smears and pelvic exams are offered every 3 years and mammograms, beginning at age 50, are offered every 2 years. This is less treatment than the American Cancer Society recommends. In general, they suggest a pap smear and pelvic exam once a year and an annual mammogram for women beginning at age 40. I want to work with my colleagues to ensure that our coverage for women's health meets the highest medical standards.

So, yes, let's raise our concerns. But, let's raise them in the spirit of partnership, not of obstruction. Let us support the underlying themes of this critical plan and work with the President to revolutionize the way we think about and receive health care.

As the debate moves forward, we also need to remember the human faces behind this issue. Like many of my colleagues, I have received many letters from constituents on the need for health care reform, and I would like to conclude my remarks by sharing two more stories with you.

Flora Moshinsky of Covina, CA, wrote to me of her children, a son and daughter who are "not covered by their employer's insurance, because they don't have employers, and are trying to get by on whatever insurance is available to them."

Her son, at the age of 29, "returned home to further his education as he found that he was not making enough money at his job to live. He was one of those people the President referred to as one paycheck away from disaster."

When his kidneys failed, and he became sick, his health insurance would not pay for his treatment. Today, he is alive and well because her son finally qualified for Medicare.

And finally there is James Snyder of Carmichael, CA, who writes lovingly about his wife Janice who has breast cancer.

In all, we consulted with six doctors regarding the appropriate treatment for Janice's condition.

They were unanimous in recommending several standard chemotherapy sessions, followed by a very high dose chemotherapy treatment coupled with an autologous bone marrow transplant.

My wife and I thought we had complete health care coverage. Then, the hospital advised us that—our health insurance—has issued a verbal denial for her treatment. They will not cover the bone marrow transplant.

These are the faces behind health care reform and the reason why we need to pass the Health Security Act.

I again thank so much my good friend from Massachusetts.

Mr. KENNEDY. I thank the Senator very much.

How much time remains?

The ACTING PRESIDENT pro tempore. The Senator has approximately 6 minutes remaining.

Mr. KENNEDY. Mr. President, I yield myself 2½ minutes. Then I yield the Senator from West Virginia 3 minutes.

Mr. CHAFEE. Mr. President, if the Senator wants to go until 10:15, that is fine by me.

Mr. KENNEDY. That is fine. I thank my friend and colleague. We rarely get people over to the floor to talk about health care, so it is welcome that we have a number of our colleagues who want to address it.

Mr. President, the President has proposed a bold plan to guarantee health security for every American and to curb the soaring cost of health care.

The legislation the President submitted yesterday is a plan that will work. It will guarantee every American family the coverage it needs at a price it can afford and put in place a comprehensive system to control cost. The cost control program is based on using market forces to achieve real competition in health care.

In addition, the budget and the firm premium controls will assure that savings are achieved if market forces do not work as quickly and effectively as we hope.

The principle we are following is called managed competition, and one of the major debates in Congress will be over the degree of management required.

The President's plan will also cut through the miles of red-tape which is strangling the current health system and frustrating patients and health providers.

The President's plan is preserving and expanding choices for the American family. Today people fortunate enough to have coverage are often unable to choose the coverage they prefer. Instead, their employer chooses it for them. The President's plan puts the choice where it belongs—with individuals and their families.

The President's plan preserves and improves the quality of care. For the first time, the American people will have access to report cards on doctors, hospitals and health plans. These reports will help them choose the plans that provide the best care and put pressure on all providers to improve their services.

Finally, the President's plan is based on the principle of shared responsibility. Everyone, workers and employers, the unemployed and self-employed, will contribute to the cost of care, as most Americans and most businesses do today. But, premium discounts will be granted to assure that care is affordable for low-income citizens and vulnerable small businesses.

The President's plan contains the greatest advantage for senior citizens. They have had guaranteed health insurance coverage since the passage of Medicare in 1965. But Medicare has serious gaps today—gaps that have become a greater and greater problem as medical costs have risen.

The President's plan provides desperately needed prescription drug coverage under Medicare.

The interesting fact is, in the debate in 1965 many of the doctors and the dentists resisted the coverage because they did not want to be included in the program. And now, most of the groups that excluded themselves want to be part of the system.

Any plan as broad and comprehensive as a Health Security Act will require adjustment and compromise as it moves through the legislative process. But the President's plan provides an

excellent start and solid structure for reform as Congress now begins to address the legislation. I look forward to working with my colleagues to deal with it as effectively and expeditiously as possible.

I thank the Senator from Connecticut for his kind references to me. And I want to mention his special knowledge of, awareness, and energy about children as chairman of the Children Caucus. Senator DODD is one who had been a leader on children's issues in our Labor and Human Resources Committee. His contribution to this debate on issues affecting children who are, as we know, the ones who are left out and left behind, will be a very, very powerful incentive for support of this legislation.

I yield the remaining time to my friend, the Senator from West Virginia.

The ACTING PRESIDENT pro tempore. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, I will be very brief this morning. If anything is clear about the reform debate, it is that we can count on plenty of time to talk through all the issues over the next several months.

I come to the Senate floor to simply congratulate President Clinton and the First Lady.

Speaking more as an American, and not just as a Senator, I felt enormous gratitude yesterday as they delivered the President's Health Security Plan to the Congress yesterday morning. Finally, after all these years of handwringing, the American people have a President with the commitment and the capacity to lead our way through a solution to the health care crisis.

Mr. President, we have not just been handed a bill—the legislative language that suddenly took on such importance in the recent weeks—we have been handed the ball. The President has submitted a serious detailed, comprehensive plan for achieving health security for all Americans.

It is up to us to get it to the finish line.

Yesterday, the President spoke for the American people when he reminded us of the job ahead. He promised an open mind and an open door when it comes to working with us through the specifics. But he was the messenger of the people when he declared what cannot be compromised. No matter what we must produce a final product that will deliver what Americans have every right to expect—security savings, quality, choice, simplicity, and responsibility.

I have been immersed in the health care debate for years. I have watched colleague after colleague, expert after expert, interest group after interest group struggle over the best way to fix our broken-down health system. The temptation to avoid the tough decisions is almost irresistable. That's why we are still seeing health care bills that pledge the idea of universal coverage, and leave out completely the way to guarantee it. The discomfort with the hard choices involved is natural. And that's why we are still seeing health care plans that don't assign responsibility for a solution, and that will not change the rules that are leaving so many Americans out in the cold.

In his health security plan, the President doesn't punt, or dodge, or hide behind promises that can't be redeemed. And now, it's time for everyone to do their part.

I also want to point out this morning how many people deserve to be thanked for the position we're now in to enact health reform. I think of the people of my State who helped me to make this issue a priority. As I have listened to their burdens of rising health care costs, and their fears of losing coverage just when they need it most, I made the decision to devote myself to hammering out the solution to ease those burdens and those fears.

Americans everywhere have spoken out in the recent elections, and are saying in every way they know how that it's time for us to do something about the health crisis. It is their crisis.

The President and First Lady have drawn on a team of some of the most dedicated public servants—inside and outside the Government that this Nation will ever know.

I will finish here this morning. Again, I congratulate and thank the President and the First Lady, and everyone who helped us get this far.

Everyone in this body now has an opportunity to help chart the course to health security for every American. I hope we will surprise all the pessimists and the pundits. I hope and pray that we'll devote the courage and the conviction that it will take to get the job done.

Mr. President, I would simply note that the Senator from Massachusetts [Mr. KENNEDY], has been at this issue of health care now for 31 years. His efforts and his work diminish the efforts of all the rest of us, not in intensity but simply by comparison.

I also thank our Republican colleagues, the Senator from Missouri, with whom I work on health care issues with children, the Senator from Washington, whom I worked with on tort reform and many other tricky issues, and the Senator from Rhode Island, with whom I work on everything.

Mr. President, my point in coming to this floor this morning is very simple, I simply want to congratulate the President and First Lady.

Speaking frankly, more as an American than as a Senator, I feel enormous gratitude, and I felt it yesterday as strongly, as they delivered the President's health security plan to Congress. Finally, after all these years of handwringing, of talk, the American people have a President with the commitment and the capacity to lead our way to a solution to this vast health care crisis.

Mr. BOND addressed the Chair.

The PRESIDING OFFICER (Mr. FEINGOLD). The Senator from Missouri.

Mr. BOND. Mr. President, I thank my distinguished colleague from West Virginia, as well as my colleagues from Massachusetts and Connecticut. These three distinguished Senators—Senator ROCKEFELLER, Senator KENNEDY, and Senator DODD—all indicated they wish to work in a bipartisan spirit to achieve the goal that we all seek, and that is universal health care with security, with containment of costs. We thank them for their willingness and their expressed intent to work with us.

Now, it is my pleasure to yield 7 minutes to the Member on our side, the Senator from Rhode Island [Mr. CHAFEE], who has been the leader of our task force and a leader not just of the task force but a leader in developing health care proposals and insights into health care that we find absolutely essential.

Mr. CHAFEE. Mr. President, first, I wish to thank the distinguished floor manager here, the junior Senator from Missouri, for the kind comments he made.

Mr. President, I would like now to discuss some of the concerns that I have with the Clinton health care reform package that was presented yesterday.

First, I would like to start off by commending the President and Mrs. Clinton for their efforts in bringing the whole subject of health care reform to the front burner, making it one of the most prominent items for legislative action that this Congress will face. But for their actions, we would not have health care reform at the high visibility point that it is now. Certainly, both Mrs. Clinton and the President deserve a lot of credit for that.

Mr. President, these objectives of reforming health care are goals that I share, as do those 22 Senate Republicans who have joined with me on a plan we call the HEART plan.

Mr. President, as we start on health care reform, I think it is important to remember that we are embarking on one of the most significant legislative undertakings this body has considered. Much of it is uncharted waters we are heading into, with a potential for imposing enormous new costs on the system if we make the wrong choices.

Just consider for a moment the scope of health care reform. It will affect $1 out of every $7 spent in the United States of America. It will affect every citizen, from the youngest—and, indeed, the unborn, as we try to care properly for expectant mothers—right through to our oldest citizens in the Nation; and from our poorest citizens to our richest citizens. The plan will

provide health security for tens of millions of our fellow Americans who never had health insurance or, if they have it, do not have adequate coverage presently. Current estimates indicate some 37 million Americans are at any one time uninsured and another 20 million underinsured.

What we do will affect the way doctors and nurses and other health care professionals practice their profession. It will affect new technologies, new drugs, new procedures. It will have a tremendous impact on Federal, State, and local government spending, as well as the private sector spending and household budgets across our country.

In short, Mr. President, health care reform will be the most significant change in our society in this half of the 20th century.

Bearing this in mind, I think it is terribly important that we proceed with care, indeed, with extraordinary care, and that we recognize our inability to precisely predict the future. We should take some steps and see what happens and then take the next step.

I would like to highlight just three aspects of the Clinton plan I believe would take us down the wrong path and which should be rejected.

I would start off by saying there is much in the Clinton plan that we, the sponsors of the HEART Plan, agree with. There are some 16 points of commonality. But there are some major differences, and I would like to just touch on three of these this morning.

First, the Clinton plan writes a very highly detailed, uniform benefit package into law. That is the first thing—very, very highly detailed.

Second, the Clinton plan expands universal coverage, coverage for everybody in America, at a very rapid pace without knowing the cost that this will entail.

Third, the Clinton plan embarks on new entitlement programs.

An entitlement program is a program in which there is no limitation on the funding. Anybody that is entitled to it gets it, regardless of whether there is money, regardless of the cost of it. The Clinton plan embarks on new entitlement programs without, in my judgment, proper calculation of the potential costs. These are giving new benefits that currently do not exist.

I think all of us would agree that health care quality and technology will change dramatically over just the next 10 years, never mind over the next two decades. Our struggle must be to ensure that we allow health plans to evolve over time and that we do not freeze them into perpetuity by writing overly detailed benefits into statute, as the Clinton plan would do.

To leave the design of the benefits package to the political process—indeed, the Congress would create a package that is way more than the Nation can afford.

Let me just give you a couple of illustrations. Medicare benefits are a complicated mix of statutory language and regulation. But they are very specific. In fact, they are so specific that almost every year since 1984 we have the incongruous situation of a Senator—in this instance, it has been me, and a Representative, Representative PETE STARK, and some others, ending up in a room in this Capitol at 2:45 in the morning to consider highly specific benefit provisions under the Medicare Program.

And, indeed, I clearly remember one time at 2:45 a.m., Congressman PETE STARK and I were arguing over which professional should be reimbursed for reading an EKG. This is ridiculous.

First of all, we do not know much about reading an EKG. And why should we, a Congressman and a Senator, be writing that into law?

Second, the Medicaid Program has been expanded since its inception to include long-term care for the elderly and disabled. That is fine. But the changes were specifically written into law. Unfortunately, these changes were based on what was the state of the art for long-term care 25 years ago, when you had 24-hour-a-day institutional care. But time is proceeding, and the cutting edge of care has changed. It has been discovered that it is more humane and more cost effective to have community-based programs, and to keep individuals out of institutions and in the home setting, if at all possible.

But the Medicaid program does not pay for that. As it is written into law, Medicaid only pays for the care of the individual in an institution, in the most expensive place you can care for an individual, instead of paying something, far less, toward the individual being cared for in his or her home. That is the law, and we do not seem to be able to change it because there are so many vested interests, including the hospitals and the long-term care institutions, there to fight us every step of the way.

By writing very specific benefit features into this bill, the Clintons, I believe, would invite this same problem.

The PRESIDING OFFICER. The Senator has spoken for 7 minutes.

Mr. CHAFEE. I wonder if I might have 3 more minutes?

Mr. BOND. I yield 3 additional minutes to the Senator from Rhode Island.

Mr. CHAFEE. This draft bill—here it is—this draft bill has 58 pages devoted to what is to be in the uniform benefit package. Here it is: Outpatient prescription drugs and biologicals described in section 1122, outpatient rehabilitation services described in section 1123; 58 detailed pages of what is to be in the uniform benefit package.

Mr. President, you know and I know when this bill comes to the floor of the Senate in this form, Senators will be popping up all over the floor making sure that their little group is taken care of that they are concerned about, whether it is chiropractors or podiatrists. If they are not already written into this bill, they will be. And when Congress is through, it will be the most expensive benefit package known to man. That is our concern. This is the ultimate form of congressional micromanagement and it should be avoided.

Under our plan we provide only minimal guidance to the national benefits commission comprised of experts who then develop and refine a uniform benefit package, taking into account the costs to the Nation. Is Congress involved? Yes, Congress is involved. But under our plan Congress can only vote up or down—just as we do in the base closure process now. We can say we want it or we do not want it. But we will not have the power to amend it. And that is very, very important. Keep Congress from amending the package or we all know it will be so large that the Nation will not be able to afford it.

Our guidance to the commission under the Senate Republicans' plan is to ensure basic coverage with an emphasis on preventive care. Beyond that, we leave it up to the commission.

As to universal coverage. I will just say we all seek that goal. Under the Republican plan we first cover those at 90 percent of poverty and see if the savings that we have set forth indeed do create the savings that we think should be there. If so, then we expand the coverage to those at 100 percent of poverty and below, and thus work our way upward until eventually we get to 240 percent of poverty. We do not cover the entire premium at that level, only a portion, on a sliding scale. But it is a pay-as-you-save proposal.

While I was relieved to see the Clinton draft bill establish a more realistic timetable for achieving universal coverage than the original outline—the plan still fails to tie the extension of coverage to actual savings. Instead, it relies upon an unspecified ceiling to prevent the subsidies from becoming an open-ended obligation for the Federal Government. If, and when, the ceiling is breached, Congress would be called upon to either cut the program or identify new funding sources—a decision most of us could predict today. Thus, the proposal amounts to an enormous new liability—one that we have no earthly way of estimating.

Finally, I want to speak to the issue of creating new entitlements in health care reform legislation. The growth in the Medicare and Medicaid programs, two of our most significant entitlements, is one of the most compelling reasons to reform our health care system. Despite our best efforts to control the cost of these programs over the past decade, both have grown by 10 to 15 percent annually.

We have to be very careful about adding new open-ended spending programs.

By their own estimates, the administration says adding the prescription drug benefit to Medicare will cost $66 billion over 6 years. Enhancing long-term care benefits, they estimate, will cost $65 billion over that same period. The Federal Government paying 80 percent of the retiree health premiums for many citizens who retire at age 55—an obligation normally borne by private industry—is another extremely costly obligation we cannot afford.

In closing, let me make one final observation. As a member of the Finance Committee who has been involved for many years in efforts to hold down the rate of increase in Federal health expenditures, the estimates we based our decisions on were always wrong—sometimes exponentially wrong. And I predict the assumptions we base our health care reform decisions upon over the next year will prove wrong, too. That's why we must proceed with caution.

Let us find what works and what doesn't work. We can achieve coverage of all Americans. Let us do it right.

Mr. BOND. Mr. President, the Senator from California is on the way out to her State to deal with the disaster there. She has asked for 2 minutes. I ask unanimous consent she be recognized for 2 minutes not to be charged against our time.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Chair recognizes the senior Senator from California.

CALIFORNIA FIRES

Mrs. FEINSTEIN. Thank you, Mr. President. I thank the Senator very much and beg the indulgence of the United States Senate in this regard.

It is my view that the situation in California is extraordinarily serious, and I believe the President will most likely declare a disaster very shortly. I believe, also, based on the fact that I have had a lot of disaster training, I can be helpful in California with FEMA. I would like to ask one thing of FEMA, that in five counties they immediately get their eligibility people working in those counties so they are available. Second, I think Senator BOXER will be joining me, and, quite possibly, the Secretary of the Interior, Bruce Babbitt.

It is my request of the leadership, if possible, to move up the cloture vote. We would like to get to California just as soon as we possibly can. The most serious fire is the Laguna fire, which has burned 8,000 acres, destroyed more than 300 homes, has 1,000 firefighters and 125 engines; 25,000 people have been evacuated. It is at about 30 percent containment with no control. That is the fire that was believed to have been started by an arsonist.

They are hopeful to be able to gain some containment on it. As you know, it has destroyed a school, it has approached the town. These are very large and very serious fires. And, with the Santa Ana winds blowing, it makes it even more serious.

I would like to say just one thing to the people in the fire area. That is, we are all Californians for one reason. We believe we can conquer things like this. Now is the time for all of us to come together, to stand together, and to be helpful to one another. I would be hopeful that there would be no looting and that no one would proceed in any way other than a helpful manner, to help one another. We can survive this and we will if we work together.

I yield the floor and thank the Senator very much for the time.

The PRESIDING OFFICER. The Senator from Missouri has approximately 17 minutes left from his half-hour.

Mr. BOND. I thank the Chair. Mr. President, our thoughts and sympathies and very best wishes go with our colleagues to California as they deal with these disasters. As one who has experienced this all of this summer and into the fall, we truly understand the problems they face.

HEALTH CARE REFORM

Mr. BOND. I wish to yield to my colleague from the State of Washington who has a very pressing engagement himself and has been a great leader in developing health care proposals. I yield 4 minutes to Senator GORTON.

The PRESIDING OFFICER. The Senator from Washington is recognized for 4 minutes.

Mr. GORTON. Mr. President, those Members on the other side of the aisle who just a few moments ago lauded the President, his administration, and Mrs. Clinton, for their proposal and for putting health care at the top of the agenda of the Congress of the United States, did so accurately and did so in a way in which this Senator would like to join. We are in this debate because of their interest in the subject. It is an important first step toward an accommodation, toward a melding of plans which will provide health care security for the people of the United States at a price which they can afford.

This Senator wishes to associate himself with the remarks of the Senator from Rhode Island on a number of the features of this bill, most particularly the attempt to create a basic health care plan by statute and to share his apprehensions that, if Congress places itself in the midst of that debate, this will not be a basic health care plan but the most expensive which could possibly be devised under any set of circumstances.

This Senator, representing the State of Washington, however, has some extremely serious concerns about other aspects of the President's plan. The legislature of the State of Washington in the spring of this year, at the insistence of our Governor, passed a comprehensive health care reform which was approved by a wide sector of the population of the State of Washington. At the time of its passage, our Governor came to Washington, DC, spoke to President and Mrs. Clinton, and was assured that the Washington State plan would be a pattern for the Federal plan and that the State would be able to implement what its legislature had decided to do.

This Senator got the same assurances in writing from the Secretary of Health and Human Services and from Mrs. Clinton. Reading the plan, however, those promises have not been kept. The State of Washington will not be able to implement its plan. Its legislature will have to meet and revamp it totally from the beginning. The plan which the President has is far more regulatory and far more centralized. It is far more expensive from the point of view of employers, both large and small in the State of Washington. The President's plan includes no ERISA waivers that are needed by Washington or by any other State requiring those waivers, and allows flexibility to the State only if the State becomes more regulatory than is the Federal system and goes directly to a single-payer plan.

This is not the flexibility which the people of the State of Washington were explicitly promised by the administration. It frustrates all of the work that they have done to bring people together and says that work has been wasted.

This is an extremely serious problem. Our citizens do not want and do not deserve to be taxed twice for the same set of services. They do deserve the flexibility to carry out their own desires in a way which is responsible, which provides health security for all of the people of the State, which covers everyone, which is universal in coverage and which will not inevitably end up being the tremendous Cadillac or Mercedes of a specific statutorially imposed plan that is inevitable with respect to the President's bill.

We do need to work together. We do need to come up with a proposal which the people of the United States can afford which guarantees health care security for all and which allows States which have acted responsibly in this area to enforce and to administer their own plans. I regret that at this stage, the President's plan does not do so. I trust that during the course of the debate, it will be modified very much in the direction of suggestions of the Senator from Rhode Island and others who are concerned with this issue and become a true health security plan for all Americans which all Americans can afford.

Mr. BOND. Mr. President, I thank the distinguished Senator from Washington. I think he has done an outstanding

job in outlining concerns that many of us have about overregulation in the proposed health care plans.

Certainly, I can understand the view as a Senator from Washington he would have about the potential denial of flexibility for that State to determine its own health care programs and needs. Similarly, I believe that the comments by the Senator from Rhode Island [Mr. CHAFEE] outlined the real dangers in having the political process try to determine benefits.

Mr. President, I had the pleasure of serving as Governor of the State of Missouri for 8 years, and if ever there was a time when the old adage applied that, "If you like sausage and the law, don't watch either one of them being made," if it ever applied to the legislative process, it was during the debates on what had to be provided in terms of health insurance and health care coverage. That is the political process at its least charming, its least effective, and its most costly.

Mr. President, in the previous hour, I spoke about the HEART Program, the program that many of us on this side of the aisle are supporting. We said clearly that we believe under this program we do achieve universal access and coverage to all Americans. We provide them with the security of knowing there is health insurance or their health plan is not going to be canceled or the premiums jacked up when they get sick. If they move from job to job or into or out of the job market, they are not going to lose their insurance. They are going to have to pay the premiums, but they will either get tax deductions or, if they are poor, they will get vouchers to pay them, but they will have to pay.

We also believe that competition is working today where employers and other purchasers have come together and they have used information, electronically developed information to find out which hospitals and doctors and plans provide the best health care.

We believe that can assure competition and will drive the provision of health care services to the most effective and least costly.

We have spoken already, and I have addressed the question of why we did not go for employer mandates. Very simply, they cost jobs, particularly low-wage jobs. Also, I talked about the budgetary dangers of promising a gold-plated plan. We could not only destroy the health care services in this country, but we could bankrupt the Federal Government if we continue to provide more and more expensive plans without paying for them.

I want to spend just 2 minutes to talk about why we believe voluntary cooperatives are necessary for purchasing. Voluntary entities are working now—they were established in California and other States—they are working without being established by the State but by individual business groups in Cincinnati, Minneapolis-St. Paul, and in other areas. They have to work well if they are voluntary and not mandated. They have to provide good service.

I was a little bit concerned as I flipped through the Health Security Act. I apologize; I have not read it all yet and may not, but I went through to see what these mandatory alliances that everybody would have to acquire their health insurance for would do. They are not just purchasing cooperatives. They would monitor premiums to ensure they stay below 120 percent of the weighted average; they would establish a fee schedule for fee-for-service plans; they would update rates of fee schedules; they would monitor the budget, and if it turns out that spending more than the National Health Board, the Federal Government says is appropriate, they would reduce payments to meet the budget. People are going to get their health care rationed by these mandatory health alliances.

The alliances would be required to ensure the enrollment of all eligibles. Where there is oversubscription, if too many people are on a fee-for-service plan, then they engage in random selection. If you go to an alliance, you might not get the plan you want because they have to live under a budget and that limits them.

They would approve or disapprove marketing promotional materials provided by the health plans and they would require health plans to serve designated community service providers.

These are regulatory activities that I do not believe are the proper mandate of Government or supposedly a voluntary purchasing cooperative.

We want to work together with the Members on both sides of the aisle to ensure universal access and coverage for health benefits that cannot be taken away if you get sick and cost containment through competition.

Mr. President, I yield the remainder of my time to the Senator from Texas [Mr. GRAMM].

The PRESIDING OFFICER. The Senator from Texas has approximately 6 minutes.

Mr. GRAMM. Mr. President, I thank our dear colleague from Missouri for yielding.

As we all know, yesterday we finally got a copy of the President's bill, and the most striking thing to me about the President's Health Security Act is that with all the discussion about universal coverage, with all the discussion about guaranteeing that Americans get health insurance and keep it, when I look at this bill, I find that 19 pages of this bill have to do with universal coverage and 1,323 pages of this bill have to do basically with the Government taking over and running the health care system of America.

The President said yesterday that he was willing to compromise on health care and so are we. We think we can work with the President to help Americans get a good insurance policy and to help Americans keep that insurance policy. If they change jobs, we want to change the system so they do not lose their insurance. If they get sick, we want to change the system to ensure they do not lose their insurance. But where there is going to be a major difference—a difference in philosophy, a difference in values, a difference in belief about how markets work and how Government does not work—is not about the 19 pages having to do with universal coverage; it is about the 1,323 pages that have to do with the Government taking over the health care system.

The real debate is not going to be about helping Americans get covered. The real debate is whether or not we can control cost by trying to promote price sensitivity and price competition, which is the basic Republican approach and, quite frankly, the American approach. We do not have efficiency in providing food to the American people because of the Government. We do not have efficiency in terms of producing automobiles because of the Government. We do not have efficiency in providing housing because of the Government. We have efficiency in those areas because of price competition, and we want to bring that price competition to medicine.

That is what the debate is about: Shall we deal with costs by having the Government run the health care system? Is there anybody who can believe that by having the Government take over the health care system that we are going to reduce costs, that we are going to reduce paperwork, that we are going to reduce bureaucracy?

I sometimes wonder, Mr. President, if this is a joke or a debate.

I wish to share one little interesting thing with my colleagues this morning which I think is a perfect example of the doublespeak of this bill on a fundamentally important subject.

Let me begin on page 15. On page 15 of the President's bill, we have a subheading that everybody is going to love to see. It says:

> Protection of Consumer Choice.

The President is very sensitive because he knows his bill limits consumer choice, but he does not want the American people to know it. So he has a subheading:

> Protection of Consumer Choice.

Then he says:

> Nothing in this Act shall be construed as prohibiting the following:

And the big item is:

> An individual who is not an eligible individual from purchasing health insurance (other than through a regional alliance).

In other words, if you are ineligible for this plan, you can go out and buy

private health insurance. It sounds good. But then you look back to page 14. You find out who is eligible:

A citizen or national of the United States; an alien permanently residing in the United States; a long-term nonimmigrant.

Who is eligible to buy private health insurance under the President's plan? It looks to me like an illegal alien. Nobody else would qualify for this consumer choice. The real story on this issue, Mr. President, is over on page 239. And when the American people understand this provision, the President's plan to have the Government take over the health care system is going to die a quick and deserved death. Let me read it:

No health plan, insurer, or any other person may offer to any eligible individual—

That is everybody in America but illegal immigrants—

a supplemental health benefit policy that duplicates any coverage provided in the comprehensive benefit package.

That provision on page 239 cancels the private insurance policy of virtually every person living in the United States of America. Now, what happens if somebody tries to sell you a private insurance policy, remembering that this is the United States of America we are talking about. What happens is, and this is on page 241:

An entity that knowingly and willfully violates any provision of this section with respect to the offering of a supplemental health benefit policy to any individual shall be subject to a civil monetary penalty (not to exceed $10,000) for each such violation.

In other words, under the President's plan, if you work for a normal company with 200 employees, your health insurance is going to be canceled. You are going to have to buy health insurance and health care through a government collective. Anybody who tries to sell you private health insurance can be fined $10,000 for trying to do it. Is that consumer choice, when you cannot go out and buy a private health insurance policy from Blue Cross-Blue Shield? Is this a free country? That is the relevant question.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. HOLLINGS addressed the Chair.

The PRESIDING OFFICER. There is 30 minutes under the control of the majority.

Mr. HOLLINGS. Mr. President, I ask unanimous consent that I proceed for 15 minutes under that 30-minute order.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Chair recognizes the Senator from South Carolina for 15 minutes.

NORTH AMERICAN FREE-TRADE AGREEMENT

Mr. HOLLINGS. Mr. President, with respect to the North American Free-Trade Agreement, I am very saddened to see the attack strategy of our administration, the dissembling, and outright fraud they have resorted to in their campaign to sell this agreement—an agreement that is clearly to the detriment of U.S. economic interests.

The President earlier this week touted his White House tent display of products the United States exports to Mexico. He pushed the theme. "Why Can't We?" And he was very passionate about the United States: "Don't tell me we can't compete with little Mexico."

That is a complete misstatement of what is at issue with NAFTA. It is not the worker of the United States failing to compete with the worker of Mexico. It is the President of the United States failing to compete with the President of Mexico. The President of the United States is a democratically elected executive whose power is checked, generally speaking, by the power of the Congress. It is the President and the Congress that have burdened U.S. industry with huge, mandated costs of production. We come in, Republican and Democrat, President and Congress, and we require that businesses foot the bill for Social Security, health care, safe working place, safe machinery, plant closing notice, parental leave, clean air, clean water, and so on. And every one of these mandated costs increases the cost of U.S. production. In contrast, the President of Mexico, virtually a dictator, assures that regulation of industry exists on paper only—is not enforced—and that independent labor unions are strangled in the cradle.

So we face a totally incongruous situation of free United States markets and free United States labor competing with controlled Mexican markets and controlled Mexican labor. This is a sure-lose situation for the United States. Look at what has happened in a similarly incongruous trade relationship with China. In a 5-year period, we have gone to a $23 billion annual deficit in the balance of trade with China. And if they think this is the model for proceeding now with Mexico, they are crazy. If so, why not get a free trade agreement with China, which has prison labor and strict control by the Communist government?

Do not dare question the ability of the U.S. worker to compete. The Christian Science Monitor recently ran an article titled "U.S. Still Leads the Pack on Productivity." The article confirmed that, with respect to national output per capita, with respect to labor productivity, with respect to manufacturing productivity the American worker is No. 1 by far. Japan and Europe trail way behind.

We are No. 1, yet we have cut back our real wages in the United States. Our take-home pay has been going down the last 20 years and we are still the most productive. So do not preen at the White House with these tents and toys. And do not portray this cross-border competition as some kind of sports show by saying, yes, we can compete with little Mexico. It is he, the President, we, the Government, who are not competing with the Government down there.

The next dissembling point, of course, is to plead that, well, the United States is going to lose jobs to Mexico anyway. Mr. President, I have a personal experience in this light. I have been championing now for 27 years the adoption of a textile bill. It was passed five times, vetoed four times, but passed in this Senate five times. Each time I have been in intimate association with the executives and labor leaders of the textile industry.

One of the things we have been fearful of for the last 7 years is the General Agreement on Tariffs and Trade—GATT—the Uruguay round. GATT includes a proposal that would phase out our multifiber arrangement regarding textiles.

Interestingly, the Bush administration U.S. Trade Representative produced a study showing that GATT's phaseout of the multifiber arrangement would lose over a million U.S. jobs. Carla Hills deep-sixed that particular report. This was followed by a study by the Wharton School of Business showing we would lose 1,300,000 jobs and the U.S. textile and apparel industries would be devastated.

Now comes NAFTA. The textile industry stands to lose a million jobs, but many executives in the industry do not care about it. I quote one leading voice, a distinguished citizen of my own State and chairman of the board of Springs Industry. He says:

We will always lose the lowest paying, least productive firms in any industry. That is the free market system.

That is Mr. Walter Elijah. Now, this is what disturbs this particular Senator. As their representative, the textile industry wants me to say, "Oh, no, we cannot lose a million jobs because of GATT, but let us endorse NAFTA, it is OK to lose a million jobs."

By the way, do not construe my opposition to NAFTA as blanket opposition to free trade. I supported and voted for the Canadian Free-Trade Agreement because our two countries have similar standards of living and the same free press, free markets, clean judiciary, and so on.

But Mexico is a very different story, with its one-party State, corrupt judiciary, Government-manipulated trade unions, and so on.

Mr. President, after months of denying that NAFTA will cost U.S. jobs, the administration has now moved to create a $3 billion fund to provide relief to communities that will be devastated by NAFTA. This morning's Washington Post reports a proposed new $3 billion North American Development Bank to help clean up the job-loss wreckage that NAFTA will inflict.

Well, that is good news to this Senator from South Carolina because, having myself carpetbagged in the Northeast 30 years ago, now Mexico is carpetbagging in my own backyard in South Carolina.

As companies now based in South Carolina depart for Mexico, now I will have a source of compensation for thousands of South Carolinians who will lose their jobs.

It is too bad we do not have a development bank for South Carolinians who have already lost their jobs to Mexico—unemployed workers from Cummins Engine in Charleston, Pratt Read in Liberty, Kyocera in Conway, United Technologies in Bennettsville, Rotron in Orangeburg. I visited the new Kyocera plant in Mexico 2 weeks ago. Kyocera laid off 681 in Myrtle Beach and another 153 in Conway.

So I am going to call up the folks down in Horry County and tell them we will have welfare now for the 834 jobs lost there.

Mr. President, let me address the matter of Lee Iacocca's TV ads in support of NAFTA. I know Iacocca well, having worked with him a decade ago to extend a $1.5 billion loan guarantee to bail out Chrysler.

I will ask Lee Iacocca to withdraw his ad because it is absolutely false, an absolute fraud, and he knows it. He says:

> Let us not twist the facts. We are worried about the wrong thing at the time and the wrong place. NAFTA opens up Mexico to our machine tools, computers, cars, trucks, electronics—

But Business Week exposes the real game, which is to export to Mexico not products but investment and factories, which will then be used to produce for the United States market. Quoting from a March 16, 1992, article in Business Week:

> Even if negotiations for a NAFTA bog down, Big Three executives expect the Mexican auto industry to double by the year 2000 to 2 million vehicles. And with an agreement, says Ford Motor de Mexico President Victor Barreiro, "We could be making 3 million units a year here, or more."

The same article quotes one Big Three executive in Mexico City: "We would put a lot more plants in Mexico if it were not for the UAW."

That tells the story. The UAW is trying to maintain standard of living, health care, and jobs.

> We would put a lot more plants in Mexico if it were not for the UAW.

Of course, we well understand Mr. Iacocca's enthusiasm for Mexico and NAFTA. As chairman at Chrysler, he built an engine plant in Rames Arizpe; expanded his Toluca, Mexico, plant by $100 million, and built a new truck plant at Alargo Roberto with a capacity of 150,000 vehicles.

Incidentally, Chrysler pays the 25 percent on the trucks they import from Mexico. With NAFTA, that tariff is reduced to 12.5 percent immediately, then phased to zero in 5 years.

It is not just the Big Three. Nissan is investing $1 billion in a new plant in Mexico. Volkswagen has announced a $1 billion investment in their plant in Mexico. Those cars will be produced not for the Mexican market, but for the United States market.

The sucking sound is not only caused by investment and jobs leaving the United States for Mexico. The sucking sound is caused by investment from Asia and from Europe locating in Mexico as a duty-free export platform for flooding the United States consumer market. That is the big game under chapter 11 of NAFTA. European and Asian investors get security that they cannot get from the Mexican dictatorship government right now without NAFTA's safeguards.

Along comes the Special Trade Representative, Ambassador Kantor last week, and he parroted the same line. I quote again from Iacocca's pro-NAFTA ad.

> Now the Japanese and Europeans think NAFTA is a bad deal. Why? Because it is good for us and it is bad for them. It puts them on the outside looking in on the biggest market in the world.

It puts them on the outside, shipping into the biggest market in the world. Who is kidding whom? I asked Mickey Kantor. I said, "Mr. Ambassador, you show me one article that says folks are against NAFTA in Asia. Show me one article that says folks are against NAFTA in Europe." On the contrary, Europe and Asia are gung-ho for NAFTA for their own selfish reasons.

I recently returned from the British-American Parliamentary Union in Edinburgh. There were Senators there, and 13 British parliamentarians. The British were constantly chattering: "NAFTA, you go ahead with NAFTA."

It got so oppressive that I finally said, "Wait a minute. What about Turkey and the Common Market? You don't mind Turkey in NATO, where they are fighting and dying for you, but you don't want the Turks to trade with you within the Common Market?"

He said, "That is insulting."

I said, "That is the fact. You support NAFTA because you plan to set up plants there with the Asians in order to export duty free into the richest market in the entire world."

Look at this headline from the Japanesse press: "Bank of Tokyo Bullish on Mexico."

I quote from the article:

> Manufacturers and exporters to the United States market would obviously benefit by locating in Mexico where their products crossing the border north would not be subject to tariffs.

I quote further:

> Mr. Hayama said, "Some Japanese companies may have bad memories of the Mexican Government's attempts to enforce policies on foreign ownership and industrial strategy. But I believe that once Mexico is part of NAFTA, its government will find it more difficult to change policy at its own convenience. Moreover, since Mexico will be concerned about being overwhelmed by the gigantic United States economy, it likely will want substantial Japanese investment as a counterbalance."

Let me cite an article from the Journal of Commerce titled, "U.S.-Mexican Firms Join to Provide Real Estate Services."

In the article, Frank Binswanger is quoted saying:

> There has been a tremendous amount of movement by European, American, and Japanese companies into Mexico to take advantage of NAFTA.

A 1992 headline in the Daily News Record reads: "NAFTA No Barrier to Apparel From Asia."

The Journal of Commerce reports that Chinese textile companies are negotiating joint ventures to move production behind the trade barriers into their No. 1 market, the United States. The Journal quotes an Asian businessman saying, "Let there be no doubt. Exemption from quotas and duties is the main motive for the venture." The article notes that the Shanghai Textile Bureau bought 100,000 square feet of land in the Mexican trade zone for a textile factory.

Rho Tae Woo, the President of South Korea, said in the Journal of Commerce that the proposed North American Free-Trade Accord would boost Korean investments in Mexico.

Mr. President, who is kidding whom about the Asians being afraid of NAFTA? This is another strawman in the NAFTA debate. That is the whole fraud. And they do not want to have any debate here in the U.S. Senate. They put on these tent shows, orchestrate articles in the press, and buy these double page pro-NAFTA ads. Iacocca says support for NAFTA is a "no brainer." Mark Twain said, "The truth is such a precious thing it should be used very sparingly." That is the Iacocca philosophy.

"So let us not build a wall around ourselves just when they are coming down all over the world," says Iacocca.

Break down a wall? We are trying to break down the wall of one-party rule and corruption down there in Mexico. We want to open it up with a common market approach, to build democracy, and build the economic strength of both countries. We are for Mexico. We are for the Common Market approach. But we are not going to be sold this bill of goods on NAFTA which is going to inflict very real harm on the economy of the United States.

I thank the distinguished leader for the extra time.

Mr. DASCHLE addressed the Chair.

The PRESIDING OFFICER (Mr. AKAKA). The Senator from South Dakota is recognized.

Mr. DASCHLE. Mr. President, as I understand it, a certain amount of time has been designated to the majority for morning business purposes.

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The PRESIDING OFFICER. The Senator has 15 minutes remaining.

Mr. DASCHLE. Mr. President, I ask unanimous consent that that 15 minutes be extended 5 minutes, to make it 20 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

THE HEALTH SECURITY ACT

Mr. DASCHLE. I yield myself 10 minutes at this time.

I rise to join many of my colleagues this morning in congratulating the President and the First Lady for the presentation of the Health Security Act yesterday in Statuary Hall. I commend them not only for making the presentation but for the specificity with which they have now addressed comprehensive health care reform in this country.

The President, in elaborate detail, outlined exactly what his intentions are. He committed himself a month ago to six very important principles when he enunciated his goals for health care reform. Yesterday, we had the opportunity to hear exactly what he has in mind as he addressed each and every one of those principles. I hope over the next several months, as we examine the worthiness of each of those principles, we also ensure that we define those principles exactly.

There is a big difference, for example, Mr. President, in talking about the need for universal coverage when some of the competing plans also talk about something universal—but it is not coverage, it is access. The President outlines his strategy for providing universal coverage to every single American. That is what we are talking about when we talk about security—security for every American regardless of his or her circumstance. But there is a difference between providing universal coverage and, as many of the other plans do, providing some degree of additional access. I think that is a very important distinction.

The President has also indicated exactly how he intends to acquire savings, another principle he announced, along with simplicity, choice, quality, and responsibility. The President specifies in elaborate detail how he fulfills each of these principles, and his method for achieving these goals will be the subject of intense scrutiny over the next several months, as it should be. So I commend the President and this administration for their leadership in bringing us to this point.

Let me also commend the large number of cosponsors who have indicated they, too, want to be part of the increasing momentum for health care reform, led by the President. They are: the Presiding Officer, Senator AKAKA; Senator BAUCUS; Senator BOXER; Senator BUMPERS; Senator NIGHTHORSE CAMPBELL; Senator CONRAD; Senator DODD; Senator FEINSTEIN; Senator GLENN; Senator GRAHAM; Senator HARKIN; Senator INOUYE; Senator JEFFORDS; Senator KENNEDY; Senator LEAHY; Senator LEVIN; Senator MATHEWS; Senator METZENBAUM; Senator MIKULSKI; Senator MITCHELL; Senator MOSELEY-BRAUN; Senator MOYNIHAN; Senator MURRAY; Senator PELL; Senator PRYOR; Senator REID; Senator RIEGLE; Senator ROCKEFELLER; Senator SIMON; and Senator WOFFORD.

Mr. President, already 31 Senators have committed themselves to the passage of the Health Security Act. We have 20 more to go, and I am convinced that over a period of time that is exactly what we will have.

This is a historic opportunity. It is an opportunity for us to address, in a comprehensible way, a problem that has been undermining the economy, and the fabric of our society for too long. It is an opportunity not only to address one of the most perplexing and complex domestic issues facing our country, but I believe it is an opportunity for us to prove to the American people that we have the capacity to address and solve a problem as consequential as this. We need to be able to tell the American people when this day is done that we have, in a constructive, bipartisan way, led the country to a new day in providing health security and savings to all citizens. We must be able to assure all children they have the opportunity to receive health care for their entire lives. We must be able to tell workers that they no longer have to worry about whether they work for an employer who provides insurance or an employer who does not, because that worker will always have coverage. That is the kind of leadership our people want from this Congress. This is our opportunity to demonstrate that we can lead, that we can provide innovative approaches to solving the problems this country faces.

There is a good deal of cynicism about that, Mr. President, about whether we have it within ourselves to put partisanship aside, to put all of the special interests outside of this Congress where they belong as we begin to grapple with this problem.

Americans are saying: Show me. If you want my respect and support, then show me that you can take a problem as important as this and solve it. Show me. Prove to me that my cynicism is not warranted.

Well, I hope that as we begin this debate, we can deal with what I consider to be the single biggest obstacle facing us. That obstacle, Mr. President, is misinformation. It is perpetrated by special interests who do not want this legislation passed. It is perpetrated by people even within this body who do not feel the need to pass comprehensive health care reform. There will be a good deal of misinformation, and it is up to us to sort it all out.

I am concerned about the degree of hyperbole that I have already heard about socialized medicine and all of the old rhetoric that we have heard for years and years that has kept us from passing comprehensive health care reform. So let us beware that we are going to hear misinformation and hyperbole, and it is important that we filter it out.

In that regard, I do hope that we hold all health reform plans to the same standard of scrutiny to which we hold the President's plan. I do hope that as we analyze the Health Security Act, we put all of the plans side by side and evaluate just what they do. I must say that I have had that opportunity, and in so many of the categories that we agree are important, the competing plans fall miserably short. Many do not provide universal coverage. Many do not provide a plan for savings. Many do not provide a comprehensive financing scheme. Many do not require personal responsibility on the part of the American people.

So if, indeed, we are going to analyze all the plans and look at their strengths and weaknesses, let us compare them in an honest way.

In that regard, I must say I am very disappointed at today's edition of the Washington Post for the cursory manner with which it tried to compare various health reform plans. The chart they printed is a real disappointment. I believe they can do better than this. For example, when I look at the financing category, the chart says the way that Senator CHAFEE intends to finance his plan is to limit deductions on premiums and reduce Medicare and Medicaid spending. Is that the entire financing mechanism? For the Clinton plan, they list several financing sources: an employer payroll premium, an employee contribution, a 75-cent cigarette tax, and a 1-percent payroll tax on large employers. They have quite a bit of detail when it comes to the Health Security Act. But when they discuss the Chafee, Cooper, Michel or Gramm plans, they do not have nearly the same level of detail. For the Gramm plan, for example, all it lists is a cut in Medicare and Medicaid. Does this imply that a cut in Medicare and Medicaid is going to finance the entire health care system?

Let us be more thorough and honest as we analyze these plans.

I think it is important as we look at these proposals that we analyze them correctly, in a way that gives us the best information, in a way that compares apples to apples and oranges to oranges.

There was an article this morning in the Wall Street Journal that I feel does merit mention in the RECORD, Mr. President. The article discussed the effect that the Health Security Act will

have on small businesses. It contains a chart that describes in very elaborate detail what your responsibility will be if you have a certain wage and if you work in a certain firm. That, of course, is determined in part by the size of the firm and also the level of wages.

I ask unanimous consent that this be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

WHAT SMALL-BUSINESS OWNERS FACE UNDER HEALTH PLAN

(By Eugene Carlson)

WASHINGTON.—On the morning after the official unveiling of President Clinton's massive health-care legislation, small-business owners will be facing a single question: What do I do?

The simple answer: nothing, for now, but stay tuned.

The plan naturally is subject to great change, or even defeat, in Congress. In any event, the administration says it will take three years of groundwork to provide health coverage under the new plan for even the first 15% of the U.S. population. While the program could begin in some states as early as 1996, coverage for all Americans isn't expected until Jan. 1, 1998. And with congressional debate over the plan likely to last for months, the start-up in many states could take even longer.

While the final form of any new health-care plan is uncertain. Mr. Clinton's Health Security Act is likely to form the framework for a policy that will affect every small employer and self-employed person in the nation. The bill that the White House presented yesterday is the most detailed and definitive version of the plan yet.

Here are the basics of how it would work:

All employers would be required to pay at least 80% of a basic health insurance package for full-time employees. Workers would pay up to the remaining 20% through payroll deductions. Part-time workers would be covered by smaller employer contributions.

Low-wage businesses with 75 or fewer employees would receive substantial subsidies on the price of insurance, depending on the size of the company and the average wage. That is a change from earlier versions of the plan, which had said the financial assistance would apply only to firms with 50 or fewer workers.

A White House briefing paper accompanying the bill says, "For the smallest firms that pay the lowest wages—such as restaurants—the percent of payroll devoted to health care may be as low as 3.5%. That amounts to $350 a year [per worker] for a company with average wages of $10,000—or less than $1 a day per employee."

To get the plan rolling, every employer would be required to submit employee names, Social Security numbers, family status and wages. The information would be collected by a health alliance in the employer's state.

Alliances would be the engines that drive the Clinton health plan. They would negotiate the terms of health coverage by insurers and bill companies for their contributions. Each state would have at least one alliance, and populous states might have several. Alliances would bill employers monthly or quarterly, and the bill would be adjusted for changes in employment levels and hours worked.

The White House says it has tried to simplify bookkeeping for employers by requiring alliances to levy a fixed contribution for each employee category: single person, couple, single parent and two-parent family with children. "There will be one employer price for family policies, regardless of whether both spouses work, or how many children they have," the Clinton briefing paper says. (In cases of two-income couples, both employers will pay the price.)

Here are two examples provided by the White House illustrating how the Clinton plan would affect small employers.

FLOWER SHOP

Mr. and Mrs. Jones, who have two children, own a flower shop. They have three employees—Matt, Jane, and Scott. Matt is a 16-year-old high school student who works part-time after school. Jane and Scott work full time. The shop's average payroll, which includes the Joneses' salary, is $17,000 per year per worker.

Without figuring in subsidies, the flower shop would pay the employer share of $1,546 each for Scott and Jane for a single-person policy, and $2,479 each for Mr. and Mrs. Jones for a two-parent policy—a total of $8,050.

But subsidies for small business would limit the shop's contribution for each employee to 5.3% of the average payroll. The shop would pay no more than $901 a year for each worker. For all four workers and their dependents, the cost would total no more than $3,604 a year.

Because Matt would be covered under his parent's policy, the flower shop wouldn't contribute toward his health insurance.

In addition to what they pay as owners of the shop, Mr. and Mrs. Jones would pay the employee share of their family policy—$872 a year if they enrolled in an average-priced plan. Totaling the employee share and the employer share, Mr. and Mrs. Jones would have family coverage for $2,674 a year.

The total insurance bill: $4,476, consisting of $2,674 for the Jones family coverage and $901 each for Jane and Scott.

SELF-EMPLOYED CONSULTANT

Susan Addington is a single parent living in Virginia. She is self-employed with an income of $40,000 a year. For the family share of her premium, for an average-priced plan, Susan would pay 20% of the $3,893 annual premium for a single parent family, or $779 a year.

She would also pay the employer share for a single parent, or $2,479, for a total of $3,258 a year or $272 a month. And she would be able to deduct 100% of the premium from her taxable income. Currently, self-employed persons can only deduct 25% of their health costs.

The final requirement will depend on what, if any, bill eventually emerges from Congress. Alternative bills proposed by the Republicans and some moderate Democrats wouldn't require companies to provide health coverage for employees.

CURBING THE COST

[Revised cap on small-company payments for health-care coverage as a percentage of payroll]

Average annual wage (in thousands)	Firm size		
	Less than 25	25–50	50–75
Less than $12	3.5%	4.4%	5.3%
$12 to $15	4.4%	5.3%	6.2%
$15 to $18	5.3%	6.2%	7.1%
$18 to $21	6.2%	7.1%	7.9%
$21 to $24	7.1%	7.9%	7.9%
More than $24	7.9%	7.9%	7.9%

Source: White House.

Mr. DASCHLE. Mr. President, I will close simply by saying that yesterday was an important moment. It was the second in a series of stages that we will see over the next several months, the third being the formal introduction of the President's bill, perhaps within the next couple of weeks. With formal introduction comes the official consideration of the plan. Let that consideration begin. Let us analyze these bills. Let us develop in a bipartisan way the very best bill we can, but let us make sure we all have the same facts.

I yield the floor.

The PRESIDING OFFICER. The Chair recognizes the Senator from Pennsylvania, [Mr. WOFFORD].

Mr. DASCHLE. Mr. President, will the Senator yield for a moment for me to make a unanimous consent request?

Mr. WOFFORD. I yield.

UNANIMOUS-CONSENT AGREEMENT

Mr. DASCHLE. Mr. President, on behalf of the majority leader, I ask unanimous consent that when the Senate resumes consideration of H.R. 3167, the unemployment bill, there be a time limit of 40 minutes for debate on the Nickles amendment No. 1089, with no second degree amendments in order; that the time be equally divided and controlled in the usual form; that when the time is used or yielded back, the Senate vote on or in relation to the Nickles amendment; that upon disposition of the Nickles amendment, the Senate then resume consideration of the motion to invoke cloture on the conference report accompanying H.R. 2520, the Interior appropriations bill; that there be 25 minutes of debate, with 15 minutes under the control of Senator WALLOP and 10 minutes under the control of Senator REID; that when the time is used or yielded back, without any intervening action or debate, the Senate vote on the motion to invoke cloture.

This has been cleared by the Republican leader.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DASCHLE. I thank the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

HEALTH SECURITY ACT

Mr. WOFFORD. Mr. President, yesterday we did indeed reach another milestone, a milestone in the work that Pennsylvanians sent me down here to do. Nearly half a century ago Harry Truman first proposed national health insurance and he was beaten, but now, after decades of false starts and gridlock, Washington is finally responding to the self-evident truth that quality, affordable health care is a right of all Americans not a privilege for the use of the few.

Everyone has now, I think, got the message Pennsylvanians sent in 1991

that American families and companies cannot afford the growing insecurity, the skyrocketing costs, the loss of choice of doctors and plans, the out-of-control paperwork and red tape of our current system.

During that debate 2 years ago the question was whether to reform our health care system. Now we won that debate. The question is how.

The President's proposals, I am happy to say, are in line with the bill that Senator DASCHLE and I introduced last year. But what is more remarkable is the amount of common ground so many Democrats and Republicans now share, common ground that did not exist 2 years ago. The challenge for us in Congress in the months ahead is to build on that bipartisan common ground and craft a uniquely American plan to change what is wrong and preserve what is right with our health care system in this country.

I believe the President's Health Security Act provides the best single blueprint for action. No one believes that any one plan is perfect, and there is plenty of finetuning to do. Some improvements were made in the President's plan in the last 2, 3, or 4 weeks.

No one side has all the answers. There are a number of alternative health care plans now on the table. Up to now almost all the debate has focused on the preliminary draft of the President's plan. Now we have the full details and full weight of the President's proposal and we will examine them closely in public hearings.

We must also apply that same standard of critical, skeptical scrutiny to the other main alternatives. I am convinced that nothing will do more to build support for the Health Security Act than a full discussion with the American people about what the alternatives are and how they fall short.

Some are arguing that we should only take a few steps at this time and enact partial solutions, that the status quo is not all that bad. But reforming a $900 billion, going on to $1 trillion health care industry is like crossing a canyon, a deep canyon. We have to reach the fixed goals on the other side of universal coverage and cost control. As Wile E. Coyote always found out chasing the road runner, you cannot get across the abyss in two jumps. Getting only half way there leaves you in midair, heading for a long, painful fall. To do the job right—and we have the historic opportunity now to do the job right—we must make it all the way across that deep canyon to the other side and get to health care that is always there and that we can afford.

To varying degrees each of the other alternatives before us fails to get us there. They fail the fundamental test of real health care reform that I have been working for and so many Members of this body have been working for since they came to this body. Those alternatives do not guarantee comprehensive coverage for everyone, and they do not control the out-of-control costs, the inflation in our health care system.

That is why I have, with due respective, called the Chafee, Cooper, and Gramm proposals, respectively, a tourniquet, a Band-Aid and snake oil. One has some strong insurance reform that will provide only partial help. Another bandages part of the wound. I told Representative COOPER yesterday, a Band-Aid is not bad, it can help, but it offers no cure. And the last, Senator GRAMM's plan, is really just a placebo. More medi-spend, spend your life saving than medi-save.

Mr. President, I will just add a few words now about the third alternative, because both the Cooper and Chafee plans contain a number of similarities to the Health Security Act, and I believe that in the months ahead through debate and analysis the logic of the facts will help us expand those areas of agreement and find the ways to come together on the areas of disagreement. I look forward to that.

As for Senator GRAMM's plan, it does almost nothing to reform a health care system in which costs are out of control and millions of Americans are losing their coverage and millions more are worried every day about losing it. It does not even accept the idea that coverage ought to be guaranteed for everyone, that benefits ought to be comprehensive, or that costs must be controlled. It leaves consumers to go it alone and sink or swim in a ocean of insurance redtape that is leaving Bambi to deal with Godzilla.

The President's Health Security Act, which so many of us are now cosponsoring, guarantees coverage for everyone throughout their lives no matter where they live or work. It guarantees cost controls for both the private and public sector. It does not push the balloon of public sector down only to have it pop up in the private sector on families and companies. It assures that health care benefits will be truly comprehensive with no lifetime limits; that there will be preventive care for all; that there will be consumer choice of health plan and of doctors more than people now have, as they are losing that choice under the cost pressures from their companies and there will be simplicity through the health security card, single claims form and electronic billing.

Now, we have a President who has put a serious proposal on the table that has been the result of months of hard work and bipartisan consultation. Now Congress must take the ball and run with it. The people want action on health care, not more gridlock; they want hard results, not easy answers. We have come too far and worked too hard and the problem is mounting too high for us to turn back or slow down. We have to get across the canyon and deliver the goods.

I yield the floor, Mr. President.

The PRESIDING OFFICER. There is 1 minute 20 seconds remaining in morning business.

The Chair recognizes the majority leader.

Mr. MITCHELL. Mr. President, I yield back the remainder of that time.

RAUL WALLACH

Mr. REID. Mr. President, from time to time, as public servants, we receive correspondence of the most vicious type. I am particularly disturbed when I receive, as I am sure most of us have, letters and materials aimed at trying to prove that the Nazi holocaust never occurred.

Recently our Nation lost a national treasure; a man who by his very existence refuted the claims of those whom Theodore Roosevelt first called the lunatic fringe.

I first met Raul Wallach when I was the best man at his cousin's wedding. I had heard stories about him for years, he seemed a man who was larger than life until I met him. Raul lived up to everything I had heard.

In 1941, when he was still a teenager, the Germans invaded Russian-occupied Poland where Raul lived with his parents, his five brothers and sister. Shortly thereafter, Raul was kidnapped by the Gestapo and turned over to the SS for slave labor. He stole a machinegun and returned to the ghetto where he found his younger brother. Together they escaped to the woods where they joined a Jewish partisan unit.

Raul fought the Germans for the next 4 years. He became a demolitions expert and a partisan leader. After the war he rescued Jewish children and helped smuggle them to what was then Palestine. Unfortunately, except for his younger brother Moishe, Raul's family was not among the survivors. His mother, father, sister and three other younger brothers were murdered by the Nazis at Auschwitz. Raul spoke with eyewitnesses to that murder.

While leading a group of Czech children on a perilous trip to Palestine, Raul was captured crossing the German border. He was interned in an American-run displaced persons camp. Eventually, American cousins serving in the Army of Occupation managed to get Raul and Moishe out of the camp. Raul eventually became a professional motorcyclist and soccer player in Munich.

In 1952 Raul emigrated to Cuba. He spoke seven languages at the time, but Spanish was not among them. On his first day off, while wandering in a Havana casino, Raul met a little old Jewish man with whom he could speak Yiddish. That man was Meyer Lansky. Raul also knew Fidel Castro and Che Guevara during those days in Cuba, but

when the Communists took power he fled the country and moved to Mexico. He had had enough of living under totalitarian regimes.

Eventually Raul and his brother built up a large family steel business. Raul had a beautiful home in Guadalajara and it was in that city that he met the young American woman whom he eventually married.

Raul and Susan were married for over 25 years and were blessed with three children. One of the proudest and happiest moments of Raul's life was when he lived to see his son Ari bar mitzvahed.

Mr. President, Raul Wallach died last week. His family's loss was ours. There is one fewer just man to stand and tell the truth. One fewer just man to bear witness. We who are living must remember him and what by living he taught us. We must, we shall, never forget.

THE AUDIOVISUAL INDUSTRY

Mrs. FEINSTEIN. Mr. President, I rise today to draw attention to an issue that is important to my State of California and important to our Nation's economy—the free trade of audiovisual products.

American movies, television programs, and home video materials, aside from being the best in the world, are also of great value to America's economy. The industry accounts for a balance of trade surplus of over $4 billion a year, up from $3.5 billion in 1991. As a commodity, audiovisual products rank among the top surplus trade items for the United States.

Our trading partners push for access to America's markets, but also attempt to protect their own domestic markets by arguing for a cultural exemption for audiovisual goods. This is plainly unfair and as I told the President, I expect the United States to reject any agreement which includes such as exemption.

Last week both the Los Angeles Times and the Washington Post ran editorials calling for a free market in audiovisual products. I ask unanimous consent that those editorials be printed in the RECORD immediately following my remarks.

I also want to commend the President for his strong statement in support of the inclusion of the audiovisual services in the upcoming GATT accord. I ask unanimous consent that a copy of the President's statement be printed in the RECORD immediately following my remarks. I also applaud the bipartisan leadership of the Senate Finance Committee who have expressed their concern on this important matter.

Mr. President, this industry is more than mere entertainment. It is one of the most dynamic and important industries in my State and in this Nation. I expect that our trade negotiators will not allow our trading partners to exclude the audiovisual industry from the upcoming GATT agreement or any future trade agreement.

There being no objection, the articles were ordered to be printed in the RECORD, as follows:

[From the Los Angeles Times, Oct. 24, 1993]

LIGHTS, CAMERA, QUOTAS!

French films have charmed, entertained and inspired over the years. But do they deserve the special protection that France provides by limiting the importation of movies and other audiovisual products? The French say oui, for the sake of culture. Au contraire, counters Hollywood, which wants unfettered access for its films, TV programs, videos and sound recordings. Who's right?

Open markets best serve consumers and industry. Protectionism, even when it's veiled in the glamour of French stars like Catherine Deneuve and General Depardieu, is a bad script for both box office receipts and cultural relations.

In Geneva, the French are trying mightily to exempt all audiovisual products from a new world trade agreement on services being negotiated under the auspices of the General Agreement on Tariffs and Trade. France and other European Community nations already have quotas on foreign broadcasting materials and films. An exemption would allow import restrictions to continue.

U.S. filmmakers Steven Spielberg and Martin Scorsese recently made the unusual move of issuing statements decrying any restrictions or quotas on audiovisual materials. President Clinton has said that audiovisuals must not be singled out for restrictions.

The American film, television and home video industries generate $18 billion in foreign sales yearly. That is $4 billion more than U.S. purchases of foreign audiovisuals. Without quotas in Western Europe, the market would be even greater.

France and its fellow EC members maintain that limits are needed for the sake of cultural preservation. The French—concerned that opening markets would mean the end of its small, government-subsidized film industry—say works of art should not be subject to crass commercial competition like mere commodities.

The issue isn't French culture or even subsidies. In the case of audiovisuals, French subsidies are not subverting free trade. The issue is import restrictions. Let French audiences decide for themselves what's good, bad or ugly.

[From the Washington Post, Oct. 24, 1993]

FRENCH FILM FIGHT

One of the more colorful subfights to the huge GATT trade negotiation is the one being waged between American movie and TV producers and their European counterparts, mainly in France, on whether "cultural products" such as movies should be exempted from the promised lifting of most trade barriers under the treaty. The combination of strong European emotions on the cultural-patrimony front—especially from the French—and a serious financial irritant to American TV and film producers has fueled a debate being conducted at full rhetorical force and with such supporting characters as Martin Scorsese, a French coal-mining epic and the dinosaurs from Steven Spielberg's "Jurassic Park." Some French commentators have gone so far as to criticize the un-Frenchness of those who flocked to the opening weekend of the hugely popular dinosaur movie, not to mention local media outlets that have given it a tidal wave of hype.

Despite the cultural hoopla, the driving issue here is financial. If the current "cultural exemption" to GATT is refused—the result the U.S. entertainment industry is pushing hard for, with the Clinton administration's support—European Community countries would have to lift a variety of cultural protection mechanisms they have created for their own products against the much larger and stubbornly successful American ones. In all likelihood, for instance, they would have to drop the year-old EC rule that 40 percent of all material broadcast on a country's TV channels be produced in that country, a direct hit at the cheap, plentiful and easy-to-dub American series that those channels are known to buy up when given the choice. Not coincidentally, foreign resale rights have become a larger proportion of American TV companies' profits over the past few years as the U.S. TV market gets tighter.

Running alongside the money question is the old issue that French intellectuals like to call *"Coca-Colonisation,"* the fact, irritating beyond measure to European governments, that American movies and TV programs enjoy huge and continuing international popularity. The French, in particular, like to point out that the American products are so successful not just because of whatever appeal they may hold for viewers—surely not that!—but because of the benefits of a giant, English-speaking home market that eliminates any need for the huge national subsidies most European countries give cultural products. The U.S. contingent doesn't contest those subsidies—only the subsequent protection of the not necessarily popular products produced with their help. Filmmaker Martin Scorsese is quoted in lobbying materials noting that "closing the borders would not guarantee a rise in creativity in the local countries or even a rise of interest on the part of local audiences." Galling as this may be to certain Europeans, he's right.

THE WHITE HOUSE,
October 14, 1993.

STATEMENT BY THE PRESIDENT

Audiovisual services must be included in any GATT accord. The United States does not want any special favors for American audiovisual creative works, but we also cannot accept that audio-products be singled out for unacceptable restrictions. The United States is ready to sign a GATT accord that is fair and just for all. But let me make it clear that fairness and justice must apply to audiovisual works as well as other elements in a final GATT deal. This is a vital jobs issue as well as a fairness issue for America.

Finally, let me say once again that the Uruguay Round is very important to the restoration of global growth, and that is why it is essential that we finish this agreement by December 15. That deadline is firm, and our trading partners must be prepared to settle with us on the many outstanding issues if we are to succeed.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1993

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of H.R. 3167, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3167) to extend the emergency unemployment compensation program, to establish a system of worker profiling, and for other purposes.

The Senate resumed consideration of the bill.

Pending:

Simpson (for Nickles/Shelby) amendment No. 1089, to prohibit the consideration of any retroactive tax increase unless three-fifths of all Senators duly chosen and sworn waive the prohibition by roll call vote.

AMENDMENT NO. 1089

The PRESIDING OFFICER. There will be now 40 minutes of debate on the Nickles amendment, equally divided.

Who yields time?

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma, [Mr. NICKLES] is recognized.

Mr. NICKLES. Mr. President, on behalf of myself and Senator SHELBY, we have an amendment at the desk that we will be voting on, I am guessing, right at 12 o'clock. We have 40 minutes of debate, equally divided. We have reduced the time to try to accommodate some Senators who have other pending business which is very important.

Mr. President, I ask unanimous consent that Senator HUTCHISON, Senator LOTT, Senator MACK, Senator COATS, Senator COVERDELL, Senator HATCH, and Senator BURNS be added as original cosponsors.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. Mr. President this amendment is an attempt to make it more difficult to pass retroactive tax increases.

I think many of us in this Chamber have a real concern about retroactive tax increases, and we have seen already on this bill a couple of votes. I know my friend and colleague from Texas, Senator HUTCHISON, had an amendment to repeal the retroactive tax increase passed earlier this year. She received 50 votes, but needed 60 votes to waive the point of order.

I notice my friend and colleague from Arkansas had an amendment to repeal the retroactive tax increase and was not successful. But I think, again, it shared a lot of concern over the unfairness of retroactive tax increases. I share that concern.

Some colleagues have even introduced legislation to make it unconstitutional to pass any retroactive tax increases. My amendment does not go as far as either of those proposals. It says prospectively we should make it more difficult to pass a retroactive tax increase.

So what this would do is allow a point of order to be raised against a retroactive tax increase proposed in the future, and that point of order could only be waived if there are 60 votes in favor of waiving it. So it does not eliminate any retroactive tax increase. It just basically says it makes it more difficult—and I believe we should make it more difficult—to raise taxes retroactively. So that is the essence of our amendment.

I have modified the amendment, to some extent, to take care of some of the concerns that were raised by members of the Finance Committee, and that is the definition of a retroactive tax increase. We state that no point of order would lie against any retroactive tax increase if the change was made effective prior to the date formal public notice was given regarding the effective date of such material by a committee or subcommittee of either House of Congress.

This would allow the members on the Finance Committee or the chairs of the Finance Committee to have a formal notice that they are planning on passing legislation that would have an effective date and they could announce that effective date. So, if they are going to close a loophole or something like that, they have the ability to do so. This is trying to accommodate some of the legitimate concerns that have been raised by people on the Finance Committee about "what if," and we tried to accommodate that.

But we also tried to say we still believe it should be more difficult to pass a retroactive tax increase if a Senator makes a point of order. It may be that everybody agrees that a retroactive increase is called for. And, if no one makes the point of order, that could happen. So this amendment does not totally, completely prohibit any retroactive tax increase. It just makes it more difficult to do it.

Again, it does not affect the tax increase that passed earlier this year that did have a retroactive tax increase on individuals and on States. My guess is, if we had an up-or-down vote on that in the Senate, it would not have passed and certainly would not have passed on the States. That is my guess.

But we do not touch that. We just say, in the future, Congress, do not do it; but, if you do it, do it so a point of order could lie against it and, if the proponents of that had 60 votes, they could waive the point of order. Again, there is no requirement that a point of order be made. It just allows a point of order to be made.

So I do not think that this proposal is extreme in any way, shape, or form.

I hope it will be supported in a bipartisan fashion by all of my colleagues. I think it is a good step in the right direction to try to protect against unfair retroactive tax increases. And, in many cases—in most cases, I believe—retroactive tax increases are unfair.

Mr. President I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. MITCHELL addressed the Chair.

The PRESIDING OFFICER. The majority leader, Mr. MITCHELL, is recognized.

Mr. MITCHELL. Mr. President, I strongly urge my colleagues to reject this amendment. This is precisely the way in which laws should not be written and especially tax laws should not be written. There have been no hearings, no opportunity for anyone to examine this amendment or this subject. There is no definition of what any of the phrases mean.

This is merely an attempt to score a few political points, to seize upon what appears to be a currently popular issue and, in the process, to create further confusion and ambiguity and difficulty in the tax law.

This amendment says that the Parliamentarian would have to become a tax judge to decide what the words "will result in an obligation to pay a larger tax" mean. What does that mean?

I ask the Senator from Oklahoma, if a person makes an investment based on a particular tax law and that law is changed in a way that makes the investment less valuable, is that a retroactive tax under this amendment?

If a person makes an investment based upon what he or she and his or her tax lawyer understands the law to be and later legislation clarifies the meaning of the law so as to result in a higher tax burden, is that a retroactive tax increase?

When Congress passed the 1986 tax law and limited the ability of investors on previous investments to take passive losses on their investments, which meant they paid a higher tax obligation, was that retroactive?

The tax-writing committees are now considering legislation to make technical corrections to prior tax legislation. Will that be retroactive?

What if a court makes a ruling that interprets a law in such a way that an enormous new loophole is created? Does that mean that Congress cannot correct that?

Mr. President, this is put forward as something to protect ordinary Americans. But we all know who the only beneficiaries of this are going to be. They are the beneficiaries of most of these types of amendments. They are tax lawyers, tax accountants, and those persons with sufficient means to employ them.

How many working Americans have full-time tax lawyers and tax accountants? How many working Americans will be affected by this? The answer is none.

The fact of the matter is, this is just another effort to score a few political points in a way that will provide the worst possible meaning of tax law.

I have asked these questions. I wish the Senator from Oklahoma would come to the floor and answer them. He is the sponsor of the amendment.

Let me cite another amendment. In the early 1980's a technique for reducing taxes by a few individuals by setting up multiple trusts was in fashion. In one publicized case, an individual spread his assets over 200 trusts. A provision that shut down this multiple trust scheme was enacted in 1984. The 1984 act was enacted on July 18, but the multiple trust provision was made effective on March 1, the date that the chairman of the House Ways and Means Committee presented the proposal to the committee.

We do not know if, under this proposal, that would have been covered. How many working Americans have 200 trusts set up and distribute their assets among 200 trusts?

In the Tax Reform Act of 1986, to give just another example, Congress specifically allowed Alaska Native corporations to sell their net operating losses in order to generate cash from their operations. This was intended to give a small boost to these corporations. But it was used in a way not intended and there was a loss of revenue of $1 billion in the first year of operation. To correct that obvious error, Congress terminated the provision in the Tax and Miscellaneous Revenue Act of 1988. The act was enacted on November 10, but that provision was made retroactive to April 26, the date the repeal was first announced in the House of Representatives. That would be prevented by this amendment.

I could go on and on. The time does not permit it. There are literally hundreds of examples of tax abuses that this amendment would insulate and protect. No hearings, no discussion, no explanation, no definition, no answers—yet to score a few political points this is being put forward and Senators are being asked to vote on it.

It is not surprising the Congress falls into disrepute with the American people when this is the way we write laws and write tax legislation. This ought to be considered by the committee. There ought to be hearings. People who have some knowledge and experience in this field ought to come in and testify so the Senate can make a mature, reasoned, considered judgment, instead of just trying to pile this onto an unemployment insurance bill, to which it has no relation, merely for this purpose.

Mr. President, I wish time permitted me to go through this long list of all of the potential problems that could arise under this amendment but I know time is limited and I therefore reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. NICKLES. I yield my cosponsor, Senator SHELBY—how much time do we have remaining?

The PRESIDING OFFICER. The Senator has 14 minutes and 40 seconds.

Mr. NICKLES. I yield the Senator 5 minutes.

The PRESIDING OFFICER. Senator SHELBY is recognized.

Mr. SHELBY. Mr. President, just a few months ago, this body not only gave the thumbs up to imposing a quarter of a trillion dollars in new taxes on the American people—it also said it was OK to raise some of these revenues retroactively. Today, Senator NICKLES and I are here to make it more difficult to retroactively raise taxes again.

This legislation is necessary and important to regain the public trust, Mr. President. It is not enough that we tell the American people that retroactive taxes are a bad idea or that we agree that they are unfair—it is enough only if we take definitive steps to prevent it from happening again or make it difficult to happen again.

I believe this legislation is one such definitive step.

The resolution we are offering today would create a presumption against retroactive tax increases. It would change the standing rules of the Senate by making retroactive tax proposals subject to a point of order. Thus, the only way that the Senate could pass another retroactive tax would be if three-fifths of all Senators agree to waive the point of order in a rollcall vote.

I believe, it should be difficult to raise revenues through retroactive taxes. I know it has been done before. But is that right? That is the question. While the Supreme Court has ruled that retroactive taxes are not unconstitutional, they have not spoken to the wisdom of them—that is our job. And while there is no question that Congress has imposed retroactive tax increases on the American people in the past—that does not say anything about their propriety today. Again, that is this Congress' job.

This is about principles, as I see it, not taxes. If we are going to ask American taxpayers to take on greater individual burdens, we should do so honestly and fairly. We should give them fair notice at the very least. Practical, financial reasons require it. Taxpayers need to be able to plan their finances and budget their income without the threat of taxes on money they have already spent, already saved or already invested. I submit that the American taxpayer deserves no less.

Again, this resolution does not prevent this body from raising taxes retroactively—it only makes it more difficult. And it should be difficult. If backdoor taxes are so required by necessity or emergency, this body can effectuate them. But, the general rule will be that they are not in order.

It seems to me that is a pretty good balance. Our resolution therefore, reinforces to the American people that raising taxes retroactively is a last resort and ensures that Congress will only use this tactic when it is absolutely necessary.

I believe this is a reasonable measure and one that I hope all my colleagues will support.

The PRESIDING OFFICER. Who yields time? The majority leader is recognized.

Mr. MITCHELL. Mr. President, let us make clear that only 1 percent of all American taxpayers were affected by the provisions to which our colleagues object, 1 percent—the wealthiest 1 percent whose incomes averaged $300,000 a year.

Someday I would like to see some of our colleagues come in here and express some compassion for the other 99 percent, the 99 percent of taxpayers who were not affected by the provisions, those whose incomes were not $300,000 a year on average. That would really be something new in the Senate, to see concern expressed for average Americans, Americans who work in factories, and nurses, and school teachers, who do not have tax shelters, who do not have trust investments spread out all over the country.

I ask my colleagues, think about that. Surprise us all someday, come in with an amendment that will express concern for the 99 percent of Americans.

Mr. President, I yield 4 minutes to the Senator from Kentucky.

The PRESIDING OFFICER. The Senator from Kentucky, [Mr. FORD] is recognized for 4 minutes.

Mr. FORD. Mr. President, I hear this "what if"—"what if"—even the Senator from Oklahoma said "what if?"

We have not studied it. We do not understand what the grave consequences of this amendment might be. I share the majority leader's concern. Also, the Parliamentarian—why should we make an accountant or CPA out of the Parliamentarian, to make a decision whether this is retroactive or not?

For 12 years I have been listening to the other side try to tell me how to do the budget. I never heard one peep out of the Senators and those who are supporting this amendment about the retroactive taxes that we voted in 1981—August 13, 1981, back to January 1, 1981. I did not hear a peep from these Senators when we had the Tax Equity and Financial Responsibility Act of 1982. I did not hear anything from the distinguished Senator from Oklahoma when we had the Deficit Reduction Act of 1984. And just to name three—all of them were signed into law, retroactive, by President Reagan.

There is the fellow we have looked at, he got the country turned around, did all these good things, and my colleagues supported all of the retroactive taxes that he proposed. Now when we have a Democrat in the White House

they are saying, Oh, you cannot do this. You cannot do this.

What are the implications? No one has told me. We finally came in here today and they have changed the amendment again. It has been changed three or four times since it was first introduced. This proposal would make, in my opinion, a significant change in the manner the Senate conducts its business.

Its implications have not been subjected to committee scrutiny and analysis. Mr. President, this proposal should be referred to the Rules Committee where hearings could be held, where all interested parties, mainly the 1 percent—mainly the 1 percent—all the interested parties could present their views and the implications of the proposal could be studied and made available to the full Senate

This proposal also affects bills that are within the jurisdiction of the Finance Committee. I know that committee wanted an opportunity to study this proposal. They have not had the opportunity.

Mr. President, we should be looking at ways to prevent and eliminate gridlock in the legislative process, not always to expand it. Under present rules, a compromise measure must survive a 60-vote test under cloture. Under this proposal, every—I want you to listen to this now—under this proposal, every single provision of a compromise, even that is a retroactive tax increase, would have to survive a vote separately. So every one of them would have to survive a vote separately.

If I have ever seen a proposal that guaranteed to produce legislative gridlock, this is it. We need a chance to study it. So, as our majority leader has said, that we are protecting now and helping that 1 percent, we need something to help the other 99 percent. I will guarantee you, the American people knew what was in the budget. I know the fight about the budget, the retroactive tax was in the budget. There was no hidden agenda there, and so we had to vote in the Senate as it related to that budget, and retroactive taxes were in there.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. FORD. Mr. President, this is a bad, bad amendment. We need to study it and try not to bind ourselves again by an emotional item that might be good for the moment.

The PRESIDING OFFICER. Who yields time?

Mr. NICKLES. Mr. President, I yield to the Senator from Alabama 3 minutes.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SHELBY. Mr. President, I do not know of any better place to ventilate an issue like this than in the Chamber of the U.S. Senate, not in a committee where it probably will never see the light of day, but in the Senate where the world is looking at us.

Why do we need hearings to consider the retroactivity of taxes?

Mr. FORD. Mr. President, will the Senator yield for a question?

Mr. SHELBY. It is my time. You got your own time.

Mr. FORD. I just want to ask a question. Twenty minutes is an awfully short time to let the world hear it.

Mr. SHELBY. I hope my time is not charged.

Why do we need hearings to consider the retroactivity of taxes, Mr. President, when we basically and the American people believe it is wrong? We do not. We already know that. I know that the American people think they are wrong. We have seen that. The resolution simply makes it more difficult in the future to pass retroactive taxes.

This is not about the top 1 percent. This is a prospective rule, in the future. It is about ensuring that this body does not so quickly impose taxes retroactively on the remaining people in the Nation that the majority leader refers to, the 99 percent.

The amendment does not change the tax law. It only makes it more difficult for the Senate to change the tax law retroactively. That is the gist of this whole argument.

The PRESIDING OFFICER. Who yields time?

Mr. MITCHELL. Mr. President, the reason we need hearings is because none of the sponsors have answered any of the questions that are asked. The Senator from Alabama spoke twice and has not answered any of the questions. I ask—

Mr. NICKLES. Will the Senator yield?

Mr. MITCHELL. What is a retroactive tax? If an investment is made based on a particular tax law and the law is later changed which makes the investment less valuable, does that fall within the definition of an obligation to pay a larger tax?

Mr. NICKLES. Will the Senator yield?

Mr. MITCHELL. Let me finish my questions. I would like to get some answers to them. I have several more questions.

How would the Senate close existing loopholes, including loopholes that were created by recently passed legislation and were clearly unintended?

How would the Senate make technical corrections which have to be retroactive, by definition, to carry out Congress' original intent?

How would the Senate make changes in the tax laws desired by taxpayers themselves if this amendment is adopted, if one taxpayer's liability is increased? One taxpayer in the country, the amendment would be subject to a point of order.

Almost every single tax law change would adversely affect someone's investment, and every tax law passed could be construed as retroactive in some respect. And there is no definition in this amendment. No definition at all. That is why we need hearings, to have definition. That is why we have hearings on anything else.

If we accept the argument of the Senator from Alabama, we would abolish committees, we would abolish hearings and we would just come out here, have everybody offer an amendment, not hear from anyone as to what does this mean, what does that mean—talk about a mishmash, that is where we would be.

So, Mr. President, I just feel that we do not have any answers to questions. There has been no debate, no discussion, no thought given to this. This is a political gesture to score a few political points, and I hope the Senate rejects it.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. NICKLES. How much time remains?

The PRESIDING OFFICER. The Senator from Oklahoma has 9 minutes and 5 seconds.

Mr. NICKLES. How much time remains on the other side?

The PRESIDING OFFICER. Five minutes and 30 seconds.

Mr. NICKLES. Mr. President, I do not want to spend all of my time trying to answer hypothetical questions.

I ask unanimous consent to add Senator MCCAIN as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. Mr. President, let me just try to answer a few of the questions generically. My colleague from Maine mentioned, what if we found some abuses and we need to stop those abuses? That has happened. We have seen cases in the Tax Code where some people were getting $3 of deduction for every dollar they put in. That is an abuse and, frankly, we stopped it, and we can do that.

You can even do it retroactively under this amendment. You would have to have 60 votes if somebody made a point of order. I might mention, there are a lot of things my colleague from Maine mentioned that I doubt anyone would raise a point of order on. This would allow someone to raise a point of order if it was a retroactive tax increase and if 60 Senators wish to waive that point of order that can happen.

We have points of order right now on budgets, for example. I raised a point of order on the underlying bill because it violated the Budget Act. There is no question it violated the Budget Act. It increases the deficit, according to the Congressional Budget Office by $1 billion in 1994. I raised a point of order. Sixty-one Senators actually voted to waive the budget and they have that right to do so.

Likewise, there would be nothing to prohibit this body from passing retroactive taxes. It would just make it more difficult to do so. They would just have to have 60 votes. I think we ought to make it more difficult to pass retroactive tax increases because I think on the whole they are unfair.

My colleague from Maine mentioned, what about the 99 percent of the taxpayers? He said this was just an effort to protect the 1 percent. That is not the case. As a matter of fact, this is introduced prospectively. It does not touch last year's tax increase in any way, shape or form, but it does say in the future we should have a supermajority before we sock it to the population with higher taxes.

I think the middle-income class people better look out because there are a lot of proposals that are going to be very expensive, they are going to cost a lot of money—like health care and so on—that I am afraid are overpromised and underfinanced and they are going to be looking for more money. Some people will be looking for retroactive ways to raise that money. I hope that is not the case. If it is the case, if we are successful in adopting this, it would take at least a 60-vote point of order. I hope my colleagues support this amendment.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. SHELBY. Mr. President, I suggest the absence of a quorum.

Mr. FORD. And that it be equally charged.

The PRESIDING OFFICER. Without objection, the quorum call will be equally charged. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. MITCHELL. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MITCHELL. Mr. President, this amendment would pose numerous administrative problems and really is intended to benefit that very small portion of taxpayers who employ tax accountants, tax attorneys, and are aggressive with respect to tax loopholes. From one standpoint or another, virtually any change in the tax law can be considered to have a retroactive effect.

This amendment would require the Senate to consider such arguments in dealing with every provision in every bill. The lobbyists promoting special interests would love to have the opportunity to stop legislation that can be argued in some way, however arcane or remote, to be retroactive.

We have not had any time to consider this amendment, but there are many serious problems that it raises. I have asked a whole list of questions and neither of the sponsors will answer the questions. They have had plenty of time, and they will not answer the questions.

Mr. President, how would the Senate close existing loopholes, including those created by recently passed legislation and which were clearly unintended?

How would the Senate make technical corrections which have to be retroactive by definition to carry out the original intent of Congress?

Mr. NICKLES. Will the Senator yield?

Mr. MITCHELL. On the Senator's time.

How will the Senate make changes in the tax laws if this amendment passes? If a single taxpayer's liability is increased? Could not every tax law change be considered retroactive? How would the Senate be able to pass any change in tax rates at all? All tax increases during the middle of any taxpayer's taxable year would arguably have a retroactive effect. Not all taxpayers are on a calendar year so every tax increase would require at least some taxpayers to close their books and file additional returns.

For example, even if the increase were effective on January 1 of a given year, any taxpayer that uses a fiscal year would have to close its books and file an extra return. This would create an incredible new burden on taxpayers.

The language and the scope of this amendment are unclear and vague. Why is the date of the committee action the appropriate cutoff date? Why not administration proposals? Why not the committee chairman's mark? Why not bills introduced by the chairmen of the tax writing committees? How is anyone going to measure the tax increase? Who will be the arbiter of whether or not it is retroactive? Will it be the Parliamentarian? Is the Parliamentarian going to have the Joint Committee on Taxation compute everyone's liability in order to determine whether a point of order lies?

Mr. President, this is a purely political amendment. It has no substantive merit. It will cause serious problems. I strongly urge my colleagues to defeat it. I yield the rest of my time to the Senator from New York.

The PRESIDING OFFICER. The Senator from New York is recognized for 1 minute.

Mr. MITCHELL. How long do we have?

The PRESIDING OFFICER. The Senator from Maine has 1 minute.

Mr. MITCHELL. Then I will yield 3 minutes of my leader time to the Senator.

Mr. MOYNIHAN. I thank the majority leader.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mr. MOYNIHAN. I say to the Senate that we have been holding our first hearing on the national health care proposal which the President sent to us yesterday. Secretary Shalala is before the Finance Committee, and so I have not been here until now.

Mr. President, I rise with a sense of urgency to plead with the Senate not to commence this extraordinary rule change which, in the judgment of the Department of the Treasury, would be disastrous to our whole internal revenue system. This amendment would reward the worst behavior, punish the best behavior, make legislation impossible, make rules incomprehensible, invite evasion, and invite derision.

This amendment says that the normal practices of the Congress, which have been in place for many decades in terms of revenue measures, will no longer pertain. And it puts in place a system that specifically rewards those taxpayers who have the most aggressive lawyers, the most aggressive accountants, and wish to avoid taxation. It, correspondingly, punishes those who think they can play by the rules and expect the Government to be fair-minded with them. It states that a provision that increases a tax retroactively will be subject to a 60-vote point of order.

This amendment is filled with ambiguity and uncertainty of an order that brings disarray to the entire Internal Revenue Code. There is a very rare measure we will adopt on the Senate floor reported from the Finance Committee and the House Committee on Ways and Means which will not have some prospective and some retroactive measure to mix and mingle and set dates.

And particularly, as the majority leader said, as we establish the date in which a measure takes place, if we approve the measure, it will be the date on which it was first proposed by the President, by the committee on legislation, or whatever, so that aggressive tax accountants and lawyers will rush in to take advantage of a window such as this measure would create.

Mr. President, it would be offensive to the House of Representatives should we so change our procedures. It would be confounding to the Treasury. It has no business of any kind on a modest measure to extend unemployment compensation benefits for 4 months.

We are changing the rules of the Senate, and there is a mode for that. There are not too many rules. But, we should change them with great deliberation; not without care and not as an amendment at the last hour to an unemployment extension bill.

I plead with Members on both sides of the aisle—and I surely speak for the majority of the Finance Committee—do not do this.

My time has expired, Mr. President.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. MOYNIHAN. Mr. President, before I leave, may I ask unanimous consent that there be placed in the RECORD

a 2-page letter from our esteemed former colleague, Lloyd Bentsen, now Secretary of the Treasury, saying Senators do not do this.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

THE SECRETARY OF THE TREASURY,
Washington, October 27, 1993.

Hon. DANIEL PATRICK MOYNIHAN,
Chairman, Committee on Finance, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Administration opposes the Nickles amendment, which would add new rule XLIII of the Senate relating to "retroactive tax increases." The amendment would reward taxpayers who exploit loopholes in the tax law, would result in significant complexity for the legislative process and the tax law, and would inhibit Congress in its efforts to reduce the Federal budget deficit.

The Nickles amendment would severely limit the ability of the Congress and the executive branch to prevent tax avoidance. Unless the point of order that the Nickles amendment would create were waived by a supermajority, tax loopholes would remain open until a bill was signed by the President. This would be true even if Congress or the executive branch had previously identified the loophole and proposed its elimination. The effect of the provision would be to invite exploitation of loopholes to the greatest extent possible prior to the date of enactment of legislation. As a result, the amendment would reward the most aggressive taxpayers, to the detriment of the public at large, who would bear the burden of paying for the revenue loss attributable to the loophole. Moreover, while tax loopholes could be closed on a prospective basis only, provisions benefitting special classes of taxpayers (*i.e.*, targeted tax expenditures) could be passed with a simple majority vote, even if retroactive.

The Nickles amendment would also greatly complicate the consideration and passage of the legislation and would add complexity to the tax laws. Many issues would arise concerning the application of the rule in the Senate. For example, would the Senate be required to obtain a supermajority to pass a technical corrections bill that clarified taxpayers' obligations under previous legislation? Would a supermajority be required in the case of "blended rates," under which fiscal-year taxpayers may pay a rate that is a blend of an old and a new rate, or calendar-year taxpayers would pay a blended rate in case of a tax rate that changed in the middle of the year? The literature on retroactive tax changes is extensive and complex. The great number of issues raised in that literature could potentially become the subject of Senate floor debate if the Nickles amendment is passed. Similarly, drafting tax legislation to avoid any theoretical possibility of retroactivity could greatly add to the complexity of legislation that is passed.

Finally, the Nickles amendment would create impediments to the executive branch's and Congress's ability to address the Federal budget deficit. The President is required to present the Administration's budget at the beginning of the calendar year. Few executive branch actions receive greater publicity than the Administration's submission of the budget. Nevertheless, even if the President proposes tax changes in the budget, those changes could not become effective until legislation is passed, resulting in a loss of revenues, and a resulting increase in the deficit, for a year or more.

The Nickles amendment appears to be motivated by concerns relating to the tax rate changes for high-income taxpayers in the recently enacted budget legislation. These rate changes were, however, a major issue in the Presidential campaign in 1992. As a result, tax advisors recommended that high-income taxpayers accelerate income into 1992 or defer deductions until later years, and Treasury data indicate that many taxpayers heeded that advice. The changes were officially announced in February of this year by the Administration, with a January 1, 1993 effective date at the time of announcement.

In view of these facts, it would be inaccurate to say that taxpayers did not have fair notice of the changes, which is the essence of legitimate concerns about retroactivity. Nevertheless, the legislation ultimately passed provides that individuals may elect to pay any additional taxes that are due to the rate increases in three annual installments, without interest. We do not believe that this set of events warrants creating new procedural impediments to Senate consideration of tax legislation. Rather, we believe that the Senate should be allowed to consider tax legislation on its merits, including any concerns about retroactivity.

In summary, the Administration believes that the Nickles amendment would unnecessarily limit the Senate's ability to consider legislation in a manner that is consistent with both good policy and fairness to all taxpayers. I urge that it be rejected.

Sincerely,

LLOYD BENTSEN.

The PRESIDING OFFICER. The Senator from Oklahoma has 4 minutes and 25 seconds.

Mr. NICKLES. Mr. President, I take it from the remarks of my colleagues from Maine and New York that they are slightly inclined to vote "no" on this amendment.

Mr. President, I ask unanimous consent that Senator ROTH be added as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LIEBERMAN. Mr. President, I oppose the retroactive income tax increases that were contained in August's reconciliation package. Earlier this week, I voted to these retroactive increases by cutting overhead in the Federal budget. While that approach failed, I continue to believe these retroactive increases were simply not fair and I will continue to look for ways to address that unfairness.

This amendment requires any future retroactive tax increases to be passed by a three-fifths majority. I have two problems with this approach. First, it does not address the unfairness of the retroactive taxes imposed in August. And second, this amendment fails to recognize that sometimes we need to be able to correct serious loopholes and opportunities for abuse in the Tax Code. To protect the U.S. taxpayer, we need to be able to reach back and close those loopholes as of the day the President or Congress announce their intention to change the tax law, so those who are enjoying the benefits of the loopholes cannot rush to evade the next taxes before Congress actually passes them and the President signs them. This bill would make such reasonable retroactivity as difficult to exact as the unreasonable retroactivity I want to stop.

Once we discover loopholes, or realize we need to make a technical correction in a tax bill, we need the flexibility to remedy these errors. I am fearful that the sponsors of this amendment—without meaning to do so—may make it tougher for us to get at these technical errors or, worse still, loopholes that lead to abuses of the Tax Code.

Mr. President, I am voting against this amendment. However, I continue to hope that we will find a reasonable way to address the unfairness of retroactive tax increases.

Mr. BAUCUS. Mr. President, I rise today in opposition to the amendment offered by Senators NICKLES and SHELBY. On the surface, this amendment has great populist appeal. However, we must look below the surface to what this amendment would actually do.

If enacted, this amendment has the potential to reduce the authority of the Finance Committee and increase the complexity that accompanies any legislation containing changes to the Internal Revenue Code. Further, this amendment proposes a major change to the Senate rules that has no relevance to a bill that extends emergency unemployment benefits for 4 months.

The proponents of this amendment have offered it under the guise that it protects all American taxpayers from the sting of retroactive tax increases. However, the amendment makes no attempt to define such retroactive tax increases and is likely to serve primarily as a protection for wealthy taxpayers benefiting from loopholes uncovered by high-priced tax lawyers and accountants.

This amendment also raises a myriad of administrative issues for Congress, taxpayers, and the IRS. The amendment would effectively make the Parliamentarian the final arbiter of what constitutes a retroactive tax increase. When considered in conjunction with the Budget Act the amendment would further complicate the budget reconciliation and revenue estimation processes. Further, the fate of technical corrections legislation, which is by definition retroactive, would be jeopardized.

Approval of this amendment will add to the difficulties taxpayers have in accurately filing their Federal income tax returns on a timely basis. For example, if the effective date of legislation to repeal a deduction is July 1, in order for such legislation to not be considered a retroactive tax increase, taxpayers would have to split their tax year in two. Taxable income from January 1 to June 30 would have to be calculated with the deduction, and income from July to December 31 without it.

The IRS would have to work closely with the Joint Committee on Taxation

in determining whether a particular change would result in a retroactive tax increase to any taxpayer. In addition, the technical steps necessary to comply with the amendment would compound the difficulties associated with the IRS audit process.

Mr. President, an amendment of this magnitude should be the subject of hearings and extensive debate before a decision is made as to whether it should become a rule of the Senate. Unfortunately, Members of this body have not been given the opportunity to adequately reflect on the consequences of this amendment. I have no choice but to vote against this amendment. I urge my colleagues to do the same.

Mr. NICKLES. Mr. President, I am becoming more concerned about Treasury all the time, and I am becoming more concerned about this Congress all the time because I was not aware that there is such a great effort to pass retroactive tax increases. I would like to think this is not necessary. As a matter of fact, I put in the amendment a definition of what is retroactive. Using some guidance from the Finance Committee, we exclude anything—we define retroactive. If a committee or subcommittee issues a formal notice on the effective date, then it would not be retroactive.

So they can close loopholes, I tell my friend and colleague from Maine. And if there are loopholes, you can close them anyway, because I am sure we can get 60 votes.

Then I hear my colleagues say, well, wait a minute. This is just to benefit the upper 1 percent. I will admit the retroactive tax increases in last year's bill hit primarily upper incomes.

But I will also tell my colleagues, if you have be out in the States, you will find out that it also hits a lot of people that you would not classify as upper income. I am thinking of farmers, ranchers, and others who found that their State taxes went up dramatically as a result of the tax bill we passed this year. We did not get to vote on the retroactive aspects of the estate tax increase. I think that was unfair.

But what about for the future? This amendment is really a fairly reasonable measure. It is not a constitutional amendment. It is not a repealing of retroactivity on past law changes. This is prospective. It says, if we are going to have retroactive tax increases in the future, a point of order may lie against it. It takes 60 votes to waive that point of order. It would still happen if most of us agree that is the right thing to do.

I think that is the right thing to do. We are giving latitude to the committees of jurisdiction. If they issue a notice, they can do so.

What concerns me now is that Treasury is so opposed to this. Are they planning a big retroactive tax increase on America? I do not know where they are coming from. Why would they want to do that? Retroactive tax increases by their nature are unfair. We should not be doing them except under the most unusual circumstances. And we should be voting on it.

So that is the reason this amendment is here. My colleague from Maine said this is just for political points. That is not the case. That is not the case. As a matter of fact, I am interested in seeing this become law and trying to implement whatever we can do to make sure that we would make it more difficult, but not impossible, to pass retroactive tax increases in the future; not to score political points, but to make sure that we make positive public policy in the future that does not lean toward retroactive, unfair tax increases.

Mr. President, I yield the remainder of our time.

The PRESIDING OFFICER (Mr. MATHEWS). All time has been yielded. The question occurs on the amendment of the Senator from Oklahoma.

Mr. NICKLES. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Oklahoma. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative clerk called the roll.

Mr. FORD. I announce that the Senator from Nevada [Mr. BRYAN] is necessarily absent.

Mr. SIMPSON. I announce that the Senator from Minnesota [Mr. DURENBERGER] and the Senator from Utah [Mr. HATCH] are necessarily absent.

I further announce that the Senator from Kentucky [Mr. MCCONNELL] is absent due to an illness in the family.

I further announce that, if present and voting, the Senator from Minnesota [Mr. DURENBERGER] would vote "nay."

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 40, nays 56, as follows:

[Rollcall Vote No. 339 Leg.]

YEAS—40

Bennett	Faircloth	McCain
Bond	Gorton	Murkowski
Boren	Gramm	Nickles
Brown	Grassley	Pressler
Burns	Gregg	Roth
Chafee	Hatfield	Shelby
Coats	Helms	Simpson
Cochran	Hutchison	Smith
Cohen	Jeffords	Specter
Coverdell	Kassebaum	Thurmond
Craig	Kempthorne	Wallop
D'Amato	Lott	Warner
Dole	Lugar	
Domenici	Mack	

NAYS—56

Akaka	Ford	Mitchell
Baucus	Glenn	Moseley-Braun
Biden	Graham	Moynihan
Bingaman	Harkin	Murray
Boxer	Heflin	Nunn
Bradley	Hollings	Packwood
Breaux	Inouye	Pell
Bumpers	Johnston	Pryor
Byrd	Kennedy	Reid
Campbell	Kerrey	Riegle
Conrad	Kerry	Robb
Danforth	Kohl	Rockefeller
Daschle	Lautenberg	Sarbanes
DeConcini	Leahy	Sasser
Dodd	Levin	Simon
Dorgan	Lieberman	Stevens
Exon	Mathews	Wellstone
Feingold	Metzenbaum	Wofford
Feinstein	Mikulski	

NOT VOTING—4

Bryan	Hatch
Durenberger	McConnell

So the amendment (No. 1089) was rejected.

Mr. MOYNIHAN. Mr. President, I move to reconsider the vote.

Mr. MITCHELL. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. MOYNIHAN. Mr. President, I make the point of order the Senate is not in order.

The PRESIDING OFFICER. Will Senators please take their seats or please take their conversations outside the Chamber?

DEPARTMENT OF THE INTERIOR AND RELATED AGENCIES APPROPRIATIONS ACT, 1994—CONFERENCE REPORT

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of the conference report on H.R. 2520, the Interior appropriations bill, which the clerk will report.

The legislative clerk read as follows:

Conference report to accompany H.R. 2520, an act making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 1994, and for other purposes.

The Senate resumed the consideration of the conference report.

CLOTURE MOTION

The PRESIDING OFFICER. There will now be 25 minutes of debate on the motion to invoke cloture with 15 minutes under the control of the Senator from Wyoming [Mr. WALLOP] and 10 minutes under the control of the Senator from Nevada [Mr. REID].

Who yields time?

The Senator from Nevada.

Mr. REID. Mr. President, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state it.

Mr. REID. I think it is OK with the Senator from Wyoming and the Senator from New Mexico as to the agreement previously entered to have the time cut to 12 minutes for them and 10 for us.

The PRESIDING OFFICER. Is there objection?

Mr. WALLOP. Mr. President, I do not object, but I do not accept the clock to begin running until order is in the Senate.

The PRESIDING OFFICER. Will the Senate please be in order? Will Senators please take their seats or take the conversations outside the Chamber.

The Senator from Wyoming.

Mr. WALLOP. Mr. President, I yield 4 minutes to the Senator from Colorado [Mr. CAMPBELL].

The PRESIDING OFFICER. The Senator from Colorado [Mr. CAMPBELL] is recognized.

Mr. CAMPBELL. Mr. President, I thank the Senator from Wyoming.

Mr. WALLOP. Mr. President, may we have order before the clock begins?

The PRESIDING OFFICER. The Senator from Colorado.

Mr. CAMPBELL. Mr. President, we have been debating the Interior appropriations bill, and sections that conferees inserted in that bill that many of us believe will dramatically change western economies—with drastic results.

I have reiterated my concerns with setting policy in an appropriations bill, I have told you of my State's Governor's objections to changes in water policy that will impact heavily on the West, and I have told my colleagues how this bill could rob the family farmers in the West of their future.

At this point in the debate, however, I would like to focus on a part of this picture that bodes well for the future of the West. I will be the first to admit that the West is changing. But I will also argue that we must move carefully and thoughtfully to see that those changes are best for the most people.

Mr. President, the Rocky Mountain West still conjures up images that touch the independent spirit and longing for the wide open spaces that burns in all Americans. But the people who live today in the West, and in rural communities throughout our land, are not living the American myth embodied by John Wayne in the old westerns or recalled in haunting western songs accompanied by harmonica.

The life we live is often a struggle that some may not recognize as a modern life. There are thousands of families who are still trying to wrest their livelihoods from the public lands, supporting their families, and building communities in places that can be naturally inhospitable. We aren't complaining, the rewards are many.

We simply want other Americans—from the East, the South and the urban areas of our country—to understand our way of life, a culture that is both glorified and assailed by our fellow citizens. We are trying to maintain that culture and way of life.

We do not want special breaks that other Americans do not get. We do not want to be coddled or subsidized. We simply want to be able to make a living and raise our children—and preserve these special places.

We are not the environmental monsters some would make us out to be. We care about this land—why else would we stay here, when so many have fled economic hardships for the promises of the city?

In fact, in my State of Colorado, the diversity that makes up our rural communities is stunning. Living side-by-side are many new arrivals, who have fled the cities to find a quieter or less hurried lifestyle, and third and fourth generation representatives of pioneer stock.

Those making their living off the public lands today can be running a ski lift, running cows in the high country, or running the rapids. They can be finding valuable ore in a mine seam, finding inspirational scenes to shoot for calendars or finding valuable tourist dollars in a bed-and-breakfast business.

In some places, the diversity we see spells divisiveness. In others, cooperation is replacing conflict. In areas of my State, the newcomers and old-timers are coming together to preserve the quality of life and the natural resources by which we all—directly or indirectly—sustain ourselves.

Small businesses that earn their living from the tourist trade, cattle ranchers, timber concerns, and tree huggers are really more closely aligned in the 1990's than some of us ever thought they could be. Local environmental groups in forward-thinking communities in my State know that if the ranchers and farmers can not make a go of it, their land will be subdivided for condos and the wide open spaces will become crowded and polluted.

Most of us can agree that if we cut down all the trees, we summarily fell the recreation and tourism trade, but that without modern management of the forests, disease and fire will take what mankind could have put to good use. We know that proper grazing of livestock creates forage for wildlife and that everything depends on a dependable water supply.

We know our city cousins do not really want a rural America devoid of people or filled with ghost towns. We simply ask them to consider our culture and needs as we all strive to preserve the environment and build the economy. These are not necessarily mutually exclusive concepts, and in Colorado, communities are coming together to demonstrate this.

All we ask is that these far-reaching proposals be delayed until we can study them. I am ready to proceed with legislation in the subcommittee I serve on—the Subcommittee on Public Lands, National Parks and Forests to raise grazing fees.

My colleagues will get an opportunity to vote on higher grazing fees, and on sweeping land use reform. After all, this body did approve a bill to reform the mining law of 1872, but with the consent of the Senators whose States will be impacted. Now my constituents want to be heard on how land management reforms will affect them. That's the fair and that's the best way to accomplish these reforms and to integrate what's known as the old West and the new West into the whole West—with respect for the past, ready for the future.

Therefore, I ask that my colleagues continue to support us by voting no on the cloture motion.

Mr. President, I have spoken numerous times in opposition to this conference report and will not belabor it.

I sat in my office this morning trying to think of one final plea in opposition. Perhaps the best words came from one of the Senate's most thoughtful Members himself, and so I have borrowed a few of his words and his considerable logic, if not his vote, in this matter.

Just less than an hour ago in opposing the Nickles point of order, the majority leader of this Senate, a Senator for whom I have great respect and admiration for both his wisdom and leadership, opposed the point of order for the following reasons:

> There were no hearings. There was no debate. There is no definition of terms. It is attempt to seize on a popular issue and score political points. There is no explanation. It creates further ambiguity. It would create numerous administrative problems. It will cause serious problems.

I submit, Mr. President, that we in the West deserve the same standard both procedurally and from the standpoint of basic fairness, and in borrowing the words of the Senator from Maine to support our position, I think that we adequately rest our case.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Wyoming.

Mr. WALLOP. Mr. President, I yield myself 3 minutes.

The PRESIDING OFFICER. The Senator is recognized.

Mr. WALLOP. Mr. President, last night the Senator from Nevada repeated his assertion that the concern which every State engineer in the Western States, every attorney general in the Western States, and every western Governor——

Mr. President, may we please have order before the clock runs? It is not fair on an issue of such importance to the West.

The PRESIDING OFFICER. The Senate will be in order.

Mr. WALLOP. Mr. President, last night the Senator from Nevada repeated his assertion that the concern which every State engineer in the Western States, every attorney general in the Western States, and every Western Governor has over the water language in his amendment is simply

ghosts and goblins of an early Halloween. He went on to say that the savings clause in the Federal Land Policy and Management Act should reassure us since it was not being amended and that all he was doing was conforming BLM to the practices of the Forest Service.

Personally, I have more faith in our State engineer and our attorney general and our Governor. Endorsement from environmental groups who have opposed State jurisdiction over water resources doesn't reassure me either. But it is time to lay out how misleading the statements really are. The Senator does not amend the savings clause in FLPMA. That is true. He emasculates it. Neither does his language conform BLM to the Forest Service.

The Forest Service applies to the State for water rights on forest lands for grazing where that is necessary. The Forest Service submits to State jurisdiction and is bound by the terms and conditions attached to the water right permit if granted. The language in this amendment does not require the BLM to apply to the State for water rights nor to comply with the procedural and substantive requirements of State law. The amendment seeks to prohibit the States from issuing any water rights for grazing related activities on public lands except in the name of the United States. There is no such abrogation of State authority in the Forest Service.

Furthermore, the language in the amendment sponsored by the Senator from Nevada does not refer to water rights on public lands, but to water rights for grazing related activities on public lands. As I mentioned yesterday in my remarks, I once had grazing allotments which I supported with water rights on my own private land. Under the amendment proposed by the Senator from Nevada, the State of Wyoming would have been required to issue that water right on private land only in the name of the United States despite the fact that only the owner of the property could apply for the right. That is an unbelievable interference with private property rights and State jurisdiction and is not the policy or the practice of the Forest Service.

If that is not the intent of the Senator from Nevada, then I submit that he has been hoodwinked by whoever drafted this language. Rather than continuing to defend this language, he ought to be outraged. That is the reason why we have authorizing committees, so that we can have hearings and make certain that the language which is reported to the Senate accurately reflects the intent. In seeking to end run the authorizing committee, the Senator simply opened himself up to either sloppy drafting or someone with a different agenda who thought they could slip something through.

I also want to point out that there is a free standing sentence buried at the end of the new section 406(i)(2) which has nothing at all to do with grazing, but which is also at variance with both the Forest Service and BLM policy. That sentence states that the Secretary will exercise rights to water developed on public lands for the benefit of the public lands and the resources thereon. Both the Forest Service and the BLM exercise any State-granted water rights for the purposes and subject to the requirements contained in the water right permit. A water right for grazing may not be used for other purposes. A water right for irrigation may not be used for other purposes. A water right obtained for a reclamation project is subject to the requirements of State law absent a clear congressional directive as the Supreme Court held in US versus California. The sentence has nothing to do with grazing and nothing whatever to do with compliance with State law.

This is the type of language which would have been laughed out of committee when we considered FLPMA. This is the same type of expansive assertion of Federal supremacy which the executive branch, especially the Justice Department, has repeatedly claimed and which the Supreme Court has repeatedly rejected. I do not dispute what the Senator thinks he agreed to. I submit that the language does not do what he says. This is not the policy of the Forest Service nor was it the policy of the BLM prior to 1982. The Senator was hoodwinked. The State engineers are right. The western attorneys general are right. The western Governors are right. His colleagues from Colorado and New Mexico and North Dakota and Oregon and Idaho are right.

Mr. President, these concerns are not goblins and ghosts. They are real. This is not a debate on fees. Senator CAMPBELL and I have legislation pending in the Energy Committee which would raise fees and we are prepared to have that legislation move forward and let the Senate work its will. This debate is over what the language in the amendment by the Senator from Nevada means. This is not a debate over what he intends or what he thinks he agreed to. This is a debate over language cobbled together in a back room which was never subjected to hearings and which was never run past the Governors, attorneys general, State engineers, or the water users and private property owners who will be affected. There is a reason for that and the Holloween analogy is apt. The reason is that like the vampire, this language can not stand the clear light of day. What we need to do is drive a stake through its heart.

So let us hear no more about how all this language does is return the BLM to a pre-1982 policy and conform it to the Forest Service. That is simply false. The western Governors know it, the western attorneys general know it, the State engineers know it, and Secretary Babbitt should know it.

I yield 2 minutes to the Senator from Pennsylvania for the purpose of directing an inquiry to the Senator from Nevada.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, I thank my colleague from Wyoming.

Mr. President, when this bill was originally before the Senate, I voted in opposition to the position articulated by my colleague, Senator DOMENICI, but I have since been concerned about the provisions included in the conference report.

I have discussed these matters with the distinguished Senator from Nevada [Senator REID] and I have met with the Secretary of the Interior, Secretary Babbitt, in an effort to understand these matters more fully. I have conferred with the distinguished chairman of the Appropriations Committee, Senator BYRD, and understand the concerns that Senator BYRD has on getting a bill. This is his subcommittee, in fact, and I serve on the full committee.

But my questions go to whether the conference report, as I understand it, contains items which were added that have not had hearings, such as improvements to public lands, which, according to the conference report, will be changed to be the sole ownership of the Federal Government. I am concerned as to whether that may constitute a taking by the Federal Government of improvements without compensation.

May we have order, Mr. President?

The PRESIDING OFFICER. The Senate will be in order.

Mr. SPECTER. Further, I raise a question as to whether my understanding is correct that the conference report makes the Federal Government the sole owner of water rights, and in so doing, makes a change to existing law which has provided a preemption of State laws. I question whether the conference report has a change to eliminate the grazing advisory councils, and whether there is a change on restrictions and surcharges on subleases.

The PRESIDING OFFICER. I remind the Senator that his time has expired.

Mr. SPECTER. I ask my colleague for 1 additional minute.

Mr. WALLOP. I yield 1 additional minute.

Mr. President, I ask unanimous consent that the time during which we were trying to establish order in the Senate not be charged against the Senator from Wyoming's time. It is an important thing for those of us in the West, even if the rest of the Senate does not wish to listen.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WALLOP. I yield 1 additional minute to the Senator from Pennsylvania.

Mr. SPECTER. May I add to the statement by my distinguished colleague from Wyoming that it is an important thing to others, as well.

Mr. WALLOP. It is, indeed.

Mr. SPECTER. At least, that the West is fairly treated.

"I do not have a dog in this race," as Senator Baker used to say, but I want to see that we do it right, and that is why I have taken the time to make the inquiries which I have. I think we owe that to the country.

And I was coming to the last point, that there are restrictions and surcharges on subleases. The significance of these matters warrant thorough consideration by Congress, not just the administration.

I have discussed this with my colleague, Senator REID from Nevada. What I seek to find out, as someone who has to vote on the cloture issue, is whether, in fact, it is true that these changes have been made and whether or not they are substantial matters. When I listened to Senator DOMENICI speak at length on this subject a few weeks ago, I saw his emotional level, suggesting that they were.

The PRESIDING OFFICER. The Senator's time has expired.

Who yields time?

Mr. REID. Mr. President, I ask the chairman of the Appropriations Committee, the manager of this bill, if I could have 1 minute to respond.

Mr. BYRD. Absolutely.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I say to my friend from Pennsylvania, the changes made are comparable to the Forest Service; no radical change. The Forest Service has been doing most of these things since the turn of the century.

The chairman of the Appropriations Committee will read a letter that will set forth in some detail what Secretary Babbitt will do with these regulations.

I would also state that the water issue is something that was changed by Secretary Watt. I have a letter dated August 10, 1982, from the—could we have order, Mr. President?

The PRESIDING OFFICER. Could we have order in the Senate? The Senate will be in order.

Mr. REID. The letter is from the State water engineer of the State of Utah, who basically says that he does not understand why Watt changed the rule. He says—and I will make this part of the RECORD—"I would encourage you to maintain the old policy since it would seem to have very little impact on the leases if the Bureau of Land Management was the actual owner of the water right."

In effect, these changes only take it back to the way it used to be prior to Secretary Watt being the Secretary of the Interior.

Mr. WALLOP. Mr. President, I yield myself 30 seconds to say, that is completely untrue. The Forest Service does operate under State law. This will not put the BLM under State law. It completely changes the relationship. And that is the purpose for which hearings should have been held. And the ability to modify it should have been available. They will not be if this were to pass. The States involved will have been severely affected by this.

I yield 2 minutes to the Senator from Colorado.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. BROWN. I thank the Senator from Wyoming.

Mr. President, the distinguished Senator from Nevada has been, I think, a thoughtful, sincere advocate in this exchange.

One of the things that he mentioned was to list specifically the provisions of section 701 of the Federal Policy Management Act, indicating that the exemptions and the respect for private property there and the protections against unreasonable elimination of permits would provide protection in certain circumstances.

Mr. President, I wish that were true. I must say that if that were true, we would solve many of the problems, not all of the problems, here.

But, Mr. President, the facts are these: We raised that issue specifically with the Forest Service, and the Forest Service has specifically said that section 701 of FLPMA does not apply. In other words, Mr. President, the arguments raised by those who advocate this new legislation of a dramatic change and say it provides exemptions are ones specifically rejected by this administration.

Mr. President, this is not an idle matter. This affects not just reservoirs, it affects gas lines, oil lines, highways, reservoirs, and it affects them throughout the Nation, whether in West Virginia or in California or in Nevada. It has the potential of shutting down these.

Now some would say, "Surely, no one would come along and shut down reservoirs or vital pipe lines." Mr. President, they are doing it right now to 11,000 families in Colorado.

I ask unanimous consent to have printed in the RECORD at this point a letter that we sent to Secretary Madigan; an article from the Greeley Tribune; a letter from many Democratic and Republican legislators of Colorado on the interim water and State land issues committee; editorials from the Denver Post and Rocky Mountain News; and a letter from a water expert, a legal attorney in Colorado, who has written on this subject.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
Washington, DC, August 12, 1992.

Hon. EDWARD R. MADIGAN,
Secretary, Department of Agriculture, Washington, DC.

DEAR ED: The Arapaho/Roosevelt National Forest is located in Colorado and Wyoming. Many cities depend upon water diversion, storage, and treatment structure in the Arapaho/Roosevelt National Forest to maintain secure municipal water supplies. These facilities are operated and maintained under Forest Service special use permits issued under the Federal Land Policy and Management Act of 1976 ("FLPMA") or prior federal right-of-way grants. Some of the facilities are quite old and were even constructed prior to the reservation of the National Forest, nearly 100 years ago.

We have been informed that the Forest Supervisor for the Arapaho/Roosevelt National Forest takes the position that the Forest Service has the authority to impose bypass flow requirements as a condition of the renewal of the special use permits or approvals of the maintenance and rehabilitation of municipal water diversion and storage facilities located on the Forest. If implemented, these requirements would result in the loss of the historic yields relied upon by these water providers. This position violates the law, injures vested property rights, destroys established management practices, and would result in the implementation of environmentally damaging alternatives by the cities which would be forced to replace these supplies from other sources.

The Forest Supervisor relies upon the FLPMA and the National Forest Management Act ("NFMA") as authority for the bypass flow program. Neither of these acts, however, compel, or even authorize, the Forest Service to restrict the yield of pre-existing water rights. To the contrary, a primary purpose for the establishment and management of the National Forests, including the Arapaho/Roosevelt National Forest, is to supply western communities with water under state established and administered water rights.

Moreover, the environmental goals of the Forest can be achieved under existing law without taking private property and overturning a century of federal deference to state water allocation and administration systems. Water rights can be obtained for instream purposes under state law, and if additional water is needed, it can be purchased and transferred to instream flow uses.

The water rights held by these cities are critically important. Many western communities store water on the national forests during the spring snow melt for release and use downstream during low flow periods over the remainder of the year. Other communities, because of the location of their service areas, rely on direct diversions from streams which flow through the national forests. Such water management practices actually provide environmental and recreational benefits, rather than impair or destroy fish and wildlife. A cooperative system of water management, for example, in the Upper Poudre River Basin, has evolved since before the turn of the century. The policy of the Arapaho/Roosevelt National Forest should be designed to continue fostering these practices, not to destroy or diminish the value of these important assets.

The value of an acre-foot of developed water in Colorado's Front Range varies from $2,500 to $11,500 per acre-foot of yield, averaging approximately $7,500 an acre-foot. Moreover, many communities have invested millions of dollars in capital facilities such as

pipelines, reservoirs and water treatment plants. These expenditures will be lost or diminished in value, and significant new investment will be required if the bypass flow program is implemented. The Forest Service does not propose to compensate any of the communities for loss of water yield or their capital expenses. The present and future well-being of these communities depends upon continued exercise of their existing rights or, if they are to be deprived of any portion of their water yield, being provided with the necessary funds and governmental approvals required to replace the lost yield and facilities.

We cannot overemphasize the importance of this issue. If the Forest Service is allowed to proceed in this manner, this administration will have taken private property rights, interfered with the development and use of state and interstate water allocations, and replaced state water administration systems with a federal permit system.

In 1984, Mr. Douglas W. MacCleery, Deputy Assistant Secretary of the U.S. Department of Agriculture testified on behalf of the Department of Agriculture regarding the position of the Department on related FLPMA issues. He stated that: "I want to make it clear that there is no intention to jeopardize water rights or other rights held by the permittee at the time of renewal." This position should not be changed. We are certain that neither you nor the President intend such a result, and request that you immediately adopt a policy which confirms that the special use permitting authority of the United States will be exercised in a manner which is consistent with the preservation of private property rights, assists States in the development of important water resources, and does not usurp state primacy over water allocation and administration.

We would like to meet with you to discuss this matter at your earliest convenience after the conclusion of the August recess.

Sincerely,

Malcolm Wallop, Alan Simpson, Hank Brown, Conrad Burns, Orrin Hatch, Pete V. Domenici, Larry E. Craig, Steve Symms, Jake Garn, Wayne Allard, Ben Nighthorse Campbell

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[From the Greeley (CO) Tribune, Oct. 22, 1993]

GREELEY RESERVOIRS A HABITAT HAZARD?

(By Bob Kretschman)

Two of Greeley's high-mountain reservoirs that are subjects of a permit dispute with the federal government adversely affect the habitat of threatened and endangered species in Nebraska, according to a draft study by the U.S. Fish and Wildlife Service.

The wildlife service has issued biological opinions on the environmental effects of seven water projects whose permits to operate in the Arapaho and Roosevelt national forests are up for renewal. Federal officials want to require owners of those permits, including the city of Greeley, to offset the water facilities' adverse effects on wildlife. Permit holders say their projects do not harm wildlife.

Biological opinions by the Fish and Wildlife Service are required by the Endangered Species Act before the permits can be renewed, and the agency has determined in the draft opinions that Barnes Meadow Reservoir and Peterson Lake, two reservoirs owned by the city of Greeley in the upper Cache in Poudre river basin, affect the habitat of endangered species in Nebraska.

However, the city hired an environmental consultant earlier this year to study the reservoirs' effects on wildlife, and the city's studies determined the reservoirs had no effect on streamflow in Nebraska, and John Gauthiere, Greeley's water operations manager.

"It's a long stretch of the imagination that we do have any effect in Nebraska," he said.

Lee Carlson, Colorado field supervisor for the USFWS, said water depletions in the South Platte River basin affect whooping cranes, least ferns, piping plovers, and pallaid sturgeons. The three bird species and one type of fish are dependent on Platte River streamflows, and Greeley's two reservoirs contribute to depletion of the river's water, he said.

Water is lost from Barnes Meadow Reservoir and Peterson Lake, as well as the other five permitted projects, through evaporation and consumptive use. The reservoirs store water during peak flows of the spring, which also creates habitat problems for wildlife in Nebraska, Carlson said.

The opinions issued this week are in draft form and will not be final until the USFWS and the U.S. Forest Service—which will decide in January which conditions to attach to renewal of the permits—attempt to work out differences with permit holders, officials said.

"We'll be working with all the applicants trying to resolve issues," Carlson said.

The draft opinions present two alternatives to reduce what the agency says are adverse impacts of the water projects.

The first alternative is for the permit holders to replace water that is being lost from their projects. Carlson said that in a separate case, a water entity bought water from the Riverside Irrigation District to replace the flow lost by an upstream water project. But he said there may not be enough water available for sale in the lower South Platte basin to replace the water from all seven projects.

Another alternative is for permit holders to provide funding or other support for habitat restoration along the South Platte, and to participate in an organization dedicated to recovery of species in the Platte River basin. Such an organization already exists in the Colomdo River basin, he said, and water users there pay a surcharge on their water use to improve wildlife habitat.

Gauthiere said city officials received the biological studies on Barnes Meadow Reservoir and Peterson Lake Thursday and were beginning to review them.

"These are drafts, and I hope we can have a meaningful negotiation with (the federal agencies)," Gauthiere said. "It looks like they want water."

GENERAL ASSEMBLY,
STATE OF COLORADO,
Denver, October 27, 1993.

Hon. BILL CLINTON,
President of the United States, The White House, Washington, DC.

DEAR MR. PRESIDENT: The Interim Committee on Water and State Lands Issues of the General Assembly of Colorado is strongly opposed to the Reid Amendment to the fiscal year 1994 Interior Appropriations bill. Our Committee supports and agrees with Governor Roy Romer, Attorney General Gale Norton, Senator Hank Brown and Senator Ben Nighthorse Campbell, that it is essential that this legislation not proceed in its current form.

The Reid Amendment is not merely an increase in the rate lessees are currently charged by the federal government to graze livestock on public lands. The Reid Amendment is an overhaul of rangeland management and an attempt to overturn state water law without the benefit of public comment.

There is no doubt that the provisions in the Reid Amendment are poorly drafted and subject to incorrect interpretations that would seriously encroach on the water laws of the State of Colorado. The Reid proposal would have the following impacts:

Preempt state law by prohibiting water rights from being obtained for grazing related activities on public lands.

Provide the federal government with a right to control water, a right that under U.S. water law vests the states with the power to create and administer water rights.

Require the Secretary of Interior to develop standards and guidelines that would provide for the restoration and protection of riparian values. This is a major shift from existing law. No current law requires restoration of riparian values.

Limit the exercise of water rights on private lands that are used in "conjunction with grazing-related activities" on public lands.

Given the critical importance of these issues, we believe that it would be irresponsible and undemocratic for the legislation to proceed without any public hearing on the intent of this legislation regarding the water resources of the State of Colorado. The future of our nation depends on the cooperation between state and federal governments. A unilateral and purposely secretive change of important state/federal relations will only increase the public distrust and suspicion of Congress and the Federal government and government in general.

Very truly yours,

Senator Don Ament, Chairman, Interim Committee on Water and State School Lands Issues; Representative Bill Jerke, Vice Chairman, Interim Committee on Water and State School Lands Issues; Senator Tilman Bishop; Senator Tom Blickensderfer; Senator Joan Johnson, Senator Bob Pastore; Senator Linda Powers; Senator Dave Wattenberg, Representative Bob Eisenach; Representative Michelle Lawrence; Representative Jeannie Reeser; Representative Mike Salaz; Representative Bob Shoemaker; Representative Jack Taylor.

[From the Denver Post, Oct. 28, 1993]

GRAZING REFORMS SHOULDN'T TRAMPLE ON WATER RIGHTS

The Clinton administration's plan to tighten the reins on livestock grazing on federal lands has been sidetracked in the Senate by a dispute over its possible effect on water rights.

The disagreement, which has helped stall action on the measure for more than a week, was triggered by a section some Westerners fear could let federal agencies disrupt water flows to locally owned reservoirs or irrigation canals.

As Gov. Roy Romer put it in a letter to Senate leaders this week, the provision "could be construed to reserve a federal water right on federal lands not only for grazing but for any other purpose as well."

Interior Secretary Bruce Babbitt promptly denied that the bill would make any change in traditional water law, and he labeled such concerns a "red herring."

But as the former Arizona governor must recognize this is a morass in which advocates of reform can't afford to get trapped. A similar fight over water language, it's worth noting, delayed passage of the latest Colorado wilderness bill for years.

The provision dealing with water rights on rangelands should be clarified to ensure that it won't upend state-run allocation systems or unduly restrict the operation of water projects unrelated to grazing.

It's important to protect riparian areas along streambeds from damage caused by overgrazing or unwarranted water diversions. But the needs and rights of other water users, including cities that depend on the rivers flowing into and out of federal lands, shouldn't be trampled in the process.

[From the Rocky Mountain News, Oct. 28, 1993]

WASHINGTON'S WATER GRAB

While we have a hard time believing it possible, there may be a few of our readers who remain oblivious to the Clinton administration's tendency to push for greater federal control over the economy. The latest example is its support of legislation that would give Washington far greater authority over Western rivers and water rights.

This water grab is part of the dispute over grazing fee increases, currently being filibustered in the Senate. Water is, quite probably, even more important than the grazing dispute, though grazing fee increases have drawn most of the attention. Perhaps this is not by accident. A Department of the Interior memo, written to Interior Secretary Bruce Babbitt and leaked to the office of Wyoming Sen. Malcolm Wallop, explains why: "We realize you want to use price increases as a straw man to draw attention from management issues"—management issues that include turning elements of current water law on its head.

Not everyone is fooled. On Monday, Gov. Roy Romer joined Rep. Scott McInnis and state Sen. Don Ament in raising concerns about the water grab. Any grazing increases, Romer said, have "got to be pursuant to our water law" in order to gain the governor's support. But according to a detailed study of the legislation by the Denver law firm of Hobbs, Trout & Raley, state control of water will be all but washed away if the legislation passes.

"We have concluded that the bill, if adopted, would constitute a radical departure from the principles of federalism and respect for state water law by imposing a national riparian water law for public lands," lawyers in the firm recently wrote Sens. Hank Brown and Ben Campbell. Among other things, passage of the legislation would give the federal government control over water "which flows into, arises upon, or runs through federally owned lands." In Colorado, where the federal government owns about one-third of the land, the impact would be enormous.

As it now stands, the states determine water allocation laws and the rights created under those laws, which the Clinton administration hopes to pre-empt. The result: a flood of problems for Coloradans.

Hobbs et al. sum up the damage this way: "Water rights holders throughout the West will surely be faced with at least a decade of administrative proceedings and litigation brought by regulatory agencies and the Justice Department to establish federal riparian rights on rivers throughout the West. The citizens, in turn, will be forced to initiate expensive defensive proceedings and litigation to protect their water rights, including takings litigation."

Sen. Ament agrees, noting that the legislation requires Babbitt "to develop standards and guidelines that would provide for the restoration and protection of riparian values. This a major shift from existing law"—and "riparian values" themselves are subject to considerable debate.

The Interior memo also touches on this subject: "Our own statistics can be used to show the range is in better shape than at any point in this century. With that in mind, we must make deliberate and public attempts to prove how bad the conditions are in many riparian zones."

Babbitt says he'll institute "reforms" with or without congressional backing. The administration must be made to realize that belligerence on this issue will cost it support on policies dearer to its heart.

HOBBS, TROUT & RALEY, P.C.,
ATTORNEYS AT LAW,
Denver, CO, October 26, 1993.

Re your letter to Senate Leadership regarding H.R. 2520.

Hon. ROY ROMER,
State Capitol,
Denver, CO.

DEAR GOVERNOR ROMER: Your letter of October 25, 1993, to Senators Mitchell and Dole concerning H.R. 2520 was timely and well-done.

We have reviewed Secretary Babbitt's October 26, 1993, response to you. Taking the Secretary at his word about the intent of the bill, it certainly should be possible and advisable to amend the bill to clarify its intent. Otherwise, I am quite certain that ambiguities in the language will lead to prolonged and expensive controversy and litigation.

Secretary Babbitt cites the savings provision of the Act of October 21, 1976, annotated in the notes to 43 U.S.C. 1701(g), for the proposition that federal-state changes in water law will not be interpreted to occur as a result of H.R. 2520.

However, two prevailing propositions of law can and will be argued to the contrary, in our opinion, if H.R. 2520 is adopted. First, specific provisions control over general provisions. Second, subsequent enactments of Congress can impliedly repeal or amend former Acts of Congress when a conflict in provisions arises.

H.R. 2520 contains specific, heretofore unprecedented amendments to FLPMA which provide that FLPMA permits and leases shall be utilized to restore, maintain and protect riparian values and that the United States shall assert its claims and exercise its rights to all water developed on federal land to benefit the public lands and resources thereon.

The explicit language regarding "riparian values" juxtaposed with "United States * * * claims and rights to water developed on the public lands" is entirely new to FLPMA and Courts will be called upon and required to give it effect. As a long-time practicing water lawyer I cannot counsel the State or any of my clients to contemplate such legislation becoming law in light of very recent experience with how such language—and a lot less specific administrative authority—can be applied in administrative and judicial proceedings.

We have recently encountered in Colorado very costly litigation and demands for water in the name of United States based on much less than the language in H.R. 2520. The recent reserved rights litigation, which the Division 1 Water court decided against the Government, was brought on the theory that "favorable conditions of water flow" in the 1897 Organic Act established reserved channel maintenance flows. The litigation is estimated to have cost citizens of the United States and the State of Colorado approximately $10 million dollars.

Presently, the Forest Service and the Fish and Wildlife Service are utilizing FLPMA and the Endangered Species Act, in the FLPMA renewal process for Greeley, Fort Collins, Boulder, and the Water Supply and Storage Company, to demand the by-pass or release of water from perfected, historically-utilized water rights, as a condition of continued access across Federal lands.

These actions by the Government are 1) freezing in place what was emerging as an active water market in transfer of existing water rights instead of building new water storage projects and 2) critically threaten co-operative efforts between farmers and Colorado Front Range cities to extend the benefit of already-developed water supplies. No agricultural ditch company or city facing the possibility of losing part of its already-developed water yield because of FLPMA requirements is going to part with water it may need for dry years or in the future. Whatever reserve or excess supplies may have gone to the water market are being jealously guarded because of the insecurity being caused by these administrative actions and pending legislation such as H.R. 2520.

It may well be that the rush of drafting these FLPMA amendments led to general or careless language. If the water provisions of H.R. 2520 are intended to apply only to grazing-related activities on the public lands, and State water law and water rights are intended to be protected, amendments to H.R. 2520 are surely in order.

In the meantime, let me tell you that your efforts on behalf of Coloradans and their water rights have been magnificent and, in no way, was your letter to the leadership wrong or ill-advised.

Best regards.

GREGORY J. HOBBS, Jr.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. WALLOP. Mr. President, I reserve the remainder of our time.

The PRESIDING OFFICER. Who yields time?

The Senator from West Virginia.

Mr. BYRD. Mr. President, I have a letter from the Secretary of the Department of the Interior which I ask unanimous consent to have printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

THE SECRETARY OF THE INTERIOR,
Washington, October 28, 1993.

Hon. ROBERT C. BYRD,
U.S. Senate, Washington, DC.

DEAR SENATOR BYRD: As consideration of the grazing reform compromise adopted by the Conference Committee continues, I would like to clarify certain provisions included in that compromise. These clarifications pertain to four important issues addressed in the legislation: grazing-related water rights; range improvements; subleasing; and prohibited acts.

Water Rights—Opponents of the Conference Committee compromise grossly mischaracterize the provisions relating to water rights. A detailed response is contained in the attached letter to Governor Romer. I would highlight these points: First, the policy change would be prospective only and would not affect existing property rights. Second, it simply aligns the BLM position on this issue with existing Forest Service policy. Third, these provisions affect only range-related water rights on BLM public lands used for grazing. Therefore they

have no application outside the Western public lands states. The language and context of these amendments makes that unmistakably clear; it is simply unreasonable to construe them otherwise.

Range Improvements—New section 406(i) addresses the issue of range improvement ownership. The Conference Committee compromise provides that the United States would have title to all permanent range improvements constructed in the future on public lands. Title to temporary range improvements used primarily for livestock handling or water hauling would be retained by the permittee or lessee. The Conference Committee compromise would not change the agreements currently in effect or affect the ownership of existing range improvements. Here too, in other words, the policy change would be prospective only and would not affect existing property rights. A permittee's interest for contributed funds, labor, and materials would be documented for proper credit in the event the land is disposed of or the permit or lease is subsequently issued to a different party. The proposal is similar to existing Forest Service policy with respect to range improvements. It applies only to range improvements on public lands administered by the BLM for grazing purposes; it does not affect hydroelectric developments, electric power lines, natural gas pipelines, or other permanent improvements unrelated to grazing, nor to improvements on Forest Service lands. Again, the language and context of these amendments makes that unmistakably clear; it is simply unreasonable to construe them otherwise.

Subleasing—New section 406(e) imposes a leasing surcharge for authorized leasing of base property to which public land grazing preference is attached or authorized grazing of livestock owned by persons other than the permittee or lessee. I will construe this provision to recognize and leave unchanged the current Bureau of Land Management practice which allows subleasing to family members when they are operating within the family operation or are assuming control of the family operation.

Prohibited Acts—New section 406(1) requires the Secretary to promulgate regulations to make violation of the Wild Horse and Burro Act, the Endangered Species Act, and federal and state laws concerning "conservation, protection of natural or cultural resources, and protection of environmental quality" prohibited acts. Upon expiration of appeal or review periods following a conviction for violation or administrative finding of violation of these laws, the authorized officer may consider cancellation or suspension of the permits or leases where the violation has occurred on public land or is related to authorized grazing of public land. The proposal would adopt language that existed in the BLM's regulations prior to 1984, and is compatible with existing Forest Service policy. It deserves emphasis that the Conference Committee compromise ensures that no suspension or cancellation of a permit or lease can occur until there has been a full opportunity for appeal of the finding of a violation or a conviction. Finally, convictions and violations unrelated to these environmental and land use issues are not "prohibited acts" as used in the statute.

It also seems appropriate to clarify the Department's intentions with regard to public hearings on the new regulations required by the grazing reforms contained in the Conference Committee compromise legislation. The Department is committed to conducting public hearings in every Western grazing state prior to the implementation of any regulations. Moreover, the Department would welcome the opportunity to participate in any Congressional oversight hearings reviewing the Department's implementation of the grazing reform provisions of the compromise.

Finally, as I discussed with Senator Hatfield yesterday morning, most of the administrative authority which the Department has over grazing is entirely outside of, and unaffected by, the Conference Committee compromise. For example, the promulgation of standards and guidelines which govern stocking numbers, length of grazing seasons, use of riparian areas and the like, is a matter still within my administrative discretion with regard to which I remain ready and willing to discuss and negotiate with interested Senators. Likewise, the role of grazing permittees in the all important Resource Advisory Councils is a matter that I am ready and willing to discuss at any time.

I hope these clarifications regarding the Department's interpretation and intention with respect to implementing these provisions are of assistance in the Senate's consideration of the Conference Committee's grazing reform compromise. So there is no misunderstanding, I want to make clear that my interpretation of these provisions does not in any way bind my decisions regarding the Rangeland Reform '94 rulemaking which the Department would proceed to undertake should Congress decline to enact the grazing reform compromise.

Sincerely,

BRUCE BABBITT.

THE SECRETARY OF THE INTERIOR,
Washington, October 26, 1993.

Hon. ROY ROMER,
Governor, State of Colorado, Denver, CO.

DEAR GOVERNOR ROMER: In your letter dated yesterday to Senators Mitchell and Dole you express particular concerns about certain provisions of Senator Reid's compromise public lands grazing reform (the Reid compromise) being debated as part of the FY 1994 Interior Appropriations bill. I must respectfully disagree with your characterization that these provisions would "inject such ambiguity and confusion into the process for allocating water in the West that litigation and uncertainty would prevail for years to come."

My staff and I have carefully examined the provisions in question. In my judgment as a former Western State Attorney General, Governor, and private practitioner in water law, these charges simply cannot be sustained. Those parts of the Reid compromise that relate to water are in fact in the mainstream of water law as applied in the western states.

For example, nothing in new section 406(d) changes the traditional practice of acquiring water rights for livestock grazing on public lands under state law. It only ensures that, subject to valid existing rights, such water rights be obtained in the name of the United States. This has long been the practice on the national forests, as well as state law in many western states, including my home state, one of the most arid in the country.

Your letter expresses specific concern that the Reid compromise "could be construed to reserve a federal water right on federal lands not only for grazing but for any other purpose as well." Apparently you are referring to language in the last sentence of section 406(i)(2). But this sentence does not address federal/state relations in water law. It simply confirms the common sense principle that federal claims and rights to water "developed on public lands [shall be exercised] to benefit the public lands and resources thereon." Moreover, the sentence is part of a subsection addressing grazing-related water rights; more specifically, cooperative range improvement agreements. (It is captioned "Range Improvement Ownership.") There is simply no way a court could read this innocuous language to create broad new categories of federal water rights, whether for grazing or non-grazing purposes, in denigration of state water law.

You have also raised concerns about section 406(o), which directs the development of standards and guidelines that "establish minimum conditions for the protection of rangeland ecological health," and which shall include, among other things, "restoration and protection of riparian values, such as healthy wildlife and fish habitat and diverse vegetation." Nothing in this section addresses water rights or state-federal relationships in the area of water; rather, it merely furnishes direction for the Department in the implementation of existing law. That law (the Federal Land Policy and Management Act, or FLPMA) has for nearly two decades required BLM lands to be managed for "multiple use" and "sustained yield," and defines these terms to require accounting for, among other things, "the long-term needs of future generations for renewable and nonrenewable resources, including recreation * * * watershed, wildlife and fish, and natural scenic [and] scientific * * * values." 43 U.S.C. 1702(c).

Each of the provisions is the Reid compromise about which you have concerns is an amendment of FLPMA. That Act's general disclaimer on water rights (Section 701 (g), 43 U.S.C. 1701 Note) remains intact. No court has ever interpreted FLPMA as changing state-federal relations in water law. The experience under it has been exactly the contrary.

You have my assurance that the Department of the Interior will, if these provisions are enacted into law, interpret and apply them in conformance with their intent—not to make drastic changes in state-federal relations in water law, but rather to ensure that water rights obtained under state law for grazing-related purposes on public lands serve federal grazing-related needs, and that the ecological health of federal rangelands is secured.

As a native Westerner I know the sensitivity of water rights issues and the legitimacy of states' concerns that their water law systems be protected. I also know a red herring when I see one. The attempt to portray the water provisions of the Reid compromise as a massive federal water grab is just that. I hope this clarifies the matter.

Sincerely,

BRUCE BABBITT.

Mr. BYRD. Mr. President, at the moment, I will read only three sentences therefrom. Two sentences deal with water rights.

Opponents of the Conference Committee compromise grossly mischaracterize the provisions relating to water rights. A detailed response is contained in the attached letter to Governor Romer.

Another sentence from the Secretary's letter:

The department is committed to conducting public hearings in every Western grazing State prior to the implementation of any regulations.

Mr. President, there has been much discussion about this grazing issue and

what will happen with the Interior appropriations conference report. This issue has consumed a great deal of the Senate's time already. I know this issue is important to many people in the West. However, we have to move forward and let the Senate work its will on this bill.

The way to do this is to invoke cloture and allow the Senate to vote on the conference report and then turn to the amendments in disagreement. Any Senator has the opportunity to offer an amendment to an amendment in disagreement if he or she desires to do so. What do the opponents fear in allowing the Senate to work its will?

Is it that they fear they do not have the votes? Mr. President, I think the answer is clear. The opponents of this proposal do not know what they want. They know what they do not want—they do not want any change. But what do they want? I have heard a lot of talk about compromise, but no specific proposal has been offered. Continuation of the moratorium is no compromise.

It has been suggested that the Secretary of the Interior or the Members who support the compromise reached in conference are unwilling to negotiate or further compromise. This is simply not the case. Let us review the facts—Secretary Babbitt announced his proposed fee increase and range management reforms in early August. That was nearly 3 months ago. The proposal contained in this conference agreement represents a compromise from that position—it involves a lower fee and proposes fewer reforms than initially proposed by Secretary Babbitt. So, it seems to me that Mr. Babbitt has compromised. I repeat—the proposal in the conference agreement contains a lower fee and fewer range reforms than originally proposed by the Secretary. How can one suggest that this is not compromise?

Mr. President, the responsibility is on the Senate to act on this issue and move this appropriations bill forward. Continuing the current stalemate does not help to resolve this issue. If the Senate desires further compromise, it should consider a proposal and vote on it. The solution to this issue may be to remove everything having to do with grazing from this bill—just take it all out. That means no fee increase. It means no range management reforms. But it also means no moratorium. I repeat—no moratorium, no fee, no reform. This would leave the issue subject to current law, and allow Secretary Babbitt to proceed with the higher fee and greater reforms he proposed back in August. Is this what Senators want? Those are the choices as I see them. We have to finish this bill. This issue has consumed time on the Interior appropriations bill every year since 1976, and I am sick and tired of it. Why does this have to be on an appropriations bill? Why does the authorizing committee, on which these western Senators sit—why does it not act? This subject confronts us on this Interior appropriations bill every year.

The time has come to put this to an end.

On Tuesday, I discussed several possible scenarios that could affect the Interior bill agencies if the Senate perpetuates this stalemate and refuses to invoke cloture on this conference report. I did not advocate any one of those alternatives. I am not interested in shutting down these agencies. I am not interested in freezing their operations at the fiscal year 1993 level for an entire year. I am interested in approving this conference report and getting on with the amendments in disagreement; these agencies need to receive the funding recommended in this conference report.

My point is simply this—if the Senate fails to take action on this conference report, some decisions will have to be made affecting these 40 agencies. Those decisions will have to be made by the House, the Senate, and the President. Will there be a shutdown? Will there be another short-term continuing resolution? Will there be a full-year CR for the Interior agencies that would maintain the fiscal year 1993 level? The way to avoid these choices is to invoke cloture, or at least agree to vote on the conference report, and then go to the amendments in disagreement. If we do not move forward today, I am not prepared to continue to engage the Senate's time on this issue.

There have been inferences made by certain Senators that I have somehow threatened their projects or programs by my statements that a full-year continuing resolution at the 1993 levels could be required if we cannot get over this impasse on grazing fees.

I did not threaten anyone. I did not state any threats. I stated facts. And they are not the only Senators, those Senators whom I mentioned, or rather whose projects and programs I mentioned—we all will suffer, including this Senator. But I am not willing to continue down this road.

I am not cowed by the comments of those Senators. In fact, let me make another possibility clear. If we cannot overcome this impasse and if this bill is recommitted to conference, I can assure all Senators that I have no control over the position of the House conferees regarding not just the grazing fee issue but also every item in the conference. What I am saying is that it could well be that the House conferees may take the position, if that happens, that we start all over, all over with a clean bill, and renegotiate every amendment that is in the conference report—we just wipe everything clean, start all over again.

I have worked to include items in this conference report for other Senators on both sides of the aisle.

Anyone may take that statement as a threat, if anyone wants to. That would jeopardize every item that was successfully included in the conference agreement at the request of Senators.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. REID. I ask unanimous consent the time be extended for the Senator from West Virginia, and the other side, an additional 3 minutes on each side.

The PRESIDING OFFICER. Is there objection?

Mr. DOMENICI. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from West Virginia.

Mr. BYRD. Mr. President, as I say, anyone may take my statement as a threat if anyone wants to, but I can assure Senators that this is a distinct possibility, and could occur if we are required to reconference this bill.

I am not going to ask for another vote on cloture after today unless something breaks, or until the last day set forth in a continuing resolution. I am not interested in taking this Senate's time every 2 days on another cloture vote. So if we do not get cloture today, unless something breaks, as far as I am concerned, we will not have another cloture vote. We will not take up the time of the Senate with another cloture vote until the last day of the continuing resolution.

I have about had it up to my ears. All the years I have been chairman of this Interior appropriations subcommittee, we have had this, this item of grazing fees; in one way or another—on many occasions, it had to be dropped—since 1976. These Senators who are opposing this conference report, many of them sit on the authorizing committee. That is where the action ought to be taken. We hear so many complaints about the Appropriations Committee taking over the work of the authorizing committees. And here is one reason why. Here we have grazing fees stuck on this bill every year. I am tired of it. Let us settle it once and for all.

So if some Senators do not want to vote for cloture today, there will not be another opportunity until the last day of the continuing resolution, unless something breaks in the meantime. It seems to me that the Secretary has gone a long way toward compromise. Senator REID has been a very diligent member of the committee. He does much of the work on the whole bill in the committee. He holds many of the hearings at my request. He is an honorable man; he has done his best; he has been fair. And I hope that Senators will sober up.

I do not expect this cloture motion to be invoked today, but I will say to Senators, you are not going to have another chance until the last day of the continuing resolution. And if it is not invoked, then I will not ask for cloture until the last day of the final CR. So

we had better get busy, There has to be some give.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. WALLOP. Mr. President, I yield the remainder of the time to the control of the Senator from New Mexico [Mr. DOMENICI].

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. I yield to Senator BURNS 30 seconds to address the issue.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BURNS. Mr. President, I rise today to present my thoughts on the proposal by the administration to raise grazing fees and change the policy for managing the public lands. The focus has been on grazing fees instead of changing policy and principles for public land management.

The proposed increase in grazing fees are the tip of the iceberg. Fee increases are proposed for hardrock mining, timber, recreation, and irrigation. I have not figured out how anyone can justify raising public land user fees in order to balance the budget. The numbers just do not add up.

The administration expects to raise $82 million by raising grazing fees. At the same time, operating expenses have more than doubled, and an $800 million per year industry in my State of Montana is brought to their knees. The current tax base is killed. I believe someone with some experience needs to think this out.

The same philosophy holds true for the timber and mining industries. In Montana, we have several billion board feet of manageable timber in the timber base. This is timber located on acreage suitable for management. Millions of dollars are being thrown away because the Federal Government is incapable of managing commodities for the benefit to the schools, tax base, Government amenities, and people.

Mining is essential to the economy of Montana. The industry employs about 3,500 people in Montana alone, with a payroll of about $150 million annually. About $29 million in taxes are paid annually by mines and their employees. Over $574 million was generated in Montana in 1990.

Nearly 5,000 ranches will be placed to economic risk if we go forth with drastic public land management changes. Rural America will be severely eroded as the tax base is destroyed.

In 1992, the Secretaries of Interior and Agriculture reported to Congress in "Grazing Fee Review and Evaluation: Update of the 1986 Final Report," that their costs for administering the grazing programs were $2.18 and $2.40 per AUM. The weighted average is $2.26 per AUM.

The Reid-Babbitt compromise would codify a fee 53 percent higher than the reported cost of administration. Using the Secretary of Interior's own data, the $3.45 grazing fees would exceed the full costs of the entire multiple use programs by 23 cents per AUM. Thus, the rancher would subsidize all the other users, like wildlife, of Federal lands.

A 1993 scientific report to the BLM and Secretary of the Interior, "The Federal Grazing Fee: 1993," on test plots for nutrients and grass availability in Wyoming, Idaho, and New Mexico, indicated that the average value of Federal forage was about 13 cents per AUM. The Federal forage fee that year was $1.92, or $1.79 per AUM more than the grass was worth. Why? Because there was no alternative.

State and private fees aside, Federal lands are not as productive as State and private lands. If the U.S. Forest Service and BLM are trying to charge for trespass, user fees, stewardship, a method should be devised to be fair and honest to denote cost equalization. Even then, the grazing fee for an AUM would be about $0.89 per AUM.

This issue is increasingly complicated. In fact, cost comparisons for U.S. Forest Service allotments for sheep indicate negative forage values. In many cases, ranchers are paying more for public grazing leases because they have no alternative. Public land ranchers are paying full market value for grazing public lands when higher nonfee grazing costs and investments in leases on the public lands are considered.

RECOGNITION OF CORRESPONDENCE SUPPORTING WESTERN SENATORS DEBATING H.R. 2520

Mr. BURNS. Mr. President, I rise today to request unanimous consent to include in the RECORD, the report on file in numerous western Senators' and the Secretaries of the Interior and Agriculture offices entitled "Report to Congress and to the Secretaries of Interior and Agriculture, A Comparative Analysis of the Economic, Financial, and Competitive Conditions of Montana Ranches Using Federal Forage and Montana Ranches Without Federal Grazing Allotments, Pepperdine University, July, 1993."

In addition, I request unanimous consent to include for the RECORD, a reference to the files in my office containing the compilation of letters from individuals, State organizations, banks, and other pertinent correspondence of interest parties supporting the position of the western Senators in opposing the Reid-Babbitt grazing reform proposal.

The theme of these documents, representing hundreds of thousands of people in the West, is an acute opposition, deep concern, and fear that the Federal Government is succeeding in taking water rights, range improvements, and private property from the people of the West.

From all appearance, the livelihood of western America is on the line and folks are ready to make a stand for what they believe in. This information is requested to be part of the RECORD and I thank you.

Mr. DOMENICI. How much time does the Senator from New Mexico have?

The PRESIDING OFFICER. The Senator from New Mexico has 4 minutes and 40 seconds.

Mr. DOMENICI. Mr. President, let me remind my good friend from West Virginia, he said get busy; there has to be some give. That is exactly what I say. I am sure when he gets up in rebuttal he will say "over there," on our side.

The point is, we do not have any place to give or anybody that is receptive to anything that we might give.

I want the Senate to know that yesterday afternoon, five of us—two from the Democratic side, three from our side—had a meeting set with the Secretary to talk about getting busy and giving, and guess what happened? The Secretary canceled it. He said there is nothing to talk about.

There is something to talk about, and it is very, very simple. What do we want, said my good friend from West Virginia. We want simple fairness. We want 1 year to have hearings on matters of grave import to thousands of our constituents on subjects that there have been no hearings on.

If we are accused of gridlock, let me suggest that the only issue we have had in years past are grazing fees. My friend from West Virginia says it comes up every year. There have not been issues on water rights, who owns them; improvements, who owns them; what are your rights on appeal; what will it do to the family ownership of a ranch. They have not been before anyone yet, and they are pushed right into an appropriations bill.

I could say to my good friend from West Virginia, what are they doing in an appropriations bill? They do not belong there. It denies the people of the West a hearing. To say the Secretary is going to have hearings is to deny us an opportunity to write some law that might be reasonable on the subject.

Do we think we should turn over the destiny of our people to the Secretary of the Interior? I think he is a nice man. He has a great academic background. I think he went to Notre Dame. That means he is pretty good, I guess—and he is. But I am not willing to say, "It is in your hands, Mr. Secretary." I will tell you that for sure.

Now who is stonewalling? Some people say we are stonewalling. We cannot do any better than to say we will sit down with the Secretary, we will sit down with Senator BYRD, we will sit down with HARRY REID, but not—not—with a gun that says, "It is our way or no way."

What kind of negotiating is that? What kind of fairness is that? For those who wonder about filibuster and here we are pushing Interior right to the wall, let me say to anybody listening, we do not have any other way to

do it. This happens to be the system. We are operating under the rules.

My friend, the chairman of the Appropriations Committee, has said, "Operate within the rules," and he said, "I compliment you when you are operating within the rules." We are. We have no other way to get fairness and justice for our people, and if we have to stay here another 5 or 6 days, somebody is going to give and it is not going to be just us. How about some give on the other side?

I understand the House is saying the President supports our position full speed ahead, as they debate a continuing resolution. So I say, it is going to be us against them, and if we lose, we are going to go down with every rule of this Senate having been used by us to protect our people. Nothing less is right. And I know there are a lot of people wondering about the Interior appropriations items. I am worried about them, too. But I am more worried about determining, once and for all, in a bill that has had no hearings, the destiny of the ranchers of the West, their families and rural communities across this land. That is it.

If anybody wonders whether it is complicated, who is doing what to whom, I cannot make it any clearer. Nineteen pages of new law in an appropriations bill. There are not three members of that committee who voted who know what is in it, know what it does—and I compliment them all for being very dedicated Senators—but they do not know because this deal was not made in that committee. This deal was made with the Secretary of the Interior, who now cannot deal with us. His staff wrote all this. We saw three different versions. This was not prepared in a last-minute little effort on an appropriations bill.

So I say our message is very simple.

I yield the floor and stand on simple justice and fairness.

Mr. BYRD. How much time do I have?

The PRESIDING OFFICER. Senator BYRD has 19 seconds.

Mr. BYRD. How much time?

The PRESIDING OFFICER. Nineteen seconds.

Mr. BUMPERS. Will the Senator yield that 19 seconds to me?

Mr. BYRD. Yes, I yield.

Mr. BUMPERS. I would like to say to the Senator from New Mexico, how about fairness and justice for the other 250 million taxpayers of this country?

Mr. BYRD. Mr. President, I ask unanimous consent for 1 minute additional on each side.

Mr. DOMENICI. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BYRD. Mr. President, what started this? The Senator from New Mexico knows I have the greatest of respect for him. He was behind the moratorium. That is what started it. That opened the door, and the House has amended his moratorium amendment.

Now, the distinguished Senator from New Mexico may break all the desks here, if he wishes, and bruise his knuckles; it does not intimidate anybody that I know of. The Senator was behind the moratorium. Let us wipe it all off, all of it. Take out the moratorium, too. But we need to get the amendments in disagreement.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, in answer to my friend, Senator BUMPERS, the taxpayers of the country will lose more money. While they pick up $19 million in fees, the taxes collected by the American Government will go down more than that and we come out with the taxpayers losing.

Second, with reference to the moratorium, it is one thing to have one line in the bill that says you have a year to debate, have hearings and another to come back with 19 pages of new law written into this bill. I think they are very different. I started what I thought was fair. We end up with absolute unfairness and unwillingness to move even 1 inch.

Mr. HATCH. Mr. President, I, along with many of my colleagues, have already addressed the many respects in which the Reid-Babbitt compromise is unfair and is bad policy. I would now like to focus briefly on some of the serious constitutional defects in the amendment—specifically, the problems raised under the takings clause and the due process clause of the fifth amendment.

Let me begin with the fact that range rights owned by ranchers—including water rights, grazing rights, and rights in improvements—clearly constitute property for purposes of the fifth amendment. Among other things, these rights are transferable by the same deed that transfers a rancher's private land and improvements; they are subject to an estate tax; and the military, when it takes a Federal range for military use, is required to pay the ranchers for their interest in the Federal range. [Hage, Storm Over Rangelands, at 4.]

Now let me address some of the ways in which the Reid-Babbitt language tramples these property rights:

Section 406(d) fails to protect existing water rights recognized under State law. That section provides: "Subject to valid water rights existing on the date of enactment, no water rights shall be obtained for grazing-related actions on public lands except in the name of the United States." The problem with this sentence is that the phrase "valid water rights" is not defined with respect to applicable State law. Thus, a Federal agency could make a Federal validity determination under which water rights recognized under State law would not be "valid" under section 406(d). The consequence would be the unconstitutional taking by extinction, without just compensation, of the private property in water rights.

This section also raises a serious 10th amendment issue. Under the Desert Land Act, Congress severed water from the Federal lands and vested plenary justification in the several States. The constitutions of several Western States claim the ownership of all water and those provisions were confirmed as a part of their Admissions Acts. The adoption of a Federal validity determination in subsection (d) would place an impermissible test on property rights created and vested solely by reference to State law. The assertion of a Federal claim and right to exercise water rights contained in subsection (i)(2) under these circumstances violates the 10th amendment.

Under section 406(i)(1), an owner of existing range improvements would not even be able to use or maintain these improvements—much less modify them or install new ones—without obtaining a permit from the Federal Government. Moreover, whether or not to issue the permit would rest entirely in the arbitrary and unguided discretion of a bureaucrat. This provision is doubly offensive to the Constitution. At the very core of the right to property are the rights to use that property and to maintain it? What does it mean to possess property if you cannot use it? Section 406(i)(1) would take away these vested property rights, and would do so without providing compensation. This would clearly be an unconstitutional taking.

Section 406(i)(1) would also violate the fifth amendment requirement that Government not take property without due process of law. Due process requires that a property owner have clear notice of the procedures and standards to which his property will be subjected. Section 406(i)(1) provides no notice whatsoever. It vests completely unconstrained and standardless discretion in a bureaucrat to deny a person all use of his or her property in range improvements.

The mandatory qualifications for renewing a grazing permit or lease are also unconstitutionally vague. Under section 406(j)(2), any applicant "must be determined by the authorizing officer"—the Government bureaucrat—"to have a satisfactory record of performance." What does the phrase "satisfactory record of performance" mean? What does it even refer to? It is clear from section 406(j) that the phrase means something other than, and in addition to, compliance with the terms and conditions of the existing permit or lease, since subsection 406(j)(3) separately makes such compliance a mandatory qualification. Here again, the Reid-Babbitt compromise would simply place completely arbitrary and

unguided discretion in the hands of a bureaucrat, and would subject the rights of ranchers to this arbitrary discretion. This is a mockery of due process.

As these examples illustrate, the Reid amendment/Babbitt compromise would trample the legitimate constitutional rights of ranchers. For these reasons, and for the policy reasons that I and others have already voiced, I continue to oppose adoption of the Reid-Babbitt language to the Interior appropriations bill and urge my colleagues not to invoke cloture.

The PRESIDING OFFICER. Without objection, all time will be considered as having been yielded back.

CLOTURE MOTION

The PRESIDING OFFICER. Under the previous order, pursuant to rule XXII, the Chair lays before the Senate the pending cloture motion, which the clerk will state.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on the conference report accompanying H.R. 2520, the Interior appropriations bill, 1993:

Patty Murray, Dianne Feinstein, Harry Reid, Harris Wofford, D. Inouye, Wendell Ford, Carol Moseley-Braun, Russell D. Feingold, Dale Bumpers, Robert C. Byrd, Claiborne Pell, Edward M. Kennedy, Paul Simon, Barbara Boxer, Howard Metzenbaum, Harlan Mathews.

CALL OF THE ROLL

The PRESIDING OFFICER. By unanimous consent, the quorum call has been waived.

VOTE

The PRESIDING OFFICER. The question is, Is it the sense of the Senate that debate on the conference report accompanying H.R. 2520, the Interior appropriations bill, shall be brought to a close? The yeas and nays are required. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. SIMPSON. I announce that the Senator from Minnesota [Mr. DURENBERGER] is necessarily absent.

I further announce that the Senator from Kentucky [Mr. MCCONNELL] is absent due to an illness in the family.

The PRESIDING OFFICER (Mr. CAMPBELL). Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 54, nays 44, as follows:

[Rollcall Vote No. 340 Leg.]

YEAS—54

Akaka	Glenn	Mitchell
Biden	Graham	Moseley-Braun
Boren	Harkin	Moynihan
Boxer	Heflin	Murray
Bradley	Hollings	Nunn
Breaux	Inouye	Pell
Bryan	Johnston	Pryor
Bumpers	Kennedy	Reid
Byrd	Kerrey	Riegle
Chafee	Kerry	Robb
Cohen	Kohl	Rockefeller
Daschle	Lautenberg	Roth
DeConcini	Leahy	Sarbanes
Dodd	Levin	Sasser
Exon	Lieberman	Shelby
Feingold	Mathews	Simon
Feinstein	Metzenbaum	Wellstone
Ford	Mikulski	Wofford

NAYS—44

Baucus	Domenici	Lugar
Bennett	Dorgan	Mack
Bingaman	Faircloth	McCain
Bond	Gorton	Murkowski
Brown	Gramm	Nickles
Burns	Grassley	Packwood
Campbell	Gregg	Pressler
Coats	Hatch	Simpson
Cochran	Hatfield	Smith
Conrad	Helms	Specter
Coverdell	Hutchison	Stevens
Craig	Jeffords	Thurmond
D'Amato	Kassebaum	Wallop
Danforth	Kempthorne	Warner
Dole	Lott	

NOT VOTING—2

Durenberger	McConnell

The PRESIDING OFFICER. On this vote, the yeas are 54, and the nays are 44. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1993

The Senate continued with the consideration of the bill.

Mr. PRYOR addressed the Chair.

The PRESIDING OFFICER. The Senator from Arkansas [Mr. PRYOR] is recognized.

Mr. PRYOR. Mr. President, may I inquire? What is the pending business before the Senate?

The PRESIDING OFFICER. The pending bill is H.R. 3167, the Unemployment Compensation Amendments of 1993.

NAFTA: GOOD FOR ARKANSAS, GOOD FOR AMERICA

Mr. PRYOR. Mr. President, not seeing the managers of the pending business in the Senate Chamber at the moment, it gives me great pleasure to rise and announce my support for a plan to keep America ahead in a world undergoing monumental change.

Today we see mind-boggling change in technology, strategic change in Government and industry, and extraordinary political change in foreign capitals all over the world.

The times we live in are very uncertain. They are even frightening. And I think America now has two choices: We can lead and benefit from world change, or we can hold back and lose as change passes us by.

Nowhere, I think, Mr. President, is that choice more clear than in international trade. And nowhere is the choice on trade more clear than in the North American Free-Trade Agreement, or NAFTA.

Mr. President, I have heard from hundreds of Arkansans from all walks of life about NAFTA. I have studied it as it impacts Arkansas and American business, and as it impacts Arkansas and American farmers.

As a supporter of American workers, as an advocate for a cleaner environment, and as one who has fought against unfair foreign trade practices, I today announce my support for this agreement.

My conclusion is that NAFTA on the whole is good for our State. It is good for our country. I believe NAFTA will create thousands of jobs in the long run. It will open vast markets to farmers and to businesses. And it will allow America to be more competitive in the global economy.

Accordingly, I intend to vigorously support NAFTA.

Let me say that NAFTA is not perfect. I believe NAFTA, as negotiated by the previous administration, did not go far enough on labor and environmental issues. The current White House negotiated with the Mexicans and the Canadians and got significant further protections for the environment and the American workers.

These so-called supplemental agreements on labor and environment are major factors in my support for NAFTA.

Also, Mr. President, I believe that while NAFTA will cause an overall increase in American jobs, there may be and could be a net loss of jobs in certain companies or localities, especially in the short run. I think we should discuss and face that fact.

For these dislocated workers, Labor Secretary Reich has put forward a comprehensive safety net program that keys off of the proven unemployed worker programs.

Ultimately, what has convinced me of NAFTA's worth at this time are the comments and the analysis I have received from and about the State of Arkansas.

Yes, there are those in our State who oppose NAFTA, but I think today a majority of—if I am not mistaken—of the many letters and comments that I have received in recent weeks have basically supported the agreement.

There are some real life examples of Arkansans who will benefit from NAFTA. Let us take the 600 employees in Rogers, AR, and the employees of the Daisy Manufacturing Corp. Their main product is the world famous Daisy air rifle—the BB gun. It is far superior to and price competitive with any air rifle made in Mexico. However,

according to the Daisy people, the company currently sells nothing directly to Mexico due to market access problems.

Mexico is Daisy's biggest potential market, but it is off limits today for this particular company.

Under NAFTA, Daisy should be able to pursue that market aggressively, and it expects significant new sales. That should mean jobs and growth in Rogers, AR.

Next, take the case of the Arkansas rice farmers. Currently, rice exports to Mexico from the United States are hit by a 20-percent tariff on milled rice and a 10-percent tariff on rough rice. With NAFTA, these tariffs will be phased out over a 10-year period.

Last year alone, the United States exported an amazing 200,000 metric tons of rice to Mexico. Clearly, Mexicans recognize the quality of this rice, 40 percent of which is grown in our home State of Arkansas—a plus for America and Arkansas rice farmers.

Eliminate that 10 to 20 percent import duty on American rice, and it is not hard to see how American rice farmers will benefit from the level playing field between them and Mexico's 87 million consumers.

What about poultry, Mr. President? This is a major Arkansas product. Currently it gets a 20 percent import duty in Mexico. Let me repeat: On all of our poultry shipped to Mexico, there is a 20 percent duty imposed. NAFTA would totally eliminate that Mexican poultry tariff, opening the gates for the high-quality, efficient American poultry industry to penetrate the large Mexican market. That will mean jobs for Americans and economic stimulation and growth in our State of Arkansas.

In fact, Mr. President, almost all of the major agriculture commodity groups in our State of Arkansas have now endorsed this trade agreement.

A somewhat different example is the Arkansas retail giant which is based in Arkansas known as Wal-Mart. Given the chance, Wal-Mart can out-compete just about anyone. They have shown that in the past. But in Mexico, duties on United States goods that are generally 2½ times that of United States duties on Mexican products, and other Mexican trade barriers, stifle Wal-Mart's southward expansion.

I assume that the aggressive businessmen and women of Wal-Mart will take advantage of an open Mexican economy if NAFTA is agreed to. That means jobs for Wal-Mart workers and economic growth for Wal-Mart and its hundreds and thousands of American suppliers, not only all across the United States but across the world.

The stories of Arkansas employers and employees who say NAFTA will help them and benefit our State are numerous, impressive and, I add, they are persuasive. I am persuaded now that our State of Arkansas will eventually become a major winner as a result of the passage of the NAFTA agreement.

I am encouraged also as to environmental concerns, by the recent endorsements of NAFTA by such well-known environmental groups as the Audubon Society, the National Wildlife Federation, the World Wildlife Federation, and the Environmental Defense Fund.

Finally, I want to refute two very misleading things being said today about Arkansans, about NAFTA. The first says that NAFTA will allow unlicensed Mexican truck drivers to drive our highways in old, unsafe truck rigs that do not meet United States safety standards. Nothing could be further from the truth.

Under NAFTA, all Mexican and Canadian trucks and truckers will continue to be required to comply with all United States safety and environmental standards.

The second red herring says that NAFTA will permit poorly trained Mexican medical personnel to invade the American health care system.

Again, Mr. President, this is totally wrong. It is false. There is no truth to it. Under NAFTA, Mexican doctors, or any professional for that matter, must be licensed in and observe the standards of whatever State they seek to practice in. In addition, all Mexican professionals must obtain the appropriate United States visa before they enter the United States.

Mr. President, these are what I call scare tactic arguments against NAFTA that can lower the debate to the level of a brawl, based upon emotions and fear, rather than a thoughtful deliberation based upon fact and clear thinking. I hope that in the coming weeks, our NAFTA debate in the U.S. Senate, and in the House of Representatives, will rise to a level befitting a subject of such great national import.

I want to state my strong support for NAFTA. I think it is right for my home State; I think it is right for America, and I think it is right for the changing times that we face throughout the world.

Finally, I ask unanimous consent that a document entitled "Arkansas NAFTA Facts" and a list of several Arkansas organizations and companies that support NAFTA be printed in the RECORD following my remarks.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ARKANSAS NAFTA FACTS

JOBS

Arkansas jobs supported by trade with Mexico and Canada—22,200.

EXPORTS

Arkansas exports to Mexico and Canada reached $540 million in 1992.

Arkansas was one of 17 states which ranked Mexico among their top three markets. Canada, our other NAFTA partner, was Arkansas' top export market; Mexico was third largest.

4,900 jobs in Arkansas in 1992 were supported by exports to Mexico. Over 50 percent of those jobs were created in the past five years, since Mexico began liberalizing its import regime.

Arkansas' merchandise exports to Mexico rose from $38 million to $118 million from 1987 to 1992.

By more than tripling its exports in 1992, Arkansas ranked among the top half of all 50 states for the percentage change in state exports.

Arkansas' exports to Mexico grew 214 percent from 1987 to 1992, 97 percentage points faster than the state's export growth to the rest of the world.

Arkansas' exports to Mexico in 1992 were broad-based, led by: transportation equipment ($40 million), food products ($17 million), agricultural corps ($15 million), chemical products ($9 million), industrial machinery & computers ($7 million), and primary metal industries ($6 million).

Arkansas boosted exports of a range of goods to Mexico over the five year period. Included were transportation equipment (from $1 million to $40 million), furniture & fixtures (from $0 to $1.5 million), and lumber & wood products (from $25,000 to $1 million).

In 1992, Arkansas' exports to Canada totalled $421 million. Arkansas' exports to Canada more than doubled over the past five years, during which the U.S.-Canada Free Trade Agreement was implemented (January 1, 1989).

ARKANSAS SUPPORTERS OF NAFTA

AT&G Company, Inc., AZ Industries, Inc., Aermotor Pumps, Inc., Allen Engineering Corporation, Alliance Rubber Company, Alumax Aluminum Corporation, Aluminum Company of America, Amoco Foam Products Company, Anthony-Higgs Lumber Company, Arkansas Best Corporation, Arkansas Bus Exchange, Arkansas Eastman Division, Arkansas Farm Bureau Federation.

Arkansas Power & Light Company, Arkansas State Chamber of Commerce, Aromatique, Inc., Associated Industries of Arkansas, Inc., Baird Manufacturing, Inc., Baker Car & Truck Rental, Baldor Electric Company, Bancroft Cap Company, Belden Wire, Bemis Company, Inc., Benton Veneer Company, Best Foods, Division of CPC International.

Bibler Brothers, Inc., Boston Industrial Products Division DANA, Branscum Harness Lumber Company, Carco Transportation Systems, Carlson Company, Inc., Central Moloney Transformer Division, Century Tube Corporation, Colson Caster Corporation, Cooper Tire & Rubber Company, Cope Plastics, Inc., Delta Consolidated Industries, Inc., Earle Industries, Inc., Firestone Tube Company,

FPEC Corporation, Garreco, Inc., George Koch Sons, Inc., Georgia-Pacific Corporation, Global Manufacturing, Inc., Great Lakes Chemical Corporation, Halstead Metal Products, Hitech, Inc., Hot Springs Packing, Hudson Foods, Inc., Innovation Industries, Inc., International Paper Company.

Jason International, Inc., J.B. Hunt Transport, Inc., L.A. Darling Company, Magnetek, Inc., Mazander Engineered Equipment, Mid-South Engineering Company, Moll PlastiCrafters, Moore Forest Products, Inc., National Filtration Corporation, Morac Company, Inc., Nucor Yamato Steel, Okla Homer Smith Furniture Mfg. Company, Orbit Valve Company.

Phelps Industries, Inc., Phillips Litho Company, Inc., Polyvend, Inc., Potlatch Corporation, Power Technology, Inc., Producers Rice Mill, Quest Corporation, Riviana Foods,

Inc., Rose Law Firm—Charles Baker, Southwestern Bell Corporation, Speciality Rice Market, Strong Systems, Inc.

Sugar Hill Partners, The Alan White Company, Tri-State Iron & Metal Company, Tyson Foods, Inc., Union Camp Corporation, Weldon, Williams & Lick, Inc., Weyerhauser Corporation, Whirlpool Corporation, Winrock Enterprises, Inc.

Mr. BRADLEY. Mr. President, I would like to say how significant I believe the speech that we have just heard is for the prospects for NAFTA. The distinguished Senator from Arkansas is known as someone who carefully reviews the issues and all of the facts and arrives at a considered judgment. His view really does influence people far beyond this Chamber. I thank him very much for his statement.

Mr. PRYOR. I thank my friend from New Jersey, my colleague who I was privileged to enter the Senate with in 1979.

Mr. BRADLEY. Mr. President, nearly 2 months ago, I came to the Senate floor to raise an alarm about the way we spend taxpayer money. At that time, we were all making it very plain that this summer's budget package did not go far enough to cut Federal spending. "More cuts," we said; "less spending," we said—a sentiment with which I agreed.

I knew, though, that making real cuts would not be possible unless we could agree on some kind of guideline that would steer our spending decisions. Without a larger definition or principle, we could argue forever about the essential value of each individual program, making it appear as if every dollar in the Federal budget were absolutely indispensable.

So, early in September I suggested that the remaining appropriations bills before the Senate be considered in the light of two specific principles: One, does the proposed spending provide something that is in the general interest and is essential in American public life, and two is taxpayer funding the only and most cost-effective way that the proposal can be financed?

We have almost finished our work on appropriations bills. We are not, Mr. President, flush with savings generated by successfully applied principles—mine or anyone else's. We have instead dutifully responded to our unique Pavlovian bell, the one that rings "business as usual." We have enacted routine appropriations bills, routinely passing the buck to the next generation because we would not live up to the tough choices of our own generation.

In the course of the last 2 months, I offered several amendments that I felt would help steer us toward a more rational stewardship of our constituents' money. I proposed that we cut funding for wasteful coal liquefaction research and Federal timber subsidies; for unrequested Army Corps of Engineers projects; for the gas turbine-modular helium reactor, a nuclear reactor whose construction is opposed by the National Academy of Sciences; for unspecified Army National Guard aircraft; and that we eliminate the Selective Service System, a dinosaur in the post-Soviet world.

Slightly more than $500 million in cuts, $500 million in taxpayer money that failed the test of principles I had established, $500 million in taxpayer money I was—and am—sure would be better used to reduce our massive deficit.

With one exception, these amendments failed. There were arguments against each, to be sure, and interests that felt threatened. But these amendments did not fail because they were actually in the general interest or because taxpayers were the only source of financing; they failed because business as usual is easier than good business, tough choices, and sound fiscal policy.

Several other Senators offered spending cut amendments as well. I was not the only one. There were proposals to reduce funding for the space station, the Market Promotion Program, *Seawolf* submarine procurement, and so on. A conservative estimate shows that amendments totaling $5.8 billion in real cuts in fiscal year 1994 were offered to the appropriations measures. I supported 90 percent of the cut votes, amounting to $5.2 billion of the $5.8 billion total.

Most of those amendments offered by other Senators to cut the budget were defeated as well. Of the $5.8 billion in cut amendments offered to the 13 regular appropriations bills, we succeeded in striking only 60 million dollars' worth of spending. In other words, we only passed 1 percent of the spending cuts that were proposed in the Senate on appropriations bills—only 1 percent.

More cuts, we said. Less spending, we said. More spending, we voted. Less cuts, we voted. And while no one is faultless, the record shows very plainly that Democratic Senators supported more spending cuts than Republican Senators.

And yet, despite my disappointment, I have found that it is not so easy to stop spending taxpayer money. The appropriations process, like Plato's cave, presents us with little more than shadows at which to take aim. Most of the spending occurs behind closed doors, and by the time the decisions emerge, opportunities to make real cuts are more illusory than real.

Before an appropriations bill gets to the floor, about the only chance a noncommittee Senator has to impact the process is during consideration of the budget resolution. But what kind of impact is this?

A Senator can offer an amendment to lower broad aggregates of spending, claiming elimination of honey subsidies or the space station or anything. You reduce the nondefense discretionary aggregate and say, well—what I mean to imply by that is that I am after the honey subsidy. But it does not really matter what you say because no funds are spent pursuant to the budget resolution. The best we can get is a lowered set of aggregates. You cannot cut a specific program, however wasteful, at a budget resolution level. You are simply reducing the overall aggregate.

The real decisions and the real tradeoffs come when the 602(b) allocations are made to the appropriations subcommittees. At that point anything could happen—and the decisions might or might not be based on a rigorous comparison of priorities, the assumptions of the budget resolution, or directions offered by the President's budget.

If you do not sit on the Appropriations Committee you just do not know how or why this program or that program got a 602(b) allocation or a 302(b) allocation; you do not know.

Finally, the appropriations bills come to the floor in a form, shaped by the Appropriations Committee. An outsider might think this is where the action can really begin. When it comes to the floor, you can stand up like many of us did over the last several months and propose to eliminate that wasteful program. But the outsider who assumed that would be wrong. First, you have to decipher the various codes used to identify programs and decide which lack merit. It is not always easy in an appropriations bill to tell which programs are which. Even if you are able to do that, however, there is really no way to cut these programs, no way.

You are locked into a vicious circle. If your amendment eliminates a specific program account, your opponents claim that unless you reduce the 602(b) allocation as well, your proposed reduction can just be siphoned off into other programs under the subcommittee jurisdiction. In other words, you can come out here and vote to cut honey subsidies or whatever, but that does not mean that you are going to eliminate the honey program. It just means the money is then available for the subcommittee to allocate in another way, maybe even to that program.

So you try to lower the 602(b) allocation and reduce the discretionary caps. You are then greeted with a point of order, demanding 60 votes as payment for trying to alter the allocations that unless you are on the Appropriations Committee you never voted on in the first place. A real catch 22. Or, given the way we spend money around here, a real catch 22 billion.

Perhaps it should be no surprise then that we could only cut $60 million from the regular appropriations bills. And lest we count that savings too fast, we should not forget that it could reappear in conference reports.

As long as the House conferees wield a larger allocation than you do in the Senate you cannot be sure that the cuts that you have made and approved will even stick. I even found cases this year where the Senate zeroed out programs and the conference came out with funding levels higher than the House figures.

Let me repeat that. The Senate zeroed out a program and the conference committee came out with a number higher than the amount that the House even approved.

In this U.S. Senate, in this Congress you can zero out a program and you can come back with more money than even the one body that approved the spending requested.

This is not a happy sequel to this summer's tough talk about spending cuts. Each year about this time we make a tally and see how we did. We have been failing for a long time. We have failed again.

Perhaps we have one more chance. We will soon consider a package of rescissions offered by the President. Several Members of the Senate, myself included, are anxious to work on this package. Although it would be better to tackle the spending headon than to pound on the barn door with a rescission package after the spending horse has already galloped away, this effort is welcome.

I am hopeful, but not optimistic, for the prospects in this rescission bill. There is simply too much evidence of our willingness to look the other way. We have looked the other way and accepted failure too many times for me to expect new resolve and stronger will now.

The experience of the last 2 months tells me that the time has come for a new wave of budget reform. We need to vote on national priorities and budget resolutions, but we also need to be able to take meaningful votes on individual programs.

Right now, the budget process, the appropriations process, and the authorizing committees work at cross purposes, always tending toward higher spending, business as usual, and meaningless votes. We need to get them working together, toward our common purpose of reducing the deficit and building economic security for all Americans.

Mr. President, last, we have to keep in mind that discretionary appropriations are just a small part of that total picture—a $1.5 trillion budget, $750 billion for entitlements, $300 billion for defense, $200 billion for interest, and you end up with a little under $250 billion for discretionary.

Mandatory spending programs—entitlements—now account for roughly half of all Federal spending, and tax loopholes add tens of billions more to the deficit every year. We all know that we have to come to grips with entitlements. That means Medicare, it means Medicaid, it means Social Security, it means civil service and military pensions, and it means special interest tax breaks in the Tax Code. Everything, Mr. President, has to be on the table if we are going to cut spending.

You cannot simply say we will just do appropriations or we will just do entitlements. You also have to say we will also do that spending we do in the tax committees for example by collecting less tax from you if you rent tuxedos and get rapid depreciation.

But before we lower health care subsidies for seniors, ask more of our civilian and military retirees, or ask for restraint in tax expenditures, we have to show the American people that we can eliminate wasteful, inefficient, and obsolete spending in the appropriations process.

How high does our national debt have to go before we are willing to succeed in cutting spending? Well, if that debt goes much higher, Mr. President, we will have to live with our failures for generations to come.

I yield the floor.

Mr. EXON addressed the Chair.

The PRESIDING OFFICER. The Senator from Nebraska [Mr. EXON] is recognized.

Mr. EXON. Mr. President, I want to compliment my friend from New Jersey for his outstanding remarks. He comes right to the point, as he usually does.

I would simply say to the Senator from New Jersey that he has been talking about the evils that have been evident in the system for a number of years and that is how much legislation and how much spending is agreed to frequently in conference between the House and Senate. Laws are written there that never passed either body, appropriations are approved there that never come from either body.

It was a great Senator from the State of Nebraska, George Norris, who many, many years ago fought the battle for reform. He always felt that one of the biggest problems that we had in this body was just what the Senator from New Jersey is talking about, and that is the conference committees working their own will in sometimes strange and unusual ways, maybe sometimes for the good rather than the bad. But he thought that was an evil in our system.

I do not know how we are going to correct it, because I am not sure we want to change things dramatically. But the Senator's point is well taken.

In fact, former Senator George Norris, of Nebraska, felt so strongly about this that he was the father of the one-house system in Nebraska. In Nebraska, we are the only State in the Union that has a single house legislature. And the reason that George Norris created that, among other reasons, was to eliminate the evils that he saw taking place in the conference between the House and the Senate many, many, many years ago.

I thank the Senator for bringing it up.

UNAUTHORIZED DISCLOSURES

Mr. EXON. Mr. President, I rise on the floor of the U.S. Senate to discuss a very important and sensitive matter—the unauthorized release of national security information by someone in our Government.

This morning's Washington Post contained a column by Mr. D. Robert Novak, entitled "Allegations About Aristide."

Mr. President, I ask unanimous consent that the article be printed in the RECORD following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1).

Mr. EXON. Mr. President, I am in an awkward position because I cannot, and will not, confirm, deny, or verify one single word in this column. Suffice to say, not a sentence, word or punctuation in that article came from me in any form and I had no staff present at the meeting described.

Nevertheless, it appears that an unauthorized leak of possibly highly classified national security information may have taken place. For the record I emphasize again that I was not the source of any information which led to this column or any other report in the news media about the classified CIA briefing held here in the Senate last week. I never have, and never will, reveal classified information.

As chairman of the Senate Subcommittee on Nuclear Deterrence, Arms Control and Defense Intelligence, I have been privy through the years to most of our Nation's most closely held secrets. I feel distressed making a statement ensuring everyone that I was not the source of a classified leak; however, the average reader of this morning's Washington Post column might have the impression that I was the source and I feel compelled to dispel any such notion.

Mr. President, the Standing Rules of the Senate provide very specifically for the protection of classified and confidential information. I quote from rule 29, paragraph 5 of the Standing Rules of the Senate:

> Any Senator, officer, or employee of the Senate who shall disclose the secret or confidential business or proceedings of the Senate, including the business and proceedings of the committees, subcommittees, and offices of the Senate, shall be liable, if a Senator, to suffer expulsion from the body, and if an officer or employee, to dismissal from the service of the Senate, and to punishment for contempt.

Since I do not know exactly what was leaked—whether classified information itself was leaked or simply the impressions of those present or a list of Senators present, it is hard to know

how severe this episode was. The disclosure of classified information is covered not only by the Senate rules but also by Federal statutes, namely United States Code, title 18, section 798. The leak of actual classified information is an offense for which there is no ambiguity regarding whether or not laws and rules were violated.

Nevertheless, even if classified information, per se, was not leaked, I believe that the Senate rules still prohibit what may have happened. The Senate rule that I cited earlier, was amended just 1 year ago to further tighten the Senate's procedures against the disclosure of confidential business or proceedings of the Senate so as to include all business and proceedings of the Senate, including briefings such as the one given on Haiti. In this sense, the word confidential does not necessarily correspond to the standard levels of classification in the national security sense as we know them—namely confidential, secret, and top secret.

Rather, confidential in the sense of Senate rule 29, paragraph 5, can refer to information which simply should not be disclosed whether or not it falls under the strict classification guidelines as enunciated by the Department of Defense.

Either way, the disclosure of information from last week's briefing in my view constitutes a violation one way or the other of at least the Senate rules.

Mr. President, something very unethical and in violation of the Senate rules has taken place with regard to the leak by some person or persons which led to not only to this morning's Washington Post column but also other occurrences during the intervening period between the CIA briefing and today.

I received several calls from reporters questioning me about what took place during the CIA briefing. Several of these calls were from reporters I did not know and some I have not yet come to know and, for the most part, had not even heard of before. It is obvious to me that some sort of concerted effort was undertaken by some person or persons to not only alert the media to what went on during the CIA briefing but also to advertise the names of the Senators who attended.

As U.S. Senators, we have taken an oath and have a solemn responsibility to work in concert with whatever administration is in power in order to pursue the national security objectives of the United States. We are given a trust. Congress and the executive branch each have responsibilities in this area. While the President and the executive branch execute our foreign and defense policy, the Congress under our Constitution has a collaborative role to play.

During the 1970's, the rules of the game were changed to involve Congress more intimately in the execution of our national security policy following disclosures of intelligence activities run amok during an earlier time. Congress insisted and passed laws to involve itself further in these areas as a check and balance against a potential runaway President and administration. With that increased involvement, and the trust placed in us, comes a responsibility. That responsibility is to safeguard the classified information which we ourselves have insisted we receive in order to become a fuller partner in these policies.

Mr. President, all of this background I have provided is a preface to my main reason for coming to the Senate floor today. I do not know for sure who leaked information about last week's CIA briefing. I do not even know for sure if the leaker was a member of the legislative or executive branch of our government.

But I want to say here and now, very loud and very clear, that this practice of disclosing classified information must stop and must stop now. The reasons for any such leaks do not interest me in the slightest. Apparently some people leak in order to further their own side of a policy argument. Others may leak to exonerate themselves for whatever reason, possibly including publicity seeking.

In short, the reason makes no difference. The act of leaking is the problem and it must stop.

I ask the Senate leadership to initiate whatever steps may be necessary in an effort to determine who caused this leak of classified national security information. In doing so, I recognize that our Government's record of tracking down and punishing leakers have been very poor, primarily because the act of leaking is a clandestine one and also because the media insist on protecting its sources. And I can understand that.

Nevertheless, I believe the leadership of the Senate should launch an appropriate investigation to attempt to find out who violated Senate rules in this regard. Even if we are not successful, hopefully the enforcement of Senate rules will act as a deterrent to future such violations.

Again, Mr. President, this is a very serious matter and I believe that it is important for us to get to the bottom of it, if we can.

I yield the floor.

EXHIBIT 1

[From the Washington Post, Oct. 28, 1993]

ALLEGATIONS ABOUT ARISTIDE

(By Robert D. Novak)

Hearing shocking allegations about Jean-Bertrand Aristide during a CIA briefing of 13 U.S. senators, Sen. James Exon of Nebraska was so exercised that he asked: Have President Clinton and Secretary of State Warren Christopher been told that the exiled Haitian president's past predicts a violent future?

Administration officials present Oct. 20 said they did not know. Exon, one of three Democrats present, sent Wendy Sherman, assistant secretary of state for legislative affairs, to find out. She returned shortly to say yes, Clinton and Christopher had heard it all, but added there was a "dissenting" view to what the senators had just been told.

CIA briefer Brian Latell, a 30-year career officer, bristled. "There is no dissenting view within the intelligence community," he said, rejecting claims that the Defense Intelligence Agency takes a friendlier view of Aristide.

Latell's certitude generated unease in the Democratic cloakroom. The senators' opinion of Aristide has been so changed that willingness to send U.S. troops to Haiti to restore him is radically reduced. There is also concern about Bill Clinton's continuing blank-check endorsement of Aristide in the face of his own intelligence community's damning assessment.

The extraordinary briefing was insisted on by Sen. Jesse Helms, senior Republican on the Foreign Relations Committee. The majority and minority leaders, George Mitchell and Robert Dole, agreed to call the CIA. The small turnout (not including Mitchell) is partly explained by the fact that senators were notified at 5:30 p.m. that the event was starting immediately in secure room S-407 at the Capitol.

Latell began by documenting the case that Aristide, a defrocked Catholic priest, has psychological disorders and has used 13 kinds of medication. He next gave details of how Aristide, in seven months as president, incited mobs to "necklace" enemies—put burning rubber tires around their necks. He then listed the chain of command, starting with Aristide, that ordered the jail-cell murder of political foe Roger LaFontant on the night of the military coup that deposed the president of Haiti.

But what was most stunning was Latell's projection for the future. The CIA briefer is reported by one participant as predicting this about an Aristide restoration: "He will rule with violence. He will settle scores."

Exon and Republican Sen. Larry Pressler, political centrists, expressed outrage over the U.S. government putting its power behind such a man. But nobody seemed as affected as Democratic Sen. John Kerry of Massachusetts, who came into the Senate eight years ago as a Vietnam War combat-veteran-turned-dissenter and has become a thoughtful student of foreign policy.

When Kerry first heard Latell talking about Aristide's alleged psychological disorders, the senator looked unimpressed. But as the allegations rolled on, the smile left his face. On the record, he told me that "legitimate questions were raised" about U.S. policy.

Senators of both parties worry why Clinton did not react more like John Kerry. On his morning jog Saturday, Clinton said Aristide is fit to govern Haiti—a view he said was backed by "everyone else in the administration working with him." The president then went on to denigrate CIA information as "not always accurate." The next morning on national television, Vice President Al Gore extolled Aristide as "reliable" and "very thoughtful."

That contrasts with the State Department position, in both the Bush and Clinton administrations, that Aristide is violence-prone and certainly no democrat but should be restored for the sake of democracy. Alexander Watson, the newly installed assistant secretary for Latin America, during the Oct. 20 briefing defended backing Aristide because he was "duly elected" and "has to be supported."

The State Department formulation is subject to legitimate debate. The president's open-ended endorsement of Aristide, sounding like a political backslap of an errant White House aide, is not.

The PRESIDING OFFICER. The Senator from Wisconsin [Mr. KOHL] is recognized.

THE YOUTH HANDGUN SAFETY ACT

Mr. KOHL. Mr. President, I rise today for two reasons: First, to discuss a tragedy of epidemic proportions, namely the explosion of handgun violence, especially among our youth; and second, to tell the Senate that last week the Juvenile Justice Subcommittee took a step toward curbing this bloodshed by endorsing the Youth Handgun Safety Act.

From Wisconsin to Washington and from Miami to Marin, we are witnessing an eruption in the number of children killing people—and being killed—with handguns. We need only to open a newspaper any day to find the terrible proof: A 15-year-old Madison girl shooting her teenage boyfriend; the drive-by shooting of a 12-year-old Milwaukee boy; an Anacostia student shooting his 13-year-old classmate in the locker room of their junior high; a 4-year-old D.C. girl killed in the crossfire of a brutal gang shootout. The list goes on and on.

The national statistics on youth violence are equally disheartening. In 1984, a total of 1134 juveniles were arrested for murder. But by last year, that number had gone up 2½ times to 2829. According to the Justice Department, the vast majority of these murders were committed with firearms, and most were committed with handguns.

The numbers for juvenile weapons arrests are equally discouraging. In 1982, 21,122 juveniles were arrested on weapons charges nationally. But by last year, that number has spiraled to more than 46,000. Again, guns were involved in the vast majority of these arrests, and handguns in most of them.

Wisconsin's increases in these categories were even worse: My State went from 12 juvenile murder arrests in 1982 to 94 in 1992. That is not only unacceptable, Mr. President, it is unconscionable.

It is not the kind of world that our children deserve. It is no the kind of world we ought to give them.

But we can begin to change that world. Not easily. Not quickly. Not painlessly. Not with a single simple solution. But we can begin to change it.

To start, we need new laws, stronger as well as enforceable, to restrict the flow of handguns in our communities and to our children. To that end, my subcommittee last week took a step in that direction: It favorably reported the "Youth Handgun Safety Act." Our bill would make it a Federal crime to sell or give a handgun to minors under the age of 18, and for a minor to possess a handgun under most circumstances. I plan to offer it as an amendment to the anti-crime legislation that we will begin to debate next week. The measure is supported by the President, the Attorney General, police organizations, and gun control advocates. Even the NRA is supportive.

We know that the proposal by itself will not end youth violence.

How can it when so many of our children come from broken homes? When so many are raised in front of TV sets, which teach them that violence is a normal, natural, appropriate way to act? When guns and crime and violence are seen, by some, as the only way to get ahead? When some parents can not or do not discharge their primary responsibility of supervising their children.

We know there are many causes for this problem. And we need many different initiatives to address it.

But our Juvenile Justice Subcommittee held hearings on kids and guns in Washington, Wisconsin, and Arizona. It heard from a wide array of witnesses: teachers, doctors, ministers, police, victims, and teens. And, Mr. President, the verdict was unanimous: kids and handguns do not mix.

Even some gun manufacturers agree. The NRA told my subcommittee that it is "generally supportive of the [bill's] approach." And the retired president of Browning Arms, Harmon G. Williams of Utah, went further: he now supports a ban on handguns for juveniles.

Let me read from an article in the October 14 New York Times:

> For most of his life [Williams] said, he viewed such measures as "absolutely unnecessary," but now supports outlawing handguns for minors. "All of a sudden," he said, "we're looking around at what's happening—all this terrible violence—and thinking, things have gotten out of hand. Something has got to be done."

Mr. President, Mr. Williams was absolutely right. Something has got to be done. That something—or at least a start—is the enactment of the Youth Handgun Safety Act.

Because unless we act now, the future we are creating is one that too many of our children will not live to see. And it will also be a future we will not want to live in.

Mr. DECONCINI addressed the Chair.

The PRESIDING OFFICER (Mrs. MURRAY). The Senator from Arizona.

Mr. DECONCINI. Madam President, I want to say to the Senator from Nebraska, having read the article he pointed out, that it is most discouraging that someone, indeed, has obviously leaked that information. I went to that briefing that he was at. I think it was 4 o'clock at first, then 4:30. They postponed it, and then when they finally had it, I could not go.

I witnessed the same briefing as the Senator did on the same subject matter. So I know the significance of the information that was given. I also know from working with the Senator from Nebraska, there is nobody in this body who would ever even suggest that he would take any impropriety toward any information.

The article in the paper that you point out, certainly might be construed otherwise. I think it is most unfortunate, first of all, that anybody—staff or Member—would disclose the information that was given in that briefing, or any other briefing, and then to be quoting the Senator who did not even talk to the writer of the article is very, very disturbing. I know where the Senator stands on such issues.

GRAZING

Mr. DECONCINI. Madam President, I want to spend a few minutes regarding the vote that we just had on the conference report. Where we tried to end debate and impose cloture. I rise today to set the record straight on a few things that have been said over the days and weeks of this debate.

It is apparent that many of my colleagues have not taken the time to read and fully understand this legislation; that is, the grazing reform part of the legislation. My friend from Wyoming, Mr. WALLOP, has referred to the opposition of State water engineers.

I am going to have printed in the RECORD a letter from the director of the Arizona Department of Water Resources, Ms. Rita Pearson, and my response to it. The letter does, indeed, raise some very fundamental questions that deserve response. It is unfortunate that those who sought an opinion from Ms. Pearson chose only to provide portions of H.R. 2520.

I must guess that her response would have been very different if the entire bill and relevant portions of the legislation, as amended, and the Federal Land Policy and Management Act, as amended, would also have been provided to her. I know her. She is a very competent lawyer in water, as well as other issues, and she is very thorough. In this case, she did not have all the information. She only had part of it.

The first question raised is if rangeland reform applies exclusively to BLM land and if "public land" refers only to BLM lands.

The amendment contained in H.R. 2520 applies only to the Department of the Interior. Page 62, section 317 of the conference report specifically directs that:

> Title IV of the Federal Land Policy and Management Act of 1976 is amended by adding the following sections;

Title IV, of FLPMA deals with grazing exclusively. In addition, section 406 of the conference report—entitled "Rangeland Reform"—specifically directs the Secretary of the Interior to promulgate regulations. It is without doubt that the rangeland reform only applies to the Department of the Interior, Bureau of Land Management. The

Secretary cannot direct and promulgate regulations for other Cabinet and other agencies.

I would like also to respond to another very important question raised in this letter: Does public land refer only to BLM land?

The Federal Land Policy and Management Act of 1976 provides a definition of public land.

Section 103(e): The term "public lands" means any land and interest in land owned by the United States within the several States and administered by the Secretary of the Interior through the Bureau of Land Management, without regard to how the United States acquired ownership.

The answer is clear: This reform applies only to BLM land and public lands are clearly defined as those managed by the Bureau of Land Management.

A second question that deserves an answer is: Does the law need to be clarified so that the water rights currently existing or to be developed in association with BLM land must be established pursuant to State law?

Good question, and I have a good answer.

Once again, if all the appropriate records and laws pertaining to the issues are examined, it is clear that the Federal Land Policy and Management Act of 1976, Public Law 94-579, provides specific directions.

Title VII of FLPMA, "Effects on Existing Rights," provides specific language to address the Federal responsibility as it pertains to water on the public lands managed by the BLM.

Section 701(g) provides that:

Nothing in this Act shall be construed as limiting or restricting the power and authority of the United States, or (2) as expanding or diminishing Federal or State jurisdiction, responsibility, interests or rights in water resources development or control;

(3) as displacing, superseding, limiting or modifying any interstate compact or the jurisdictional responsibility of any legally established joint or common agency of two or more States or of two or more States in the Federal Government.

Madam President, under this compromise action concerning water rights, which will be before us when this conference report returns to the floor, future actions on water rights will be taken in concert with State laws. That is so clearly stated in FLPMA. Secretary Babbitt has provided a letter to that effect, also, which has been included in the RECORD, and I will include another copy which I would like to have attached to my remarks.

The Federal Land Policy and Management Act provides legal recognition of the State's responsibility and jurisdiction over water issues. Period. Paragraph.

I share the concerns expressed over water issues in the West. This Senator has fought long and hard for Arizona's water rights. It is fair and responsible for the State water agencies in the West to be concerned about our water rights. It is especially so given that it appears that incomplete information has been provided for their review.

The definitions and the specific language contained in H.R. 2520 and in the Federal Land Policy and Management Act of 1976 clearly define that the reform applies only to public lands managed by the Bureau of Land Management.

In addition, State water rights and State water law will be adhered to by the Secretary of the Interior. For the information of my colleagues, FLPMA addresses the multiple use of public lands. It has sections dealing with rights of way, water rights, grazing, and a host of other multiple-use issues. Any one line of one of these sections taken out of context could be construed as having serious effects on other multiple-use activities. We who are lawyers, as well as those who are not, and those who write laws, know that the whole context of a law must be taken into consideration.

Additionally, FLPMA has been the law of the land since 1976. With the exception of title IV—range management—the law will not change.

I am chagrined at the misrepresentation of the facts of this compromise. And, I would encourage my colleagues to examine the Reid compromise closely, but also look at what the compromise amends. You cannot accurately assess the effects of this compromise without understanding the very basic facts I have laid out.

Scare tactics and partial information are creating an inaccurate perception of this compromise. There is a lot of apprehension based on uninformed assumptions, and I am sorry to see the seeds of fear being planted in my constituents and other Western citizens. I would have hoped that opponents of this compromise would have looked at the whole picture when such an important issue as grazing reform and the whole Interior and related agencies appropriations bill are in jeopardy.

Mr. President, I represent my whole State: Ranchers, Federal employees whose jobs depend on passage of this appropriations measure, and others who use or enjoy the public land in ways other than grazing. The best thing that we can do for all of our constituents is to support this compromise and vote for passage of this conference report.

Finally, Madam President, I ask unanimous consent to have printed in the RECORD a letter from Peterson Zah, President of the Navajo Nation, describing the importance to the Nation of the passage of this appropriations measure and encouraging Senators to vote for cloture.

I represent my whole State, Madam President, ranchers, Federal employees, native Americans, and others who benefit from this bill, and it is a bill which ought to be passed.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ARIZONA DEPARTMENT
OF WATER RESOURCES,
Phoenix, AZ, October 25, 1993.

Re: H.R. 2520; Interior appropriations.

Senator DENNIS DECONCINI,
Washington, DC.

DEAR SENATOR DECONCINI: I recently obtained a copy of that portion of HR 2520, the Bureau of Land Management (BLM) Grazing Bill, containing language affecting water rights on BLM lands. The water rights language raises several issues I hope will be addressed prior to action on this bill.

First, it is not clear from the portions of the bill I reviewed that the rangeland reforms apply exclusively to BLM lands. These provisions do not apply to state public lands and an ambiguity should not be created regarding this application. If it is not already clear from a provision defining "public lands", it should be clarified that "public land" referred to in section 406(d) and 406(i)(2) refers only to BLM lands.

Second, it should be clarified that the water rights currently existing or to be developed in association with BLM lands must be established pursuant to state law. Any doubt should be eliminated regarding the continuing application of state law to water rights on BLM lands.

Third, the term "grazing-related actions" needs to be defined and the location of these actions should be limited to "on public lands".

To accommodate these concerns, I suggest changes indicated below. Deletions are indicated by brackets and new language by italic.

SEC. 406(d) WATER RIGHTS.—Subject to [valid] water rights *established pursuant to state law* existing on the date of enactment, [no] water rights *on public lands* shall be obtained *pursuant to state law* for grazing-related action on *such* [public] lands [except] in the name of the United States.

Section 406(i)(2) The permittee or lessees may hold the title . . . to protect the public interests for multiple use of rangeland ecosystems. *For water rights developed pursuant to Section 406(d)* the United States shall assert its claims and exercise its rights to wager developed on public lands *pursuant to state law* to benefit the public lands and resources thereon.

Finally, while these comments are limited to concerns about the language used in water-related provisions of H.R. 2520, I believe they are indicative of a general concern that additional review and comment by western states is necessary before this legislation is formally adopted. I would like to offer my assistance to you, or your staff, in any efforts to consider the effects of this proposed legislation on our state, and encourage you to support current efforts to stop this legislation until it is properly amended.

Thank you for your consideration of this matter.

Sincerely,

RITA P. PEARSON,
Director.

U.S. SENATE,
Washington, DC, October 27, 1993.

Ms. RITA PEARSON,
Director, Arizona Department of Water Resources, Phoenix, AZ.

DEAR RITA: Thank you for your letter of October 25, 1993 concerning the conference

report on H.R. 2520, the Fiscal Year 1994 Interior and Related Agencies Appropriations bill.

Your letter raises several questions concerning the possible impacts of provisions known as the "Reid compromise" on grazing reform contained in the bill. From the questions you raise in your letter, I can only conclude that you were not furnished the complete set of records on the subject.

On page sixty-two of the Conference Report accompanying H.R. 2520, there is an amendment to the Federal Land Policy and Management Act of 1976 (FLPMA), PL 94-579. The amendment specifically amends Title IV—Range Management of FLPMA. In addition, FLPMA contains language (Section 103) which further defines that the Act applies only to public land. The definition of public lands contained in FLPMA, is as follows:

Section 103. (e) The term "public lands" means any land and interest in land owned by the United States within the several States and administered by the Secretary of the Interior through the Bureau of Land Management, without regard to how the United States acquired ownership.

As you can see, both the "Reid compromise" and the FLPMA clearly limit action on grazing reform to the BLM and to public lands administered by the BLM.

The other question you posed is whether the water rights currently existing or to be developed in association with BLM lands must be established pursuant to state law. Title VII of FLPMA—Effects on Existing Rights—provides specific language to address the federal responsibility as it pertains to water on the public lands managed by the BLM. Specifically, Section 701 (g) of FLPMA, provides that:

Section 701. (g) Nothing in this Act shall be construed as limiting or restricting the power and authority of the United States—

(2) as expanding or diminishing Federal or State jurisdiction, responsibility, interests, or rights in water resources development or control;

(3) as displacing, superseding, limiting, or modifying any interstate compact or the jurisdiction or responsibility of any legally established joint or common agency of two or more States or of two or more States and the Federal Government;

When FLPMA was passed in 1976, water rights were a major issue throughout the West. The questions concerning Federal and State water law were addressed through the inclusion of Section 701(g).

Secretary Babbitt, in response to a letter from Governor Roy Romer of Colorado, also addresses the issue of water rights, including Section 701(g) of FLPMA. I have enclosed the Secretary's letter.

I appreciate your input on this issue. Unfortunately, the questions you raised have not been adequately addressed in the debate on this compromise and I am pleased to have the opportunity to correct some of the misunderstandings surrounding this amendment. I am confident that given all the information on the proposed changes you will conclude that valid existing water rights in Arizona are not in jeopardy.

As you know, water is very important to Arizona as is the multiple-use of our public lands. Please feel free to contact me if you have any additional questions or need further information.

Sincerely,

DENNIS DECONCINI,
U.S. Senator.

THE SECRETARY OF THE INTERIOR,
Washington, October 28, 1993.

Hon. ROBERT C. BYRD,
U.S. Senate, Washington, DC.

DEAR SENATOR BYRD: As consideration of the grazing reform compromise adopted by the Conference Committee continues, I would like to clarify certain provisions included in that compromise. These clarifications pertain to four important issues addressed in the legislation: grazing-related water rights; range improvements; subleasing; and prohibited acts.

Water Rights.—Opponents of the Conference Committee compromise grossly mischaracterizes the provisions relating to water rights. A detailed response is contained in the attached letter to Governor Romer. I would highlight these points: First, the policy change would be prospective only and would not affect existing property rights. Second, it simply aligns the BLM position on this issue with existing Forest Service policy. Third, these provisions affect only range-related water rights on BLM public lands used for grazing. Therefore they have no application outside the Western public lands states. The language and context of those amendments makes that unmistakably clear; it is simply unreasonable to construe them otherwise.

Range Improvements.—New section 406(1) addresses the issue of range improvement ownership. The Conference Committee compromise provides that the United States would have title to all permanent range improvements constructed in the future on public lands. Title to temporary range improvements used primarily for livestock handling or water hauling would be retained by the permittee or lessee. The Conference Committee compromise would not change the agreements currently in effect or affect the ownership of existing range improvements. Here too, in other words, the policy change would be prospective only and would not affect existing property rights. A permittee's interest for contributed funds, labor, and materials would be documented for proper credit in the event the land is disposed of or the permit or lease is subsequently issued to a different party. The proposal is similar to existing Forest Service policy with respect to range improvements. It applies only to range improvements on public lands administered by the BLM for grazing purposes; it does not affect hydroelectric developments, electric power lines, natural gas pipelines, or other permanent improvements unrelated to grazing, nor to improvements on Forest Service lands. Again, the language and context of these amendments make that unmistakably clear, it is simply unreasonable to construe them otherwise.

Subleasing—New section 406(a) imposes a leasing surcharge for authorized leasing of base property to which public land grazing preference is attached or authorized grazing of livestock owned by persons other than the permittees or lessee. I will construe this provision to recognize and leave unchanged the current Bureau of Land Management practice which allows subleasing to family members when they are operating within the family operation or are assuming control of the family operation.

Prohibited Acts—New section 406(1) requires the Secretary to promulgate regulations to make violation of the Wild Horse and Burro Act, the Endangered Species Act, and federal and state laws concerning "conservation, protection of natural or cultural resources, and protection of environmental quality" prohibited acts. Upon expiration of appeal or review periods following a conviction for violation or administrative finding of violation of these laws, the authorized officer may consider cancellation or suspension of the permits or leases where the violation has occurred on public land or is related to authorized grazing of public land. The proposal would adopt language that existed in the BLM's regulations prior to 1984, and is compatible with existing Forest Service policy. It deserves emphasis that the Conference Committee compromise ensures that no suspension or cancellation of a permit or lease can occur until there has been a full opportunity for appeal of the finding of a violation or a conviction. Finally, convictions and violations unrelated to these environmental and land use issues are not "prohibited acts" as used in the statute.

It also seems appropriate to clarify the Department's intentions with regard to public hearings on the new regulations required by the grazing reforms contained in the Conference Committee compromise legislation. The Department is committed to conducting public hearings in every Western grazing state prior to the implementation of any regulations. Moreover, the Department would welcome the opportunity to participate in any Congressional oversight hearings reviewing the Department's implementation of the grazing reform provisions of the compromise.

Finally, as I discussed with Senator Hatfield yesterday morning, most of the administrative authority which the Department has over grazing is entirely outside of, and unaffected by, the Conference Committee compromise. For example, the promulgation of standards and guidelines which govern stocking numbers, length of grazing seasons, use of riparian areas and the like, is a matter still within my administrative discretion with regard to which I remain ready and willing to discuss and negotiate with interested Senators. Likewise, the role of grazing permittees in the all important Resource Advisory Councils is a matter that I am ready and willing to discuss at any time.

I hope those clarifications regarding the Department's interpretation and intention with respect to implementing these provisions are of assistance in the Senate's consideration of the Conference Committee's grazing reform compromise. So there is no misunderstanding, I want to make clear that my interpretation of these provisions does not in any way bind my decisions regarding the Rangeland Reform '94 rulemaking which the Department would proceed to undertake should Congress decline to enact the grazing reform compromise.

Sincerely,

BRUCE BABBITT.

THE SECRETARY OF THE INTERIOR,
Washington, DC, October 26, 1993.

Hon. ROY ROMER,
Governor, State of Colorado, Denver, CO.

DEAR GOVERNOR ROMER: In your letter dated yesterday to Senators Mitchell and Dole you express particular concerns about certain provisions of Senator Reid's compromise public lands grazing reform (the Reid compromise) being debated as part of the FY 1994 Interior Appropriations bill. I must respectfully disagree with your characterization that these provisions would "inject such ambiguity and confusion into the process for allocating water in the West that litigation and uncertainty would prevail for years to come."

My staff and I have carefully examined the provisions in question. In my judgment as a

former Western State Attorney General, Governor, and private practitioner in water law, these charges simply cannot be sustained. Those parts of the Reid compromise that relate to water are in fact in the mainstream of water law as applied in the western states.

For example, nothing in new section 406(d) changes the traditional practice of acquiring water rights for livestock grazing on public lands under state law. It only ensures that, subject to valid existing rights, such water rights be obtained in the name of the United States. This has long been the practice on the national forests, as well as state law in many western states, including my home state, one of the most arid in the country.

Your letter expresses specific concern that the Reid compromise "could be construed to reserve a federal water right on federal lands not only for grazing but for any other purpose as well." Apparently you are referring to language in the last sentence of section 406(i)(2). But this sentence does not address federal/state relations in water law. It simply confirms the common sense principle that federal claims and rights to water "developed on public lands [shall be exercised] to benefit the public lands and resources thereon." Moreover, the sentence is part of a subsection addressing grazing-related water rights; more specifically, cooperative range improvement agreements. (It is captioned "Range Improvement Ownership.") There is simply no way a court could read this innocuous language to create broad new categories of federal water rights, whether for grazing or non-grazing purposes, in denigration of state water law.

You have also raised concerns about section 406(o), which directs the development of standards and guidelines that "establish minimum conditions for the protection of rangeland ecological health," and which shall include, among other things, "restoration and protection of riparian values, such as healthy wildlife and fish habitat and diverse vegetation." Nothing in this section addresses water rights or state-federal relationships in the area of water; rather, it merely furnishes direction for the Department in the implementation of existing law. That law (the Federal Land Policy and Management Act, or FLPMA) has for nearly two decades required BLM lands to be managed for "multiple use" and "sustained yield," and defines these terms to require accounting for, among other things, "the long-term needs of future generations for renewable and nonrenewable resources, including . . . watershed, wildlife and fish, and natural scenic [and] scientific . . . values." 43 U.S.C. 1702(c).

Each of the provisions in the Reid compromise about which you have concerns is an amendment of FLPMA. That Act's general disclaimer on water rights (Section 701(g), 43 U.S.C. 1701 Note) remains intact. No court has ever interpreted FLPMA as changing state-federal relations in water law. The experience under it has been exactly the contrary.

You have my assurance that the Department of the Interior will, if these provisions are enacted into law, interpret and apply them in conformance with their intent—not to make drastic changes in state-federal relations in water law, but rather to ensure that water rights obtained under state law for grazing-related purposes on public lands serve federal grazing-related needs, and that the ecological health of federal rangelands is secured.

As a native Westerner I know the sensitivity of water rights issues and the legitimacy of states' concerns that their water law systems be protected. I also know a red herring when I see one. The attempt to portray the water provisions of the Reid compromise as a massive federal water grab is just that. I hope this clarifies the matter.

Sincerely,

BRUCE BABBIT.

THE NAVAJO NATION,
Window Rock, AZ, October 26, 1993.

Re: Fiscal Year 1994 Interior Appropriations

Hon. DENNIS DECONCINI,
U.S. Senate, Washington, DC.

DEAR SENATOR DECONCINI: I am very disturbed about the action on the Fiscal Year (FY) 1994 Interior Appropriations (H.R. 2520). I have learned that a second cloture vote to end debate has been defeated today and that a third cloture vote has been filed. I understand that if the third cloture vote is defeated again, and knowing that the extension for consideration of appropriation measures expires October 28, 1993, the Interior Appropriations stand to remain at the FY 1993 level. This means that a substantial gain in report language and funding for Navajo projects is at stake.

With your help and support, we have worked very hard to include a report language and funding for Navajo projects, including $1,450,000 for former Bennett Freeze area housing improvement, $25,700,000 for the Navajo Indian Irrigation Project (NIP), $250,000 for Navajo Community College (NCC) and other priorities for the Navajo people. Should the FY 1993 funding level remain the same for the upcoming fiscal year, Indian Health Service (IHS) would lose $23 million in Arizona alone and $121 million in operations nationally, with a $150 million decrease in the Bureau of Indian Affairs (BIA). Under BIA, decreases of $55 million in education, $20 million in tribal allocations and $65 million in settlements are expected if FY 1993 levels remain. Schools and tribal colleges will be hit very hard including NCC and our BIA-funded schools. Further, if the FY 1993 funding level remains, it gives discretion to the Interior Department since Senate and House report language is no longer applicable.

I realize that the grazing fee issue is of importance to you, but the FY 1994 Interior Appropriations measure should not be defeated at the expense of funding for much needed projects for the Navajo Nation and Indian Country. The vast majority of programs funded by the Department of Interior go toward natural resources, land and water, except for the "people programs" of the BIA. We stand to lose all of this by a handful of grazing permitees who in number hardly compare to the needs of the Navajo people and members of other tribes.

With your help, we have worked hard to improve the deplorable status of the Navajo people where 56 percent live below the poverty line and the unemployment rate is as high as 50 percent depending on the season. We cannot now reverse the progress we have made for this one issue.

I respectfully urge your vote for the third cloture and ask for your continued support to fund our important Navajo projects. If you have any questions, please call my office at 602-871-6355 or Faith Roessel of our Washington office at 202-775-0393.

Sincerely,

THE NAVAJO NATION
Peterson Zah, President.

INTELLIGENCE AUTHORIZATION

Mr. DECONCINI. Madam President, yesterday, I apprised the Senate of the unfortunate situation we are in regarding the fiscal year 1994 intelligence authorization bill. To briefly recapitulate, several Republican Senators on the Armed Services Committee have placed a hold on the bill solely because the CIA has been unable to locate a particular document that is alleged to exist relating to the nomination of Morton Halperin. His nomination is pending before the Armed Services Committee, not the Intelligence Committee, and it is opposed by Senators on that committee.

I respect their opposition to Mr. Halperin. I respect their desire to get information regarding this nominee. What is disturbing to me is that they have elected to put a hold on a bill that is irrelevant to the nomination of Mr. Halperin.

My good friend and colleague, Senator WARNER, came to the floor yesterday and explained his participation in that hold, and I respect the two hats that he must wear, one as the second-ranking member on the Armed Services Committee, and the ranking member and vice chairman of the Select Committee on Intelligence. He stated yesterday that he now has new information which may help locate the document in question, which the CIA claims they are not able to find. Senator WARNER said he does not intend to lift the hold on the intelligence bill until the CIA has completed another file search.

He has every right to do that, and I respect his right to do that. I only hope he and the other Republican Senators on the Armed Services Committee will seriously consider finding some other vehicle, if they must continue to hold up a piece of legislation.

I am disappointed that the hold is now tied to an entirely new search of CIA files. I was led to believe last week that once the CIA had conducted its search in response to the original October 4 request and the Director of the CIA had provided assurances that requested documents could not be located, the hold would be lifted. Nevertheless, I am delighted to hear that new information has come to light which may help locate the documents. Maybe we can still do this before the Appropriations Committee finishes its conference.

In fact, the CIA last week repeatedly asked for any such information that might exist which would help in its record search and help bring this to a conclusion, and none could be provided. Now that additional information is available, we can have another search. Perhaps after that, there will be a request for another search. Every Senator has the right to make such a request. They have the right to put holds on legislation.

This Senator, in a short time, is going to ask the leadership to bring the intelligence bill up and let those Senators who want to use this bill to stop

the nomination of Mr. Halperin filibuster it, if that is what they want to do. In the meantime, I presume the hold on the intelligence bill will not be lifted. Quite frankly, that is most disturbing to me.

I must say, in candor, I am genuinely disappointed to find myself in this situation. I work very well with Senator WARNER, I respect him and understand that he is in a very difficult situation being on both committees. He is a strong supporter of the intelligence community, and he and I have worked amicably together to establish what I think has been a worthwhile agenda and a worthwhile authorization bill. The bill is literally noncontroversial.

There will be an amendment from the distinguished Senator from Ohio [Mr. METZENBAUM], which we will debate, but he has been most gracious in agreeing to a time limit.

Why is it so important? As chairman of the Select Committee on Intelligence, I cannot stand idly by while the authorization is held hostage because of some nomination in another committee. I reiterate what I said yesterday. There are plenty of alternatives available rather than placing a hold on this bill. These Senators already have a hold on the Halperin nomination, so the nomination is going no place.

So what is gained by holding up this bill? It is clearly not going anywhere until their requests for information are satisfied. I understand that, and I respect their right to obtain the information requested. I would welcome an explanation as to why a hold on a nomination is not sufficient.

In the meantime, the efforts of the Intelligence Committee over the last year are effectively being stymied. The plans we have carefully worked out to provide for an appropriate satellite capability to take us into the next generation are on hold. The funds we have provided to protect this country against new incidents of terrorism are on hold; to counter the proliferation of weapons of mass destruction around the world are on hold; to detect the shipment of narcotics coming to our borders are on hold; to provide information needed by the U.S. military forces to defend themselves and put our awesome military capability to its maximum use are on hold.

Madam President, there has been an intelligence authorization bill passed by the Congress every year since 1977. We are in danger of not having a bill for the first time in the history of the committee, not because the bill is controversial, not because there is any disagreement about the bill, except for the one amendment I mentioned, but because a few Senators see it as a way to force the CIA to produce a single document about a nominee they oppose. A document that the CIA cannot find. A document which, I should point out, has never been seen or read, to my knowledge, by any Senator or staff person.

I urge these Senators to please consider the necessity to let this bill pass so that the Defense appropriations subcommittee that is now in conference—and I serve on that as well—will have an authorization guideline of what money should be spent in the intelligence area.

Madam President, I truly hope Senators will work on this for the best of the country and the institution. It is important that we have an appropriation for the intelligence community that is realistic and one that is properly done in a manner in which this institution is supposed to operate.

I thank my colleagues.

The PRESIDING OFFICER. The Senator from Wisconsin.

Mr. FEINGOLD. Madam President, I ask unanimous consent to speak as if in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

REFORM OF THE NATION'S HEALTH CARE SYSTEM

Mr. FEINGOLD. Madam President, let me, first of all, join with the many other Senators who have come to the floor today to express our congratulations to and admiration for the President and First Lady in their continuing effort to reform our country's health care system.

When all is said and done and the bill is signed, as I believe it will be, these two individuals will have to get the greatest share of credit for the power and the strength that they have put behind the effort to change our system. Their efforts have made it possible for me to stand in the Chamber of this Senate and have it be very relevant for the first time to talk about one particular aspect of health care reform.

And that is the issue of long-term care reform as a part of health care reform.

As I had a chance to note earlier, long-term care reform in my view is essential if we are going to talk about true health care reform. But we need to not just offer long-term care benefits in the health care reform package. We also need to make fundamental reforms to our long-term care system if we are going to really be able to call it part of the reform.

At the core of this, this means emphasizing community- and home-based flexible services that respond to individual consumer choice and preference all the way from the initial assessment of the individual right on through to ongoing services involving case managers and others who regularly consult with the consumer and also involving family members to be sure their needs are being met in a satisfactory manner.

Madam President, beyond creating such a system, we also need to ensure that these services are actually accessible to people. This means not only providing adequate service capacity, but we also have to remove some of the system related barriers that exist today. In particular, it means integrating our acute care system with the long-term care services that we hope to provide.

Madam President, this integration is vital. It is especially important in the area that I want to talk about today. That is in the area of hospital discharge. Hospital discharges is a major source of new long-term care consumer.

Unfortunately, individuals being discharged from a hospital who may need some long-term care services all too often end up in a nursing home, not back in their own home or in a community center. But they end up in a nursing home placing a financial burden on families and taxpayers, and limiting consumer choice of long-term care services.

As we strive to build a new long-term care system centered around home and community-based services we have to remove this barrier and establish and enhance the linkage between hospital and other acute care settings and home and community-based long-term care.

The long-term care structure that has evolved since Medicaid began in the mid-1960's has strong systemic incentives for institutional care that is too often to the exclusion of community-based alternatives. Services for long-term care consumers who wish to remain in their homes represent only a fraction of the long-term care budget, and waiting lists for these services are the norm. In my own State of Wisconsin, it is not unusual to find people waiting for these community- or home-based services for as much as 2 years. And some of these people are already in their nineties.

Madam President, one feature of this structural bias is most visible in trying to discharge patients from hospitals, not to the nursing home but to get them back into their own homes where they can have some managed long-term care.

The population most in need of long-term care uses the hospital and acute care facilities of course at a disproportionate rate. In my own State, for example, in a study published by our Wisconsin Department of Health and Social Services, patients aged 65 and older account for nearly one-third of all people who are discharged in hospitals. Indeed, a large number of people over 65 spend some time in a hospital. Nearly 32 people in every 100 over the age of 65 were discharged from a hospital. Looking at older groups, we get to an even more dramatic level. For those aged 75–84, the rate was 38 out of 100; and for those over 85, who are the biggest users of the long-term care services, the rate of this discharge was 45 out of 100.

So what it means is once their acute-care needs are met they do not go back

home, usually. They far too often are sent to nursing homes. That is how the system is set up.

A recent survey done in Milwaukee County shows that more than 70 percent of the older adults discharged from hospitals never return home. It is their last stop. They never get to go back home. Rather, those individuals in need of managed long-term care all too frequently end up in a nursing home.

The single greatest source of admissions into nursing homes now is often the hospital.

In Wisconsin, according to a 1990 report, Wisconsin Nursing Home Utilization, 70 percent of all nursing home admissions are from the hospital—four times the number of nursing home admissions from private homes.

The reasons for this lopsided statistic are really straightforward.

As I mentioned earlier, grossly inadequate funding for community- and home-based long-term care alternatives have resulted in long waiting lists. Even individuals fortunate enough not to be languishing on one of these waiting lists must often wait for some days or weeks before overburdened community case managers are able to perform the necessary screening to make sure they are appropriate for the home care and case planning.

The Medicare DRG and prospective payment system have put a lot of pressures on hospitals, as we all know, to discharge more quickly so they can keep the hospital stay as short as possible. As a result, the uncertain of community- and home-based services, especially when they are contrasted with the pretty easy alternative of an accessible nursing home bed that may be available, makes the choice for the discharge planner very easy. That choice is usually not to have the person go back to the community.

In addition, hospitals and local agencies administering the community- and home-based care program each have their own sets of rules and procedures. Because the community options are relatively new, there has been little time for these two different systems to interact and sort of become familiar with each other. So discharge planners often find it difficult to identify patients who might well be served by community care programs, and thus frequently fail to give these local individuals working in the community enough lead time to effectively react and provide for home- or community-based care in timely fashion.

In sharp contrast, the nursing homes and the hospitals have learned to interact with each other very, very well. There are few if any bureaucratic barriers to discharging a patient from a hospital into a nursing home. Having learned about this as chair of the Wisconsin State Senate Committee on Aging, I became aware of this problem through a series of hearings in 1988, that there might be a way to deal with this problem. So we offered a small provision that was included in the State budget that initiated a pilot program to explore ways to enhance linkages, not between hospitals and nursing homes, but between hospitals and community-based care and home-based care.

I am happy to say that this pilot program has been a success. The primary goal of decreasing nursing home placements from hospital discharges was achieved. On top of those expected results though the pilot program also produced some unexpected additional benefits as the average in-patient cost of participating hospitals dropped as did the average length of stay. For one of the hospitals participating in our pilot program there was a 23-percent drop in the discharge rate to nursing homes, while the average in-patient costs at the hospital dropped by an average of nearly $2,250. At the same time, the average length of stay for the patient population participating in the pilot program dropped by over 2 days.

The hospital also reported improvements in the quality of discharge planning for its most complicated and problematic cases.

Madam President, there are a number of examples that chronicle the success. But let me just give two examples that make it a little more real, a little more human.

First of all, a 65-year-old woman had a medical history that included diabetes mellitus, hypertension, Bell's palsy, chronic obstructive pulmonary disease, congestive heart failure, hypertensive heart disease, atherosclerosis, obesity, cerebral vascular accident, and degenerative dementia. A lifelong introvert, she had dementia that compounded her problems and caused her to fear people with whom she was not familiar.

Without this program, this individual is pretty clearly headed from the hospital to a nursing home. As a participant in the Wisconsin Hospital Link Program she was discharged from the hospital back to her home, and is now cared for by her spouse and grown children, supported by one person who was hired to help care for her.

The other example, a 92-year-old widowed woman named Daisy was hospitalized for a large, deep ulcer on her lower back. Grieving the death of her son a year before, she was receiving less daily contact, and spent long lengths of time lying in bed.

This situation was recognized and this program came to help her and her family. Her grandson and his wife opted to move in with her to act as caregivers in her home, but they each had to work full time and their young daughters attended school.

Needing assistance for dressing changes toward wound care, plus hygiene, ambulating, and transfers, she was discharged with home health aide support Monday through Friday while her family works. Several pieces of durable medical equipment were delivered to her home, most notably an alternating pressure pad positional bed. An RN makes regular assessment of her wound's slow healing process. The family has adapted with great comfort to the aides assigned and Daisy describes herself as doing well.

So again, this is someone who almost surely would have been in a nursing home but was able to stay in the community because of this pilot program.

Madam President, under these scenarios, every party involved in the program, State, county government, Hospitals, and former patients, benefited. As discharge planners have noted, a particularly valuable benefit was the ability of the case managers to monitor the discharge plan in the patient's home.

Often, patients, older patients especially, looked different at home than they did in the hospital. Having a case manager who can monitor the changing conditions and needs is a critical asset for planners and for this program to work.

So, by every measure, this pilot program is beneficial. As a result, in January, on the first day we could introduce bills, knowing that this President and First Lady were going to lead on health care, I took the opportunity to introduce S. 52, which would establish and enhance the very kind of linkages I have mentioned in this talk that we created in Wisconsin and that I think we can replicate throughout the country.

Just as it is vital to include long-term care in an overall health care reform program, so, too, is it essential that we take care to establish and enhance linkages between acute care providers and home- and community-based long-term care as a part of reforming the entire long-term care system. If we are to achieve long-term reform, then we must reform our long-term care system. If we are to succeed in reforming long-term care, then we must ensure that the barriers that currently exist to using home- and community-based services are finally overcome.

To summarize, I encourage those committees that will be working on health care reform legislation to very seriously consider the issue of acute care/long-term care links, and to include, in the legislation they report out, adequate provision to address the system-related barriers that cause an individual who could still be in our community to go to a nursing home instead of to his or her own home after a hospital stay. I yield the floor.

Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRAMM. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRAMM. Madam President, did the distinguished majority leader wish to speak?

Mr. MITCHELL. No.

UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1993

The Senate continued with the consideration of the bill.

AMENDMENT NO. 1090

(Purpose: To reduce Federal employment to the levels proposed in the Vice President's Report of the National Performance Review)

Mr. GRAMM. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Texas [Mr. GRAMM] proposes an amendment numbered 1090.

Mr. GRAMM. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 10, line 16, strike "1994"."; and insert in lieu thereof the following: "1994".

SEC. . REDUCTION OF FEDERAL FULL-TIME EQUIVALENT POSITIONS.

(a) DEFINITION.—For purposes of this section, the term "agency" means an Executive agency as defined under section 105 of title 5, United States Code, but does not include the General Accounting Office.

(b) LIMITATIONS ON FULL-TIME EQUIVALENT POSITIONS.—The President, through the Office of Management and Budget (in consultation with the Office of Personnel Management), shall ensure that the total number of full-time equivalent positions in all agencies shall not exceed—

(1) 2,095,182 during fiscal year 1994;

(2) 2,044,100 during fiscal year 1995;

(3) 2,003,846 during fiscal year 1996;

(4) 1,963,593 during fiscal year 1997;

(5) 1,923,339 during fiscal year 1998; and

(6) 1,883,086 during fiscal year 1999.

(c) MONITORING AND NOTIFICATION.—The Office of Management and Budget, after consultation with the Office of Personnel Management, shall—

(1) continuously monitor all agencies and make a determination on the first date of each quarter of each applicable fiscal year of whether the requirements under subsection (b) are met; and

(2) notify the President and the Congress on the first date of each quarter of each applicable fiscal year of any determination that any requirement of subsection (b) is not met.

(d) COMPLIANCE.—If at any time during a fiscal year, the Office of Management and Budget notifies the President and the Congress that any requirement under subsection (b) is not met, no agency may hire any employee for any position in such agency until the Office of Management and Budget notifies the President and the Congress that the total number of full-time equivalent positions for all agencies equals or is less than the applicable number required under subsection (b).

(e) WAIVER.—Any provision of this section may be waived upon—

(1) a determination by the President of the existence of war or a national security requirement; or

(2) the enactment of a joint resolution upon an affirmative vote of three-fifths of the Members of each House of the Congress duly chosen and sworn.

Mr. GRAMM. Madam President, the amendment before us is, I believe, a very important amendment, because it seeks to achieve a national goal that I believe is supported by the Congress and a national goal which has been set for the Nation by the President. As I am sure all of my colleagues will remember, the President and the Vice President, on the lawn of the White House, with two forklifts behind them holding all of the paperwork related to various forms of regulation, talked about reinventing Government. They presented to the Nation a document —which, as it turned out, we paid twice as much to print than if we had followed the prescription of the document and done it by competitive bidding.

The National Performance Review by the Vice President states two basic objectives. The first objective is contained on page 3 of the preface, and that objective is to reduce the number of jobs in the Federal bureaucracy over the next 5 years by 252,000. That is the stated objective of the administration. I have offered an amendment today for myself; for the distinguished Senator from Iowa [Mr. GRASSLEY]; and for the Senator from Arizona [Mr. MCCAIN], which seeks to strengthen the President's position in achieving this objective and seeks to put the Congress and the Government on record in setting out a procedure to assure that we achieve this goal.

Let me explain how the procedure would work. Basically, we take the President's actual figures for Federal employment for 1994 and 1995, which were set out in the President's budget submission, we take the remaining reduction of 150,000 personnel slots, and on a proportional basis, we reduce the number of full-time-equivalent positions in the executive branch of Government each year to guarantee that, when achieved, these targets would fully implement the President's goal of reducing the number of employees in the Federal bureaucracy by 252,000 between fiscal years 1993 and 1999.

How the process would work is quite simple: We would set out in law, as outlined in the amendment, employment caps for fiscal years 1994, 1995, 1996, 1997, 1998, and 1999. Employment caps for 1994 at a level set by the President as his objective; in 1995 as set by the President as his objective. And the objectives for 1996 through 1999 would simply take the target and assume an equal reduction over the 4-year period.

So we would set in law an employment cap for the executive branch of the Federal Government. We would then give the OMB Director the responsibility for reporting quarterly to the President and to the Congress what the actual full-time employment level of the Federal Government is, and whether or not we are violating the totals that we have set out in law. If, in fact, the actual employment level exceeds the target for that fiscal year, then the OMB Director, on that basis, would report to the President and report to the Congress, and there would be an automatic hiring freeze in the Federal Government until the OMB Director can certify to the President and to the Congress that these actual targets, which the President has set out as a national priority to reinvent Government, have been achieved.

In essence, what we are doing by law is committing ourselves to the President's goal, setting into place by law the requirement that this goal be met, setting up a procedure to assure that if the goal is not met, that we have a hiring freeze that will stay in effect until we have come into compliance.

Let me explain why this is so very important. Quite beyond the objectives of the President to achieve this overall level of reduction in the size of the Federal bureaucracy, let me tell you why it is not going to work, unless we set out in law this objective and unless we have an enforcement mechanism.

I just want to refer back to one vote last night because it is so indicative of the problem we have. When the House voted to kill the SSC, when we had an extensive debate in the Senate where every person who argued against the SSC argued that it should be killed in the name of deficit reduction. The assumption was that by killing the SSC and paying $1 billion of termination costs and lawsuits attendant to that decision, we were actually going to reduce the deficit. Last night, we voted on an amendment that would have guaranteed that the savings from the SSC would have gone to deficit reduction, and that amendment failed.

So, in essence, our entire rhetoric in the debate turned out to be hollow because, as a result of last night's action, we now are not going to see one penny that could have been saved had we taken the savings from the termination of the SSC and applied them to deficit reduction by lowering the overall targets for spending.

Now, here is why we need these caps to help the President achieve this result which the Nation supports. Let us say that as part of the President's objective in reinventing Government, he comes to Texas and says we have to shut down these county offices of these various departments within the Department of Agriculture. We have too many offices, the President says, or the Secretary of Agriculture says, in

Texas, and we are going to consolidate those offices.

I submit that virtually every Member of the Senate, especially those of us from big farm States, is going to be looking at exactly this kind of problem. This is why this amendment is so vitally important.

If I know that the targets have to be met by law, if I know we have set out in law that there is a 252,000 reduction in Federal employment that we have committed ourselves to, and that there is hiring freeze when these targets are not met, I can judge these proposals on their merits. I can support them or oppose them. But one thing I will know for sure, and that is that we are not going to shut down a farm credit office in Texas and open up some other office in Iowa or in Massachusetts. I know that if, in fact, we engage in this consolidation, as painful and unpleasant as it may be, at least we are not shifting around personnel slots; at least I know that the sacrifice that we make would not end up being an addition of new personnel slots somewhere else.

Let me also hasten to add here that what we are doing is simply allowing natural attrition to occur, and, as the President has made clear, in any consolidation, a maximum effort would be made to see that people who are in positions that are eliminated have the first crack at any other position within the Government.

So, basically, what this amendment does is it locks into law a steady achievement of the President's objective in his reinventing Government initiative. It has an enforcement mechanism so that if we violate it, we are notified, the President is notified, and there is an overall freeze on hiring in the executive branch of the Federal Government which stays in effect until the OMB Director certifies that the objective has been met.

The great strength of this process is that we do then have a benchmark to measure success; we have an enforcement mechanism to discipline both the Congress and the executive branch. And each of us knows, as individual sacrifices occur in our own States, as offices are consolidated in our own States, as our own people are forced to adjust to the changing reality in terms of reinventing Government, we can then know that we simply are not making a sacrifice in Texas so that we can expand an office in Arkansas.

I think, in order to make this work, as difficult as it is going to be, we need some kind of guarantee. And short of that kind of guarantee, it is going to be very difficult or impossible to achieve the President's objectives. That is why I have offered this amendment, as part of a bipartisan effort, to see that we achieve the goal that the President stated and that I strongly support, and that I believe the vast majority of Republicans in the Senate support the objective of reinventing Government, of making the Government smaller. I decided to start today, in conjunction with my cosponsors, by focusing in on the part of the President's plan which is easiest to understand; and that is, the President, in looking at his objectives, believes that he can reduce employment by 252,000. He has set it out as a goal. I say, let us make it our goal. Let us make it the Nation's goal. And let us achieve it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, first of all, I commend my colleague from Texas for his initiative in bringing this concept to the floor and doing it through this very specific amendment and, of course, as he said, I am joining him in offering it, and I am pleased to do that.

This is a real opportunity, Madam President, for Members of this body to make sure that decisionmaking in Government and the carrying out of that decisionmaking, that performance, is commensurate with the rhetoric of the policy.

I think too often we are not put to tests often enough about statements we make and policies we adopt—whether it be in the legislative branch of Government or the executive branch of Government—as to whether or not we follow through and carry out.

Through this amendment, I think that we are putting all of us to the test; not just the Vice President, because he is leading the charge on reinventing Government; not just the President, because he is the Chief Executive and he is working and supporting the Vice President; but those of us in the Congress, as well. Because if jobs are said to be saved, the implication is money is going to be saved, and we tell the public that it seems to me that we ought to make sure to the best of our ability that happens.

So it is from that standpoint that I see this Gramm-Grassley amendment as a constructive approach. I am one who, of course, has often spoken on the floor of this body in support of the administration's National Performance Review, in support of its general thrust, if not in all of its details. And I have even questioned to some extent its limited scope. But it is a start, a very good start, and we ought to help it along and even expand upon it.

This amendment is not an expansion upon the National Performance Review. It is just a motion made by this body, hopefully taken by this body, that is going to see that what limited review we have thus far is carried out.

I hope that this is only a first step to real, fundamental changes in our Government as a result of the National Performance Review. I have commended the President and the Vice President for their leadership and for their positive beginning in reinventing Government.

To me, this amendment can be characterized in two ways: First, it is the teeth that ensures that we get the reforms desired by the President and the Vice President. Second, it puts the pressure on the Congress to follow through. Congress has a very clear choice. We can either become the harbingers or the resisters of reform.

Madam President, I view this effort as an extension—as I have said before, when I think I have spoken out on the NPR—I consider it an extension of my work to reform defense management; in a sense, to reinvent defense.

I started my efforts to reform defense in 1983, when some challenged the feasibility of even a freeze of the defense budget. It became clear to me from that early time that true reform needed teeth. And there were two ways to bring this about.

First, the level of funding would have to be lowered by an amount commensurate with the reform. If it were not, the targeted activity would grow right back again, and absorb the original budget level. You would then have the same level of inefficiency as you started with.

Second, those employees once performing the functions that are reformed away in defense must also be reformed away. That is the only way to ensure the integrity of the decision to reform or kill a program.

Now let me mention an important point here. What do I mean by "reforming away those employees?"

The President has set forth a credible program for early retirement and buyouts. Only as a last resort would the RIF process be used.

If we in Congress cap the overall level, it is important that we give the President the tools he needs to accomplish the reduction. We should be willing to trade off caps for the flexibility for the President to do the job effectively.

This Gramm-Grassley amendment would provide the second of these two sets of teeth; that is, lowering the number of workers to match the reform. We will address the first set of teeth another day, that dealing with funding.

What this amendment does is it ensures the integrity of the reforms put forth by the President and the Vice President. And again, I must stress my support for what they are trying to accomplish overall through the National Performance Review.

The real question, in my view, is whether the Congress has the stomach to swallow reform. And it cannot swallow reform without teeth. Rhetoric aside, this amendment is where the rubber meets the road.

Many of my colleagues clamor for reform or speak in support of reform. The American people can hear us, but they

will not believe us until they see the whites of our "pearly whites." They want to see reform with teeth. And not false teeth—real teeth. This amendment gives us a chance to vote for real reform, not false reform.

Madam President, Senator GRAMM, has done an eloquent job of explaining what our amendment would accomplish. I cannot add to what he has said. Let me just reiterate that I am pleased to join with my colleague from Texas. Our purpose is to help ensure that the reforms requested by the administration are enacted exactly as envisioned, and that Congress support—and not impede—accomplishment of those reforms.

I yield the floor.

Mr. MITCHELL addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. MITCHELL. Madam President, we are prepared to accept the amendment.

Mr. GRAMM. If the distinguished majority leader will yield, we would be delighted with that, but we would like to have a rollcall vote.

Mr. MITCHELL. The Senator is entitled to that. I simply say to him that it is my practice, as majority leader, to minimize unnecessary rollcall votes when Senators are absent due to important other business. Two Republican Senators, Senators DURENBERGER and MCCONNELL, are necessarily absent. Two Democratic Senators, Senators FEINSTEIN and BOXER, have left a short while ago to go to California, where there is a serious, as you know, national tragedy occurring with the fires there.

I see no reason to punish them by having a vote that is not necessary. But that is the Senator's right, and if he wants to have a vote, we will have a vote.

Mr. GRAMM. If the distinguished majority leader will yield further, let me have a moment to think about it.

Mr. MITCHELL. Fine.

Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRAMM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. LIEBERMAN). Without objection, it is so ordered.

Mr. GRAMM. Mr. President, I understand from a check in our cloakroom that we will have a recorded vote later today on final passage of the unemployment extension bill. And so on that basis, Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senate majority leader.

Mr. MITCHELL. Mr. President, I simply want the RECORD to note—and I, of course, have supported the request for rollcall vote—that I have made it a practice when Senators are necessarily absent not to have rollcall votes that are not necessary. The Senator from Iowa has always been very concerned about rollcall votes and I have tried to accommodate him and the Senator from Texas and others.

It is true that there will be another vote but those four Senators are missing a vote here that I believe is unnecessary. But the Senator has a right to request a vote and, therefore, I support his request.

The PRESIDING OFFICER. Is there further debate?

If not, the question is on agreeing to the amendment.

The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. FORD. I announce that the Senator from California [Ms. BOXER], and the Senator from California [Mrs. FEINSTEIN], are necessarily absent.

Mr. SIMPSON. I announce that the Senator from Minnesota [Mr. DURENBERGER] is necessarily absent.

I further announce that the Senator from Kentucky [MCCONNELL] is absent due to an illness in the family.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced, yeas 82, nays 14, as follows:

[Rollcall Vote No. 341 Leg.]

YEAS—82

Baucus	Faircloth	Mack
Bennett	Feingold	Mathews
Biden	Ford	McCain
Bingaman	Gorton	Mitchell
Bond	Graham	Moseley-Braun
Boren	Gramm	Moynihan
Bradley	Grassley	Murkowski
Breaux	Gregg	Murray
Brown	Harkin	Nickles
Bryan	Hatch	Packwood
Bumpers	Hatfield	Pell
Burns	Heflin	Pressler
Campbell	Helms	Reid
Chafee	Hollings	Robb
Coats	Hutchison	Rockefeller
Cochran	Inouye	Roth
Cohen	Jeffords	Sasser
Conrad	Johnston	Shelby
Coverdell	Kassebaum	Simpson
Craig	Kempthorne	Smith
D'Amato	Kerrey	Specter
Danforth	Kohl	Stevens
Daschle	Lautenberg	Thurmond
DeConcini	Leahy	Wallop
Dodd	Levin	Warner
Dole	Lieberman	Wofford
Dorgan	Lott	
Exon	Lugar	

NAYS—14

Akaka	Kerry	Riegle
Byrd	Metzenbaum	Sarbanes
Domenici	Mikulski	Simon
Glenn	Nunn	Wellstone
Kennedy	Pryor	

NOT VOTING—4

Boxer	Feinstein
Durenberger	McConnell

The amendment (No. 1090) was agreed to.

Mr. MOYNIHAN. Mr. President, I move to reconsider the vote.

Mr. ROBB. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mrs. KASSEBAUM. Mr. President, we are about to extend for a fifth time Federal unemployment benefits for displaced workers. These benefits are important to many families, and I believe we should extend them. But we also should pay for them—as the law requires that we do—rather than passing the buck to our children in the form of more national debt.

CBO estimates this extension will cost roughly $1.1 billion in fiscal year 1994. The bill before us purports to offset that cost through two cost-saving reforms spread out over 5 years. In other words, we will once again spend money today and promise to pay for it by cutting spending in the future.

Moreover, one of the offsetting provisions, the requirement that States profile all new claimants for benefits, may well be nothing more than smoke and mirrors. This provision is supposed to offset about $800 million of the cost of this extension; however, CBO estimates that implementing the proposal will cost almost $900 million. We may well lose money on this spending cut.

Mr. President, we simply cannot afford any longer to play budget games and gamble on future savings. If we are going to extend unemployment benefits, we should pay for them—we should pay for them today, and we should pay for them with real cuts in other spending.

These unemployment benefits are very important to many Americans including many in my home State of Kansas. For that reason, I initially cast my vote yesterday to extend them, despite the fact that they are financed by running up the debt.

But as I spoke with my colleagues during that debate, it became clear to me that many in both political parties share my deep concern about paying for these benefits. There was a sense of optimism among some that we could reach agreement on real cuts to pay for this new spending. Because of the tight vote margin, I had hoped I was in a position to encourage negotiation. For that reason, I switched my vote in the hope that we could reach a financing agreement.

Since yesterday's vote, I have raised this matter with a number of Senators, including the distinguished chairman of the Finance Committee, and it is now clear to me that no such agreement is possible. I deeply regret that we will be allowed only two options: Support unfunded benefits, or support no benefits at all.

Given that choice, I will today cast my vote to extend unemployment benefits—the immediate human cost for many families is simply too high to do otherwise.

But I want to make clear my belief that we should not be facing this difficult choice. There are many real spending cuts that could have been included to pay for this package. For example, Vice President GORE has included a number of proposed reforms in his National Performance Review that we could have considered. Indeed, some of these proposals would fall within the jurisdiction of the Finance Committee—the same committee that sent us the debatable financing mechanisms included in the bill. For example, the Vice President has proposed:

Amending the Health Care Financing Administration's contracting authority to allow for competitive contracting: 5-year savings—$985 million.

Providing electronic intergovernmental tax filing, reporting, and payments processing. A similar proposal by the Grace Commission would have saved roughly $2.1 billion over 3 years.

Consolidating 55 categorical grant programs into 6 broad flexible grants—in job training, education, water quality, defense conversion, environmental management, and motor carrier safety. A similar proposal by the Grace Commission would have saved roughly $1 billion over 3 years.

Improving Social Security Administration disability claims processing to reduce backlogs and avoid paying benefits to individuals who are no longer disabled: 5-year savings—$4 billion.

Mr. President, I am not passing judgment on the merits or demerits of these individual proposals—I merely point out that they are strongly advocated by the Vice President.

I also recognize that these programs involve multiyear savings. But surely there is some combination of proposals such as this that could have yielded sufficient savings in fiscal year 1994 to offset the unemployment benefits extension.

Today marks the fifth time we have extended these benefits, and each time we have had to waive the Budget Act to do so. That is simply irresponsible. I am deeply concerned that we are on the road to transforming unemployment benefits into a new entitlement program and that, like our existing entitlements, it will continue to grow unchecked.

By our vote today, we will charge at least another $800 million to the national debt. I will vote in favor of the extension because these benefits are so very important to those who have lost their jobs. But I want to make very clear my displeasure that we have not anted-up to pay the bill.

Mr. President, there is no doubt that the passage of the emergency unemployment benefits will be very important to many families. I believe it should be extended and I will vote to do so.

I was very disappointed that in many ways our only two options were to support unfunded benefits or to support no benefits at all.

Just briefly I will say why I think this is troubling.

Over the last 2 years we have extended emergency supplemental unemployment benefits to the tune of $24.5 billion just in the last 2 years. This was an additional $1.1 billion for this fiscal year 1994.

It troubles me, Mr. President, that we are really starting down the path of a new entitlement for Federal emergency unemployment insurance. I think that this should trouble us all.

There was not time to work out an agreement on funding for this additional $1.1 billion. But I would hope that we would take a look at recommendations that the Vice President has proposed for reorganization of Government and before we have to again support expanding unemployment benefits or any other emergency funding, we look at these proposals and see if we cannot indeed enact them and find the savings that the Vice President has projected just, for example, amending the Health Care Financing Administration contracting authority to allow for competitive contracting, provide electronic intergovernmental tax filing, reporting and payments processing, consolidating 55 categorical grant programs into 6 broad flexible grants, and job training, education, water quality, defense conversion, environmental management, and motor carrier safety.

This is a proposal that has estimated a savings of $1 billion over 3 years, and is just eminently, I think, sound and sensible as far as effective and better accountable Government program improving Social Security Administration disability claims processing, to reduce backlogs and avoid paying benefits to individuals who are no longer disabled.

Mr. President, these are just some suggestions which I believe have merit which I know many here would like to see thoughtfully considered and not really just continually spoken to but action taken to the relevant committees.

So, just to conclude, these were the things that I think troubled many of us who did believe that unemployment benefits should be extended but also worry about a path that we have started down that has become very different from the initial emergency support program that we were providing States for unemployment insurance. If we are not to take some concerted action now, we are going to face being in a similar situation, I am afraid, in the future.

I yield the floor.

INDIAN TRIBAL GOVERNMENTS AND EMPLOYEES

Mr. DURENBERGER. Mr. President, I had planned to offer as an amendment to the pending legislation the text of S. 391, sponsored by Mr. MCCAIN and which Mr. CAMPBELL and I have cosponsored. That legislation would address the serious problems faced by Indian tribal governments and their employees with respect to the State-Federal unemployment compensation system by providing for uniform treatment of Indian tribal governments and their wholly owned subsidiaries on a par with States, localities, and nonprofit entities.

Mr. President, one would think that Indian tribal governments would be covered under the same unemployment compensation rules as States, municipalities, and nonprofit organizations. In fact, Indian tribal governments are significantly disadvantaged in comparison to those entities. Although practices vary around the country—some Indian tribal governments are considered by the States to be completely exempt from the UC system at the State level, some tribal governments are permitted to elect reimburser status, as if they were governments, and some tribal governments have chosen not to be covered—under Federal law, Indian tribal governments are required to be treated for unemployment tax purposes, if they are covered at all, as if they were profit-making entities. This treatment is, in my view, inconsistent with their responsibilities and status under Federal law.

There have been some questions raised regarding the implementation of a policy putting tribal governments on a par with States and local governments for FUTA purposes that need to be considered. I appreciate the cooperation of the Senator from New York and the staff of the Committee on Finance in this regard. But because of the pending assessment situation in Minnesota—and the possibility that assessments could be made against other tribes—those questions ought to be addressed with reasonable speed.

Accordingly, Mr. President, I would ask the Senator from New York whether he can expect to address these issues at an early date.

Mr. MOYNIHAN. Mr. President, the Senator has raised some important questions, and I can understand his special interest in the situation that has arisen in his State.

The matters he has just addressed affect policies under the jurisdiction of the Treasury and Labor Departments and we have begun discussions with them. The agencies have raised concerns about changing the status of tribal governments for FUTA purposes. These concerns, and the views of other Indian tribes and the several States, must be carefully considered. Nevertheless, I would hope that we could reach some consensus on an appropriate way to address the issues raised by the Senator.

Mr. WELLSTONE. I, too, want to express my continued strong interest in changing the treatment of Indian tribes under the Federal unemployment compensation program to put them on par with States and local governments. I have worked with Congressman PETERSON and Senator DURENBERGER on this issue for some time.

Early this year, I wrote to the Treasury and Labor Departments asking for their views on this legislation. Several weeks ago, I again asked representatives from both departments to come to my office to explain their views on the bill introduced by Senator MCCAIN, and other alternative solutions, in greater detail. Frankly, I had hoped that we would have been able to address this problem earlier this year. I requested at that meeting formal written expressions of their views on this issue, which I have not yet received.

The special status of Indian tribal governments must be taken into account as potential solutions to the problems are developed to ensure the fair treatment of such organizations under the act. I agree with Senator DURENBERGER that the treatment of tribal governments should be similar to that of States, localities, and nonprofit entities. It is my view that a permanent solution can be developed which ensures coverage for employees of Indian tribal organizations while meeting the concerns expressed by the Department of the Treasury, the Department of Labor, and various States about its fair implementation.

I will continue to work closely with you, Mr. Chairman, and with my distinguished colleague from Minnesota, Senator DURENBERGER, toward that end. I hope we can develop such a permanent solution, and that it would then be considered by the Finance Committee very soon.

UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1993—H.R. 3167

Mr. MOYNIHAN. Mr. President, I ask unanimous consent that a description of the Unemployment Compensation Amendments of 1993, H.R. 3167, as passed by the House of Representatives be included in the RECORD at this point.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

DESCRIPTION OF THE UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1993, H.R. 3167

I. EMERGENCY UNEMPLOYMENT COMPENSATION [EUC] PROGRAM

Present Law.—The Federal Emergency Unemployment Compensation (EUC) program was first enacted in November 1991 and extended most recently by P.L. 103-6 on March 4, 1993. The EUC program, which expired on October 2, provides workers who have exhausted their regular State unemployment benefits (and who began receiving EUC benefits on or before October 2) with 15 weeks of benefits in States with the highest unemployment and 10 weeks of benefits in all other States. States with adjusted insured unemployment rates (the average of the current week and the preceding 12 weeks) of at least 5 percent, or total unemployment rates (6-month moving average) of at least 9 percent, are eligible to pay the higher number of weeks of benefits. At present, only four States (Alaska, California, Rhode Island, and West Virginia) are eligible to provide 15 weeks of benefits.

The statute provides for a decline to 13 and 7 weeks of benefits if the national unemployment rate falls below 6.8 percent for two consecutive months. The rate for the months of August and September was 6.7 percent.

The EUC program expired on October 2. Unless the program is extended, workers who exhaust their regular State benefits after that date will be ineligible for EUC benefits. Workers who began receiving EUC benefits on or before October 2 will be entitled to the full number of weeks of benefits for which they were found eligible. However, no benefits are payable after January 15, 1994.

Individuals who have exhausted their rights to regular State benefits either because their benefit year has expired or because they have received all of the benefits to which they are entitled, may elect to receive either EUC benefits or regular State benefits under any new benefit year that has been established.

Proposed Change.—The EUC program is extended through February 5, 1994. Workers who exhaust their regular State benefits after October 2 will be eligible for up to 13 weeks of benefits in States with the highest unemployment. In all other States they will be eligible for up to 7 weeks of benefits. Workers who exhaust their regular State benefits after February 5 will not be eligible for EUC benefits. Workers who begin receiving EUC benefits before that date will be entitled to the full number of weeks of benefits for which they were found eligible. However, no EUC benefits will be payable after April 30, 1994.

The provision giving individuals the option to choose between EUC benefits and regular state benefits is repealed. After the date of enactment, no new EUC options will be exercised. However, individuals who began or continued EUC based on an option exercised before October 2, 1993, may continue to receive EUC until exhaustion of their EUC account.

II. ADDITIONAL UNEMPLOYMENT COMPENSATION FOR RAILROAD WORKERS

Present Law.—Workers in the railroad industry are eligible for a separate unemployment compensation program that provides benefits basically equivalent to those provided under regular State unemployment compensation programs. Railroad workers with under 10 years of railroad service are not eligible for extended benefits. The UC law temporarily provides extended benefits to railroad workers with under 10 years of service and additional weeks of extended benefits to other qualifying railroad workers in order to maintain comparability with the EUC benefits provided to workers in other industries.

Proposed Change.—Eligible railroad workers will continue to receive the additional benefits provided under the EUC law for other workers.

III. WORKER PROFILING AND REEMPLOYMENT ASSISTANCE

Present Law.—P.L. 103-6, enacted March 4, 1993, directs the Secretary of Labor to establish a program for encouraging the adoption and implementation of State systems of profiling all new claimants for regular unemployment compensation. These systems are to be used to determine which claimants might be most likely to exhaust their regular unemployment compensation benefits and might need reemployment assistance services to make a successful transition to new employment.

Proposed Change.—Each State's unemployment agency is required to establish a profiling system as described above, and to refer claimants identified as needing services to reemployment services available under any State or Federal law. The State agency is also required to collect follow-up information relating to the services received by claimants and the employment outcomes for such claimants subsequent to receiving services, and to use this information in making identifications under the profiling system. States that fail to comply substantially with these requirements may be subject to withholding of administrative funds until the Secretary is satisfied that there is no longer an such failure.

In addition, the bill provides that as a condition of eligibility for unemployment compensation benefits, a claimant who has been referred to reemployment services pursuant to the profiling system must participate in these or similar services unless the State agency determines that the claimant has completed such services, or there is justifiable cause for failure to participate.

Reemployment services will include job search assistance and job placement services, such as counseling, testing, occupational and labor market information, assessment, job search workshops, job clubs and referrals to employers, and other similar services.

The Secretary of Labor is directed to provide technical assistance and advice to assist the States in implementing the profiling system, including the development and identification of model profiling systems.

Not later than three years after the date of enactment, the Secretary of Labor is required to report to the Congress on the operation and effectiveness of the profiling system and the participation requirement, with such recommendations as the Secretary determines to be appropriate.

Effective Date.—The profiling requirement is effective one year after the date of enactment.

IV. TECHNICAL AMENDMENT TO UNEMPLOYMENT TRUST FUND

The bill restores language in section 905(b)(1) of the Social Security Act that was inadvertently changed by P.L. 102-318. This section provides for the transfer of funds to the State administration accounts.

V. EXTENSION OF REPORTING DATE FOR ADVISORY COUNCIL

Present Law.—P.L. 102-164, the Emergency Unemployment Compensation Amendments of 1991, provided for the establishment of a quadrennial advisory council on unemployment compensation to examine the purpose, goals, and functioning of the unemployment compensation system, and to make recommendations for improvement. The first report is due by February 1, 1994.

Proposed Change.—The due date for the first report would be delayed for one year. Subsequent reports would be due the third year following the establishment of the council, rather than the second year.

VI. INCREASE IN SPONSORSHIP PERIOD FOR ALIENS UNDER THE SUPPLEMENTAL SECURITY INCOME [SSI] PROGRAM

Present Law.—The SSI program provides Federal benefits to aged, blind, and disabled

individuals whose income and resources are below specified amounts. To be eligible, an individual must be either a citizen of the United States or an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Under current law, the income and resources of an alien's sponsor are considered in determining the alien's eligibility for SSI benefits. A sponsor is an individual who has signed an affidavit of support as a condition of the alien's admission for permanent residence in the United States. This "deeming" of income and resources applies for 3 years after the alien's entry into the United States. After 3 years, the alien's eligibility for SSI is determined without regard to the income and resources of the sponsor. The "deeming" requirement does not apply with respect to an individual who becomes disabled after entering the United States.

Proposed Change.—The period during which the sponsor's income and resources would be "deemed" to the alien would be extended from 3 to 5 years.

Effective Date.—The provision would be effective January 1, 1994 through fiscal year 1996. The provision would not apply in the case of individuals who are eligible for SSI for December 1993 (or whose eligibility is suspended but not terminated) and whose 3-year deeming period ended prior to January 1994. Thus, individuals who apply for SSI benefits on or after January 1, 1994, and individuals on the SSI rolls (because their sponsors' deemed income and resources do not make them ineligible) whose 3-year deeming period has not ended by January 1, 1994, would come under the 5-year rule.

VII. COST ESTIMATE

The Congressional Budget Office [CBO] estimates the cost of the EUC benefit extension at $1,070 million in fiscal year 1994. The profiling provision is estimated to reduce unemployment benefits by $764 million over the 4-year period 1995–1998. The provision relating to aliens receiving SSI benefits is estimated to reduce SSI and Medicaid outlays by $330 million over the 3-year period 1994–1996.

Mr. BYRD. Mr. President, for 2½ years now, the American economy has been, technically speaking, in an economic recovery. Yet, unemployment is hardly any lower today than it was in March of 1991 when the last recession officially ended. Despite some improvement in recent months, unemployment remains stubbornly high. Nowhere is this more true than in the State of West Virginia. Unemployment there continues to hover near double-digit levels, standing at 9.6 percent in August—the highest unemployment rate in the Nation.

The problem, however, is not just the fact that the overall rate of unemployment remains unacceptably high; it is that the number of long-term unemployed is so high. Of the 8.5 million Americans unemployed today, more than 1.7 million—one of every five—have been out of work for 27 weeks or more.

As a result, we find ourselves with little choice but to enact yet another extension of emergency unemployment benefits. When we enacted the first such bill in November of 1991, the number of long-term unemployed stood at just under 1.4 million. To repeat, today that number stands at 1.7 million. Although we all know that an unemployment check is no substitute for a paycheck, now is not the time to cut off assistance to those who continue to bear the heavy burdens associated with long-term unemployment.

To those in West Virginia who might exhaust their regular State unemployment benefits between October 2, 1993, and February 5, 1994, the bill before the Senate, H.R. 3167, will provide 13 weeks of emergency unemployment compensation benefits. The same will be true in other high unemployment States. For those in States not suffering from such high unemployment, 7 weeks of additional benefits will be made available.

The additional benefits provided under this bill are paid for by reductions in spending elsewhere. As a result, enactment of this bill will not result in an increase in Federal spending, nor will it cause our deficit to grow. This legislation thus represents a fiscally responsible effort to assist those in desperate need of a helping hand, and I am pleased to support this important measure.

SOME QUESTIONS ABOUT THE LEGISLATION

Mr. RIEGLE. Mr. President, I would like to raise some questions about this legislation with the distinguished chairman of the Finance Committee.

Mr. MOYNIHAN. I would be glad to discuss this legislation with my colleague from Michigan.

Mr. RIEGLE. When emergency unemployment compensation expired on October 2, the rate of Michigan workers filing for emergency unemployment compensation benefits was 2,500 per week. The past few weeks have been understanding frightening for the families of the estimated 7,500 Michigan workers who could no longer file for emergency unemployment compensation—not knowing when, or if, the Government would act to extend this critically needed program. I think that we can all agree that the compromise reached was a different one; the heated debate and lengthy legislative action in the other body bears testimony to that fact. I think that we can also agree that finding adequate funding for the 4 month extension was an arduous challenge for the administration.

I have some concerns about the new profiling proposal included in this measure. I have the utmost confidence in the Secretary of Labor and fully realize that the structure of the profiling program will be developed further under his guidance. I would like to raise a few of the issues that will deserve his attention.

In the area of worker compliance with profiling requirements, the bill specifically recognizes a State's right to exempt claimants where there is justifiable cause for the claimant's failure to participate. To prevent a patchwork quilt of varying State justifiable cause criteria, some reasonable standard exemptions would be useful. While there is a compelling interest in complete participation in the profiling program, many claimants are understandably concerned that certain circumstances, such as State work search waivers, will not be recognized as justifiable cause under this new program.

Another provision which will be especially helpful to those of us whose States have experienced consistently high unemployment is the Secretary's reporting provision. Secretary Reich has been such a strong advocate on employment issues that I suspect he may choose to go beyond what this bill requires, and provide Congress with detailed data regarding demographic and industry-specific claimant impact and reemployment. I hope that the Secretary will take advantage of this opportunity to explore the real-life results of our new profiling system, to help those of us in Congress ensure that this program is fair and equitable to all claimants.

In order for any profiling program to work, we must require that claimants participate as much as possible. It may take a little time for claimants to adjust to this completely new system, and there may be some who will temporarily fail to participate in the profiling requirements. I hope that the Department of Labor will extend a second chance to those claimants who have initial misunderstandings about this new program, and its technical requirements, and welcome them back into the system. By reaching out and establishing the profiling process as a true partnership between Government and workers, the Department may exceed even their own expectations for the program.

I am confident that these concerns can be effectively addressed by Secretary Reich during the next few weeks, and I look forward to working with him on these matters.

Mr. MOYNIHAN. I appreciate the Senator's concerns in this area. He raises issues fully deserving of the Secretary's attention.

WE CAN DO BETTER; WE SHOULD DO BETTER

Mr. DOLE. Mr. President, here we go again. For the second time this year, the Senate is debating an extension of unemployment benefits that is not paid for.

Since November 1991, Congress has acted to extend unemployment benefits four times, with the most recent extension coming in March 1993. The first three extensions, under President Bush, were paid for each year consistent with the budget law. But, the first extension under President Clinton was declared an emergency and added $5.7 billion to the deficit. I voted against that extension of benefits.

THE FACTS ABOUT H.R. 3167

The Congressional Budget Office—the President's own hand-picked budget

scorekeeper—says that all of the new spending in H.R. 3167—a total of $1.07 billion—would occur in 1994, but the bill will not be paid for until 1998. CBO projects that in fiscal year 1994, this bill would increase the deficit by more than $1 billion.

As if that were not bad enough, the major offset contained in this bill is a gimmick. Essentially, the bill claims entitlement program savings from a discretionary spending increase that appropriators must finance in future years under the discretionary spending cap.

The new profiling system created in this bill is effectively an unfunded Federal mandate on the States. The bill requires States to establish a new worker-profiling system which will cost the States an estimated $897 million over 5 years to administer. The problem is that, in reality, these administrative costs are only covered in the first year. In the future, States will have to seek appropriations to cover the administrative costs of this new program.

Back in September, OMB Director Panetta said—and I quote—

> We're not going to submit [a proposal to extend unemployment benefits] * * *, unless it's paid for.

OMB Director Panetta was one of the authors of the original pay-as-you-go requirements. He knows what they mean. Perhaps, that is why the administration never submitted a formal proposal to extend these benefits.

Mr. President, Senator NICKLES and I worked in good faith with the chairman, the majority leader, and representatives of the administration to try to find a solution. We were unable to find a mutually acceptable way to pay for the bill, but we were able to make a positive contribution to this debate. We crafted a sense of the Senate resolution that puts the Senator on record on two important points: The first is that, based on current economic forecasts, we believe this will be the last extension of the Emergency Unemployment Compensation Program. Second, we believe the administration should come forward with a proposal to reform the Unemployment Compensation Program at the earliest possible date. This resolution was adopted with bipartisan support and the support of the administration.

The final point I would make is this: We will never get the deficit under control until we are willing to control entitlement spending. It is no secret that this bill has the votes to pass, but it is important to establish a record. We hear a lot of tough talk about the deficit, but actions speak louder than words.

Mr. President, we can do better. We should do better. The least we should be able to do is prevent this spending increase from adding to the deficit.

Mr. BIDEN. Mr. President, I am relieved that we are finally about to pass an extension of long-term unemployment benefits.

In my own State of Delaware, we know how important this legislation is. In recent years, we have been more fortunate than many other States, having an unemployment rate that remains below the national average. Nevertheless, we have not been immune to the forces at work throughout our country's economy.

In fact, in recent weeks, Delaware's unemployment rate rose substantially, to the highest point this year, 5.4 percent. This amounts to a 4-percent increase in the number of Delawareans out of work.

These unhappy statistics are just more proof that our Nation's economy is undergoing fundamental changes, changes that challenge the assumptions and policies of the postwar era. Among these changes, Mr. President, it is particularly frustrating that we continue to see layoffs by our country's major corporations even as falling interest rates and healthy corporate profits give us reason to believe that we are entering a period of stronger growth.

For every two steps forward our economy takes, these continuing layoffs force us one step back.

And, Mr. President, for each of those impersonal numbers we read every week, there are hundreds of thousands of Americans whose families are thrown into the tragic circumstances of unemployment. More than at any other time, Americans find themselves unemployed for prolonged periods.

That is why this bill is so necessary, and why I opposed amendments that would only slow down the assistance unemployed Americans so desperately need.

But now, Mr. President, two important tasks remain. The first is to overhaul our Unemployment Insurance Program to assure that we no longer must drag out this process through a continuing series of temporary fixes. One benefit of this most recent debate has been the recognition of this need.

The second, and more important task, is to overhaul the economic policies of the postwar period—and the assumptions behind them—that are now so obviously out of date. To restore our economy to the healthy levels of growth we need will require more imagination, and more fundamental choices, than extending the funding for unemployment programs.

THE UNEMPLOYMENT COMPENSATION EXTENSION BILL

Mr. MACK. Regrettably, I must vote against the bill in the form it has been presented to the Senate. It is unfortunate because I support the extension of emergency benefits. There are many needy Americans who desperately need this unemployment assistance.

However, the problem with the legislation in front of the Senate today is the way which it pretends to pay for cost of this relief. In fact, this legislation requires State governments to create new reemployment services at substantial costs to State taxpayers. It's just wrong to add new unfunded mandates on States.

It is clear the majority and the administration could pay for this legislation if they chose to do so. If this legislation is a priority—and I think it should be—then there ought to be lower priority spending which could be eliminated to pay for it. In fact, just yesterday, the administration sent to the Congress a package of reforms, including cost cutting measures, which could have easily paid for this legislation.

If Congress wants to help Americans in a responsible manner, we should stop deficit spending.

The PRESIDING OFFICER. The bill is open to further amendment. If there be no further amendment to be proposed, the question is on the engrossment of the amendments and the third reading of the bill.

The amendments were ordered to be engrossed and the bill to be read a third time.

The bill was read the third time.

Mr. WELLSTONE. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The bill having been read the third time, the question is, Shall it pass? On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The bill clerk called the roll.

Mr. FORD. I announce that the Senator from California [Mrs. BOXER], and the Senator from California [Mrs. FEINSTEIN], are necessarily absent.

I further announce that, if present and voting, the Senator from California [Mrs. FEINSTEIN], would vote "Aye."

Mr. SIMPSON. I announce that the Senator from Minnesota [Mr. DURENBERGER], is necessarily absent.

I further announce that the Senator from Kentucky [Mr. MCCONNELL], is absent due to an illness in the family.

The result was announced—yeas 76, nays 20, as follows:

[Rollcall Vote No. 342 Leg.]

YEAS—76

Akaka	Cochran	Harkin
Baucus	Cohen	Hatch
Bennett	Conrad	Hatfield
Biden	D'Amato	Heflin
Bingaman	Daschle	Hollings
Bond	DeConcini	Hutchison
Boren	Dodd	Inouye
Bradley	Domenici	Jeffords
Breaux	Dorgan	Johnston
Bryan	Feingold	Kassebaum
Bumpers	Ford	Kennedy
Burns	Glenn	Kerry
Byrd	Gorton	Kohl
Campbell	Graham	Lautenberg
Chafee	Grassley	Leahy

Levin	Nunn	Shelby
Lieberman	Packwood	Simon
Lott	Pell	Simpson
Mathews	Pryor	Specter
Metzenbaum	Reid	Stevens
Mikulski	Riegle	Thurmond
Mitchell	Robb	Warner
Moseley-Braun	Rockefeller	Wellstone
Moynihan	Roth	Wofford
Murkowski	Sarbanes	
Murray	Sasser	

NAYS—20

Brown	Faircloth	Mack
Coats	Gramm	McCain
Coverdell	Gregg	Nickles
Craig	Helms	Pressler
Danforth	Kempthorne	Smith
Dole	Kerrey	Wallop
Exon	Lugar	

NOT VOTING—4

Boxer	Feinstein
Durenberger	McConnell

So the bill (H.R. 3167), as amended, was passed.

Mr. MITCHELL. Mr. President, I move to reconsider the vote.

Mr. FORD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. MITCHELL. Mr. President, I move that the Senate insist on its amendments, request a conference with the House on the disagreeing votes of the two Houses, and that the Chair be authorized to appoint conferees.

The motion was agreed to, and the Presiding Officer appointed Mr. MOYNIHAN, Mr. BAUCUS, and Mr. PACKWOOD conferees on the part of the Senate.

Mr. MITCHELL. Mr. President, I thank my colleagues for their cooperation in completing action on this important measure. Unfortunately, it took a lot longer than should have been the case. In any event, we have completed action.

Rollcall votes remain possible today, as there are other measures upon which action must be taken before we recess for the day. I repeat, so that Senators are on notice and fully aware, that rollcall votes remain possible today, as we will have to take action on other measures before recessing for the day.

(At the request of Mr. MITCHELL, the following statement was printed in the RECORD.)

• Mrs. FEINSTEIN. Mr. President, for the vote on final passage of H.R. 3167 I was en route to California to lend my assistance with the Federal response to the catastrophic fires in southern California. Had I been present, I would have voted "aye" on passage of the unemployment benefits extension bill.•

EXPRESSING THE SENSE OF THE SENATE THAT THE DEPARTMENT OF LABOR SHOULD PROVIDE RESOURCES TO COVER CERTAIN COSTS

Mr. MITCHELL. I now ask unanimous consent that the Senate proceed to the consideration of Senate Resolution 159, submitted earlier today by Senators COVERDELL and KEMPTHORNE, that the resolution be agreed to, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the resolution (S. Res. 159) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, is as follows:

S. RES. 159

Resolution expressing the sense of the Senate that the Department of Labor should provide adequate resources to the States to cover the costs of developing and implementing the worker profiling system and should provide the Governors with adequate flexibility to ensure that the funds appropriated will be made available to provide reemployment services for profiled claimants.

Whereas Federal regulation of State and local governments has become increasingly extensive and intrusive in recent years;

Whereas such regulation has, in many instances, adversely affected the ability of State and local governments to achieve their independent responsibilities and meet their established priorities;

Whereas such regulation has forced State and local governments to use existing revenue sources or generate new property tax revenues to enable them to adhere to Federal mandates;

Whereas the resulting excessive fiscal burdens on State and local governments also undermine the ability of State and local governments to attain the goals of Federal regulations;

Whereas over 1,000 mayors through the United States Conference of Mayors recognized October 27, 1993, as National Unfunded Federal Mandates Day to call the attention of Congress to the fiscal emergency facing local governments as a result of the onslaught of Federal unfunded mandates;

Whereas support was given to the National Unfunded Federal Mandates Day by the National Association of Counties, the International City and County Management Association, the National Governors' Association, the National Conference of State Legislatures, and the Council of State Governments;

Whereas the report of the National Performance Review, issued September 7, 1993, states that "the President should issue a directive limiting the use of unfunded mandates by the Administration," and recommends that "Congress refrain from this practice"; and

Whereas the States must have adequate resources to implement effectively any new requirements placed on them by Federal laws and regulations: Now, therefore, be it

Resolved, That it is the sense of the Senate that the Department of Labor should provide adequate resources to the States to cover the costs of developing and implementing the worker profiling system and should provide the Governors with adequate flexibility to ensure that the funds appropriated will be made available to provide reemployment services for profiled claimants.

Mr. COVERDELL. Mr. President, this Senate resolution states that the U.S. Department of Labor shall provide adequate resources to the States to cover the costs of development and implementation of the worker profiling program and provides that the Governors have adequate flexibility to ensure that the Federal money appropriated will be made available to provide the reemployment services to which profiled claimants are referred.

There is a certain irony that as we recognize National Unfunded Federal Mandate Day 1993 and the burdens mandates placed on States and local communities, the Senate would be debating a measure that could add a mandate or greater burden on our States and local communities.

Today, rallies and press conferences have been held throughout the Nation to call the attention of Congress to the fiscal emergency facing local governments as a result of the onslaught of Federal unfunded mandates.

On the surface it is easy to see how the Federal Government got into this mess of unfunded mandates. Congress and the Federal Government have spent every dime they have, and over $4 trillion they don't have, to carry out their unending desire to spend, spend, and spend. Now Congress has turned to local communities and has begun a full scale raid on property taxes in their hunt for more dollars.

The result is that States and local communities have less control over their own resources and must dig deeper and deeper to pay for Federal regulations the Federal Government won't pay for itself.

Mandates, however, cost more than money. They cost jobs.

It is time for Congress to take fiscal responsibility for the measures it passes. If we truly believe a worker profiling system should be established, then we must pay for it. We cannot continue to pass measures while passing the costs of implementation on to others. We are in the process of bankrupting our States and local governments.

This resolution is a start at bringing discipline to our spending habits.

Mr. KEMPTHORNE. Yesterday, all across the Nation, mayors, city council members, county commissioners, and State officials demonstrated in their local communities. They demonstrated to educate their citizenry on the intolerable practice of this Congress of imposing unfunded Federal mandates on local governments.

On Tuesday, this week, I met with a bipartisan delegation of mayors and county officials, including Mayor Richard Daley of Chicago and Mayor Jerry Abramson of Louisville, who have expressed support for my bill, S. 993, the Community Regulatory Relief Act of 1993. Their message of support for S. 993, the Community Regulatory Relief Act of 1993. Their message of support for S. 993, mirrored by local officials across the country on National Unfunded Mandates Day, was very simple. Congress is breaking the backs of American cities by imposing a hidden 12-percent tax on local governments.

The Congress of the United States has the right to decide that, in the national interest, national standards and national priorities dictate the imposition of mandates. I recognize this need. However, I reject the reasoning that because the U.S. Treasury is broke, we can rob from the treasuries of local communities and States to fulfill our promises. I reject the premise that Congress should require States and local communities to ignore the critical needs in their own communities to pay for Federal dictates. I reject the invisible hand of the Federal Government reaching into the pockets of the American taxpayers under the guise of local property or sales taxes.

I believe that there is a rising tide in America. A fresh current of revolt which is changing the political landscape and shaping the debate of the nineties. A rebuking of unfunded Federal mandates has crept into the language of Congress. You hear it every day on the floor of the Senate and House Legislators decry the imposition of unfunded mandates and vigorously oppose the label on legislation they offer. And yet, some still don't get it. Those of us committed to educating the mandate makers on the Hill must continue to scrutinize legislation to make sure that the burden on local government is reduced.

That is why I want to congratulate my colleague, Senator PAUL COVERDELL, for his leadership and partnership on this resolution.

As written, H.R. 3167 would make mandatory to States, without funding provided in the bill, a system of worker profiling designed to identify claimants who will need assistance services. This is, by any definition, an unfunded Federal mandate. The resolution is clear. It expresses the sense of the Senate that the Department of Labor provide to the States the moneys necessary to cover the costs of developing and implementing the worker-profiling system.

The requirement contained in this sense-of-the-Senate resolution is not opposed by the Department of Labor. Funding for this provision was suggested in a letter by Secretary of Labor Reich on October 5, 1993. But the issue, the critical issue, is, that no one thought to provide for that funding in the bill. If the funds are identified, if an agreement has been reached, why can we not go the next step and provide the funds needed so we do not further burden the American taxpayer?

There is only one American taxpayer. There is not a Federal taxpayer and a State taxpayer and a local taxpayer. There is just one packet. And this Congress must have the courage, if we are to impose new standards on the people, to own up to the cost of that standard. If its purpose is so pressing and just, we must lead the people to see its rationale. But just the same we must stop imposing mandates and begin a national debate of our national priorities and stop ignoring the impact of our acts on those who must carry out our legislation.

MORNING BUSINESS

Mr. MITCHELL. Mr. President, I now ask unanimous consent that there be a period for morning business with Senators permitted to speak therein for up to 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

IRRESPONSIBLE CONGRESS? HERE IS TODAY'S BOXSCORE

Mr. HELMS. Mr. President, anyone even remotely familiar with the U.S. Constitution knows that no President can spend a dime of Federal tax money that has not first been authorized and appropriated by Congress—both the House of Representatives and the U.S. Senate.

So when you hear a politician or an editor or a commentator declare that "Reagan ran up the Federal debt" or that "Bush ran it up," bear in mind that it was, and is, the constitutional duty of Congress to control Federal spending. Congress has failed miserably in that task for about 50 years.

The fiscal irresponsibility of Congress has created a Federal debt which stood at $4,415,934,724,518.77 as of the close of business yesterday, Wednesday, October 27. Averaged out, every man, woman, and child in America owes a share of this massive debt, and that per capita share is $17,192.06.

SENATOR ROBERT PACKWOOD

Mr. BRYAN. Mr. President, the Senate Ethics Committee is asking the Senate to vote to proceed to U.S. district court to enforce compliance with a subpoena for documents from Senator ROBERT PACKWOOD.

On February 4 of this year, the Ethics Committee announced it was conducting a preliminary inquiry of Senator PACKWOOD concerning allegations of sexual misconduct, attempts to intimidate and discredit the alleged victims, and misuse of official staff in efforts to intimidate and discredit. Since that time, the committee has been conducting a thorough inquiry. The committee had announced that it anticipated completing the preliminary inquiry by the end of October. Regretfully, the committee has encountered a roadblock to its efforts, and has been forced to come to the Senate.

A subpoena was issued by the Ethics Committee and signed by the chair and vice chair on Wednesday evening, October 20. The subpoena was made necessary when Senator PACKWOOD halted the ongoing review of his diaries to which he had earlier agreed.

Let me recount the events leading to this point. On March 29, the committee issued a document request to the Senator seeking documents relevant to the committee's preliminary inquiry. As the inquiry progressed, the committee needed additional materials, and a second document request was issued on July 16. In response to these two requests, the committee did not receive any pages or material from the diaries. The committee was aware of the possibility of the existence of the diaries; however, the committee assumed in good faith that Senator PACKWOOD would comply with the two document requests and provide information from the diaries if there was relevant information. The committee did not receive such diary material, and had no cause at that time to believe the diaries contained relevant information, since they had not been provided under the document requests.

On October 5 and 6, the Ethics Committee counsel conducted a deposition of Senator PACKWOOD. During the questioning, Senator PACKWOOD under oath testified that information relevant to the committee's inquiry was contained in the diaries. Senator PACKWOOD also said he might one day use the diaries to write a book. The committee realized that Senator PACKWOOD, by not turning over the diaries earlier, had not complied with the document requests. The deposition was halted. The Ethics Committee concluded it needed the diaries before it could complete the deposition of Senator PACKWOOD. Negotiations began between committee counsel and Senator PACKWOOD's counsel as the committee sought access to the diaries.

To respect the private nature of certain information in the diaries, the committee offered to allow the Senator's attorneys to mask with tape portions of the diaries dealing with attorney-client privilege, physician-patient privilege, and personal and private family matters. The Senator's attorneys would judge what information fell into each category. They would then deliver the masked diaries to the committee counsel. The committee staff would, in the presence of the Senator's attorneys, then review each volume. The committee staff would not take notes or make copies. Committee staff would mark pages of each volume which they wanted copied. The attorneys for Senator PACKWOOD would then take the diaries back to their office to copy the marked pages. At no point in this process would the committee retain physical possession of the diaries.

This process was agreed upon by Senator PACKWOOD himself, as well as his attorneys. From October 12 to 16, the committee reviewed some 5,000 pages of the diaries covering a period of 20 years.

On Sunday, October 17, while reviewing the diaries under the original

agreement, the committee counsel came across information indicating possible misconduct by Senator PACKWOOD unrelated to the current inquiry. This information raised questions about a possible violation of one or more laws, including criminal laws. Committee counsel brought this information to the attention of the chair and vice chair.

On Monday morning, October 18, Senator PACKWOOD'S attorneys expressed concern that the Ethics Committee might consider additional potential violations. Late Monday afternoon, his attorneys informed the committee that no copies would be made of the material seen the day before, and that no more diaries would be delivered for committee review until additional material was masked, thus breaking the original agreement.

The committee refused to agree to this change in the agreement, and did not agree to the Senator's counsel's request to not pursue the information reviewed on October 17 which raised questions of other possible violations outside the ongoing inquiry.

The committee then proposed that a hearing examiner be brought into the process. Under the proposal, Senator PACKWOOD would turn over the remaining diaries to the examiner. The examiner would ensure that the only masked material would be material related to the three categories in the original agreement—attorney-client and physician-patient privilege and personal and private family matters—and would then allow the committee counsel to review the unmasked material. The diaries would be returned to the examiner for safekeeping.

Senator PACKWOOD'S counsel rejected the committee's proposal, and again refused the turn over copies of the material reviewed on October 17 and the remaining unreviewed diaries. Let me point out here that information supplied to the Senate and to the media by Senator PACKWOOD'S attorneys seems to indicate that Senator PACKWOOD'S attorneys were willing to turn the diaries over to a hearing examiner. What has not been made clear is that Senator PACKWOOD'S attorneys stipulated that neither the hearing examiner nor the committee would receive those portions of the diaries that would raise questions of other possible misconduct, and that they would mask additional material. In addition, they were not willing to provide any diary material unless the committee agreed not to pursue as part of this inquiry evidence of other possible misconduct reflected in the diaries.

The committee told Senator PACKWOOD that the committee could not agree to this limitation on its responsibility, and that the diaries must be produced under the original agreement or the committee would take steps to subpoena the documents.

On the evening of October 20, the committee issued a subpoena for the diaries. The subpoena required that the diaries from January 1, 1989, to the present be provided immediately to a hearing examiner. At approximately 9:30 a.m. on October 21, the subpoena was served on Senator PACKWOOD and his attorneys. Senator PACKWOOD'S attorneys were told that if the documents were not produced, the committee intended to meet later in the day to consider a resolution to the Senate to compel compliance with its subpoena.

After discussion during the day failed to convince Senator PACKWOOD to produce the diaries, the committee met at 5 p.m. on October 21, and voted unanimously to seek a Senate resolution to go to court if the documents in question were not produced by 7:30 p.m. Senator PACKWOOD'S attorneys were so informed. When the documents had not been produced by 7:30 p.m., the chair and vice chair prepared to go forward, and the resolution was introduced.

Since then, a statement has been issued by Senator PACKWOOD'S attorneys which is misleading. In addition, Senator PACKWOOD made a statement on the Senate floor which included inaccurate information.

Let me recount the events leading to this point:

Senator PACKWOOD relied on material from his diaries as part of his deposition. The Ethics Committee then asked for access to the diaries.

The committee reached an agreement with Senator PACKWOOD which allowed the committee to review the diaries with attorney-client, physician-patient, and personal and private family matters taped over, in order to respect the private nature of that material. The committee reviewed some 5,000 pages, covering a period of 20 years.

There was no agreement, as one of Senator PACKWOOD'S attorneys has erroneously claimed, that if the Ethics Committee saw information which could indicate possible violations of rules or laws outside the inquiry underway, the committee would not pursue such material. Quite the opposite. Ethics Committee counsel specifically informed the Senator's attorneys that if the committee saw information related to possible other misconduct, the committee would be compelled to pursue that material.

Senator PACKWOOD'S attorneys broke off the committee review of the diaries only after committee counsel found information which may—and I emphasize may—indicate possible misconduct unrelated to the inquiry underway and which raised questions about possible violations of criminal laws. Committee counsel brought this information to the attention of myself and Senator MCCONNELL, and we took it to the full committee.

The Ethics Committee is not interested in the personal, consensual sexual relationships of any other Senator or Member of the House. The new information which the committee is attempting to pursue is related to actions by Senator PACKWOOD. No committee counsel removed tape, as the Senator charged on the Senate floor, so the counsel could see the name of a Democratic official written about in the diaries. Senator PACKWOOD later corrected this misstatement in the official version of the CONGRESSIONAL RECORD. However, the committee counsel is owed an apology for this untruthful charge, which was widely played in the media.

Senator PACKWOOD'S diaries were maintained in his Senate office, and for many years were transcribed by his Senate-employed secretary. They are not strictly personal, handwritten diaries. Senator PACKWOOD told the committee that he was considering using the diaries to write a book.

The question before the Senate is, Will the Senate of the United States back up its own Ethics Committee, which voted unanimously to ask the Senate to enforce its subpoena of documents from Senator PACKWOOD. The committee seeks these diaries for two reasons: Because the committee knows they contain information relevant to an ongoing preliminary inquiry, and information which suggests other possible violations of rules and/or laws. The Ethics Committee and the Senate cannot permit a Senator to withhold information related to possible violations and misconduct. Nor can it permit the Senator to determine what is relevant under these circumstances.

There is no constitutional right being violated. There is no witchhunt or fishing expedition underway. The Ethics Committee has no interest in pursuing information related to the private lives of Members of Congress.

It would have been far easier on the members of the Ethics Committee to have taken another course. However, we chose to do what we believe is our duty, and we stand united behind that action. The Ethics Committee is simply doing its job of conducting a thorough and creditable inquiry. The Senate and the public should settle for no less.

The Ethics Committee voted unanimously to ask the Senate to go to court to enforce the committee subpoena to obtain documents from a Member of the Senate. I regret we are in this position, but we cannot look the other way. It is essential for the Senate to support the Ethics Committee to preserve the integrity of the institution and the ethics process.

THE PRESIDENT'S HEALTH CARE REFORM PLAN: THE HEALTH SECURITY ACT OF 1993

Mr. PRYOR. Mr. President, late last month, President Clinton described for

the Congress and the American people his plan to reform our Nation's ailing health care system. And this week, he has presented the Health Security Act of 1993 to the Congress. The President and the First Lady have worked tirelessly to produce an impressive health care reform proposal. Finally, we have a President who has shown the leadership needed to fix our flawed health care system. Finally, all people will have the security of guaranteed, comprehensive benefits. The presentation of the bill is a first step toward tackling a complex problem, and I applaud the President's goal of making our health care system work—not just for some Americans, but for all Americans.

Just last week I received a letter from Andrea Mann, a young woman from Benton, AR. She is unemployed, and her husband works for a small business. Even if they could afford it, she cannot find an insurance company that will provide her with insurance because of some previous medical problems. Mrs. Mann is eager to start a family—but not without health insurance—so she wanted to see when the President's plan would pass. She wrote, "I am literally waiting on a family while Washington argues this issue." I am hopeful that the Congress will take swift action on health reform so that Andrea Mann, and many like her across the country, will not have to wait any longer to start their families, or get that checkup they have been putting off, or the surgery they need but cannot afford.

The unveiling of the President's bill marks the beginning of what is sure to be a lengthy, yet productive, process. Some are saying this plan goes too far, and others are saying that it does not go far enough. However, I believe nearly everyone agrees that the health security plan is a strong start in the right direction which strives to fix what is broken in our system and preserve what is best about American health care.

This health care reform initiative once and for all gives us an opportunity to provide health security for all Americans. I look forward to achieving this goal and plan to work with all interested parties—not only the administration and my colleagues in Congress, but also consumers, older Americans, hospitals, doctors, nurses, pharmaceutical manufacturers, the States, and many others. And in the development of this legislation, you can be sure that I will work to balance the needs and concerns of all involved while working to guarantee health security for all Americans. In the wake of many divisive national debates, I am hopeful that this one will bring our Nation together and make our democracy a stronger one.

Mr. President, the cost of doing nothing far outweighs the cost of the proposed plan—both in financial and human terms. Recognizing that, certainly some aspects of the plan need additional review. My statement today is an effort to comment on just a few aspects of the President's plan.

PRESCRIPTION DRUG COVERAGE

I am pleased to see that the President's plan would expand prescription drug coverage to the some 72 million Americans—including millions of older Americans—that do not have any way to pay for the drugs that keep them healthy and alive. Prescription drugs are one of the most cost-effective medical tools that we have at our disposal, yet because of the lack of public and private insurance coverage and skyrocketing medication prices, too many Americans have had to make the unfortunate choice between buying drugs and food.

The proposed Medicare prescription drug benefit would certainly help a 68-year-old woman with cancer from Russellville, AR, who recently wrote to me. She wrote that her medication bills sometimes force her to go without food because such a large part of her monthly check goes to pay for drugs. The Medicare drug benefit will also help an elderly couple in North Carolina—both of whom are very ill and cannot afford all the medications that they need. Their daughter wrote to me, "My parents often do without their medications. They have worked all their lives, have raised seven children, and they do the best with what they have * * *" This Medicare drug benefit will put an end to these heartbreaking stories.

While I applaud the plan for recognizing that pharmaceutical cost containment is long overdue, I am not convinced that the plan goes far enough. For example, the plan does not propose any meaningful pharmaceutical price restraint during the period of transition to the new system, when millions of older Americans will still be very vulnerable to significant prescription medication costs. While the establishment of an Advisory Council on Breakthrough Drugs to review new drug prices is a step in the right direction, it does not appear that the Council has any real power. The plan, however, does incorporate meaningful pharmaceutical cost containment principles into the Medicare drug program. That is only fair, since Medicare will be the largest prescription drug program in the Nation.

I am pleased that the plan increases Federal support for research and development of new pharmaceuticals and treatments for the medical challenges that we face today, such as Alzheimer's cardiovascular diseases, and AIDS. The plan will also help to cover the cost of clinical trials, which is often the most expensive part of the new research and development process. In summary, the plan does a good job on expanding drug coverage, but falls short on the cost containment side. I will work to see that reasonable mechanisms are included in the final legislation to assure that research and development incentives are preserved, while the prices that Americans pay for these drugs are fair.

THE PRESIDENT'S PLAN AND THE ELDERLY

The President's plan will benefit our Nation's elderly in many different ways. Just like all citizens, they stand to benefit significantly from overall reductions in the cost of care expected to result from efficiencies in the new system. These efficiencies will likely translate into slower increases in Medicare premiums and copayments. His plan also includes the two things that senior citizens in this country need the most—prescription drugs and long-term care.

As far as Medicare is concerned, the elderly will see little difference initially in where, how, or from whom they receive their health care. Although Medicare will remain a separate program, there will be additional choices and options available to both beneficiaries and States. For example, once a State's system is established, it will have the option to include everyone, including Medicare beneficiaries, under one system. If a State chooses to do this, the coverage it provides must be greater than or equal to Medicare, at no additional cost to the Medicare program or the Medicare beneficiary. In addition, those older people who become newly eligible for Medicare will have the option to remain in their health plan provided through the alliance, or enroll in the Medicare Program.

Our Nation's elderly and disabled and their families will rest easier knowing that the President's plan also includes long-term care. Currently, millions of people go without needed support and services in the home and community because little or none are available. And once their physical and financial resources are nearly exhausted, they must further impoverish themselves to become eligible for Medicaid nursing home coverage. This desperate situation was articulated again and again by witnesses of all ages and walks of life at a hearing held by the Special Committee on Aging this past spring. No one made the point more eloquently than Walter Dawson, age 10, who because of his father's Alzheimer's disease, knew more about home care and nursing homes and Medicaid and the terrible toll that this disease takes on families than any of us would ever wish to know.

The President's plan emphasizes home and community-based care, including a broad array of services such as home health care, adult day care, and respite services. These services would be available to those who meet certain disability requirements, with some cost-sharing based on income.

The Medicaid Program for nursing home residents will remain the same, with some long-needed improvements. The plan gives States an option to allow nursing home residents to keep $12,000 in assets before they spend-down to Medicaid eligibility, compared to $2,000 currently. And, once they are eligible for Medicaid, residents are permitted to have $70 each month for their personal needs, as compared to $30 each month currently. There will also be significant improvements to the private long-term care insurance market, providing consumer protections with tax clarification to encourage employers to offer this type of insurance to their workers.

The plan also requires all States to have what is called a medically needy program for Medicaid nursing home care. This basically means that anyone whose income is insufficient to pay for nursing home care will be eligible for Medicaid. Recently, my office heard from Mrs. Ann Clem of Little Rock whose mother, a nursing home resident, made $1 over the Medicaid income eligibility limit. However, she was still about $400 short of having enough to pay her nursing home bill. If Arkansas had a medically needy program, Mrs. Clem and her siblings, who have families and responsibilities of their own, would not have to scramble every month to come up with the extra money her mother needs to stay in the nursing home.

This country's elderly and disabled have gone for too long without an affordable, broad-based long-term care program. I am very pleased that the President included those critically needed benefits in his health reform plan. Earlier this year, young Walter Dawson began writing letters to people all over the country to let them know not only about his personal situation, but also to educate them about the plight of millions of families just like his. We all need to follow Walter's example—it is our duty to educate one another on the great need for these services.

The new long-term care and prescription drug programs will be paid for by savings achieved by slowing the growth of the Medicare Program as well as beneficiary premiums and copayments and deductibles. I am hopeful we can achieve savings in the Medicare Program without cost-shifting or reducing access to care. We also need to ferret out fraud, waste, and abuse, reducing the administrative burdens currently on providers and beneficiaries, and identifying those components of the Medicare Program that could operate more efficiently. I do believe that Medicare beneficiaries and the providers who serve them will benefit from a reformed health care system.

The Health Security Act will assist early retirees, as well. Millions of retired Americans are at risk of losing their health benefits as companies are cutting back benefits to control their rising health care costs. Those persons retiring between ages 55–65, at which age they become eligible for Medicare, and who have worked for at least 10 years, will be subsidized for their employers' share of their premiums. If employers elect to provide retiree health benefits, they will pay the employee's share of the premiums. Relieving employers of this burden will greatly lower their early retiree health care costs.

HEALTH CARE IN RURAL AREAS

Mr. President, our Nation's rural residents will also benefit under the reforms planned for our health care system. Many people living in rural areas struggle on a routine basis to find basic medical care. Doctors are scarce in rural areas. Only 13 percent of our Nation's doctors are set up in rural practices. Critical shortages exist as well in the number of nurses, dentists, psychologists, and other health professionals in rural practice.

The President's plan will provide a number of incentives to draw providers into rural practice and improve access to health care in rural areas. The plan will include tax incentives for health care providers, retraining and scholarships, increased reimbursement for services, and loan forgiveness programs.

The plan will strengthen the infrastructure for care in rural areas by strengthening the public health system. Public health departments provide a great deal of care to those who might otherwise be denied access to the health care system. We anticipate that the plan will significantly increase the size of the National Health Service Corps, sending more corps doctors and nurses into rural communities where they are so desperately needed.

Through these and other measures, the Health Security Act will make a positive contribution to the health care available to rural Americans.

NEEDED REFORMS TO THE INSURANCE MARKET

Last year I received a letter that has stayed in my mind. The man—who wished to remain anonymous—wrote: "Dear Senator Pryor: I am embarrassed to write you this letter. For the first time in my life, I have recommended that a child of mine lie." This man's note tells about his 35-year-old daughter from Jonesboro, AR. Because of a previous medical condition she had in her 20's, she was repeatedly denied health insurance because of medical underwriting by insurance companies. Out of desperation for this child to have insurance, this man felt he had no other option but to tell her to engage in a falsehood.

I believe that no person should be made to feel like a criminal in order to get health insurance. Under the President's plan, people would no longer be denied health insurance because of a so-called pre-existing condition. No longer will insurance companies get to pick and choose whom they cover. Other important insurance market reforms in the President's plan include: Community rating, where premiums may only vary by family size and geographic area; Guaranteed issuance of coverage, where everyone is guaranteed coverage that can't be canceled or curtailed; and, Guaranteed renewability, where people can drop their insurers, but insurers cannot drop them.

No longer will health plans be able to deny coverage to a person based on his or her health, employment status, or financial status. Consumers will not be charged more because of their age, employment status, medical condition, or risk. Employees who develop a serious illness cannot lose coverage as a result, nor will health care coverage for their coworkers be threatened.

SMALL BUSINESS UNDER THE PRESIDENT'S PLAN

Today, our health care system is stacked against small business. Insurance companies charge small businesses as much as 35 percent more than the big ones. The President's plan will bring significant relief to small businesses who have been straining under the burden of ever-rising health care costs. In fact, the Wall Street Journal said the plan will provide "an unexpected windfall" for small business.

Recently I heard from a small business owner in Little Rock. She told me that she spends hours upon hours each year searching and negotiating for the best health insurance plan for her employees. Under this plan, this type of administrative burden will be eliminated. In Arkansas, where the majority of our businesses have fewer than 25 employees, the President's plan will bring greatly needed relief.

Insurance practices which lead to discriminatory and higher costs for small business will end—no more cherry-picking. Also, the Health Security Plan provides for a permanent 100-percent tax deduction for the self-employed. The President's plan will ensure that small businesses don't get hit with premiums they can't afford.

Contributions from small business will be eligible for caps varying from 3.5 percent to 7.9 percent of payroll, depending on the employer's average wage. Today, many employers are paying over 10 percent of payroll for their health insurance. Having said that, Mr. President, this remains an area that I intend to closely monitor to minimize any negative impact the plan might have on small business. This issue is one that we will take a long, hard look at in the coming months.

There are many additional areas of this plan that will be thoroughly debated in the coming months. I believe it will be particularly important to carefully examine the financing and cost elements of the package to ensure that they cover the cost of the provisions and accurately reflect the policy.

It is my hope that this debate continues from this point on in a constructive, bipartisan manner. I look forward to working with all of my colleagues to ensure passage of a health care reform bill that makes our system work for all Americans.

NATIONAL ARTS AND HUMANITIES MONTH

Mr. GRAHAM. Mr. President, the month of October 1993, has been designated as "National Arts and Humanities Month." I would like to offer my support for this occasion by taking a few minutes to comment on the special role that arts and humanities play in our lives.

Support of the Nation's cultural institutions maintains and augments America's cultural traditions while presenting the past and exploring the future. Investment in the arts can foster a greater sense of community by engaging the public in and through the arts.

The arts provides our children with important educational benefits such as a sense of American civilization and the other civilizations that have contributed to it. The arts foster reasoning skills, creativity, effective communication and assistance in making wise choices among the products of the arts.

In addition to their educational and culture roles, arts and humanities hold great economic value. The arts benefits individuals as well as communities through tangible and intangible resources invested in attending performances, exhibitions, art classes, and other activities.

From the panhandle to Miami, arts organizations in my home State of Florida reflect its large multicultural populations. Thriving urban centers and rural areas are all served by traditional as well as contemporary artistic expressions.

The Florida Division of Cultural Affairs and local arts agencies assist artists, strengthen arts organizations, and provide cultural opportunities enjoyed by the people throughout Florida. These investments in our artistic resources enhance and transmit the richness of our Nation's cultural legacy for the benefit and enrichment of present and future generations.

I would like to take this opportunity to mention some of the exciting cultural activities currently taking place in Florida. Directed by Edward Villella, Miami City Ballet is the newest and fastest growing classical dance company in America. Since its inaugural performance in October 1986, the company has presented nearly 70 ballets, including more than 25 world premieres.

The company has been invited to perform throughout the United States as well as Europe, England, Israel, and Central and South America. Notable engagements include the Lyon, France Biennale de la Danse, Wolf Trap Farm Park Festival, the Ravinia Festival, Jacob's Pillow Dance Festival, Dance Aspen, the Chautaugua Festival, The Madison Festival of the Lakes, ArtPark, and the Brooklyn Center for the Performing Arts.

In south Florida, the company claims four home cities—Miami, Fort Lauderdale, Palm Beach, and Naples, on the west coast. Over 15,000 season subscribers see the company in regular series throughout the season. Special series of "DanceTalks" and "Ballet for Young People" as well as exclusive performances for schools are presented, where the physical, human vocabulary of the dance is described and demonstrated. I am pleased to announce that the company will be performing at the Kennedy Center here in Washington in April 1995.

The Museum of African-American Art, located in Tampa, is one of America's newest public art museums and is committed to honoring the continuing growth of African-American history and culture. The opening of this institution marked the 50th anniversary of the Barnett-Aden African-American Art Collection—one of the Nation's oldest chartered collections of African-American art. The installation of the Barnett-Aden collection in this new museum provides a formal and permanent facility to house the treasures of this unique and valuable collection.

It is significant that part of the land upon which the museum is now located was owned by African-Americans in the early 1920's and housed the first black public library for the Tampa community.

The Hispanic Cultural Arts Festival in West Palm Beach, the American Stage Co. of St. Petersburg, and the Philharmonic Orchestra in Ft. Lauderdale, are just a few of the many participants in Florida's flourishing arts community. The number of performing arts companies, museums, arts centers, and other arts organizations has grown to over 5,000 over the past 27 years, with no end in sight. Florida continues to be a cultural dynamo reflected by vibrant arts centers across the State.

Mr. President, I appreciate this opportunity to recognize the importance of arts and humanities in our lives. Through their educational, economic, and cultural manifestations, arts and humanities impact both present and future generations of Americans.

WELCOMING OF TASK FORCE 160

Mr. SASSER. Mr. President, last Sunday, the 24th of October, I was very honored to attend the homecoming of elements from the 160th Special Operations Aviation Regiment, and the 75th Ranger Regiment. They have just returned from Somalia, where they displayed unsurpassed tenacity and valor in combat. Deputy Secretary of Defense Perry aptly described their heroism during Sunday's homecoming ceremony at Fort Campbell, and I ask unanimous consent that Dr. Perry's remarks be included in the RECORD.

There being no objection, the remarks were ordered to be printed in the RECORD, as follows:

REMARKS BY DEPUTY SECRETARY PERRY WELCOMING OF TASK FORCE 160, OCTOBER 24, 1993

Soldiers of the 160th Special Operations Aviation Regiment, night stalkers, 75th Ranger Regiment, and our hosts from the 101st.

It's a real privilege to speak for Senator SASSER, Congressman TANNER, General Sullivan, Secretary Aspin, and President Clinton, to welcome you back home and to thank you. I especially want to convey a heartfelt thank you from President and Mrs. Clinton, who are meeting this morning with your wounded comrades at Walter Reed Hospital.

Thank you for taking on a tough job. And thank you for performing it with great skill and courage.

I also want to express my thanks to the family members. You have endured the separation and the agonizing uncertainty of having loved ones on a hazardous mission in a far away land.

We went to Somalia last December to deliver humanitarian aid. At that time, innocent people were dying on a massive scale. The nation was ravaged by years of brutal civil war and famine. An estimated 1,000 people were dying a day, and 800,000 refugees were forced into exile.

In a few months, we were able to bring order to the country and relieve the famine. We saved untold thousands of lives.

Then, in June, the militia forces under Aideed began attacking U.N. forces in Mogadishu, killing 28 in a few days. All that we had accomplished at that point was in danger of being lost, since the U.N. forces in Mogadishu were unable to deal with the guerrilla warfare that had begun. So our military commander in Mogadishu asked for help. The mission was a tough one, so we sent in the best—Night stalkers and rangers.

You went there to restore security to the city so that Humanitarian aid could resume. And you succeeded—but at a heavy price.

That price was exacted when we lost a Blackhawk on September 28, and again during the firefight in Mogadishu on October 3. That fight demonstrated the skill, discipline, and courage of the night stalkers and rangers.

When two of your helicopters were shot down and the crew endangered, you never hesitated. You continued to fly into the hostile fire. You ran effective fire support to the rangers, who were vastly outnumbered.

From this day forward, no one will recite the rangers creed, "Never shall I fail my comrades," without thinking of your display of courage in Mogadishu on October 3. That day you showed the world that "Night stalkers don't quit".

And we saw your determination and professionalism in Michael Durant, who braved his captors and bore his wounds with quiet courage. As tough and resolute as Chief Durant was, I was equally impressed by the courage displayed by his wife. Her message on national television to remind her husband of NSDQ reminded us of the dedication and support at home. Her courage provided all of us courage.

Because of your skill, discipline, and courage, you stood firm with your comrades and,

although you suffered significant casualties, you inflicted casualties on your attackers many times greater than what our troops suffered. In fact, your actions with the rangers that day effectively disabled Aideed's militia and led directly to his willingness to call for a cease fire and negotiate a political settlement.

I came here today to pay tribute to your courage and to express my deep personal sense of loss at the death of your fellow soldiers. I especially want to extend my sympathy to the families of the soldiers who gave their lives.

Personal hardship is not a stranger to Fort Campbell, and the Nation joins with you once again in your suffering.

When General Sullivan presented the Purple Heart to Chief Durant last week, and told him that he was proud of him, the chief replied, "I am proud to be an American". I can tell the chief and the other night stalkers and rangers, that all Americans are proud of you, and admire your professionalism and skill and all Americans are grateful for your courage and your service to our country.

God Bless you, and God Bless America.

PASSAGE OF EMERGENCY UNEMPLOYMENT BENEFITS

Mr. PELL. Mr. President, I am pleased the Senate has approved legislation to extend the emergency unemployment benefits program that will provide emergency benefits to those suffering from long-term unemployment.

Since the beginning of this month, my Providence office has been inundated with calls from Rhode Islanders who are terribly worried about if and when Congress would approve this very important legislation. I am sure they will sleep just a bit easier tonight.

My home State of Rhode Island has been beset by alarmingly high unemployment. I have a chart in my office that tracks both the national and State unemployment rates. That chart begins in December 1989 and this past July is the first time Rhode Island unemployment has been below the national rate. Unfortunately, August saw the rate again go up above the national average.

Over the span of that chart, Rhode Island's unemployment has been over 9 percent for months on end. In that regard, the long-term unemployed in Rhode Island share the dubious distinction, along with those in Alaska, California, West Virginia, and Puerto Rico, of being eligible for 13 weeks of additional benefits under this legislation. While I am pleased this bill acknowledges the special circumstances in which we find ourselves, I would much prefer a lower unemployment rate.

In conclusion, I was pleased to vote for this bill and I urge the President to sign it into law as soon as possible.

The PRESIDING OFFICER. Who seeks recognition?

Mr. BYRD addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from West Virginia.

LEAVE OF ABSENCE

Mr. BYRD. Mr. President, I make this request on behalf of Mr. HATFIELD.

Mr. President, pursuant to rule 6, paragraph 2 of the standing rules of the Senate, I ask unanimous consent that I be excused from attending the remaining session of the Senate this afternoon and the day of Friday, October 29, 1993, so that I might attend the remembrance ceremony for my friend who passed away, Bill Healy, founder and former President of Mt. Bachelor Ski Area in Bend, OR.

The PRESIDING OFFICER. Without objection, it is so ordered.

Who seeks recognition?

Mr. DORGAN addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from North Dakota.

Mr. DORGAN. Mr. President, I ask unanimous consent to speak for 10 minutes as if in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNITED STATES-MEXICO TRADE AGREEMENT

Mr. DORGAN. Mr. President, I rise today to discuss briefly the subject of the North American Free Trade Agreement, more commonly known as the United States-Mexico trade agreement. I decided it would be instructive to bring to the floor of the Senate a copy of NAFTA because my guess is no one in this body has read it. Probably very few have seen it and most will be surprised to understand its sheer volume.

This is the agreement, and I will not lift it all up, but we have volume 1, volume 2, and annex 3022, some of which is written in Spanish, and 3X322 schedule of Mexico versus the schedule of the United States. Third is a tariff schedule of Canada.

So when you talk about the treaty with Mexico, the trade treaty, that is so controversial it is not a 8½ by 11 sheet of paper on which they negotiated the specifics of trade between our countries. It represents these volumes of specific trade agreements in which a trade negotiator for our country went behind closed doors and negotiated with someone else specific rules under which trade will take place between us and Mexico.

Yesterday or the day before there was in the Washington Post an advertising supplement called Ag for NAFTA. The Ag for NAFTA folks bought a big piece of the Washington Post and put a lot of information in it.

Of course, they would have you believe that these are farmers for NAFTA. It could not be farther from the truth. These are large food processing companies that have gathered under an umbrella called ag and pretended that the family farmers in this country support NAFTA.

The family farmers I represent do not support NAFTA by and large, because they know deep in the bowels of these volumes our trade negotiators lost. I am going to explain the specifics of that in just a moment.

So, Ag for NAFTA, big food processing companies, want NAFTA. Is that a surprise that they do? They would like to access the Mexico market to hire the $1 an hour labor and make money. That is Ag for NAFTA.

NAFTA is a slick idea for those who support the Mexico trade agreement or NAFTA because they have a lot of money. At its heart is the agenda of U.S. corporations to access cheap labor in foreign markets and sell back into the U.S. marketplace. It is about money, money for big economic interests.

Part of this campaign, which again those who are able to wage it can well afford, is illustrated here in an advertisement published in Newsweek Magazine, the New York Times, and other places, by Mobil Oil, and I wanted to just show my colleagues what Mobil Oil said in this long ad. Mobil tells us why the United States-Mexican trade agreement is a wonderful deal.

They say, "Setting aside for a moment the specifics of the agreement itself." Let me say that again. "Setting aside for a moment the specifics of the agreement itself," then they go on to make that case. They would like for us to set aside the specifics of the agreement. They want, some broad theoretical discussion of trade philosophy. After all, at its root this agreement is a series of books like this that on page after page define the rules, and the fact is we lost. We will lose jobs. We will have lost access to markets, and we will have created unfair conditions at least for a decade for many of our producers, including farmers I represent. Let me give you some examples.

Let us just take a look at the United States-Mexican trade agreement through the eye of a french-fried potato, a traveling potato, one that goes from the United States to Mexico, a potato that runs from North to South, and then a Mexican french-fried potato that goes from South to North. And let us ask ourselves how did these negotiators do, the ones who wore the American jerseys when they sat down and got tough on behalf of our interests? How did they do on the french-fried potato? Did the farmers out in my part of the country who raise potatoes do pretty well? Let us look.

Now, when the United States sends french-fried potatoes to Mexico, there is now required an import license and a 20-percent tariff. Under NAFTA, when the United States sends french-fried potatoes to Mexico, we will have a quota and 20 percent tariff over the quota. When Mexico now sends french-fried potatoes to the United States they have a 10-percent duty. Under NAFTA, however, they will have no quota, and the tariff will be terminated in 5 years.

I would ask our negotiator, whoever he or she might be, why did you lose on behalf of our potato growers?

How could you lose that negotiation on french fries? I do not know who they are. They may be working for the Mexicans at the moment.

We have dozens of people who used to work on our trade issues that are now on another payroll working for other folks that want this United States-Mexican trade agreement passed.

Mr. FORD. Will the Senator yield for just a question or comment?

Mr. DORGAN. I am happy to yield.

I just want to say to my colleagues, though, that I am going to come to the good stuff. I am going to go to potatoes and I want to go to barley and finally to beans, because beans is really where the story of the Mexican trade agreement is.

(Ms. MOSELEY-BRAUN assumed the Chair.)

Mr. FORD. Madam President, I want the Senator to know that my farmers are having a tough time with tobacco, and he understands that.

Right now, the tariff for taking tobacco into Mexico is 20 percent of the value of the product. Under NAFTA, guess what? It is increased to 50 percent of the product.

Do you think we are going to sell anything down there? Why, no.

So we have to look at the fine print. The Senator said "in the bowels of the NAFTA agreement." I agree with him.

Mr. DORGAN. I appreciate the comment and question from the Senator from Kentucky.

Let me go on to potatoes. I mentioned french-fried potatoes. Let us take the whole potato. How about the whole potato trade between the United States and Mexico? Same old deal.

I do not know whether it was the same negotiator. The fact is, that person sat down to negotiate and that person lost. We used to be shrewd Yankee traders. I have not found a trade agreement yet that we won in the last 2 decades. Every trade agreement we negotiate, somehow our producers come out on the short end and the largest corporations in the world end up making more money.

Let me talk about potatoes just for a second.

Mexican potatoes to the United States, right now, small tariff. After NAFTA, no quota, 5-year phase out of the tariff.

Potatoes from us to Mexico, a quota. And for all potatoes beyond the quota, a 250-percent tariff.

Who lost on potatoes? Well, perhaps the same person that lost on barley.

We make a lot of things out of barley. We make cereal out of barley. We make some beer out of barley.

So whoever sat down and negotiated barley, here is how well they did.

Right now, if we send barley to Mexico, we have import licenses we confront. We send a certain amount. Under NAFTA, we will be limited to 25.5 million bushels, well below what we now sell in Mexico. So they say you are going to be able to sell less in Mexico, and, if you sell anything over that, a 128-percent tariff will apply. That is right, 128 percent.

Now what about Mexico, if they raise some barley and send it to us? No restrictions; no quota.

So whoever sat down and negotiated barley could not have gotten much sleep the night before.

So, United States farmers got a trade deal on barley that says Mexico to the United States, no quota, no restrictions, no problem. United States barley to Mexico, take what you used to send them, restrict it a fair amount, and then add 128-percent tariff above it.

I do not know what school this negotiator went to, and I do not know what grade this negotiator completed. But I would say, if we can find out who it is, we certainly do not want that person negotiating future trade treaties on behalf of this country.

Beans—navy beans, kidney beans, you name it; dry, edible beans. Plenty of them in this country. We raise plenty of them in North Dakota.

Beans to Mexico. It has been a pretty good market for us. But, under NAFTA, we will have a stiff quota for beans going to Mexico, Navy beans, kidney beans, pinto beans. For beans that we now sell to Mexico over the recent years, NAFTA will impose a 139-percent tariff on all shipments above the quota. However, for Mexican beans coming north, no restrictions, no quota.

Must have been a blood brother or at least a close partner of the fellow that negotiated barley. Same story.

We do not know who they are, but I guarantee you their fingerprints are here in the middle pages someplace.

Now, I have been standing here talking for weeks about what this trade agreement means in terms of jobs. At its roots, NAFTA is: Let us take American corporations to Mexico, buy dollar-an-hour labor and sell the product back into the United States and make more money. That is what the agreement is at its roots.

But Mobil Oil said, let us set aside specifics.

Let me put that chart back up because that is what the supporters of NAFTA want us to do. "Setting aside for a moment the specifics of the agreement itself." That is what they want us to do.

But I will not set aside the specifics. Yes, I will continue to talk about job loss and plant flight and movement of United States manufacturing operations to Mexico, because I think that is a serious problem in this agreement.

But, in the end, and in the final analysis, this agreement is nothing more than thousands of pages of specifics. And deep in these pages are agreements by which we decide what quantity of beans will we sell to Mexico and what quantity of french fried potatoes will they sell in the United States. And that is the basis on which our trade negotiators win or lose.

I would ask President George Bush, were he here, why his administration spent 4 years telling us in this Congress and telling the American people that he steadfastly opposes an industrial policy in America because an industrial policy would amount to the Government picking winners and losers. Why would one be opposed to an industrial policy because it picks winners and losers and then send your folks over to negotiate a trade agreement that in 2,000 pages picks page after page of winners and losers and in which, all too often, those who work for a living in this country, those who get their hands dirty because they get up early and work late raising beans and potatoes and barley, why, when they negotiated winners and losers did they negotiate so many American producers as losers?

This is, after all, a debate about the specifics. No matter how much those corporate interests and those slick advertisers and all those money folks that are trying to stuff NAFTA down the American people's throats, no matter how much they want us to believe that we ought to set aside specifics, we need continually to keep coming to this floor on behalf of the American producers and ask the question: What is in those books? What are the specifics? How did our negotiators perform on behalf of our producers? I am sad to say, Madam President, that our negotiators did not do well.

Let me make one final point, because I know that my friend from Tennessee is waiting to speak today.

We will, in the coming weeks, make a decision about this trade agreement. Most people do not know much about what NAFTA means. But NAFTA means this: NAFTA means jobs; NAFTA means opportunity.

This is a continuation of failed trade policy in which this country has said to the rest of the world, we open our markets to you and we are willing to accept restricted access for us.

We are dismissed, all of us who oppose NAFTA, routinely and continually dismissed as a bunch of uninformed, xenophobic isolationists, protectionists who know nothing and cannot quite see over the horizon. That is the way we are dismissed.

I am sick and tired of being called a protectionist. I do not believe we should put up barriers around this country. I do not believe we should restrict access of goods coming into our country. I do not believe American consumers should be denied access of goods produced anywhere in the world.

I do believe, when we negotiate on behalf of American producers a trade

amendment, that we ought to insist that the rest of the world—Japan, China, and, yes, Mexico—in any trade agreements, play by agreements that are fair.

No longer should we accept trade agreements that tie our producers' hands behind their backs, and send our jobs elsewhere in search of dollar-an-hour wages. That does not strengthen this country. That weakens this country.

Is the main question of NAFTA, as Mobil Oil and all the others would have us believe, an ethereal debate about the doctrine of comparative advantage in economics? Is that what it is really about? Or is it about who wins and who loses, because our trade policies have been bankrupt? This is not about whether the United States can compete. We can compete anywhere in the world. We have some of the best men and women working, some of the best men and women managing. We have some of the strongest and best enterprises in the world. But we cannot compete and cannot succeed unless the trade rules are fair. This trade agreement is flawed. I will not vote for this trade agreement, and I hope sufficient numbers of my colleagues are willing to stand up and say "no," to force this administration to take the product of the Bush administration's negotiation and decide to do it over and do it right.

Canada and Mexico are good neighbors. We want a good relationship with them. But if the lessons from the Canadian agreement are instruction for us, we ought to understand that the free trade agreements can be terribly harmful and hurtful to our producers, and once in law, very difficult to change.

I sat on the House Ways and Means Committee for 10 years. When the United States-Canada trade agreement was presented to us, the vote was 34 to 1. Guess who was the only person on the U.S. House Ways and Means Committee to vote against it? And guess what happened immediately afterwards?

I raised objections about how unfair this was to our grain producers. I got letters from President Reagan, I got letters from the trade ambassador, and I got promises in writing from both the President and trade ambassador. Do you know what? They were not worth the paper they were written on. They were promises never kept, promises forgotten immediately. The result of it was, at least with respect to the United States-Canada trade agreement, immediately after the agreement we began seeing a flood of unfairly subsidized grain coming across the border taking tens of millions of dollars out of the pockets of our farmers. For 4 years I fought to try to deal with it and have not yet been successful.

The instruction in all of that is this: It is very difficult to correct a trade agreement that is bad for this country. The best approach to deal with that trade agreement is to send it back and say, "Renegotiate it, do it over, do it right, and do it so it works for the best interests of this country."

Madam President, I hope in the coming weeks, as we deal with this issue, we will not, as some would have us believe, set aside the specifics. We will, instead, look at the specifics. I have only mentioned four commodities or products here. I would like to look at the specifics over a whole range of areas and decide what do they do and what is our response to it. My response is to say this country deserves better. This country deserves more. Our workers, our businesses, our producers, the American people deserve better than NAFTA.

I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from Tennessee.

Mr. MATHEWS. Madam President, if I could digress for just a moment, I would like to take an opportunity to congratulate the people of North Dakota on the selection they made when they chose BYRON DORGAN as Senator. I have come to respect him greatly in the time that I have been here, and while I differed with him on the question of whether NAFTA is going to be good or bad for this country, I know of no one who can better present the facts about the treaty, no one who can make it possible for the people of this country to better understand the choices we will be making, and that they will be making, than the Senator from North Dakota. I want to congratulate him on that presentation.

Madam President, if I could have permission to speak this afternoon as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH SECURITY ACT OF 1993

Mr. MATHEWS. Madam President, what I would like to do is to talk about President Clinton's Health Security Act.

I rise today as one of the original cosponsors of President Clinton's Health Security Act of 1993.

President Clinton and his administration have delivered—literally delivered—one of the most sweeping and monumental pieces of legislation to any Congress since the Social Security Act.

It is a mammoth bill, both in weight and in weight of its repercussions, for health care is a matter that eventually touches every American.

The goals of this legislation are clear: To guarantee lifetime health care for every American—to constrain runaway costs that threaten to bankrupt every budget—the Federal budget included—to bring coherence to an unwieldy Medicare and Medicaid system buckling beneath its own paperwork—and to preserve the choice and quality of care that make American health care the world's best.

The legislation inaugurating these goals builds upon our current health care system. But it spreads the responsibility just as it widens access and coverage.

It asks employers and employees to share proper responsibility for providing health insurance and for consuming it wisely.

It summons insurance companies to a higher involvement with the public good while reducing legal constraints that prevent doing so.

It reduces the need for physicians and providers to practice defensive medicine. It magnifies the degree of competition and the degree of control in the present system.

It gives States the important prerogative of assuring that their citizens have access to appropriate, affordable coverage and care.

Finally, this new approach recognizes the special needs of the elderly, the disabled, and other groups with singular demands for health care.

And at the same time, this measure also expands support for those who make a special contribution through medical research, teaching, and primary and secondary care.

Despite the merits—even the marvels—of our current health care system, we all know that the United States cannot continue with it in an unchanged form.

Health spending at the current rate will bankrupt us.

We cannot be fiscally prudent, economically competitive, and socially just when some of us pay nothing for the care we receive, when health costs constitute the No. 1 priority in middle-income-family budgets, and when persons in the lower income strata—millions of our fellow citizens—must decide between their medication or their groceries.

We as a Congress know this.

But because we know these things, we also know that the obverse of universal coverage must be universal participation.

We know that those who have profited by their place in the system must expand the system so more have a place in it.

And we know that some American businesses and households may have to shoulder a carefully considered burden in order to assure a greater public good.

That said, however, let us also be fully aware of what we as a Congress are about to do. We owe it to the American people to tell them the system we are about to create is going to do some things differently.

We are about to create a framework that will surround American life for generations—possibly a framework that will exist for the life of the Republic.

We are about to create an eternal obligation that we as a Nation owe ourselves as a people.

When we proclaim that every American has a right to irrevocable lifetime health care, we are creating an entitlement program that is breathtaking in magnitude.

So we have to get this right when we do.

We have to assure that this program is fully and fairly and realistically funded.

We have to assure we are not merely swapping a private sector bureaucracy for a public sector bureaucracy.

The bill we produce has to be decisive and fair and inclusive—no maybes, no favorites, no loopholes, no exceptions.

I am certain the Senate's debate and participation will make that so.

When President Clinton spoke to the Congress, he outlined the principles on which his speech is based. He stirred our imagination and our resolve, and as a cosponsor of this measure I am committed to the kind of comprehensive plan he has proposed.

However, I am not committed to every single aspect of the plan. I realize that we stand only at the beginning of a worthy effort.

I'm sure the coming debate will raise questions and new proposals. Alternative proposals are already on the table. All of them must be considered, and many will deserve being included in the final bill.

I welcome that coming dimension in this process. For as I said, we have to get this right.

Getting things right will be a Herculean task, but no less so than the effort that brought us this far. The Health Security Act of 1993 is a credible and deserving beginning toward filling the need we know is there.

The President and Mrs. Clinton and their team have done their best to do what is right and necessary. The proposal is a good beginning.

Now Congress must do the same.

I know we can, and I know we will—because we must.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

APOLOGY TO MR. BAIRD

Mr. PACKWOOD. I thank the Chair.

Madam President, the other day in speaking on the situation involving the Ethics Committee and the charges against me, I made reference to a Member of Congress and a Senator and sexual affairs they had had.

Obviously—and the way I phrased it—it was my fault because the story has come out that I was threatening to reveal these names if the Senate voted to subpoena my diaries.

I did not mean it in that sense, and if I left that impression, I apologize. Everything that was in the statement put out by my attorneys involving two affairs—the Senator and the House Member—were things that the Ethics Committee had already demanded that we produce, things they had seen in going through my diaries, and we were using them as examples of the kinds of things that the Ethics Committee was asking us for.

So it was not intended to be, "Well, if I have to produce these, I will reveal this." It was meant to be that the Ethics Committee has asked for these things and insist upon their production.

Now I would like to read a statement and then make an apology to Victor Baird, the chief counsel of the committee. This is a statement that was put out by Senator BRYAN today: "The Ethics Committee"—this is part of a statement; I am reading one paragraph.

The Ethics Committee is not interested in any of the personal, consensual sexual relationships of any other Senator or Member of the House. The new information which the committee is attempting to pursue is related to actions by Senator PACKWOOD. No committee counsel removed tape, as the Senator charged on the Senate floor, so the counsel could see the name of a Democratic official written about in the diaries. Senator PACKWOOD later corrected this misstatement in the official version of the CONGRESSIONAL RECORD. However, the committee counsel is owed an apology for this untruthful charge, which was widely played in the media.

I do apologize for my misstatement, and I corrected the RECORD to accurately reflect what happened. But I would like to again state it, and I am going to read from a memo from one of the attorneys at Arnold & Porter, my attorneys, to me involving this particular issue involving the Member of the House of Representatives to which this referred.

In it will appear the name Victor Baird who is the chief counsel and will appear the word "redacting" which is a lawyer's word meaning they take a piece of tape and cover up something they think they are entitled to cover or do not want to be seen.

This memorandum is from Michael Korens to me.

This memorandum memorializes my recollections regarding the page from your diary selected by the Ethics Committee staff which refers to the affairs of a Member of the House Democratic leadership.

The identity of the person was masked with a single-line redacting tape. Victor Baird asked me why the particular lines were masked. I then reviewed the document by removing and reapplying the tape. I told Victor that, consistent with our practice at that time of single-line masking embarrassing references to public figures, we had masked this reference since it related to a prominent Member of the House Democratic leadership. I told Victor that I would remove the tape if he wished. He said that would not be necessary. When we received, from the Ethics Committee, the pages of the diary they wanted copied, that passage was marked as "relevant" for purposes of copying.

That page is now in the possession of the Ethics Committee.

I might indicate how the practice of going through the diaries was being operated at that time.

A member of the Ethics Committee staff and my lawyers would be sitting side by side turning pages of the diary. And the Ethics Committee would note what they might want. We had possession of the diary. At night, we would have the notes and copies of the pages that they wanted copied and we would copy them.

Without waiving any rights, we were going to argue later whether these were relevant or not. We did not waive any rights as to producing them. We gave to the Ethics Committee the page that they wanted.

I hope I have accurately reflected—I was not there—how this happened. I have since read the page. I did not read it then.

To me, although you might have to be active in politics to understand it, even with the name of a person covered up, the references in the paragraph very clearly from the standpoint of politics would indicate who the person was even if you could not see the name.

I am not here in any way charging the Ethics Committee or Victor Baird of having lifted the tape. I was in error when I said that. My attorney lifted the tape, told the counsel, the chief counsel of the Ethics Committee it was a significant—I want to say just what he said—"a prominent Member of the House Democratic leadership."

Later that evening, when we received a list of the pages that the Ethics Committee wanted us to produce for them, that was one of the pages. And they had marked that passage as relevant and wanted it produced. So it is in their possession.

To ease the minds—another subject—to ease the minds, perhaps, of any Senators that may be concerned about the reference to "a Senator"—and I might emphasize that the Ethics Committee has also marked this passage as relevant—but this now falls into the contested area of the time period, and we have not given any documents, but they have seen it and they have asked for it. It is not a sitting Senator. It is somebody who was in this body some time ago but is no longer a sitting Senator.

But I emphasize again, in my lawyer's statement several days ago, he made reference to a variety of items—these being two of them—but other items, and in every instance, they were references to items that the Ethics Committee had already asked us to produce and, therefore, we had to presume at least they thought were relevant to the charges.

I apologize to Mr. Baird for having misstated myself. I did correct the RECORD so that it accurately reflected what happened. But I hope now—and I will ask unanimous consent that this

memo from my lawyer to me explaining how this happened be printed in the RECORD.

There being no objection, the memorandum was ordered to be printed in the RECORD, as follows:

OCTOBER 26, 1993.

From: Michael E. Korens.
To: Senator Packwood.
Subject: Diary issue.

This memorandum memorializes my recollections regarding the page from your diary selected by the Ethics Committee staff which refers to the affairs of a member of the House Democratic leadership.

The identity of the person was masked with single-line redacting tape. Victor Baird asked me why the particular lines were masked. I then reviewed the document by removing and reapplying the tape. I told Victor that, consistent with our practice at that time of single-line masking embarrassing references to public figures, we had masked this reference since it related to a prominent member of the House Democratic leadership. I told Victor that I would remove the tape if he wished. He said that would not be necessary. When we received, from the Ethics Committee, the pages of the diary they wanted copied, that passage was marked as "relevant" for purposes of copying.

That page is now in the possession of the Ethics Committee.

Mr. PACKWOOD. I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Chair, in his capacity as a Senator from the State of Tennessee, suggests the absence of a quorum.

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DOLE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator is permitted to speak for up to 10 minutes.

HEALTH CARE

Mr. DOLE. Mr. President, during the Finance Committee hearing this morning, we were told by the Health Secretary, Donna Shalala, that the extra costs for health care would range from $100 to $500 a year —I am talking about individual increased costs—a small price to pay for the additional benefits and security these people would have.

It was also indicated that maybe 40 percent of the American people would pay more under the Clinton proposal—40 percent of Americans would pay more—60 percent would pay less.

Now, again, these are estimates. The Federal Government always tries to low-ball the estimates. Maybe it is 40 percent who will pay more, maybe it is 50 percent, maybe it is 60 percent who will pay more. And maybe it is 40 percent or 30 percent or 20 percent who will pay less.

It seems to me, as a member of the Finance Committee, if this is the testimony—I do not quarrel with it—I just suggest it is the very reason we need to stop all the hype— everybody is going to get something for nothing; everybody is going to be covered; everybody is going to like the health care plan—and get down to the serious business of looking at the health care proposal of President Clinton and of all the other proposals, Republican as well as Democratic proposals, page-by-page, line-by-line, word-by-word, so that we can get information on how much will it cost. As I said yesterday, with the President, Mrs. Clinton, and others, who wins, who gains, who loses, and how much it is going to cost.

Well, today we have an idea; 40 percent will lose, 60 percent will gain and it is going to cost who knows how much.

I am certain in any other plans some people are going to pay more and some are going to pay less. But this is the kind of information the American people need to have before Congress makes any judgment on any health care plan, whether it is one proposed by the President, one proposed by Republicans. There is a bipartisan agreement with Democrats and Republicans. There is a Republican House plan. There are different Democratic plans. There are a lot of good ideas in all of these plans, the President's included.

So those of us who are on the committees that have responsibility in the jurisdiction over health care—and the Finance Committee in the Senate will have a great deal to do with this—I think have a special obligation to the American people to start that page-by-page, line-by-line, word-by-word review because one thing that concerns the American people is the costs, are they going to lose, are they going to gain. And another thing that concerns the American people is whether or not we want to turn over one-seventh of the total economy, 900 billion some odd dollars for the cost of health care under the President's plan and almost that much under some of the other plans to the Federal Government. Most Americans cannot recall any recent Federal program they would like to duplicate and, not only duplicate, increase to one-seventh of the total economy.

So this may be startling to some but it is the kind of information we need to make a judgment. This is just the beginning. There has still been no bill introduced. I understand it may not be introduced for another 2 weeks. We may not have a bill introduced before Congress adjourns this year.

So there will be a lot of time to talk about health care and to get down to the nitty-gritty. I think this is the first indication of how this—this is going to upset people who happen to hear it on television, read it in the paper, hear it on the radio, that 40 percent of Americans'—that is about 100 million—costs are going to go up, because they have been led to believe, or a lot of people have, everybody is going to be better off, it is not going to cost any more, we are going to get better benefits for it.

Mr. President, I yield the floor. I thank my colleague from West Virginia.

Mr. BYRD. Mr. President, I thank the distinguished Senator from Kansas, [Mr. DOLE].

CELEBRATING THE CAPITOL'S 200TH ANNIVERSARY

Mr. BYRD. Mr. President, last Saturday, October 23, the Nation witnessed the dramatic reinstallation of the Statue of Freedom on her pedestal atop the Capitol dome. That stirring event was followed by a program, conducted on the building's lower west terrace, celebrating the Capitol's two-hundredth anniversary. This ceremony, broadcast by C-SPAN to millions of Americans nationwide, featured brief addresses by the President, the Vice President, the Senior Associate Justice of the Supreme Court, the joint congressional leadership, and a specially commissioned poem offered by the Poet Laureate of the United States. Inspiring music enhanced the day's festivities, with performances by the U.S. Navy Band, the Howard University Choir, and vocalist Liza Minnelli. The noted historian David McCullough presided as keynote speaker and master of ceremonies.

As I listened to the richly inspiring speeches and poetry, I concluded that they should be made available in written form to the widest possible audience. Accordingly, I ask unanimous consent that a transcript of the proceedings of last Saturday's event be published in the RECORD.

There being no objection, the transcript was ordered to be printed in the RECORD, as follows:

A COMMEMORATION OF THE BICENTENNIAL OF THE UNITED STATES CAPITOL, 1793–1993, SATURDAY, OCTOBER 23, 1993, THE WEST FRONT OF THE CAPITOL

DAVID MCCULLOUGH. Ladies and gentlemen, the Chaplain of the United States House of Representatives, The Reverend Dr. James David Ford.

Dr. FORD. As we stand in this hallowed place surrounded by the signs and symbols of democracy, we solemnize this occasion in a prayer of thanksgiving for days past and petition for the days ahead.

Oh, gracious God, whose creation brought us forth and gave us life and true liberty, and whose providence has blessed our nation with gifts both great and small, we pray that as we lift our eyes to this Capitol with its symbols of freedom, we will be moved with reverence for the sacrifice of those who have gone before and who now stand in the shadows of history and encourage us in the paths of liberty.

May this sanctuary of freedom be consecrated by those who have been entrusted with its care and be alive with deeds of honor and acts of goodwill, that in all things, "justice will flow down as waters and righteousness like an everflowing stream."

This is our earnest prayer. Amen.

DAVID MCCULLOUGH. Mr. President. Ladies and gentlemen. My name is David McCullough. On this magnificent morning, at this historic place, here at latitude 38 degrees, 53 minutes north; longitude 77 degrees west, on a hill above the Potomac, we are gathered to celebrate the bicentennial of the best known, most important, and most revered structure in our nation. The United States Capitol.

We are Americans. And for us, this is a proud day. For this great building holds a place in our hearts and in our way of life like no other. It is a shrine on a hill, and it is the national stage upon which are enacted the difficult tasks and continuing drama of representative government. The bedrock of our faith in the land of the free.

Freedom is why we are here. Freedom is why America. And at the summit of the Dome, now there in sunshine, the emblem of freedom is again in her place. Older by a generation than the Statue of Liberty, she has stood on high since the year 1863. Since the autumn of Abraham Lincoln's *Gettysburg Address*. She has weathered civil war. World war. She has seen the deaths of presidents. The Great Depression. The sky turned dark by prairie dust blown from half a continent away. She has been pelted by sleet and snow, and struck by lightning. And, she has seen triumphant times. Good times. Lots of good times. Never has she looked better than today, October 23, 1993. [Applause]

All newly, thoroughly refurbished. Ready for another two hundred years, or more. And never—ever—has our Capitol looked better than today. Not ever before in all of its days.

Ladies and gentleman, a hundred years ago in this very place the nation celebrated the Capitol's first century. The President of the United States, leaders of Congress, and justices of the Supreme Court addressed another vast audience. On this equally festive occasion a century later, we will now hear from the successors of those leaders who represented our government's three branches.

We begin with the leadership of the Senate. To offer his observations about our government as it existed two hundred years ago when the Capitol cornerstone was put in place, here is the Majority Leader of the United States Senate, the Honorable George Mitchell. [Applause]

Senator MITCHELL. Mr. President. Mr. Vice President. Friends. Much has changed in the two hundred years since the cornerstone of this Capitol was laid. Then there were 5 million Americans, 15 states, with 30 senators, and 106 representatives. Now, of course, there are 250 million Americans, 50 states, 100 senators, 435 members of the House. But more striking than the change is that so much is the same.

In 1793 the government faced a serious national debt. In 1993, it still does. In 1793 umbrella makers in Philadelphia petitioned Congress for protection against imported French umbrellas. We still get such petitions.

But the most important thing that hasn't changed is the American commitment to liberty. The crowning achievement of the early American government was the Bill of Rights, the first ten amendments to the Constitution. They remain today, as they have been for two centuries, the most concise and eloquent statement ever written by human beings of the fundamental rights of free men and women against the power of government.

The Bill of Rights is the defining act of American history. The Constitution was ratified, and this nation was launched on the bedrock principle of individual liberty. That is, as expressed in the Bill of Rights, both uniquely American and universal in its reach. It is that spirit which we celebrate today.

This building, the United States Capitol, is the preeminent physical symbol of freedom in the world. But more important even than this great structure is the spirit which led to its construction and which inhabits it today. We are fortunate and very proud to be Americans. Citizens of the most free, the most open, the most just society in all of history. That is our benefit. With that benefit comes the responsibility to act so that two hundred years from today Americans and people all over the world will still admire this building. And Americans will still live in freedom protected by an unchanged and an unchangeable Bill of Rights. On this brilliant day it's obvious that God is smiling on America. May it always be so. [Applause]

DAVID MCCULLOUGH: The United States has had three capitols since 1789. Here to tell us about them is the Republican Leader of the United States Senate, the Honorable Bob Dole. [Applause]

Senator DOLE: Mr. President. Mr. Vice President. My colleagues. Distinguished guests. We gather this morning on the grounds of the third Capitol of the United States. When the First Congress convened in 1789 it met in New York City occupying the former city hall. That location was only temporary, however, as the recently ratified Constitution provided for the establishment of a permanent capital city. A location for that city was selected in 1790 when Congress passed the Residence Act directing by the year 1800 that the government should occupy a new Federal district along the Potomac River.

While the new capital city was under construction, Congress moved from New York to Philadelphia where they carried on the task of building a democracy. At the same time, hundreds of workmen were building a new Federal city on the Potomac. In his plan for the city, Pierre Charles L'Enfant placed the Capitol on the crest of what was then known as Jenkins Hill, a site that he described as a "pedestal waiting for a monument."

On September 18, 1793, a large and boisterous crowd gathered here to watch an elaborate Masonic ceremony highlighted by placing the Capitol cornerstone by President George Washington. As many of you know, my colleague Senator Strom Thurmond who was here on that day [laughter] refuses to reveal just exactly where the cornerstone is.

The *Alexandria Gazette* reported that the ceremony concluded with fifteen salutes from the artillery, and then "the whole company retired to an extensive booth where an ox of five hundred pounds * * * was barbecued." History will note this is the first time—but certainly not the last—that someone's ox was gored in the United States Capitol. [Laughter] [Applause]

DAVID MCCULLOUGH: To give a certain inimitable slant and perspective on today's proceedings, relating them both to ancient times and modern usage, here is the President Pro Tempore of the United States Senate, the Honorable Robert C. Byrd.

Senator BYRD: Mr. President. Mr. Speaker. Mr. Justice Blackmun. My fellow Americans. The United States Capitol building is a visible symbol of America's link to ancient Rome. Of all that made Rome great, nothing was more basic than Rome's noble attachment to a mixed constitution of checks and balances and separation of powers that lifted her from the lowest beginnings to that radiant summit of splendor and magnificence that has never ceased to attract the admiration and the wonder of the world.

But when that devotion to a mixed constitution was lost, the short sword of the Roman legions and the wooden galleys that plied the Adriatic could no longer save her, and the ancient empress of the classical world sank into a hopeless impotence and eventual obscurity as a military power and territorial empire.

Two hundred years ago, our Forefathers laid the cornerstone for this building, within which is domiciled the branch of government that springs directly from the people and from whom it derives its constant renewal, and which, only a few years before, had been set in place by the Framers of the Constitution, the cornerstone of this republic.

As we today commemorate with pride the cornerstone-laying of this temple that houses the "people's branch," let us renew afresh our fealty to the American constitutional system, the foundation upon which this republic rests. We received it from our fathers. Let us as surely hand it on to our sons and daughters and their children who will stand in our place a hundred years from now—a system of government under a mixed constitution that raised this American republic to a summit more glorious than ancient Rome ever saw. [Applause]

Now, ladies and gentlemen, I have the distinct pleasure and the high privilege of presenting to you the Vice President of the United States. [Applause]

The VICE PRESIDENT: Thank you, Senator Byrd. Mr. President. Distinguished members of the Congress. Ladies and gentlemen. Of all the symbols of our republic, none moves our hearts the way *this* Capitol building moves our hearts. We have heard about the history of this structure, and I would like to add only a brief description of some small moments in the recent history of this structure.

As President of the Senate, I still have the privilege—sometimes—of greeting visitors who are seeing this structure for the first time. And for the past seventeen years, I've had the privilege of sometimes greeting school children who come from all over the United States to stand in front of this building and look up at the Capitol Dome. It has *never* ceased to stir me, white against the sky with the Statue of Freedom at the top. The reaction of those children who still come—almost every day—to see this site is testament to the living history of this building.

It was startling these last few months to look up and see scaffolding there. And it's wonderful to see the Statue of Freedom back this morning. Our country is very different now than that first day when she was hoisted into place in 1863, but it is a comfortable feeling to see this old friend back securely in place ready to look out over Washington for another 130 years and more. A reminder to all of us that as we look ahead to the future we must never forget the legacy of our past. [Applause]

DAVID MCCULLOUGH: Ladies and gentlemen, representing the Judicial Branch of our government, here is the Senior Associate Justice of the United States Supreme Court, the Honorable Harry A. Blackmun.

Mr. Justice BLACKMUN: Mr. Chairman. Mr. President. Mr. Vice President. Distinguished participants. Ladies and gentlemen. Your Supreme Court of the United States has very substantial roots in this building. Although the Judiciary is one of three branches of our government, for the first 145 years of its existence the court had no home of its own. In

a building sense, during that period of almost a century and a half, it distinctly was an orphan.

The Court first convened in February 1790, at the Royal Exchange in New York City, then the seat of government. But the following year, the seat was in Philadelphia; and the court assembled there. First, at Independence Hall; and then, at the City Hall. It arrived in Washington in 1801; and, until 1809, sat in various, small, and rather inadequate rooms in the Capitol building. This building.

Somewhat more acceptable quarters outside the building were found for the 1809 term. But the Court returned here in 1810. It then was allowed to use the original Senate Chamber when the Senate moved upstairs to larger quarters. And that chamber, now beautifully restored and available for visiting, was its courtroom for fifty years except for the period of unpleasantness during the War of 1812, when the building was burned by the British with official court papers used as tinder. It is in *that* room here in *this* building that Chief Justice Marshall and Chief Justice Taney successively presided. And it is there that Daniel Webster argued the *Dartmouth College* case, and the *Dred Scott* case was argued and announced.

Once again, however, in December 1860, the Court followed the Senate and inherited its chamber upstairs when that body moved into the Capitol's North Wing it presently occupies. The Court used the second Senate chamber for seventy-five years, from 1860 to 1935, when it moved into its present building. I think one may say—fairly—that the Court's own edifice came into being primarily due to the influence of Chief Justice William Howard Taft, who had been President of these United States.

The site on which today's Supreme Court stands has its historical interest, too, related to this building. It is there that the so-called Brick Capitol stood. The Brick Capitol was used by Congress from 1815 to 1819, while this one was being repaired. And it is there that Henry Clay presided as Speaker of the House. And it is there that Chief Justice Marshall administered the oath of office to President James Monroe in 1817. And on that site was located the capitol prison during the War Between the States. Incarcerated there were Belle Boyd, the noted confederate; and Captain Henry Wirz of the Confederacy's own Andersonville prison.

Thus, despite the physical separation of the court's present building from the Capitol building, the Court has deep roots here in *this* building. It feels that it has been a distinct part of the edifice. It knows that long was this building its original home, and it is honored to participate in this celebration today.

The Statue of Freedom is again in place. And, again, it faces east. Does she look over to the Court as the symbol of the judiciary with the expectation and the challenge that its decisions be wise and neutral and correct? I like to think so. And I also like to think that the judiciary always will maintain its proper role in the government of this country which, despite its warts and despite its defects, we all so dearly love.

The Statue of Freedom is on its pedestal and rightly demands the best from all of us. May we fulfill that very precious promise. [Applause]

DAVID MCCULLOUGH: For a musical interlude, here is the United States Navy Band and Senior Chief Musician Chuck Yates, for their performance of *The Capitol*.

[Musical interlude.]

DAVID MCCULLOUGH: President Clinton has designated the month of October as National Arts and Humanities Month. In that spirit, we present our next speaker, reading from her specially prepared poem, *Lady Freedom Among Us*, the Poet Laureate of the United States, Rita Dove.

RITA DOVE: Mr. President. Mr. Vice President. Distinguished guests and friends, I offer this poem written for the glory of this day.

LADY FREEDOM AMONG US

Don't lower your eyes
Or stare straight ahead to where
You think you ought to be going

Don't mutter *oh no*
Not another one
Get a job fly a kite
Go bury a bone

With her oldfashioned sandals
With her leaden skirts
With her stained cheeks and whiskers and heaped up trinkets
She has risen among us in blunt reproach
She has fitted her hair under a hand-me-down cap
And spruced it up with feathers and stars
Slung over one shoulder she bears
The rainbowed layers of charity and murmurs
All of you even the least of you

Don't cross to the other side of the square
Don't think *another item to fit on a tourist's agenda*
Consider her drenched gaze her shining brow
She who has brought mercy back into the streets
And will not retire politely to the potter's field

Having assumed the thick skin of this town
Its gritted exhaust its sunscorch and blear
She rests in her weathered plumage
Bigboned resolute

Don't think you can ever forget her
Don't even try
She's not going to budge

No choice but to grant her space
Crown her with sky
For she is one of the many
and she is each of us

DAVID MCCULLOUGH: On four separate occasions between 1793 and 1958 ceremonial events have marked the placement of Capitol cornerstones. Here to tell us about one of the most significant of those occasions is the first of our three House leaders, the Republican Leader, the Honorable Robert H. Michel.

REPRESENTATIVE MICHEL: Mr. President. Mr. Vice President. Mr. Speaker. My colleagues and fellow Americans. It's a very great honor for all of us to be part of this historic ceremony. I'd like to devote my brief remarks this morning to the cornerstone of 1851, which began the enlargement of the Capitol Building.

The enlargement was necessary because, as has been mentioned by the distinguished Majority Leader, between 1793 and 1850, the number of states in the Union had more than doubled; and as the nation grew, so did the Congress.

It was evident that the Capitol building would have to be enlarged, and a plan for the North and South Wings was devised.

And so, on the Fourth of July, 1851, with church bells ringing and artillery salutes from various spots in the city, the cornerstone ceremony took place.

The principal address on that occasion was given by the great orator, Daniel Webster.

He spoke brilliantly for two, solid hours. This was, of course, before the age of the thirty-second sound bite; and, thank heaven, none of our participants today has been prone to emulate Webster.

Webster deposited in the cornerstone a sheet of paper on which he wrote to posterity the following:

"* * * the Union of the United States of America stands firm, that their Constitution still exists unimpaired * * * growing every day stronger and stronger in the affections of the great body of the American people, and attracting more and more the admiration of the world * * *"

It seems to me that the 1851 cornerstone says something very wonderful about our country.

We Americans have never seen *permanence* and *change* as contradictory terms but, rather, as complimentary parts of our national vision.

The new addition to the Capitol Building in 1851 certainly changed this building! But in doing so, it helped to keep it a permanent part of our national life.

We Americans retain the permanent things in our national life only when we are willing to strengthen them through change.

And, in Webster's words, "growing stronger and stronger every day."

This is the great paradox—and the great blessing—of American freedom and progress.

The 1851 cornerstone symbolizes that blessing, and I am glad we can all honor it here today. [Applause]

DAVID MCCULLOUGH: Ladies and gentlemen, today we have witnessed the return of Freedom to her summit. This, it would seem to me, would make a wonderful opportunity right now to express our appreciation and our admiration to the poise and the skill of the pilots and the technicians who made that thrilling event possible. [Extended applause]

So much of what we see, so much of what we are told is history somehow, and often for good reason, seems unreal. What we saw happen this morning was *real*.

For an account of the statue's early history, here is the Chairman of the Committee on House Administration, the Honorable Charlie Rose.

Representative ROSE: Mr. President. Mr. Vice President. Mr. Speaker. Mr. Justice Blackmun. Distinguished colleagues of the Senate and the House: It was less than two weeks after President Lincoln's *Gettysburg Address*, with its emphasis on binding up the nation's wounds and moving forward in brotherhood and unity, that the Statue of Freedom was first elevated to her place of inspiration atop the Capitol Dome.

Today, as our nation embarks on a new journey of regeneration and healing, it is fitting that the statue is restored, refreshed and reconsecrated. This symbolic ceremony comes at a time when the American people, our President, and our Congress are dedicated to the renewal of our beloved United States.

The crest of an eagle's head crowning the Statue is an ancient symbol of human aspiration toward universal good, of being reborn, through enlightenment, with higher awareness. Let this statue inspire our efforts.

When he left this country and returned to France at the end of our Revolution, General Lafayette said, "Freedom has found a home, and it is in this country of the United States."

Thomas Jefferson envisioned this capitol two hundred years ago, when it was dedicated, as a living shrine of democracy. It would demonstrate the principles of self-government to *all* humanity and inspire emulation throughout the world.

The Statue we honor today, a feminine figure, suggests the female role of healing; her sword depicting the defense of our values. There is no woman speaker on our program today; but the statue herself speaks louder than words.

The Holy Bible refers to a city on the hill. As we regard this statue towering above our Capitol Building, briefly recall that we are enjoined to let our light shine forth before all that they may see our good works. Standing on her own two feet, as Americans strive to do, the statue suggests that we move with individualism and autonomy to build together a better American community for the future, a society based upon reconciliation, on sharing, caring, and love for one another.

As we look above, we gather strength and courage from our past, as the spirit of freedom guides us toward a future that fulfills the dreams of those who dedicated this Capitol Building 200 years ago.

Welcome home, Lady Freedom. It's good to have you back on the dome and in our hearts. Thank you. [Applause.]

DAVID MCCULLOUGH: Our final congressional speaker will discuss the Capitol as a symbol of representative democracy. It is my great privilege to introduce the Speaker of the United States House of Representatives, the Honorable Thomas S. Foley.

The SPEAKER: Thank you, Mr. McCullough. Two centuries ago the first president of the United States, George Washington, came to this site to lay the cornerstone of the Capitol. We are deeply honored that the forty-second president of the United States has returned to help us celebrate.

And to you, Mr. President, and to the Vice President, and to the Joint Congressional leadership, and to Justice Blackmun, and the Architect of the Capitol, and to all the architects, workers, and engineers, and to the wonderful crew of the helicopter and all who placed Freedom back on her perch today, and to Rita Dove, and to all the citizens who contributed by the purchase of their commemorative coins to the elevation of Freedom today, we thank you for coming to make this a celebration of America. [Applause.]

This Capitol, this majestic architectural metaphor for the growth of a nation, adorned by the Statue of Freedom, is a symbol of an extraordinary experiment in representative democracy, and a beacon to people around the world who seek equal rights, justice, and freedom.

Today, the 103rd Congress meets here, and I have the honor to be the forty-ninth Speaker of the House. But, in November of 1800, Theodore Sedgwick of Massachusetts, the seventh Speaker, came with representatives from the sixteen United States to a wilderness town of woodland, swamp, and half-finished buildings to convene the Sixth Congress in the new Capitol where masons were still working on the first sections of the building.

As I stand here and look westward, I can see what Speaker Sedgwick could only imagine—a vista of the two hundred years of democracy—the monuments and museums that trace the political and cultural history of this nation stretched out before us. When Speaker Sedgwick looked westward in 1800, he could see only the plans of Pierre L'Enfant beginning to take shape from the forest, and the White House in the distance.

When he convened the Sixth Congress, only one wing of the original Capitol was finished, but its majesty and all that it represents were already set in stone. American democracy was in its infancy. This building was in progress, and both have sometimes gracefully, and sometimes not so gracefully, adjusted to the changing tides of history. The Capitol has survived war and destruction. It has survived restoration, reconstruction, and redesign. It is, in fact, an amalgamation of many buildings, fashioned from many materials—from limestone to cast iron, sandstone to steel, marble, and brick.

In so many ways the Capitol, with the Statue of Freedom on its dome, symbolizes not just who we are as a people, but what we are as a nation: a diverse people unified under one lasting principle that today we have raised above everything else: "Freedom."

Under the watchful eye of Freedom, in this temple of democracy, echo the voices of history—voices that rose to the challenges of war and peace, slavery and freedom, and for the preservation of the Union itself—voices of courage, dedication, sacrifice, and honor that shaped this Nation.

Speaker Theodore Sedgwick could never have imagined today's vision from Capitol Hill—the National Gallery, the Museum of American History, the Lincoln Memorial, the Air and Space Museum * * *. And, above all, the Capitol itself, the importance of which was most dramatically felt in 1865 when delegations representing the governments of the United States and the Confederacy met on shipboard at Hampton Roads to discuss the end of the Civil War.

At that historic moment, the first thing former Senator Hunter of Virginia, who represented the Confederacy, said to Secretary of State William Seward was, "How is the Capitol? Is it finished?"

Like democracy this Capitol will *never* be finished. It is a work in progress—a moving picture of a dynamic government. In the new book, *The United States Capitol*, by Fred and Suzy Maroon, published this year to commemorate the bicentennial, is this quote:

"Over the course of its two hundred year history the United States Capitol has grown, sometimes fitfully and sometimes gracefully, from being the mere symbol of an idea * * * to being a cherished monument that embodies the nation's rich remembrance of the past, and high hopes for the future. In that respect, it is timeless."

I now have the honor to present a special edition and bound version of that book to our most distinguished speaker and our most distinguished guest. It is my high honor and great privilege to present to you the President of the United States. [Sustained applause.]

THE PRESIDENT: Thank you. Thank you, Mr. Speaker. Mr. Vice President. Distinguished leaders of the House and Senate. Mr. Justice Blackmun. My fellow Americans.

We come here today to celebrate the two-hundredth birthday of this great building, the cornerstone of our republic. We come here to watch our Capitol made whole 130 years after the beautiful Statue of Freedom was first raised above this Capitol.

This is a moment of unity in this great city of ours so often known for its conflicts. In this moment, we all agree, we know in our minds and feel in our hearts the words that Thomas Jefferson spoke in the first inaugural address ever given on these grounds. He said that people of little faith were doubtful about America's future, but he believed our government was the world's best hope.

What was that hope? The hope that still endures that in this country every man and woman without regard to race or region or station in life would have the freedom to live up to the fullest of his or her God-given potential; the hope that every citizen would get from government not a guarantee but the promise of an opportunity; to do one's best; to have an equal chance; for the most humble and the most well born, to do what God meant for them to be able to do.

That hope was almost dashed in the great Civil War—when the Statue of Freedom was raised. Many people questioned whether Abraham Lincoln should permit this work to go on. But he said during the war, when so many thought our country would come to an end that, if people see the Capitol going on, it is a sign we intend the Union to go on.

In 1865 Abraham Lincoln gave the first inaugural address ever given under the Statue of Freedom. And he said,

"With malice toward none, with charity for all, with firmness in right as God gives us to see the right, let us strive on to finish the work we are in * * *."

And in that, the greatest of all presidential inaugural addresses, Abraham Lincoln gave us our charge for today. For the work of keeping the hope of America alive never finishes.

It is not enough for us to be mere stewards of our inheritance. We must always be the architects of its renewal. The Capitol is here after two-hundred years, this beautiful Statue of Freedom can be raised, renewed after 130 years, because our forbearers never stopped thinking about tomorrow.

We require the freedom to preserve what is best and the freedom to change, the freedom to explore, the freedom to build, the freedom to grow. My fellow Americans, I tell you that perhaps the biggest of our problems today is that too many of our people no longer believe the future can be better than the past. And too many others, most of them young, have no connection to the future whatever because the present is so chaotic. But the *future*, the future, has a claim on all of us.

We have, because of our birthright as Americans, a moral obligation to face the day's challenges and to make tomorrow better than today. All we really owe to this great country after 200 years is to make sure that 200 years from now this building will still be here and our grandchildren many generations in the future will be here to celebrate it anew.

Thank you, and God bless you all. [Applause.]

Mr. BYRD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The presence of a quorum having been questioned, the clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DOMENICI. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Ms. MOSELEY-BRAUN). Without objection, it is so ordered.

Mr. DOMENICI. Madam President, parliamentary inquiry. Are we open for matters as if in morning business?

The PRESIDING OFFICER. That is correct.

PROHIBITION OF FUNDS FOR LOBBYING

Mr. DOMENICI. Madam President, I have a number of responsibilities here. One of my new ones is to be the ranking Republican member of Appropriations Subcommittee on Commerce,

Justice, State, and Judiciary and related agencies. Within the purview of that subcommittee lies the Small Business Administration as well as the Department of Commerce. The entire Department gets its funding through that subcommittee's appropriations bill.

In that light, I have a statement that I would like to make so that the Senate will know what I have requested of the Secretary of Commerce and the Small Business Administration.

Yesterday, the President presented to the Congress his legislative proposal for health care reform. There will be a lot of debate on this issue in the coming year in the Congress, on the airwaves, and in the print media. It is a very complex issue, and we will be looking to many people for information on it, and analysis of it. The President's health care plan will be part of that as will other health plans.

I am concerned, however, that the administration may be using funds that were appropriated to Department of Commerce and the Small Business Administration to indirectly lobby in favor of this plan which I think may very, very well be a violation of the provision of law that prohibits the use of such funds for lobbying activities. I hope the administration will look into this. I make no accusations as to why they did it or whether some might not even have known that the law existed. But I think the facts are pretty clear, and so is the law.

Section 1913 of title XVIII of the United States Code states:

No part of the money appropriated by any enactment of Congress shall be used directly or indirectly to pay for any printed or written material or other device intended or designed to influence any Member of Congress, to favor or oppose by vote or otherwise any legislation or appropriation by Congress whether before or after the introduction of any bill proposing such legislation or appropriation.

Last month the Small Business Administration and the Department of Commerce prepared and published a brochure entitled "The Health Security Act: Benefits for Business." This brochure is not a general description of existing health care plans, their impact on small businessmen and women. It is not an informational brochure discussing various options for health care for the future. It is purely and simply a publication advocating the President's health care plan, a plan I might add which was not submitted to the Congress until yesterday. The brochure includes numerous references to the Health Security Act and clearly is intended to be part of the effort to generate political support for the President's health care legislation.

At the beginning of this brochure, a letter from the President is included which states in part,

The battle for health care reform will be fierce. Special interests who benefit from the current system will try to drown out your voice and keep us on a road that will only increase your costs and decrease America's competitiveness.

The clear implication is that those who oppose the President's health care plan in whole or in part are part of these special interests. The SBA is also establishing a toll-free number to provide information not on health care in general, but on the Health Security Act in particular. A memorandum sent by the agency to staff of the Appropriations Committee states, "We are planning to provide interested small businesses preliminary estimates of health care costs and coverage under the Health Security Act through a 1-800 information line."

Again, Madam President, this is an explicit effort to generate support for the President's Health Security Act with the use of appropriated funds. In some ways this is a minor matter. The amount of direct Federal funds involved in printing and distributing this material probably does not exceed $100,000. However, it is troubling that this administration has attempted to use this brochure to influence the public debate and indirectly lobby for its legislative package by using the scarce resources of the Small Business Administration that many of us I am sure would think could be better used for other purposes.

It is interesting to note that 10,000 of these brochures were provided to the Democratic National Committee for distribution and dissemination. Clearly, the SBA and the Commerce Department intend that these brochures be used for political purposes.

This administration took office professing to believe in high ethical standards for public officials. And I do not know, frankly, whether this incident illustrates mere incompetence. It may very well be that. Or is it an attempt to influence the political debate and thereby the Congress? In either case, I ask that Secretary Brown and Small Business Administrator Erskine Bowles to repudiate this effort and to take immediate steps to cease using appropriated funds to print and distribute this brochure.

Madam President, Republicans are interested in a bipartisan, cooperative effort to reach a compromise on health care reform. I think I heard that said by both Democrats and Republicans yesterday. I think I heard it said unequivocally by our President. Efforts by the administration to make this a partisan political debate, and turn it into that, do not help us reach that end.

I ask unanimous consent that two letters I sent to Secretary Brown and Administrator Bowles be printed in the RECORD at this point, as well as a memorandum from the SBA on the costs and distribution of this brochure, the pages of the brochure, and the memo from the Small Business Administration to John Shank, the Republican clerk.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, DC, October 27, 1993.

Hon. RON BROWN,
Secretary of Commerce, Department of Commerce, Washington, DC.

DEAR MR. SECRETARY: I am writing to bring to your attention a possible problem involving material being printed and distributed jointly by the Department of Commerce and the Small Business Administration.

The two agencies have prepared a brochure entitled "The Health Security Act", a copy of which is enclosed. The brochure is a description of the President's health care plan, which as you know has just been formally transmitted to the Congress.

I am concerned that the publication and distribution of this brochure with appropriated funds may violate the provisions of 18 U.S.C. 1913, which stats that "(n)o part of the money appropriated by any enactment of Congress shall . . . be used directly or indirectly to pay for any . . . printed or written material, or other device, intended or designed to influence in any manner a Member of Congress, to favor or oppose, by vote or otherwise, any legislation or appropriation by Congress".

I am writing to ask you to review this matter immediately and, if you determine the above provision of law is being violated: (1) take action to identify those individuals who may have been involved in said violation; and (2) cease further publication and distribution of this brochure.

Thank you for your attention to this matter.

Sincerely,

PETE V. DOMENICI,
Ranking Minority Member, Subcommittee on Commerce, Justice, and State, the Judiciary and related agencies.

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, DC, October 27, 1993.

Hon. ERSKINE B. BOWLES,
Administrator, Small Business Administration, Washington, DC

DEAR ADMINISTRATOR BOWLES: I am writing to bring to your attention a possible problem involving material being printed and distributed jointly by the Department of Commerce and the Small Business Administration.

The two agencies have prepared a brochure entitled "The Health Security Act", a copy of which is enclosed. The brochure is a description of the President's health care plan, which as you know has just been formally transmitted to the Congress.

I am concerned that the publication and distribution of this brochure with appropriated funds may violate the provisions of 18 U.S.C. 1913, which states that "(n)o part of the money appropriated by any enactment of Congress shall . . . be used directly or indirectly to pay for any . . . printed or written material, or other device, intended or designed to influence in any manner a Member of Congress, to favor or oppose, by vote or otherwise, any legislation or appropriation by Congress".

I am writing to ask you to review this matter immediately and, if you determine the above provision of law is being violated: 1) take action to identify those individuals who may have been involved in said violation; and 2) cease further publication and distribution of this brochure.

Thank you for your attention to this matter.

Sincerely,

PETE V. DOMENICI,
Ranking Minority Member Subcommittee on Commerce, Justice, and State, the Judiciary and related agencies.

U.S. SMALL BUSINESS ADMINISTRATION,
Washington, DC, October 8, 1993.

To: John Shank
From: Kris Swedin
Re: Questions on Brochure.

This is in response to your inquiry on a brochure "The Health Security Act—Benefits to Business." This publication was created jointly by the Small Business Administration and the Department of Commerce to educate the business community, and small firms in particular, about the proposed Health Security Act and its estimated effect on their businesses.

Our initial publication order was for 150,000 copies which were produced between Sept. 27–29 and delivered to SBA offices and the Department of Commerce and other organizations committed to distributing them, for informational purposes, to small business owners (see enclosure). We have not yet received the Government Printing Office bill for this order but they estimate it to be $67,000. The Department of Commerce has agreed to reimburse SBA for their portion of the order, about 25,000 copies.

The demand for this information brochure has been very high from our field offices and we have ordered a second printing of 50,000 copies which we expect to receive soon at an estimated cost of $15,000. We are also making the brochure available for reading and downloading through SBA's On-Line electronic bulletin board. This E-mail service represents no additional cost to the Agency beyond the initial set-up work, which was handled by SBA staff.

In addition we are planning to provide to interested small businesses preliminary estimates of health care costs and coverage under the Health Security Act through a "1-800" information line similar to SBA's existing Answer Desk. To date, we have outfitted a room for this information service with on-hand computers and miscellaneous purchases of related devices such as telephones and a FAX server. All of this equipment will be used within SBA at the conclusion of this information service project.

As you know, health care reform is a complex issue which will have significant effects on small business. I believe it is incumbent on SBA to provide our customers with the most current, accurate and objective information available to us. The Health Security Act brochure, our 1-800 information service, and the efforts of our staff in working on this issue are intended to do just that.

Distribution of brochure—The Health Security Act: Benefits for Business

Department of Commerce	23,800
Congressional Offices (with Commerce)	5,000
SBA Regional Offices	10,000
SBA District Offices	53,000
SBA Branch Offices	6,300
Portland, OR (town hall meeting)	350
Cleveland, OH (town hall meeting)	350
Des Moines, IA District Office	400
New York District Office	400
Houston, TX District Office	500
Houston, TX (town hall meeting)	350
U.S. Coast Guard	400
Other Executive Departments/Agencies	300
SBA Congressional Office	6,100
White House Office of Communications	1,000
White House Office of Public Liaison	4,000
Democratic National Committee	10,000
Mailing to SCORE, SBDCs and WBOs	15,200
(Service Corps of Retired Executives, Small Business Development Centers, Women's Business Organizations) Mailings to miscellaneous small business trade associations	1,200

Costs incurred to date:

Printing (from GPO estimates)	$82,000
Telephone and headsets	[1] 5,000
FAX server	[1] 4,000
FAX lines	400
Phone lines and cabling	[1] 2,000
FAX machines (2)	[1] 7,000

[1] Equipment will be retained for SBA use.

THE HEALTH SECURITY ACT—BENEFITS FOR BUSINESS

The Health Security Act preserves our employer-based, privately-financed system of health care. It will control the costs that are hurting American businesses' ability to compete. And it will help small business owners provide affordable insurance for themselves, their employees, and their families.—PRESIDENT BILL CLINTON.

MY FELLOW AMERICANS: Every American must have the security of comprehensive health care benefits that can never be taken away. That's what our health security plan is all about.

America's private sector is known for its ability to create permanent, productive, private-sector jobs, and offers many benefits, including health care coverage, to workers. But that ability has been threatened in recent years by rising health care costs.

The Health Security Act reaffirms an American principle: that our high-quality health care system should be rooted in the private sector and should respond to market forces.

The Health Security Act preserves our employer-based, privately financed system of health care. It will control the costs that are hurting American businesses' ability to compete. And it will help small business owners provide affordable insurance for themselves, their employees, and their families.

This brochure explains what our health security plan will provide and why we think it is so important.

The battle for health care reform will be fierce. The special interests who benefit from the current system will try to drown out your voice and keep us on a road that will only increase your costs and decrease America's competitiveness.

If you speak out and together we accept the challenge and responsibility, I am convinced that we can provide affordable health care to every American.

BILL CLINTON.

THE AMERICAN HEALTH CARE CRISIS

The crisis

Coverage

One out of four Americans—63 million people—will lose their health insurance for some period during the next two years. Today, more than 2 million Americans lose their insurance each month.

Losing or changing a job often means losing your health insurance, and becoming ill or living with a chronic medical condition can mean not being able to buy insurance at all.

No civilized society can justify this.

Cost

Left unchecked, by the end of the decade, rising health care costs will consume nearly 60 percent of all businesses' pre-tax profit. This spiraling growth in costs robs workers of wages, fuels the federal deficit and puts affordable health care out of reach for millions of Americans.

Complexity

The excessive paperwork now required by the system confuses and frustrates doctors, nurses, patients, hospitals and employers. Bureaucracy drives up costs and takes time away from direct patient care. So it is not surprising that the number of health care administrators is growing four times more quickly than the number of doctors in the U.S.

The response

Security

The Health Security Act provides all Americans with a guaranteed comprehensive benefits package of medical services delivered in hospitals, clinics, professional offices, and community health centers. The Health Security Act provides employers and employees with health care they can afford, regardless of their circumstances.

Savings

Health care costs are rising faster than other sectors of the economy. That rate of growth in health care costs robs workers of wages, reduces business investment capital, fuels the federal budget deficit, and puts affordable care out of reach for millions of Americans.

Simplicity

With a uniform, comprehensive benefits package offered to all Americans, businesses and consumers will no longer be faced with a confusing array of policies and forms. Employers will be relieved of the administrative responsibility for wading through health care plans, negotiating competitive premiums and administering claims. A simple billing format that converts the current paper-based claims process to a computerized, electronic system will cut costs and time.

Examples

Today: Charles, an electronic equipment manufacturer, pays $420,000 a year for health insurance. He has 130 employees and pays an average annual salary of $28,600.

Reform: Charles' premium cost will be, at most, $293,722 (7.9 percent of his payroll), saving him $126,278. And his employees will have rock-solid, comprehensive health care.

Today: Danita and her husband have a small construction company and they pay $6,000 a year for health insurance. She and her husband receive an annual salary of $12,500 each.

Reform: Their premium costs will be at most $1,100 (4.4 percent of payroll), saving them $4,900. In fact, Danita could provide insurance for 4 additional employees and their families for what it costs her to insure her family today.

The problem

All Americans, those who have health insurance and those who do not, understand that serious problems exist in the health care system:

Thirty-seven million Americans have no insurance at all. Another 22 million have inadequate coverage.

One out of four—or 63 million—Americans will lose health insurance for some period during the next two years.

Losing or changing a job often means losing insurance. Becoming ill or living with a chronic medical condition can mean losing insurance coverage or not being able to obtain it at all.

Health care costs are rising faster than other sectors of the economy. Left unchecked, rising health care costs will consume almost two-thirds of the increase in the gross domestic product (GDP) for each American for the rest of the decade. Costs are projected to grow from 14 percent of the GDP to 19 percent, even without any expansion of coverage to insure all Americans.

Bureuacracy now overwhelms employers and health providers and drives up costs. Studies show that a significant amount of the cost of running a typical doctor's office or a hospital is administrative.

Quality is uneven. Because no clear standards define best medical practice, lack of information and inadequate attention to prevention make the quality of health care across America uneven. Employers and consumers have no reliable information with which to measure the quality of their health care.

Coverage for long-term care is inadequate. Many elderly and disabled Americans enter extended care facilities when they would prefer to remain at home. Families exhaust their resources trying to provide care for relatives.

Many Americans cannot obtain quality care. In many rural and inner-city areas, shortages of doctors, clinics and hospitals prevent Americans from obtaining quality health care.

Fraud and abuse cheat everyone. Exorbitant charges, fraud and abuse undermine both quality and access to care, and cost $80 billion each year—nearly 10 cents of every dollar spent on health care.

Everything that is wrong with the American health care system is threatening everything that is right with the system. We must fix the system, while preserving every American's right to choose a doctor and obtain high-quality care, before the system self-destructs.

Small businesses face higher administrative costs

As much as 40 cents of every dollar which small businesses spend on health insurance is consumed by administrative costs.

Firm size and Administrative costs as a percentage of claims by firm size:

1 to 4, 40 percent; 20 to 49, 25 percent; 100 to 499, 16 percent; more than 10,000 5.5 percent.

WHAT IS THE HEALTH SECURITY ACT?

Overview

The Health Security Act will guarantee comprehensive health coverage for all Americans and legal residents, regardless of health or employment status. Health coverage will continue without interruption whether Americans change or lose their jobs, move, become ill or confront a family crisis. An employer's ability to afford premiums for all their employees is not dependent on the health status of a single employee.

The Health Security Act builds on our current employer-based system and asks all Americans and their employers to take responsibility for their health coverage. In return, they will have the security of knowing that they will always be covered.

The Health Security Act organizes the private market for health insurance to create incentives for health plans to compete on the basis of quality, service and price.

How It Works

The Act builds on our employer-based, privately financed system of health care. Employers and consumers will band together in large purchasing pools to strengthen their bargaining power in the marketplace. Health providers will be forced to compete for business, leading to lower prices and improved quality. This will shift the power of the marketplace in favor of employers and their employees.

Everybody's Role

Implementation will be managed at the local level by employers, employees and the states. This will create flexibility at the state level for employers and employees to design and control the local health care system. An independent National Health Board acts as the board of directors for the health care system, setting national standards for comprehensive benefits, quality and cost. Health plans must meet national standards on coverage, quality, and access to care, communities will tailor the new system to local needs and conditions, opening the way for local innovation within a national framework.

How Will the Cost of Health Premiums Be Paid?

Employers

Under reform, employers contribute 80 percent of the insurance premiums, calculated on the weighted average premiums among health plans in their area.

Under the Health Security Act, employer contributions for insurance premiums are capped at 7.9 percent of payroll. The cost of providing health coverage declines for most firms that currently provide insurance. Smaller businesses (those with fewer than 50 employees) with low wages will receive discounts of between 30 percent to 80 percent compared to what the average big business pays.

Employees

Employees pay the difference between the employer contribution and the premium of their chosen health plan. If they choose a plan that charges an average premium, they may pay up to 20 percent, unless their employer chooses to make a higher contribution.

How Employees Participate

Every employee will receive their own Health Security Card which will provide access to high quality, comprehensive health care that can never be taken away.

Caps on employer contributions

[Average wage in thousands of dollars]

	Percent
$0 to $12	3.5
$12 to $15	4.4
$15 to $18	5.3
$18 to $21	6.2
$21 to $24	7.1
$24 plus	7.9

Small Firms (fewer than 50 workers): Caps are placed on their premium contribution ranging from 3.5 percent of payroll to no more than 7.9 percent, depending on the average wage of that firm.

Large Firms (more than 50 workers): Not required to pay more than 7.9 percent of payroll for their employee's premiums.

Employer contributions are limited to a percent of their payroll costs, depending on their size and average wage. Government subsidies cover the remainder.

BENEFITS FOR BUSINESS

Reduces the cost of insurance for employers

The Health Security Act will reduce most employers' direct out-of-pocket costs, because it:

Guarantees that no employer in a regional alliance will pay more than 7.9 percent of payroll (in many cases, employers' actual premium costs will be below 7.9 percent of payroll and the cap will act only as a ceiling on costs);

Offers greater discounts (30% to 80%) to the smallest businesses and to low wage employees;

Increases the buying clout of small- and medium-sized companies through their participation in health alliances;

Ends insurance abuse: no more occupational redlining, restrictions on pre-existing conditions, or discrimination against small businesses;

Allows larger employers to continue to manage their own health care insurance programs;

Reduces the burden of early retiree health care costs by supporting the employer's share of early retiree premiums; and

Reduces the health care premiums for workers' compensation.

Increases consumer awareness of the cost and quality of health-care.

Reduces the administrative burden on businesses

Today, businesses face an avalanche of forms and a bewildering array of rules and reviews. Little wonder, then, that the number of health care administrators is growing four times more quickly than the number of doctors in this country.

The Health Security Act will eliminate much of the administrative burden of providing health care coverage, because it:

Provides a single, comprehensive benefits package, eliminating the need for time-consuming annual reviews of benefits packages;

Establishes regional alliances which will enjoy tremendous economies of scale and which will assume much of the administrative burden currently borne by businesses;

Consolidates reimbursement and claims submissions into a simple, easy-to-use format; and

Includes the health care portions of workers' compensation and auto personal injury.

Finances the new system responsibly and fairly

The present system is inequitable and unfairly penalizes companies currently providing health insurance to their employees. The Health Security Act seeks to lift that burden.

The Health Security Act injects fairness into the system, shifting power in the marketplace in favor of employers and their employees:

Today, employers who insure their employees bear a large "cost shift," amounting to $25 billion, from the uninsured. Under reform, that burden is lifted.

Today, in many cases, one employer pays the entire insurance bill for a family, while the employer of a worker's spouse pays nothing at all. Under reform, the costs for families are spread over all firms.

As in the private sector, the growth in major government programs, including Medicare and Medicaid, will be restrained.

If the savings attained through effective competition, reductions in administrative costs, and controls on public spending don't achieve the spending goals, there will be, as a backstop, a limit on the rate of increase in premiums. This brings to health care spending the kind of cost discipline which is commonplace in business.

Maintains the Best Features of the Current System

While the current patchwork of health care coverage is expensive and cumbersome, portions of the current system do provide important benefits to the business community and ought to be retained.

The Health Security Act recognizes the value of important features of the current system. The act:

Offers consumers a choice of at least three types of health plans, one of which must enable employees to choose their own doctors;

Continues to make employer premium payments tax-deductible to employers;

Continues to exclude employer premium payments from an employee's taxable income; and

Allows employers with 5,000 or more employees who self-insure to continue to manage their own plans.

Increases a Company's Ability to Attract and Retain Quality Employees

Under the Health Security Act, businesses of all sizes will enjoy all the benefits of an insured work force; less absenteeism, decreased turnover, fewer errors and a reduced need for training. Each of these elements translates into reduced costs.

By offering comprehensive health care benefits, smaller businesses will be better able to compete for qualified workers.

ADDITIONAL BENEFITS FOR SMALL BUSINESS

The plan is phased in over a period of years as the cost of health care is brought down.

The plan provides caps and discounts to hold down the cost of health insurance so that small businesses can afford to provide their employees with comprehensive, real insurance coverage. In most cases, employers' actual premium costs will be well below the caps, which serve only as a ceiling on premiums.

The plan calls for a significant percentage of the cost of insurance to be paid by the employee so that the employee has the same incentive to hold down the cost of health care as does the employer.

The plan calls for employees to pay more if they choose more expensive health plans so that the employee has a strong incentive to choose economical provider groups.

The plan is combined with the health portion of workers' compensation and brings this skyrocketing expense under control.

The plan enables the self-employed to deduct 100 percent of the cost of health care coverage from their taxes.

The plan removes all the hassle that small business now has to go through in dealing with insurance companies, and frees up valuable time for the small business owner to manage and grow their business.

The plan removes all of the abuses that are currently so rampant in the health insurance marketplace. If one worker in a small business, or a worker's dependent, becomes seriously ill, the business will no longer see astronomical rate increases or lose coverage for the sick employee or dependent.

The plan controls the future rate of growth of health care costs so that the rate of increase of health insurance costs in the future will increase by approximately the rate of growth of wages, as opposed to the skyrocketing costs that small businesses have incurred in the past.

Most importantly, small businesses get rock-solid comprehensive coverage and a guarantee that they will never be in danger of losing insurance again.

And each small business will have a happier, healthier, more productive work force.

QUESTIONS AND ANSWERS

Q. My company already offers health insurance that provides low cost, affordable care. Will it be able to continue and will I be able to remain outside of the health alliance?

A. As long as they adhere to national standards for choice, quality, and comprehensive affordable care, companies with more than 5,000 employees will be able to act as their own health alliances. As the regional alliances prove their ability to reduce costs and provide high-quality health care, larger companies will have the opportunity to join the regional alliances.

Q. I provide a generous health care plan today. Won't this plan require me to provide my employees with reduced benefits?

A. No. Your employees will have a choice among plans which offer the nationally guaranteed benefits package, and you will be able to provide your employees with whatever additional health care benefits you would like.

Q. This plan sounds complicated. Isn't it really going to drive up my administrative costs?

A. No. Health care is admittedly a complicated subject. But today's health care system is vastly more complex than this plan. Administrative costs now consume a large portion of what all businesses pay for health care. One of the goals of this plan is to reduce this burden. The plan achieves significant administrative simplification by using:

one comprehensive benefits package,

a single, standard form for insurance reimbursement claims submission; and

economies of scale for businesses pooled in the alliance.

Q. Doesn't this plan eliminate the tax benefits which I have today?

A. No. Health care premium payments will continue to be tax-deductible for employers and will not be included in your employees' taxable income. If you offer your employees more generous benefits than in the nationally guaranteed benefit package, your premium contributions will continue to be tax-deductible for 10 years, as long as that plan was in force at the beginning of 1993.

Q. I'm afraid that the new system will not really control costs—how can I know that it will?

A. In the last five years, health care costs for employers have risen almost 15 percent every year. Small business costs have risen even more rapidly. That's why a tough approach to controlling costs is a cornerstone of the Health Security Act. Providing health care and a comprehensive benefits package to every American will cut the cost of uncompensated care. Stimulating competition, increasing consumer awareness of the cost and quality of health care, streamlining administration, and changing workers' compensation and auto-insurance health coverage will dramatically reduce costs nationwide. In addition, premium increases in the whole system—including Medicare and Medicaid—will be limited as a backstop to contain costs. This will bring to health care the kind of discipline which is commonplace in business.

Q. My company operates in a number of different states. Today, I provide health benefits for my employees through one system. Under reform, will I have to change the way my employees get coverage?

A. No. Large employers will be free to operate as their own alliances, as long as they adhere to national standards for choice, quality, and comprehensive, affordable care. Small groups of employees in distant locations, however, will have the opportunity to receive health care through the local regional alliances if that is more convenient and cost-effective.

Q. Can we be confident that this plan had been analyzed rigorously and that the financing is reliable?

A. Yes. At the very beginning of this process, the President brought together some of the best minds in the country to help design a financing package for health care reform. The numbers and analyses that underline the President's proposed plan for health security represent months of rigorous work by experts from various federal agencies for the first time. An outside group of economists and actuaries audited the work that was done, and examined and validated the costs and savings projections. These cost and savings projections are solid, credible and conservative.

Q. My company is a large manufacturer experiencing very difficult international competition. Won't this plan add to my costs and make us even less competitive?

A. In fact, just the opposite is true. Today, many U.S. companies operate at a disadvantage in global competition, in part because of the costs of their health insurance. This plan is designed to get costs under control by increasing competition among health providers, increasing consumer incentives to reduce costs, reducing administrative waste, and imposing discipline on both private and public health care spending. Without this disciplined approach to cost control, your health care costs will continue to spiral out of control and make your competitive position even worse. The plan also lifts the burden of early retirees from your company. Generally, the plan was specifically designed to help control your costs and compete globally.

Q. I have heard that health care reform will drive thousands of small companies like mine out of business. How will my business be protected?

A. The Health Security Act was designed specifically to protect small businesses and help them make the transition to a system that guarantees their families and employees the health security they deserve. Businesses will pay no more than 7.9 percent of their payroll for health care. Most businesses' actual premium costs will be less than the 7.9 percent cap, which serves only as a ceiling on premium payments. Smaller businesses (those with fewer than 50 employees) with low wages will receive discounts of between 30 percent to 80 percent compared to what the average big business pays. Most businesses that provide insurance today will enjoy significant cost decreases. Businesses with insurance today will enjoy affordable health insurance for the first time ever, costing as little as a dollar per day for low-wage employers.

Q. I am a small business owner who now buys insurance for my family and my employees. What will this reform do for me?

A. Health care reform will lower costs for most small businesses that now provide insurance to their employees. Today, you pay 35 percent more for your insurance than the big companies do and your premiums increase at a rate more than 50 percent greater than theirs do. After reform, small businesses with low wages will pay between 30 percent and 80 percent less than the average big business. The Health Security Act will control costs, cut the administrative waste and paperwork that drive your premiums up, and make insuring your employees easier and more affordable. Small employers and others will join together in a health alliance to get the same bargaining power in dealing with health plans that large companies enjoy today. In addition, you and your family will gain the security of knowing that you will never lose your insurance coverage.

Q. I own a small business and can't afford to give my employees health insurance. What will this plan do for me?

A. Small business owners already risk enough; they shouldn't have to go without health insurance coverage, endangering their families' health security. Most small businesses today provide their employees with health coverage. Most of the rest would like to provide that benefit but find it impossible in a health insurance system that discriminates against them. The Health Security Act will help small businesses provide insurance to employees at affordable prices through these steps: controlling costs and making insurance more affordable; regulating insurance companies and prohibiting discriminatory pricing against small firms; and offering discounts to small companies and their employees. In the future, many small business owners could be able to provide health insurance for themselves and their employees for less than they pay for their family premiums today.

Q. I am self-employed. Will I start to have the same tax advantages as big companies?

A. Yes. Today, the self-employed can deduct only 25 percent of the cost of their health care premium from their taxes while other employers can deduct 100 percent. In the future, self-employed people will be treated fairly and be able to deduct 100 percent.

Q. Won't I continue to be at a disadvantage to larger companies in the purchase and administration of my health care?

A. No. By pooling with other employers in the regional alliance, you will enjoy the economies of scale in the purchase and administration of health care that only the largest employers have today. You also will be able to provide your employees with a health plan equivalent to what the biggest corporations offer today without being excluded for pre-existing conditions. You also may enjoy the benefit of discounts for both you and your employees which will not be available to the corporate alliances.

Q. I employ lots of part-time workers. Will I be required to pay for all of their health care?

A. No. Businesses will be required only to pay a prorated share of the employer portion of the health care premium for part-time workers. Businesses will be required to pay nothing for the health care of part-time workers who are full-time students and who are under the age of 23.

Q. My company hires independent contractors to perform many services for us. Will I be required to pay all the costs of their health care?

A. No. Truly independent contractors are considered self-employed and will be responsible for all the costs of their own health care, i.e., both the employer and the employee portions.

Q. How will my workers' compensation costs be affected?

A. Medical treatment for workers' compensation claims will be provided through the alliances and will enjoy the alliances' cost benefits. As a result, premium rates, fraud and excessive utilization all will be dramatically reduced.

For more information

Contact: U.S. Department of Commerce, 14th and Constitution, Washington, DC 20230. Attn: Health Security Act or the U.S. Small Business Administration, 409 Third St., SW., Washington, DC 20416. Attn: Health Security Act.

Mr. DOMENICI. Madam President, the SBA was very forthright. We asked them for that information, and they gave it to us. I am not trying to get the information. I have it. I have the brochure.

I thank the Chair. I yield the floor.

Mr. SHELBY. Madam President, are we in morning business?

The PRESIDING OFFICER. That is correct.

GULF WAR SYNDROME

Mr. SHELBY. I rise today to report to the Senate a startling development concerning the health of veterans who served in the Persian Gulf theater of operations.

As chairman of the Senate Armed Services Subcommittee on Force Requirements and Personnel, I have been closely following the deteriorating condition of the health of thousands of U.S. citizens who served in the Persian Gulf conflict. I held a hearing on June 30 in the Senate during which both active duty and members of our reserve forces testified about what has come to be known as the gulf war syndrome. At that hearing, two reservists testified that they believe they were subject to some sort of chemical attack in the early days of the war with Iraq.

I followed up on this hearing with extensive talks with the Department of Defense and was briefed by officials of the Joint Chiefs of Staff and the Army on the allegations of possible chemical attack. They contended then, and continue to argue now, that our forces were not subject to any type of chemical or biological warfare during the Desert Storm and Desert Shield campaigns. They also dismissed assertions by the Czech Defense Agency that that organization detected low-level chemical radiation during the gulf war.

Madam President, however, a memorandum written by an environmental physician at the Department of Veterans Affairs Hospital in Tuskegee, AL, may refute all assertions of the Department of Defense. Yesterday, October 27, Mr. William Kay, a member of the Naval Reserve Construction Battalion 24, who has been sick since his return from the gulf, visited Dr. C. Jackson at the Tuskegee VA medical facility to receive instructions to the VA claims office for his disability claim. Dr. Jackson has seen a large number of gulf war vets in the region.

I have a copy of this memorandum. I ask unanimous consent that this be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Department of Veterans Affairs, Oct. 27, 1993]

MEMORANDUM

From: C. Jackson, M.D., Environmental Physician, V.A. Tuskegee, Ala.

Subject: Disability Claim—Persian Gulf.

To: V.A. Claims office.

Mr. William Kay, ss# [redacted] has been followed by the V.A. Hospital in Tuskegee since his return from the Persian Gulf. He has experienced shortness of breath, excessive fatigue, diarrhea (intermittent), night sweats, memory problems and joint pains since the Gulf War. He was a member of the Construction Battalion 24 which was stationed at Al Jubayl in the Gulf. We have given him the diagnosis of Persian Gulf Syndrome and Chemical-Biological warfare exposure. He had none of these symptoms prior to the Gulf.

If we can be of further service, please notify.

C. JACKSON, M.D.

Mr. SHELBY. Madam President, I want to read from this memorandum. It states:

Mr. William Kay, ss# [redacted] has been followed by the V.A. Hospital in Tuskegee since his return from the Persian Gulf. He has experienced shortness of breath, excessive fatigue, diarrhea (intermittent), night sweats, memory problems and joint pains since the Gulf War. He was a member of the Construction Battalion 24 which was stationed at Al Jubayl in the Gulf. We have given him the diagnosis of Persian Gulf War Syndrome and Chemical-Biological warfare exposure.

I repeat, "chemical-biological warfare exposure." He had none of these symptoms prior to the Gulf.

Madam President, from the beginning I have tried to look at this entire situation as other Members of the Senate have, rationally and logically. I have met with Jesse Brown, Secretary of the Department of Veterans Affairs, and with numerous officials at the Department of Defense. I have worked with my good friend, Senator RIEGLE of Michigan, on an amendment to the Department of Defense authorization bill that would provide $5.7 million to research the gulf war syndrome. I want to continue to work with the executive branch on this vital issue.

However, the statement made in the memorandum I have just had printed in the RECORD cannot be ignored. We have a qualified medical physician making a diagnosis that a Persian Gulf veteran suffers from chemical-biological warfare exposure. I have contacted the Department of Defense and the Department of Veterans Affairs and will be meeting with them next week to receive their views on this issue. I will state now that the VA and the Department of Defense had better not reject this diagnosis out of hand. I recall similar statements concerning Agent Orange during the Vietnam era and thereafter.

Madam President, I mentioned earlier that the Czech Defense Ministry had reported the detection of chemical agents during the gulf war. It is my understanding that the Czech's have sent the Department of Defense a written report on their findings. I have been informed that, based on preliminary findings, the Department believes that there is little likelihood of a connection between the Czech readings and the gulf war illnesses because of low concentrations of readings, the locations of the agents and the prevailing winds.

I have asked the Department of Defense for a copy of this report that I will share with the Senate. They are in the process of reviewing the data and expect to make it available in the near future. Again, I take this opportunity here in the Senate this afternoon, to suggest to Secretary Aspin that the quicker the Department of Defense makes this information available the better. After the Senate recesses this year, I intend to meet with Czech officials personally in Prague and others. In the meantime, I expect a full accounting of these issues from the Department of Defense and the Department of Veterans Affairs to the Senate of the United States.

The PRESIDING OFFICER. Who yields time?

Mr. SHELBY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DOLE. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ETHICS COMMITTEE RELEASE

Mr. DOLE. Madam President, I have a release in my hand, a very troubling release, because it is an indication by the chairman of the Senate Ethics Committee and the release says: "The Senate Ethics Committee discovered information in Senator BOB PACKWOOD's diaries, questions about possible criminal violations," the panel chairman said today.

This all gets into the question of information diaries, what is protected, what is relevant, and it goes on to say later in the story, "BRYAN said the diaries raise questions about possible violations of criminal laws."

I know we are going to debate this on Monday. I think it is very unfortunate statement of the chairman of the committee to make. We have one of our colleagues who has been charged with certain matters before the Ethics Committee. It is under review. It is under investigation. The investigation was nearing completion. Then according to so-called committee rules they sought additional information from diaries that had no relationship to the original ethics charges.

There is a serious question whether Members of the U. S. Congress, in this case Senators, are entitled to any protection at all. Can you just rummage through anybody's files or diaries and say: "Well, this might be relevant later. If anything falls off here, it might be relevant."

That is what we hope to discuss next week. Now the chairman has already said there are questions about possible violations of criminal law.

I think that is very unfortunate. I wish such a statement had not been made. I have the highest respect for the Ethics Committee. It is a tough job. Nobody wants to be on the Ethics Committee. Nobody wants to judge their peers. But this is almost a prejudgment here. It seems to me that now the question has been raised publicly it ought to be followed up by a charge or it ought to be retracted.

It is too late to withdraw. It has already been made. This is the kind of news a lot of people like. Nail somebody, particularly a Senator. So it is too late to retract it. It should not have been made. But if it is going to stand, then there ought to be a charge. They ought to convene the committee, and they ought to say: "OK. There are additional allegations. We are going to broaden the inquiry."

If they are not going to do that, then someone ought to say, "Well, maybe I misspoke."

Madam President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. STEVENS. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. STEVENS. Madam President, are we in morning business?

The PRESIDING OFFICER. The Senator is correct.

SALUTE TO THE DOLE FOUNDATION

Mr. STEVENS. Madam President, I take this opportunity to congratulate our Republican leader, BOB DOLE, on his work to improve employment opportunities for disabled Americans.

Last night an organization that BOB DOLE founded, the Dole Foundation for Employment of People With Disabilities, celebrated its 10th anniversary. In that short time, this small, nonprofit, nonpolitical organization has awarded more than 230 grants in 40 States, totaling more than $5 million.

In my home State of Alaska, a Dole Foundation grant helped Reach, Inc., of Juneau establish a silk-screening and printing business for disabled youths.

To date, Dole Foundation grants have helped thousands of disabled people across this Nation find good-paying, high-quality jobs.

BOB DOLE's foundation is making a difference, but we still have 8 million disabled Americans who are unemployed and who could work, if they were given the chance. Today, disabled Americans of working age have an unemployment rate over 62 percent.

Madam President, my father was blind. So I know a little bit about disabilities and how a helping hand—rather than a handout—can make a difference. That is the philosophy of the Dole Foundation: to give disabled Americans the opportunity to chart their own future.

I came to the floor to congratulate BOB DOLE for his leadership, not only in the Senate, but in his work to improve the lives of America's 43 million citizens with disabilities.

Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The absence of a quorum has been suggested. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. ROTH. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

CHILD PORNOGRAPHY

Mr. ROTH. Madam President, I rise today to add my voice to the growing protest against a Supreme Court brief filed recently by the Department of Justice in the child pornography case of Knox versus United States.

I believe this case will go down in history as the Bob Jones case of the Clinton Justice Department. My colleagues will recall the Bob Jones case. In that case the Reagan Justice Department was roundly, widely, and repeatedly criticized in the press for changing the Department's previous position that IRS denial of a tax exemption to an allegedly racially segregated school was proper. Well, in the Knox case, the Clinton Justice Department has done precisely the same kind of legal flip-flop, this time on behalf of child pornographers and pedophiles.

In September, the Justice Department filed a brief that repudiated the Government's lower court victories under the Child Protection Act of 1984. The Justice Department asked the Supreme Court to set aside a judgment upholding the conviction of a man who had already previously been convicted under the Federal child pornography laws. The Clinton Justice Department told the Supreme Court that the appeals court has used "an impermissibly broad standard" to interpret and apply the law. The Clinton administration maintained that the appeals court should be ordered to reconsider the case under a narrower standard. In a reversal of its previous interpretation of the Federal child pornography statute, the Justice Department argued that this narrower standard meant nudity or visibility of genitals is required for conviction; and that the material "must depict a child lasciviously engaging in sexual conduct," as opposed to lasciviousness on the part of the photographer or consumer.

This new definition, invented by the Justice Department out of whole cloth,

is disturbing. Many children who are exploited for child pornography are too young to understand what they are doing, much less understand what lascivious behavior or even what sex is. Furthermore, child pornographers sometimes use images of sleeping children. Under this new interpretation, such terrible exploitation of innocent young children could become legal. If the Clinton Justice Department flip-flop prevails, I hope the administration will be willing to accept responsibility—responsibility for having opened the floodgates to a new wave of child pornography and sexual exploitation of children that is likely to ensue.

Why do I call this outrageous Department of Justice action a flip-flop? Because in March 1993 the acting Solicitor General filed a brief in the Knox case arguing that the third circuit had properly upheld the convictions and that the legislative history supported that court's decision. But in September 1993 the new Solicitor General filed a brief arguing precisely the opposite. Interestingly, the second brief makes no reference to the first brief's different view and does not acknowledge the flip-flop. But I hope the Supreme Court will notice and that the Justices will not be fooled.

The key holding of the third circuit is that, under Federal law, "clothed exhibitions of the genitalia are proscribed" when "a photographer unnaturally focuses on a minor child's clothed genital area with the obvious intent to produce an image sexually arousing to pedophiles." That is exactly what the facts show happened in this case.

This is how the video tapes involved in this case were described by the Justice Department in its first brief:

> The tapes showed various females between the ages of 10 and 17 dressed in bathing suits, leotards, underwear and other similar attire. The children struck provocative poses, apparently at the direction of someone off-camera. The camera would typically zoom in on the children's pubic and genital areas and display a closeup of that area for an extended time. The tapes themselves and the promotional materials * * * showed that the tapes were designed to pander to pedophiles.

An advertising catalog for these tapes included the breathless description of—I am quoting—"bathing suits on girls as young as 15 that are so revealing it's almost like seeing them naked (some say even better)."

Mr. President, I am, like the vast majority of Americans, outraged by child pornography. I was one of the original Senate sponsors of antichild-pornography legislation with some of my efforts dating back to 1977. I took an active role in the passage of the 1984 Child Protection Act. In 1986, after a 2-year probe, which I directed, the Permanent Subcommittee on Investigations issued a report on the relationship between child pornography and the sexual abuse of children. The key findings of the investigation were that child pornography plays a central role in child molestations by pedophiles. Child pornography is used by pedophiles to justify their own conduct, to assist them in seducing their child victims, and sometimes as a means to blackmail the children they have molested in order to prevent exposure. One pedophile testified before our subcommittee that he used child pornography to overcome the resistance of his child victims and that he traded photographs of his child victims with other pedophiles. As a result of these hearings, I introduced, and the Congress passed, legislation to outlaw advertising of child pornography.

I know what Congress meant when we passed antichild-pornography legislation. We meant to stamp out the business of child pornography in this country and to stop the sexual exploitation of our children by pornographers and pedophiles. The legislation and enforcement efforts have been remarkably successful. But now the Clinton Justice Department's brief represents a major setback to these efforts.

The Justice Department brief is an outrage. I am deeply disappointed that Attorney General Reno, who has expressed such concern for the welfare of children, would allow her Department to file such a brief—a brief that will, in effect, legalize a substantial amount of child pornography in this country. Is this what the Clinton campaign meant by change? I certainly hope not.

I intend to do whatever is necessary to reverse the Department's position in this case and to ensure that the Department's arguments do not prevail.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. BIDEN. Madam President, parliamentary inquiry, are we in morning business?

The PRESIDING OFFICER. That is correct.

Mr. BIDEN. Need I seek unanimous consent to speak in morning business for 10 minutes?

The PRESIDING OFFICER. Without objection, it is so ordered.

MORTON HALPERIN

Mr. BIDEN. Madam President, it would appear that the thaw in cold-war thinking and cold-war rhetoric has not yet reached the floor of the U.S. Senate.

I am at a loss to explain otherwise the criticism directed at the nomination of Morton H. Halperin as Assistant Secretary of Defense for Democracy and Peacekeeping.

Mort Halperin has served the national security of this country with great distinction for 30 years; he is widely and justly admired as a principled, patriotic public servant and it is hard to believe that in this instance he is serving as anything other than a target of convenience for critics who do not know, or do not wish to admit, that the cold war is over.

With the disunion of the Soviet Union and the collapse of the Communist movement, we cannot serve the national interest of the United States today if we remain mired in a slush of cold-war paranoia and resentment.

We cannot promote peace and the progress of democracy around the world if we permit the nomination of a man who has dedicated his life to those values to be held hostage to past policy differences among those for whom the national security has been a common lifelong concern.

The United States of America was conceived as a nation where citizens could differ significantly but with dignity, where differences of opinion could be aired safely within a framework of civility and where the resolution of those differences could not be subjected to ex post facto judgments.

And it is no exaggeration to say that it has been in large measure, our character as such a nation that has enabled us to survive and prevail over the Communist threat.

To depart from that tradition today, to impeach our own character as a Senate and as a nation that embodies the very values the world most admires and wishes to emulate, would pose a very real and present threat to the national security Dr. Halperin's critics profess to protect.

It would be hard to imagine a nominee better qualified than Mort Halperin to serve as Assistant Secretary of Defense for Democracy and Peacekeeping.

As head of the Washington office of the American Civil Liberties Union for a number of years and more recently as a senior associate at the Carnegie Endowment for International Peace and Baker professor at the Elliot School of International Affairs at George Washington University, he has been noted for the vigor and the effectiveness of his commitment to those values this Nation stands for.

He has been for more than 20 years a highly valued contributor to national security policy, having served in the Pentagon and the National Security Council under both Republican and Democratic administrations.

And it is a mark of both his patriotism and the professional quality of his work that his nomination has gained the bipartisan endorsement of former Secretaries of Defense and Directors of Central Intelligence who have known him well, not to mention the endorsement of Henry Kissinger, whom he sued successfully for wiretapping his phone.

Let me repeat that. Remember the celebrated case where Dr. Kissinger was sued as Secretary of State and as National Security Adviser for having ordered the wiretapping of the phone of Dr. Halperin? The very man who was sued, Dr. Kissinger, the Secretary of

State, endorses Mort Halperin for this post along with Republican and Democratic Secretarys of Defense and Directors of Central Intelligence.

Dr. Kissinger, obviously, sees Mort Halperin's nomination not as an occasion for controversy but as an opportunity to advance American national interests in the post-cold-war world.

Precisely, Mr. President as I believe the Senate should view the Halperin nomination.

The Senate does nothing to fulfill its responsibility to advise and consent on Presidential nominations, and does nothing to enhance its reputation as the world's greatest deliberative body by entertaining a long and disagreeable litany of past policy disagreements nor by entertaining anonymous and probably false allegations, such as the rumor, and Mr. President it is no better than that, that Dr. Halperin shared in overruling the military request for tanks in Somalia only recently.

Not only has Dr. Halperin denied that rumor, but Secretary Aspin has also denied it.

In fact, as the Secretary informs me by letter, an investigation of the allegation has found that Dr. Halperin not only played no role in making the decision, but was in fact not even aware that anyone had requested the tanks.

But, Madam President, as the Washington Post said in a recent editorial:

> The charges against the nominee are not worth dignifying by restatement. Each fresh one crumbles under the scrutiny of the record.

Morton Halperin's record of distinguished public service and scrupulous stewardship over our national security has been unblemished for three turbulent decades. As I said of him in this Chamber last year when he joined the Carnegie Endowment and George Washington University, I would like to say again and I quote from that statement:

> He is that truly rare creature, especially in Washington, perhaps, but certainly not only in Washington—he is one of those rare people for whom there is never any conflict between principle and practice. He has never sacrificed his principles and he has left the political air fresher everywhere he has passed.

That is the Mort Halperin that I know, and that I think all the Senators who have worked with him over the years know. His nomination to a vitally important post for which he is magnificently well-qualified should not be sullied in this body by an urge—an urge—to lick old wounds that should have been healed long since in the brighter light and before the increasing challenges of the post-cold war world.

Madam President, I ask unanimous consent that the Secretary's letter that I referred to be printed in the RECORD, as well as the Washington Post editorial and my remarks from last year be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE SECRETARY OF DEFENSE,
Washington, DC, October 27, 1993.

Hon. JOSEPH BIDEN,
Russell Senate Office Building, Washington DC.

DEAR SENATOR BIDEN: Thank you for your October 27 letter concerning the alleged participation of Dr. Morton H. Halperin in decisions related to General Montgomery's request for additional support for U.S. military forces in Somalia. This is a serious allegation which must be answered fully and forthrightly.

I can tell you directly that I have had no discussions whatsoever with Dr. Halperin concerning General Montgomery's request for additional support and he sent me no memoranda or other documents related to this matter.

To answer your question about whether Dr. Halperin gave anyone else in the Pentagon advice on this matter, I asked a senior officer to interview others who had knowledge of the Montgomery request. Without exception, they all have stated that they had no discussions on this matter with Dr. Halperin. Indeed, there is no evidence that Dr. Halperin had any knowledge of the request. Accordingly, there are no documents, transcripts, or notes relating to any discussion of Dr. Halperin's involvement in this issue.

Dr. Halperin made a similar statement that he had no knowledge of the request from General Montgomery before the press reports; that accordingly he played no role and had nothing to do with this matter; and therefore there are no related documents or notes.

I hope you find this response helpful and that we can put this unfounded allegation to rest. Dr. Halperin is a very talented and patriotic American who I want to be on my team at Defense. I hope the Senate will be able to move ahead promptly with favorable consideration of his nomination.

Sincerely,

LES ASPIN.

[From the Washington Post, Oct, 11, 1993]

THE HALPERIN NOMINATION

The Attack on Morton Halperin's Pentagon nomination keeps getting nastier. From selective and distorted citations of his past statements and positions, the pack has now moved on to the recent American deaths in Somalia. A nameless source accuses Mr. Halperin, the designated assistant secretary of defense for democracy and peace-keeping, of helping overrule the military on the question of whether tanks should have been sent to American peace-keepers a month ago. No evidence is presented for this charge. Mr. Halperin says it is false. But Sen. Storm Thurmond, leader of a partisan hit squad, is pursuing the matter with thunder and bile.

From the bolts of character assassination being hurled at Mr. Halperin, you would think he is coming from deep left field. In fact, he is coming from previous posts in the Pentagon and the National Security Council in the service of both Republican and Democratic administrations. From the very beginning of a notable 30-year career, he has gained regard for his contributions to national security policy. For some years he headed up the Washington office of the ACLU. This is presumable the service for which one critic darkly said he was running an organization "dedicated * * * to ensuring that U.S. intelligence agencies operated within the framework of the Constitution." A bipartisan clutch of former secretaries of defense and directors of central intelligence, not to speak of Henry Kissinger, whom he served and then sued for wiretaps, now provide the sort of lavish character references for which the average nominee would kill.

It is idle to try to imagine what may be on the minds of Sen. Thurmond and others who are baying after Mr. Halperin. If they are stirred by anything more than a nostalgia for the good old days of witch hunting, it is well hidden. The charges against the nominee are not worth dignifying by restatement: Each fresh one crumbles under scrutiny of the record.

The post to which President Clinton has nominated Mr. Halperin is focused on the post-Cold War tasks of planning peace-keeping operations, conducting military-to-military contacts to convey democratic practices, fighting the anti-drug war and providing disaster relief. In the absence of serious and proven charges against him, the Senate Armed Services Committee has no good reason not to confirm his nomination and let him get on with the job.

[From the CONGRESSIONAL RECORD, Sept. 30, 1992]

TRIBUTE TO MORTON H. HALPERIN

Mr. BIDEN. Mr. President, at the end of this month the American Civil Liberties Union will be saying goodbye to an outstanding American with a distinguished record of service to this country's great tradition of protecting civil rights and civil liberties of all individuals. At that time, Morton H. Halperin will leave the ACLU to accept a position with the Carnegie Endowment for International Peace, as well as a position as Baker professor in the Elliot School of International Affairs at George Washington University.

I am sure that we have not seen the last of Mort Halperin here in the Congress—he will remain as dedicated and as passionate in his championing of the causes of civil rights and individual liberties in his new position as he has been in the past—but this transition makes a highly suitable time to note his tremendous contributions to those causes.

Mort Halperin has made an indelible impression on the lives of many, including myself. He is that truly rare creature—especially rare in Washington, perhaps, but certainly not only here—for whom there is never any conflict between principle and practice.

This is not because he is ever prepared to sacrifice his principles, but because he is never prepared to hold his principles aloof from the hurly-burly that so often surrounds civil rights. He is never content with principles as a pose, but only content with a principled and practical conclusion to any negotiation in which he participates.

Fortunately, for him and for us, he has a reflexive, instinctive ability to reach that kind of conclusion, time after time, to some of the knottiest controversies any of us ever encountered. And he does it without falling into the habits that too often snare those who take up civil liberties as moral trophy-hunters—

He is never content to be simply a cheerleader working the crowd from the sidelines without taking any risks himself;

He is never satisfied to simply bloody the other side with a blunt instrument without gaining any ground;

And he always wants something more than to leave the other guy guilt-ridden but still in possession of the field.

When the chips are down, what works is what Mort does—as long, of course, as what works is right. And how he gets things done is as unusual in this town as what he gets done. In a place where shouts often substitute for arguments, Mort never raises his

voice, and while it is obvious he has an absolute passion for civil liberties, when he speaks it is always with the voice of reason.

He would rather persuade you than overwhelm you—not least, of course, because he understands very well that when you have come round to his point of view, you will be mightily impressed with the originality of your own thinking, and you will defend that idea as vigorously as you would defend anything else that belongs to you.

Given his abilities and his achievements among us, I used to wonder why Mort has not become a lawyer.

But I realized, finally, that he is a bit like the famous Professor Kittridge of Harvard. When a student asked Kittridge why he had never taken a Ph.D. in his field of English literature, the professor simply smiled and said, "But who would have examined me?"

None of us, certainly, would relish trying to examine the Halperin intellect or its command of civil-rights law. But there's nothing pointy-headed about the way Mort pursues his work. There's nobody in Washington smarter than he is, but there is equally nobody more down to earth in pursuing a goal, and he has all the tools for that kind of work.

He is, very simply, a man of good judgment, about both principles and people, and he has a first-rate command of the political process that aims at blending those two elements into results that are both desirable and workable.

He knows all the angles, and he plays them all, but he plays them straight. None of us has ever known a more honest man—but neither has any of us ever known a man more clearly focused on his goals or more clever at achieving them.

For Mort is, above all, a master tactician of the moral realm, and his preeminent skill is winning the big battles, outflanking and outmaneuvering the apparently unbeatable foe at the head of small, ragtag, apparently hopeless armies—for, as we have all learned, that "apparently" can be a formidable weapon in the highly skilled hands of a Mort Halperin.

I have no doubt there are people all over this town who are still trying to figure out how they lost a fight against such "apparently" insignificant opposition.

It is simply beyond imagination that anyone could have done more than Mort for civil liberties. It has been our good fortune, as well as the great good luck of the American people, to have had Mort Halperin as our "Horatio at the Bridge" for civil liberties.

It has been our good fortune to have found in Mort Halperin the Humanitarian, but supremely practical, man once described by the writer Aldous Huxley—

"A man may have strong humanitarian and democratic principles," Huxley said, "But if he happens to have been brought up as a bath-taking, shirtchanging lover of fresh air, he will have to overcome certain physical repugnances before he can bring himself to put these principles into practice."

I have no doubt that Mort has had to wrinkle his nose more than once as he has made his way through the political stockyards here in Washington, but he never avoided the occasion, no matter how aromatic he may have found it; he never hesitated to get his hands dirty, even as he never sacrified his principles; and he has left the political air forever fresher everywhere he has passed.

He has been my friend, and he has been the best friend to civil liberties in our time.

And so, I am sure, he will remain.

Mr. BIDEN. I thank the distinguished occupant of the chair for listening. I thank her for the time. I yield the floor. I see one of my colleagues wishes to speak, so I will not suggest the absence of a quorum.

Mr. CRAIG. Madam President, I ask unanimous consent to proceed as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

MANAGEMENT OF PUBLIC LAND

Mr. CRAIG. Madam President, today we had once again a very significant vote that is being used to attempt to establish a new public policy in this country as it relates to this Government's management of public land resources and the relationship this Government has with its citizenry. I am talking about the cloture vote on the Interior Appropriations Committee conference report as relates to the funding of that agency.

Those who have watched and participated in this discussion and debate have called it the grazing fee fight. I would like for a few moments this evening to broaden that argument just beyond grazing fees to what is really a good deal more important and why I mention that it is really the discussion of, or an attempt by some, to significantly change the relationship that our Government has had in the management of public lands with the citizens of our country in primarily 14 Western States where a great deal of the lands of those States are still retained in the ownership of the Federal Government. My State of Idaho happens to be one of those.

What kind of a relationship am I talking about? Our Founding Fathers were wise in many ways, but one of the things they said very clearly was that the Federal Government ought to be limited and all other nonenumerated rights would reside with the States. And for well over a century, this body and the other one defended in a strong way that concept.

Starting in 1913, no longer were Senators appointed by State legislatures but, in fact, elected by the populace through a change in our Constitution, we began to see a significant change in the relationship that the legislative body of our Government and, therefore, our Government through the policies crafted by the legislative bodies of our Government, had with State governments. Slowly but surely we saw the Federal Government beginning to say, "State governments, you will, you shall," instead of, "You may," or instead of, more importantly, requesting from them their advice. Because up until that time, and as it relates to public land policy, whether it was the Taylor Grazing Act or whether it was NEPA of decades of separation, there still remained a belief that State governments, even though they were speaking to or about public land held by the Federal Government, had a great deal of authority in how it ought to be managed. And, therefore, out of the Taylor Grazing Act that established the BLM and gave some control to the management of the nontimbered lands of our Nation came a principle that citizens ought to participate.

One of those ways of participating was to establish what was known as advisory boards. They had only the effect of advising. They did not have the power of law, but they could advise district directors of BLM. We had for a time small groups that advised supervisors of national forests as to relationships between State and the Federal entity. All of that was part of the process.

Did it give considerable control to the States? No, not really. The laws were specific. This body controlled the public policy that governed our Federal lands. But those citizens out there who were directly affected by those policies had some say in suggesting how all of that was to come about.

But as policy changed and, as I say, through the decades of the sixties and seventies, the National Environmental Policy Act—a variety of others—we saw progressively the pulling, if you will, of that relationship that once was stronger with the States away from the States toward a central Federal Government. All of the laws of the seventies and the eighties clearly show that.

So what I believe, based on those 17½ to 18 pages of substantive law change that are embodied in the REID amendment to the Senate appropriations bill is, once again, an argument about that relationship. Should it be dictated down from the Federal Government or should there be a cooperative relationship on how States and their citizens react to and with the Federal Government on the management of these resources in large public land States. I am one of those who believes that State relationship remains very important.

That is why today and over the last several days you have seen Western Senators on this floor who represent those public land States, loudly, and sometimes with an element of anger in their voice, or at least frustration, trying to express why this legislation should not pass. You have heard time and time again, it is not the fee that we are worried about, and that is absolutely true. The fee only establishes how much it cost to have a relationship with the Federal Government over their public land. It does not define the relationship.

But what those other 17 pages or 18 pages do is define the relationship. For example, it says where there used to be tenure, and that is a term that says if you have leased the public land for grazing and you have maintained it

properly, then you have a right to renew the lease, and because that right has been ongoing now for well over 50 years, those who held the right to renew the lease could take it to their local bank and it became an economic entity. It became a part of a financial relationship. In fact, the IRS said, yes, it has value and it has value to the holder of the lease, and if you sell it or if you sell your ranch, there is value in a State taxation.

So even the IRS recognized that relationship. The Secretary of the Interior, Bruce Babbitt, said that relationship ought to be discontinued. And that, if it is to become law, if that is to become the new public policy of this country about that relationship between a citizen who held a lease and his Government or her Government on the use of the resource, it would significantly change the economics of the West. Let me give you an example.

Let us say I am a rancher and I run 500 head of cows. I own 640 acres of property, fee simple property, deeded property, but I lease this Federal ground around me to graze these cattle.

Now, today, a 500-head cow operation, as we call it out West, if you were to put it on the market and sell it, would probably be worth $750,000. Is the 640 acres deeded, fee simple property worth $750,000?

No. It is probably worth less than $100,000. But that 640 acres tied with the right to graze creates an economic unit known as a cattle ranch, and that tied together has value. That value has been established by an ongoing policy of our Federal Government since the days of the Taylor Grazing Act.

Now, if the Government or if the Senate or if the Congress or if the Secretary of Interior says no longer does tenure exist, and therefore every 3 years that right is terminated and you have to go into the open market and bid against anybody else who wishes to bid, the value of that ranch on the books for $750,000, on the books of your bank for $750,000, money owed, borrowed against the value and the cash flow performance of that economic unit that we have just called a cow ranch, all of a sudden drops precipitously to maybe less than $100,000 in land value.

That is what the debate is about here. That is part of what is embodied inside that 17 pages, and it becomes increasingly valuable for this Senate to understand that. That is part of the reason for the energy, if you will, that has gone on into the debate and the effort here.

Now, I do not know what our Secretary of Interior is attempting to do. He said that a small band of Senators was holding the entire Interior Department hostage. If you believe what I have just explained, it might be arguable that the Secretary of Interior has just threatened the well-being and the financial lives of over 40,000 permittees, ranching families, across these public lands States in which this relationship develops. But nobody has said that. Certainly the Secretary does not feel that.

While that small band of Senators is holding the Department of Interior hostage, according to Secretary Bruce Babbitt, he and a small band of his underlings have been here on the Hill the last several days lobbying to break the vote down that you saw cast in the Chamber earlier in the day.

Why? Because they do want to change the relationship between the Central Government and the States and the citizens and that public land resource.

Today, as we debated the grazing issue here on this floor, in the other body they were marking up a mining law bill that could well be, if passed, the death knell of the mining industry as we know it—once again a public land resource issue.

So it is a Western grazing issue. It is a Western mining issue.

I guess I have to ask this question in closing: Mr. Secretary, what is wrong with coming before the appropriate authorizing committees, and, if my definition of the significance of what you are proposing is real, at least allowing public hearings and allowing all of the parties affected to come in and testify as to the kind of impact these potential policy changes could have on the lives of the families that ranch or the families that mine and the communities that provide the support base and the States that will be dramatically affected if this kind of public policy is to come about? Is it politics?

Well, there is an article in "Campaigns and Elections," October and November of this year, talking about the new urban West politics and how the Democrats are working very hard to gain the urban West and to divorce it from the rural West. But the urban West moves and becomes a part of the urban West to the West because it likes the rural West. It is that unique environment of the open spaces and the rangeland and the cattle ranch and the mining property that has drawn attention and brought people to the West because they like the climate and the culture and the environment and the people that is a product of a continuation of this uniqueness we call the West.

What we do here in the course of the next several weeks could significantly change the face of the Western United States for all time to come.

I will tell you, Madam President, it is not in the name of the environment that this is done. It is in the name of changing the power structure, changing the way we have done business, changing the way public laws have directed us in the past from the Taylor Grazing Act through to the National Environmental Policy Act.

I am not going to argue at this moment whether it is right or whether it is wrong, but I do represent one of those Western States, and I find it incumbent upon myself to continue to defend as best I can that unique and important relationship that Western States have had with their Federal Government over time, and that is that we could under wise and proper public policy responsibly utilize the public land resources for the purpose of maintaining western economies, for the purpose of maintaining the general value of those resources, and supporting the overall economics and well-being of this country.

Madam President, in closing, let me say I believe that is good public policy. A central run policy muted to the importance of the input of western citizens would be a public policy very, very damaging to the West.

I yield back the remainder of my time.

The PRESIDING OFFICER. The majority leader is recognized.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. MITCHELL. Madam President, I ask unanimous consent to proceed in executive session to consider the following nominations en bloc:

Calendar No. 411: Alan Blinken to be Ambassador to Belgium;

Calendar No. 413: Toby Gati to be an Assistant Secretary of State;

Calendar No. 414: Swanee Hunt to be Ambassador to Austria;

Calendar No. 415: Thomas Loftus to be Ambassador to Norway, and

Calendar No. 420: Daniel Spiegel to be U.S. Representative to the European Office of the United Nations.

I further ask unanimous consent that during the en bloc consideration, it be in order for me to present a duly signed cloture motion on each nominee; that these cloture motions be voted on en bloc; that the cloture vote occur at 2:15 p.m. on Tuesday, November 2, 1993, with the mandatory quorum under rule XXII being waived.

I further ask unanimous consent that if cloture is invoked, there be 90 minutes, equally divided between Senators PELL and MCCONNELL or their designees; and that following the conclusion or yielding back of time, the Senate proceed to vote, without any intervening action, on the confirmation of the above-mentioned nominations ad seriatim; that the motions to reconsider be laid upon the table; that the President be notified of the Senate's action; and that the Senate return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MITCHELL. Madam President, I now send up the five cloture motions, and I ask that each be stated.

The PRESIDING OFFICER. The cloture motions having been presented under rule XXII, the Chair directs the clerk to read the motions.

The bill clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on Executive Calendar No. 411, Alan John Blinken to be Ambassador Extraordinary and Plenipotentiary of the United States to Belgium:

Bob Kerrey, Daniel K. Akaka, Daniel Inouye, Wendell Ford, Tom Harkin, Bill Bradley, Paul Simon, Joseph Lieberman, Jay Rockefeller, Dale Bumpers, Harlan Mathews, Patrick Leahy, Christopher Dodd, John F. Kerry, Patty Murray, Claiborne Pell, Frank R. Lautenberg.

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on Executive Calendar No. 413, Tobi Trister Gati to be an Assistant Secretary of State:

Bob Kerrey, Daniel K. Akaka, Daniel Inouye, Wendell Ford, Tom Harkin, Paul Simon, Joseph Lieberman, Jay Rockefeller, Dale Bumpers, Harlan Mathews, Patrick Leahy, Christopher Dodd, John F. Kerry, Patty Murray, Claiborne Pell, Frank R. Lautenberg.

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on Executive Calendar No. 414, Swanee Grace Hunt to be Ambassador Extraordinary and Plenipotentiary of the United States to the Republic of Austria:

Bob Kerrey, Daniel K. Akaka, Daniel Inouye, Wendell Ford, Tom Harkin, Paul Simon, Joseph Lieberman, Jay Rockefeller, Harlan Mathews, Dale Bumpers, Patrick Leahy, Christopher Dodd, John F. Kerry, Patty Murray, Claiborne Pell, Frank R. Lautenberg.

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on Executive Calendar No. 415, Thomas A. Loftus to be Ambassador Extraordinary and Plenipotentiary of the United States to Norway:

Bob Kerrey, Daniel K. Akaka, Daniel Inouye, Wendell Ford, Tom Harkin, Bill Bradley, Paul Simon, Joseph Lieberman, Jay Rockefeller, Dale Bumpers, Harlan Mathews, Pat Leahy, Christopher Dodd, John F. Kerry, Patty Murray, Claiborne Pell, Frank R. Lautenberg.

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on Executive Calendar No. 420, Daniel L. Spiegel to be Representative of the United States to the European Office of the United Nations, with the rank of Ambassador:

Bob Kerrey, Daniel K. Akaka, Daniel Inouye, Wendell Ford, Tom Harkin, Bill Bradley, Paul Simon, Joseph Lieberman, Jay Rockefeller, Dale Bumpers, Harlan Mathews, Pat Leahy, Christopher Dodd, John F. Kerry, Patty Murray, Claiborne Pell, Frank R. Lautenberg.

LEGISLATIVE SESSION

Mr. MITCHELL. Madam President, I now ask unanimous consent that the Senate return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

EXPLANATION OF ACTION

Mr. MITCHELL. Madam President, I would like to make a comment for the information of Senators about what we have just gone through and what I believe to be a most regrettable circumstance.

On October 5, the Foreign Relations Committee unanimously approved and sent to the Senate five nominations. Three are of Ambassadors, one to Belgium, one to Austria, one to Norway; a fourth is an Assistant Secretary of State; and a fifth is the U.S. Representative to the European Office of the United Nations.

There was no opposition expressed to these nominees. The vote in the committee was unanimous, and the nominees therefore appropriately believed and expected that their nominations would receive prompt approval in the Senate. There was no reason for anyone to believe otherwise.

Accordingly, the nominees sold or rented their homes. They had their personal effects packed and ready to ship. Some of their spouses have terminated their employment. Some of them have school-age children who are to transfer to other schools and have been awaiting approval so that they can make the transfer.

But the nominees have not been approved. Here we are 3½ weeks later, and they are in limbo. Why is that?

The reason is that we have been unable to gain approval of Republican Senators to permit us to proceed to consideration of these nominees, not because of any problem with the nominees— no one has questioned the experience, the qualifications, the fitness of any of these nominees—but for what I am told is a completely unrelated matter—a dispute between a Republican Senator and the Secretary of State on a completely unrelated matter—these nominees have been held up.

The remarks I just made about homes sold or rented, personal effects packed ready to ship, spouses ending employment, school-age children anxious to transfer to schools, I am very familiar with because I know my friend and colleague, Senator DOLE, made the same comments several times in the past 2 years when nominees of a Republican President were held up and he talked about the adverse effects on these individuals.

This is not unique or limited to these people. And I emphasize that these are not nominees about whom there was any question or dispute, who in that circumstance would prudently have waited before they took these actions.

So I have been trying for the past 3 weeks to be able to proceed to get these nominees approved since there is no dispute over the nominees, and I have been unable to do so.

Several of the nominees have called me. Their spouses have called. Members of their families have called unable to understand how it can be that a nominee who has no opposition still cannot be approved.

The reason is, of course, the nominations have entered the extraordinary circumstance of having to be confirmed by the Senate under the rules of the Senate. Under the rules of the Senate, any Senator can speak for as long as he or she wants and can delay or obstruct or prevent action by the Senate. As I have said on many occasions, for most of our Nation's history, and until very recently in our Nation's history, that power known popularly as the filibuster was rarely used from 1919 for more than a half century into the 1970's—1919 having been the year at which a change was made in the rule. But for more than a half-century there was an average of fewer than one filibuster a year; fewer than one a year.

Indeed, in many Congresses over a 2-year period there were no filibusters, none. But now we have reached the extraordinary situation where in the last Congress, the 102d Congress, in that 2-year period, there were filed 48 motions to end filibusters here. That does not mean there were 48 filibusters because we have to often file more than one motion for a filibuster. But here we are in the situation now where we confront a filibuster. We have been told point blank these nominees will not be approved. There will be a filibuster. And so we have to file motions to end filibusters, delay these people for several more days, leave them in anxiety and limbo, even though, I repeat and emphasize, there has been no opposition to the nominees. Nobody ever challenged a single qualification. If that were the case, we obviously should come out here and debate them. So because we have a completely unrelated dispute, these nominees have been held up in a most unfortunate way, and it is most regrettable for them. Although I have been the principal advocate of trying to have these nominees approved on behalf of the Senate, I apologize to the nominees for what they have experienced. Many others have experienced it before. That does not make this right.

Madam President, I hope that when the Senate votes on Tuesday at 2:15, the Senators will vote to invoke cloture and to permit these nominees to

be confirmed. I am perfectly happy to have a debate on the qualifications of these nominees, to go ahead, and if someone wants to stand up and say this person is not qualified, they ought not to be in that position, we will vote on that basis. But I think it is very regrettable when these people are held up over this long period of time. I know how anxious they have been. They have been following this closely, obviously. Their careers and livelihoods are involved. I just say to them that we are going to persist, and we are now proceeding under the rules. We know there is a filibuster, and now we filed a motion to end the filibuster. We will have a vote on Tuesday, and I hope we will be able to get more than the 60 Senators necessary to end these filibusters and permit the Senate to vote on these nominations on Tuesday.

Madam President, I yield the floor.

Mr. CRAIG. Madam President, I think it is regrettable that the Senator who has had the hold on these nominations is not here this evening. He just arrived home and is on the ground and is now at the side of his mother who is in her hospital bed where she has had a very difficult and sudden illness occur. But I think it is important, and certainly the leader has represented, and appropriately and rightfully so, the circumstances that the Senator who brought the hold was within the rules of the Senate and exercised them responsibly. And that it was not extraordinary.

There is a very important issue here that I believe the Senator was in search of an answer to, as to the integrity of the files of the State Department, and how they may or may not be used appropriately or inappropriately. Certainly, the leader has just, within the rules, done what he feels he must do.

And so while it can be cast or described in any way as one would choose, I think the record shows that both entities here are within the rules of the Senate, and the rules are put here for us to use when necessary, to make what we believe to be responsible and important points, and to cause certain things to happen when it is possible to do so. But I know that if the Senator from Kentucky were here at this moment, he could speak with a good deal more detail to the issue than can I. I think it is important that the RECORD show he was clearly within the rules of the Senate and his prerogative as a Senator.

Mr. MITCHELL. Madam President, I, of course, did not assert and do not represent that anything that occurred has been outside the rules. The problem is with the rules and with the increasing absence of self-restraint by Senators to exploit the rules to the full maximum potential—a very recent development in the history of this country and of the Senate. I think it is something that creates real problems for the Senate now and will in the future.

MAKING FURTHER CONTINUING APPROPRIATIONS FOR THE FISCAL YEAR 1994, AND FOR OTHER PURPOSES

Mr. MITCHELL. Madam President, I now ask unanimous consent that the Senate proceed to the consideration of House Joint Resolution 283, the joint resolution making continuing appropriations for the Departments of the Interior and Defense; that the joint resolution be read a third time and passed; that the motion to reconsider be laid upon the table; and that any statements thereon appear in the RECORD at the appropriate place as though read.

The PRESIDING OFFICER. Without objection, it is so ordered.

The joint resolution (H.J. Res. 283) was deemed read three times and passed.

ORDER TO PROCEED TO CONSIDER S. 656

Mr. MITCHELL. Mr. President, I ask unanimous consent that at 11 a.m., Friday, October 29, the Senate proceed to the consideration of Calendar No. 242, S. 656, the Indoor Air Quality Act of 1993; that there be a total time limitation of 30 minutes for debate on the bill and amendments thereto, with the time equally divided and controlled in the usual form; that the only amendment in order, other than the committee reported substitute, be a Brown amendment to strike subsection 5 of section 7 on page 96; that upon disposition of the Brown amendment, and the yielding back of any remaining time, the committee substitute, as amended, if amended, be agreed to, and the bill, as amended, then be advanced to third reading, and passed, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR TOMORROW

Mr. MITCHELL. Madam President, I ask unanimous consent that when the Senate completes its business today, it stand in recess until 10:30 a.m. on Friday, October 29; that following the prayer, the Journal of the proceedings be deemed approved to date; the time for the two leaders be reserved for their use later in the day; that there then be a period for morning business, not to extend beyond 11 a.m., with Senator HOLLINGS recognized to speak during the period allotted for morning business, and that upon disposition of S. 656, Senator MURKOWSKI be recognized for up to 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MITCHELL. Madam President, there will be no further rollcall votes this evening. On Monday at noon, there will be a vote on a motion to request the presence of Senators and immediately following that vote, the Senate will proceed to the consideration of the resolution recorded and filed by the Ethics Committee regarding Senator PACKWOOD. There is no time limitation on that. It is possible that votes will occur during the day on Monday after that matter is brought up.

I also want to hereby announce that I will not agree to any committee meetings on Monday. I believe that the matter before the Senate is a serious one, and that Senator PACKWOOD and the committee are entitled to have Senators present on the Senate floor to listen to the debate. Therefore, I hereby notify all committees that no committee meetings will be permitted on Monday, or during the time that the Senate is considering that matter on Monday.

MESSAGE FROM THE HOUSE

ENROLLED BILL SIGNED

At 10:12 a.m., a message from the House of Representatives, delivered by Mr. Dendy, an assistant to the clerk, announced that the Speaker has signed the following enrolled bill:

H.R. 2445. An act making appropriations for energy and water development for the fiscal year ending September 30, 1994, and for other purposes.

The enrolled bill was subsequently signed by the President pro tempore [Mr. BYRD].

At 2:46 p.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the House has passed the following joint resolution, in which it requests the concurrence of the Senate:

H.J. Res. 283. Joint resolution making further continuing appropriations for the fiscal year 1994, and for other purposes.

ENROLLED BILLS AND JOINT RESOLUTIONS SIGNED

The message also announced that the Speaker has signed the following enrolled bills:

H.R. 927. An act to designate the Pittsburgh Aviary in Pittsburgh, PA, as the National Aviary in Pittsburgh.

H.R. 2492. An act making appropriations for the government of the District of Columbia and other activities chargeable in whole or in part against the revenues of said District for the fiscal year ending September 30, 1994, and for other purposes.

H.R. 2824. An act to modify the project for flood control, James River Basin, Richmond, VA.

The enrolled bills were subsequently signed by the President pro tempore [Mr. BYRD].

At 6:27 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the Speaker has signed the following enrolled joint resolution:

H.J. Res. 283. Joint resolution making further continuing appropriations for the fiscal year 1994, and for other purposes.

The joint resolution was subsequently signed by the President pro tempore [Mr. BYRD].

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. BIDEN, from the Committee on the Judiciary, with an amendment in the nature of a substitute:

S. 540. A bill to improve the administration of the bankruptcy system, address certain commercial issues and consumer issues in bankruptcy, and establish a commission to study and make recommendations on problems with the bankruptcy system, and for other purposes (Rept. No. 103-168).

By Mr. RIEGLE, from the Committee on Banking, Housing, and Urban Affairs, with an amendment in the nature of a substitute and an amendment to the title:

S. 1275. A bill to facilitate the establishment of community development financial institutions (Rept. No. 103-169).

By Mr. BIDEN, from the Committee on the Judiciary, without amendment and with a preamble:

S.J. Res. 75. A joint resolution designating January 2, 1994, through January 8, 1994, as "National Law Enforcement Training Week".

S.J. Res. 115. A joint resolution designating November 22, 1993, as "National Military Families Recognition Day".

S.J. Res. 119. A joint resolution to designate the month of March 1994 as "Irish-American Heritage Month".

S.J. Res. 122. A joint resolution designating December 1993 as "National Drunk and Drugged Driving Prevention Month".

S.J. Res. 131. A joint resolution designating the week beginning November 14, 1993, and the week beginning November 13, 1994, each as "Geography Awareness Week".

S.J. Res. 139. A joint resolution to designate the third Sunday in November of 1993 as "National Children's Day".

S.J. Res. 142. A joint resolution designating the week beginning November 7, 1993, as "National Women Veterans Recognition Week".

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. GLENN, from the Committee on Governmental Affairs:

Joseph Swerdzewski, of Colorado, to be General Counsel of the Federal Labor Relations Authority for a term of 5 years.

(The above nominations were reported with the recommendation that they be confirmed, subject to the nominees' commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.)

By Mr. BIDEN, from the Committee on the Judiciary:

Nora Margaret Manella, of California, to be U.S. attorney for the Central District of California for the term of 4 years.

Frances Cuthbert Hulin, of Illinois, to be U.S. attorney for the Central District of Illinois for the term of 4 years.

Carl Kimmel Kirkpatrick, of Tennessee, to be U.S. attorney for the Eastern District of Tennessee for the term of 4 years.

Jo Ann Harris, of New York, to be an Assistant Attorney General.

Eduardo Gonzalez, of Florida, to be Director of the U.S. Marshals Service.

(The above nominations were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. ROTH (for himself, Mr. COHEN, and Mr. GRASSLEY):

S. 1598. A bill to amend title 10, United States Code, to modernize Department of Defense acquisition procedures, and for other purposes; to the Committee on Armed Services.

By Mr. DECONCINI (for himself, Mr. D'AMATO, and Mr. HATCH):

S. 1599. A bill to establish a Missing and Exploited Children Task Force; to the Committee on the Judiciary.

By Mr. PACKWOOD (for himself, Mr. DOLE, Mr. SIMPSON, and Mr. DURENBERGER):

S. 1600. A bill to amend the Social Security Act to establish long-term-care assistance programs for the elderly, and for other programs; to the Committee on Finance.

By Mr. BRADLEY (for himself and Mr. LEAHY):

S. 1601. A bill to amend chapter 4 of title 39, United States Code, to grant State governments the discretion to assign mailing addresses to sites within their jurisdiction; to the Committee on Governmental Affairs.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. COVERDELL (for himself and Mr. KEMPTHORNE):

S. Res. 159. A resolution expressing the sense of the Senate that the Department of Labor should provide adequate resources to the States to cover the costs of developing and implementing the worker profiling system and should provide the Governors with adequate flexibility to ensure that the funds appropriated will be made available to provide re-employment services for profiled claimants; considered and agreed to.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. ROTH (for himself, Mr. COHEN, and Mr. GRASSLEY):

S. 1598. A bill to amend title 10, United States Code, to modernize Department of Defense acquisition procedures, and for other purposes; to the Committee on Armed Services.

ACQUISITION MANAGEMENT REFORM ACT OF 1993

Mr. ROTH. Mr. President, I am gratified by this year's activities in Congress and in the administration to bring change to the Federal Government's acquisition system. This is an issue that I have been working on for over a decade and the payoff from a comprehensive reform is significant. In this Congress, the House has made progress on its Federal Acquisition Act of 1993. The Federal Acquisition Improvement Act of 1993 with President Clinton's endorsement has been introduced this week here in the Senate. The national performance review has also promised personnel reform legislation. All of these efforts attempt to fix specific problems identified in the buying system. However, there is no vision or direction as to where the buying system should be going. Mr. President, for this reason, I rise today to introduce legislation which provides a vision to stimulate and guide these reforms.

The Defense Department has become increasingly unable to produce the best technology in an affordable manner, when it's needed. While the current system is able to produce good weapons, it is wasteful, inefficient, and takes too long to field needed technologies. Mr. President, in many cases the issue of affordability is not even addressed when defining the requirements for a weapon system. As a result, many analysts have noted that much time and money is wasted trying to achieve an extra 1 percent of capability that is rarely realized. In fact, the vast majority of weapon acquisition programs are experiencing serious cost and schedule problems. For example, the C-17 transport's cost and schedule overruns have seriously delayed its availability. After spending $10.4 billion and over 20 years developing the C-17, the Air Force is considering buying commercial aircraft in its place.

In all the services, we can find such horror stories. Acquisition costs for Navy major weapon systems are over budget by as much as 179 percent, Air Force systems by as much as 158 percent, and Army systems by as much as 220 percent, even after accounting for the effects of inflation and quantity. The GAO reported that program cost increases on the order of 20 to 40 percent are common. This year's report of the Acquisition Law Streamlining Task Force, also known as the section 800 panel, noted that the Defense Department takes four times as long as the private sector to field similar high-tech items. A July 1993 Defense Science Board found that: "without fundamental reform, DOD will be unable to afford the weapons, equipment, and services it needs to provide for our national security."

Two years ago, when I introduced an earlier version of this bill, I highlighted how inefficient the Defense Department's management practices were then. Mr. President, that has not changed. A Defense Department program manager still has to follow over

840 steps in order to get a weapon system concept into production.

The Army's fiber optic guided missile is an example of the buying system's inability to perform. The program was initiated in the early seventies and by 1989, 40 prototype missiles had been successfully tested. The program was then put under DOD's standard acquisition management structure and subsequently, in 1991, canceled for cost and schedule overruns. The best estimates indicate that the system is still 10 years away from an operational capability. While the Defense Department was holding briefings and managements reviews, the rest of the world was developing this capability. The Defense Intelligence Agency reported that Japan and Europe will field a fiber-optic guided missile by 1996 and that the Third World will have those missiles before 2000. It's disconcerting that other global powers will beat us in fielding such an important weapon, or worse yet may sell it to our adversaries before we have a comparable capability.

For many years, I have worked for reform of the Government's buying system and over the years, my conclusion has not changed: without major cultural and structural reform, the Pentagon cannot make major reductions in the cost and time it takes to field a technology. In December 1992, GAO reported that: "the fundamental problem of the acquisition process is a prevailing culture that is dependent on generating and supporting new weapons acquisition." Until the buying system is changed, the results will not change. Cost and schedule overruns will continue. Mr. President, there are three root causes that must be addressed.

One, the defense acquisition process is too cumbersome, takes too long, and does not produce desired results. The buying process has become more important than producing usable weapon systems. The DOD 5000 series of documents and its consensus based management process must be abandoned in favor of a results oriented process.

Two, incentives are wrong. They reward program managers and contractors for increasing the size of their program and their budget. There is no incentive for a job well done. Managers who do not spend their budget are subject to more ridicule that those who overspend their budgets.

Three, the organization is too large. It is a bureaucracy with layer upon layer of management and dozens of buying commands and subcommands spread across the four military services. Many of the bureaucratic layers exist solely to satisfy the needs of the bureaucracy. They provide no value added toward weapon system development. The current organization mistakes the continuation of the program in favor of meeting customer needs. When the Packard Commission recommended streamlining this bureaucracy to three layers and a handful of commands, the military departments added the three-tier structure to their old organization structures. As a result, the American taxpayer is now paying for two bureaucracies in each of the military departments.

Mr. President, my proposal contains six parts to reform DOD acquisition management and the relationship between Government and industry. It incorporates the principles of unity of command, lean management structure, fast processes, and pay for performance for both Government workers and contractors.

First, the bill establishes performance goals. On average, programs must be within 90 percent their cost and schedule goals. In addition, the bill requires DOD to reduce by 50 percent the time it takes to field emerging technologies. It also requires the Joint Chiefs of Staff to approve the cost and schedule goals for programs to ensure weapons reach the field when they are needed.

Second, my legislation would require the Secretary of Defense to streamline the acquisition process. Program managers will be given the authority and accountability for achieving results. My proposal also requires a commitment of full funding for each phase of the development cycle which will remove the major source of program instability.

Third, my proposal streamlines, the defense acquisition organization and its interface with operational users. The bill reorganizes the Defense Department research, development, and acquisition bureaucracies into a single DOD-wide agency. Authority for executing programs would be returned to the program manager. Program executives would be organized according to mission areas, such as Strategic Lift, to ensure responsiveness to those who use the weapons on the battlefield. Additionally, those who use weapons will regain responsibility for determining what is bought.

Fourth, the bill re-emphasizes the commitment of Congress to a professional acquisition work force and establishes the incentive structure toward program performance. My proposal will allow acquisition managers to be promoted based on the performance of the programs that they manage.

Fifth, the legislation creates an efficient contracting process. My proposal will change the culture of contracting to take advantage of time and money-saving ideas, while preserving competition and protecting the interests of the American taxpayer. The bill includes the requirement that the contracting officials support the program managers and the overall agency wide acquisition goals while maintaining the integrity of the contracting officer. The bill is consistent with the Federal Acquisition Streamlining Act of 1993, which raises the small purchase threshold to $100,000 and supports other section 800 panel recommendations.

Sixth, the Defense Department will be able to manage its contractors on the basis of performance, rather than to rely on continuous audit and the threat of penalties. In my concept of performance-based contract administration, contractors would act ethically and efficiently because it would be in their financial interest to do so. Under the concept that I am proposing, contractor profit would be tied to achievement of quantifiable performance measures. Hence, contractors would be awarded for good performance and penalized for cost growth.

Mr. President, large savings can be realized from the comprehensive reforms I am proposing. I anticipate that my approach will reduce acquisition management personnel by as much as 25 to 30 percent through reductions in duplicative headquarters staffs. CBO and the Pentagon Comptroller's Office estimated that $4.2 to $4.5 billion could be saved from this organizational streamlining. Defense systems management college professors believe that if DOD could reduce the time of the contracting process by 1 year, a savings of approximately $6 billion would result. Still, the largest dollar gains would come from comprehensive reform. The Defense Science Board Task Force on Defense Acquisition Reform in July 1993 reported that a comprehensive reform along the lines I am proposing would save $20 billion per year.

In summary, there is both a need and an opportunity for reforming Defense acquisition. Multibillion-dollar cost overruns; programs that are years or even a decade behind schedule; incentives that encourage spending rather than savings; and top-heavy bureaucratic agencies that replace good judgment with detailed regulations are the features of the current DOD buying system that must be changed. But, Mr. President, I must point out that bureaucracies are inherently unable to reform themselves. The time has come for us to make some very hard and difficult decisions which have far-reaching impact on the future of our country. Change must be brought about by those of us who are concerned about maintaining a strong defense within today's budget constraints.

By Mr. DECONCINI (for himself and Mr. HATCH):

S. 1599. A bill to establish a Missing and Exploited Children Task Force; to the Committee on the Judiciary.

THE MISSING AND EXPLOITED CHILDREN TASK FORCE ACT OF 1993

• Mr. DECONCINI. Mr. President, on September 30, 1993, around 10:30 at night, 12-year-old Polly Klaas and two

of her girlfriends had just settled down for a late night card game at a spur-of-the-moment Friday night slumber party. Not more than an hour later, Polly's mother was awakened by one of the girls who stood by her bedside, wide-eyed and terrified, and related a story of how a man, armed with a knife, had broken into the Petaluma, CA, home, forced the girls to lie on the bed, covered their heads with pillowcases, tied their wrists behind their backs, and then fled the house with Polly.

Only a month before, on the other side of the country in a small town in New York, another 12-year-old girl disappeared while biking the mile-long trip between her home and the church where her father is pastor. Police found Sara Anne Wood's pink-and-white mountain bike abandoned in a nearby ditch, along with some papers she had been carrying.

Polly Klaas and Sara Anne Wood are just two of the thousands of children abducted each year by nonfamily members. Neither of the girls was more than a mile away from their small-town homes when the abductions occurred, and, in both instances, their small communities mobilized immediately to assist local law enforcement in the investigations. Merchants from both areas immediately donated space and resources including phones, fax machines, copy machines, and supplies, while townspeople from all over took vacation time to donate endless hours stuffing envelopes, making phone calls, posting signs, and knocking on doors. In spite of these efforts, helpful leads in both cases have been few and far between, and resources and manpower are slowly diminishing.

Mr. President, the victimization of children in our Nation has reached epidemic and terrifying proportions. The most recent Department of Justice figures show that, in one year, 4,600 children were abducted by nonfamily members, two-thirds of these nonfamily abductions involved sexual assault, more than 354,000 children were abducted by family members, and over 450,000 children ran away. It is painfully clear that the time has come to increase and unite our efforts to solve and prevent such savage crimes against our children.

It is for that reason that I rise today with my distinguished colleague, Senator D'AMATO, to introduce a bill that will assist in the resolution of such crimes against our Nation's children and, ultimately, aid in the prevention of future and repeated crimes. The Missing and Exploited Children Task Force Act of 1993 would create a team of active Federal agents who would work with the National Center for Missing and Exploited Children [NCMEC] in assisting State and local law enforcement agents in their most difficult missing and exploited child cases.

The task force would be headed by a representative from the Federal Bureau of Investigation and would be comprised of two representatives from each of the following Federal agencies: the Federal Bureau of Investigation, the Secret Service, the Bureau of Alcohol, Tobacco and Firearms, the U.S. Customs Service, the Postal Inspection Service, the U.S. Marshals Service, and the Drug Enforcement Administration.

Each participating agency would nominate agents who possess some area of specialized expertise, including behavioral sciences, crimes against children, sex offenses, forensics, international investigative experience, and other areas that would be of particular value, to investigations of this nature. Each member would serve a 1-year term, with an option to extend for a year, and would be compensated by their respective agencies. Most importantly, task force members would retain full authority, be on active duty status, and retain access to appropriate databases.

Coordinating and pooling the resources and expertise of several Federal law enforcement agencies to tackle a compelling problem has been successful in the past. One example is the Organized Crime Drug Enforcement Task Force [OCDETF] program, established in 1983. The OCDETF program consists of a nationwide structure of 13 regional task forces which utilize the combined resources and expertise of its member Federal agencies in cooperation with State and local investigators and prosecutors to target and destroy major narcotic trafficking and money laundering organizations. Since its implementation, the program has experienced immense success.

Last year, Senator D'AMATO and I worked to secure funding for a program entitled "Project Alert," which enlists retired law enforcement officials to volunteer their expertise to State and local police officers for some of their toughest missing children cases. Project Alert volunteers are certified through the NCMEC and have already proven to be extremely valuable in assisting active law officers in evaluating leads, investigating longstanding, unsolved cases, promoting community awareness and prevention programs, and using the latest in scientific technology to help track the swelling ranks of missing children. Members of the Missing and Exploited Children Task Force would have similar responsibilities.

Task force members would use their expertise, data access, and official authority to work on cases chosen and updated by NCMEC as their most difficult cases. Members would also be available to go on location to assist local or State investigators, but only after a full prior consultation with the lead investigator on the case, local, State, or Federal.

While local and State law enforcement agencies are to be commended for their efforts in such cases, missing children investigations would benefit highly from a coordinated Federal law enforcement effort. By supplementing our Nation's 17,000 police departments—a majority of which have 10 or fewer officers—with task force members and resources, we can unite our Nation's best in the fight against such reprehensible crimes and increase the chances of our Nation's missing children being returned to their homes and families.

I urge my colleagues to join me in support of this legislation. I ask unanimous consent that a copy of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1599

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Missing and Exploited Children Task Force Act of 1993".

SEC. 2. FINDINGS.

The Congress finds that—

(1) the victimization of children in our Nation has reached epidemic proportions; recent Department of Justice figures show that—

(A) 4,600 children were abducted by nonfamily members;

(B) two-thirds of the abductions of children by non-family members involve sexual assault;

(C) more than 354,000 children were abducted by family members; and

(D) 451,000 children ran away;

(2) while some local law enforcement officials have been successful in the investigation and resolution of such crimes, most local agencies lack the personnel and resources necessary to give this problem the full attention it requires;

(3) a majority of the Nation's 17,000 police departments have 10 or fewer officers; and

(4) locating missing children requires a coordinated law enforcement effort; supplementing local law enforcement agencies with a team of assigned active Federal agents will allow Federal agents to pool their resources and expertise in order to assist local agents in the investigation of the Nation's most difficult cases involving missing children.

SEC. 3. PURPOSE.

The purpose of this Act is to establish a task force comprised of law enforcement officers from pertinent Federal agencies to work with the National Center for Missing and Exploited Children (referred to as the "Center") and coordinate the provision of Federal law enforcement resources to assist State and local authorities in investigating the most difficult cases of missing and exploited children.

SEC. 4. ESTABLISHMENT OF TASK FORCE.

Title IV of the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5771 et seq.) is amended—

(1) by redesignating sections 407 and 408 as sections 408 and 409, respectively; and

(2) by inserting after section 406 the following new section:

"TASK FORCE

"SEC. 407. (a) ESTABLISHMENT.—There is established a Missing and Exploited Children's Task Force (referred to as the "Task Force").

"(b) MEMBERSHIP.—

"(1) IN GENERAL.—The Task Force shall include at least 2 members from each of—

"(A) the Federal Bureau of Investigation;

"(B) the Secret Service;

"(C) the Bureau of Alcohol, Tobacco and Firearms;

"(D) the United States Customs Service;

"(E) the Postal Inspection Service;

"(F) the United States Marshals Service; and

"(G) the Drug Enforcement Administration.

"(2) CHIEF.—A representative of the Federal Bureau of Investigation (in addition to the members of the Task Force selected under paragraph (1)(A)) shall act as chief of the Task Force.

"(3) SELECTION.—(A) The Director of the Federal Bureau of Investigation shall select the chief of the Task Force.

"(B) The heads of the agencies described in paragraph (1) shall submit to the chief of the Task Force a list of at least 5 prospective Task Force members, and the chief shall select 2, or such greater number as may be agreeable to an agency head, as Task Force members.

"(4) PROFESSIONAL QUALIFICATIONS.—The members of the Task Force shall be law enforcement personnel selected for their expertise that would enable them to assist in the investigation of cases of missing and exploited children.

"(5) STATUS.—A member of the Task Force shall remain an employee of his or her respective agency for all purposes (including the purpose of performance review), and his or her service on the Task Force shall be without interruption or loss of civil service privilege or status and shall be on a nonreimbursable basis.

"(6) PERIOD OF SERVICE.—(A) Subject to subparagraph (B), a member shall serve on the Task Force for a period of 1 year, and may be selected to a renewal of service for 1 additional year.

"(B) The chief of the Task Force may at any time request the head of an agency described in paragraph (1) to submit a list of 5 prospective Task Force members to replace a member of the Task Force, for the purpose of maintaining a Task Force membership that will be able to meet the demands of its caseload.

"(c) SUPPORT.—

"(1) IN GENERAL.—The Administrator of the General Services Administration, in coordination with the heads of the agencies described in subsection (b)(1), shall provide the Task Force office space and administrative and support services, such office space to be in close proximity to the office of the Center, so as to enable the Task Force to coordinate its activities with that of the Center on a day-to-day basis.

"(2) LEGAL GUIDANCE.—The Attorney General shall assign a United States Attorney to provide legal guidance, as needed, to members of the Task Force.

"(d) PURPOSE.—

"(1) IN GENERAL.—(A) The purpose of the Task Force shall be to make available the combined resources and expertise of the agencies described in paragraph (1) to assist State and local governments in the most difficult missing and exploited child cases nationwide, as identified by the chief of the Task Force from time to time, in consultation with the Center, and as many additional cases as resources permit, including the provision of assistance to State and local investigators on location in the field.

"(B) TECHNICAL ASSISTANCE.—The role of the Task Force in any investigation shall be to provide advice and technical assistance and to make available the resources of the agencies described in subsection (b)(1); the Task Force shall not take a leadership role in any such investigation.

"(e) TRAINING.—Members of the Task Force shall receive a course of training, provided by the Center, in matters relating to cases of missing and exploited children.

"(f) CROSS-DESIGNATION OF TASK FORCE MEMBERS.—The Attorney General shall cross-designate the members of the Task Force with jurisdiction to enforce Federal law related to child abduction to the extent necessary to accomplish the purposes of this section.".●

By Mr. PACKWOOD (for himself, Mr. DOLE, Mr. SIMPSON, and Mr. DURENBERGER):

S. 1600. A bill to amend the Social Security Act to establish long-term-care assistance programs for the elderly, and for other programs; to the Committee on Finance.

SECURE CHOICE ACT OF 1993

Mr. PACKWOOD. Mr. President, elderly Americans are this country's fastest growing age group. The elderly population in the United States has doubled over the past 30 years, swelling from 16 million in 1960 to 32 million last year. By the year 2030, there will be more than 66 million people over 65. And the number of people age 85 and older is expected to triple.

As the elderly population skyrockets, and the need for long-term-care grows, our society will face tough decisions about how to make long-term-care more affordable.

I have worked with the Republican leader, Senator DOLE, for almost 2 years to revise our long-term-care bill introduced in the 102d Congress. That is why I am proud to introduce today legislation called Secure Choice—a comprehensive three-part legislative plan which tackles the explosive demand for affordable long-term-care services. This bill confronts the challenge of providing long-term-care services to our Nation's senior citizens and individuals who become disabled. I am committed to this legislation, and to finding adequate financing for its implementation.

Several objectives guided the development of this legislation. All have been achieved. First, the legislation provides services to our neediest individuals. Second, it builds on a public-private partnership that will make long-term-care more affordable. Third, tax barriers hindering the development of the private long-term-care insurance market are removed. Fourth, the legislation encourages the kind of long-term-care services Americans want—care provided in the home and in the community. Finally, the legislation is fiscally responsible in today's world of limited resources.

Secure Choice recognizes that not everyone's needs are the same. That's why we have structured the legislation to provide Americans with choices so they get the long-term-care services they need and prefer. Some may be able to stay at home with the assistance of a homemaker aide. Others may want the services provided in an assisted living facility. Still others may need more intensive services provided in nursing homes.

Secure Choice also recognizes that individual financial capacities' differ. That is why we structured the legislation to provide a public program for the most needy; a public-private partnership for people with moderate incomes, to help them purchase qualified long-term-care insurance policies; and tax clarifications for individuals and businesses wishing to purchase private long-term-care insurance.

Secure Choice recognizes that resources are limited and calls on all sectors of American society to help meet the challenge of providing long-term-care. This free market approach is the most responsible way to expand the availability of long-term-care services.

NEW PROGRAM FOR LOW-INCOME INDIVIDUALS

Many elderly Oregonians have told me they want to stay in their homes, but need help taking care of themselves. Secure Choice is designed to help them to do just that.

The bill provides nursing home care and expanded home and community-based care to individuals with incomes below the Federal poverty level—$6,970 in 1993—through a new title of the Social Security Act. long-term-care services now provided through Medicaid would be moved to this new title XXI. Eligibility would be broadened and simplified, and the need for Medicaid waivers would be eliminated. This means States could provide more home care services without the hassles associated with obtaining a waiver.

States would be required to cover eligible individuals with income up to 100 percent of the Federal poverty level. Like the medically needy option under Medicaid, individuals with incomes above the poverty level could count out-of-pocket expenses for long-term-care against their income to qualify.

BUILDING ON A PUBLIC-PRIVATE PARTNERSHIP

Secure Choice creates a public-private partnership to help Americans with moderate incomes—less than 3 times the Federal poverty level, about $21,000—purchase long-term-care insurance. One of the barriers to the development of a large private insurance market is the high cost of insurance premiums. Secure Choice helps make policies more affordable because the Federal and State governments will join together to pay part of the cost of long-term-care services when they are needed through a benefit subsidy.

Policies must offer case management, nursing home services and an

array of home and community-based services. Policies must offer benefit coverage equal to $60,000—approximately the cost of 2 years in a nursing home. This coverage could be used for any combination of nursing home, home-based, or community-based services.

I asked the actuarial firm, William M. Mercer, Inc., to estimate premiums for qualified policies under Secure Choice. They have reviewed my legislation and calculated that unsubsidized premiums for qualified policies would be comparable to premiums for long-term-care policies available on the market today. Furthermore, Mercer estimates that the benefit subsidy makes Secure Choice premiums more affordable for individuals with low or moderate income. For example, the Secure Choice premium for an individual at age 65 could be as low as $286 per year. That is approximately $23.83 per month for a state-of-the-art policy.

TAX CLARIFICATION

Finally, Secure Choice clears up the uncertainty about the tax treatment of long-term-care expenses and insurance by clarifying that long-term-care expenses and qualified long-term-care insurance are treated the same as medical expenses and medical insurance under the tax law. Under our bill:

First, out-of-pocket long-term-care expenses and the cost of qualified long-term-care insurance will be tax deductible—above 7.5 percent of adjusted gross income;

Second, payments for insured long-term-care services under qualified long-term-care insurance policies will not be taxable;

Third, employer-paid long-term-care services and qualified long-term-care insurance would be a tax-free employee fringe benefit; and

Fourth, insurance company reserves set aside to pay benefits under qualified long-term-care insurance policies would be tax deductible.

Mr. President, I believe Secure Choice is a sensible approach to solving this Nation's long-term-care needs. The legislation helps protect consumers by guaranteeing policy renewability and portability, and by requiring policies to meet certain consumer protection standards developed by the National Association of Insurance Commissioners.

Mr. President, my home State of Oregon has been on the cutting edge of finding innovative ways to provide long-term-care in the home and in the community. Secure Choice builds on the knowledge and expertise developed in my State. Many organizations in my State helped me pull together the ideas in the bill. These organizations include the Oregon Department of Human Resources [DHR], especially the Oregon Senior and Disabled Services [OSDS] Division of DHR; the Governor's Task Force on long-term-care and the Governor's Commission on Senior Services.

Mr. President, many other national organizations have worked with me to refine and improve the bill. These organizations include: the National Association of Insurance Commissioners; the National Association of Home Care; the American Health Care Association; the American Association of Homes for the Aging; the National Governors Association; the American Public Welfare Association; and representatives of insurance companies.

I would also like to thank the staff of the Congressional Research Service, the Congressional Budget Office, and the Senate Legislative Counsel for their hours of assistance in making this bill a reality.

Secure Choice reflects a collective effort. I have listened to affected organizations, the States, insurance companies, and individuals. I believe Senator DOLE and I have crafted a bill that responds to real needs in a responsible way.

Mr. DOLE. Mr. President, over the next several months, Congress will likely make historical decisions regarding health care in the United States. However, these effort will be incomplete unless the long-term-care needs of America's seniors and individuals who become disabled are adequately addressed. This, perhaps, will be the greatest challenge of health care reform.

All across America, millions of elderly and disabled men and women ask what type of long-term-care is available to them, and if they are able to afford it. Middle-aged and younger adults have also shared their concerns on this issue—will their parents get the high quality care they deserve—will a system be in place which will care for them as they grow older?

Mr. President, it used to be that when we talked about long-term-care, we really were referring to nursing home care. Today, that is no longer the case. long-term-care consists of a wide range of services, which include nursing home care, but also home care, personal care, and community-based care, such as adult day care.

For over 2 years, Senators PACKWOOD, SIMPSON, DURENBERGER, and I have worked together to craft comprehensive legislation, Secure Choice, which addresses the concerns we hear so often. We believe this bill is a responsible, three-step approach to the long-term-care issue.

The first step, Mr. President, involves providing a wider range of long-term-care services, such as home and community-based services, than are currently available to low income elderly and disabled Americans under Medicaid.

Part two of our legislation recognizes that the only responsible solution to long-term-care is one that calls upon the initiative of private enterprise, as well as Government. Through Government subsidies, Secure Choice would create a public/private partnership which would encourage lower income persons to purchase long-term-care insurance. This will put long-term-care insurance within the financial reach of a greater number of Americans.

The third part of Secure Choice, Mr. President, is a clarification of the Tax Code, which encourages individuals to buy long-term-care insurance, and which provides incentives for business to provide such insurance to their employees. Through this legislation, all long-term-care expenses would be treated the same as medical expenses. In addition, consumer protection standards are defined.

Mr. President, we strongly believe that this free market approach is the most responsible way to provide long-term-care services to America's seniors and disabled citizens.

long-term-care is a national problem, requiring a national solution. And Secure Choice calls on all sectors of American society—Federal and State government, private employers, insurance companies, and families and individuals to join together in ensuring that our seniors, and those with disabilities, can live with dignity.

Mr. President, we have a duty to assist those who have given so much to our country. Secure Choice fulfills that duty by offering a comprehensive approach that will result in security for Americans facing the prospect of long-term-care.

During the coming months, as we, in Congress, continue to debate health care reform, we must keep in mind that there is no true reform without long-term-care reform.

We certainly realize that Secure Choice is not the only solution that has been offered. There are others out there. But, one thing on which we can all agree is that we must do something. We simply cannot wring our hands and wish the problem away.

I am committed to this legislation, and to finding adequate financing for its implementation.

Mr. President, I ask unanimous consent to submit for the RECORD a copy of a summary of our bill.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

EXECUTIVE SUMMARY

Individuals and their families are fundamentally responsible for planning and providing for their own future long-term-care needs. Government should limit its role to providing assistance to individuals who have low income and assets either because of their economic situation or because of catastrophic long-term-care expenses. However, efforts must also be made to make long-term-care both more accessible and more affordable. This bill establishes a three-pronged approach to accomplish these goals.

A. SECURE CHOICE PROGRAM

First, the bill establishes a new Title (XXI) of the Social Security Act for long-term-care

services for functionally impaired, low-income individuals. long-term-care services now provided to these individuals through the Medicaid program would be moved to Title XXI. However, the link to cash welfare assistance would be served, and eligibility would be broadened and simplified.

Under Title XXI, states would be required to cover persons who:

1. need substantial human assistance in performing a specified number of Activities of Daily Living (ADLs);

2. have income below 100 percent of the Federal poverty level (FPL); and,

3. have assets no greater than $2,000 (if they are in a nursing facility— or $5,000 (if they are receiving home and community-based care).

States would also have to cover individuals with income above 100 percent of the FPL and who contribute enough of their income toward the cost of their care (the "medically needy" program under existing Medicaid law).

Similar to Medicaid current law, states would be required to cover nursing facility services and a mix of home and community-based services. However, a waiver would not be required to provide home and community-based services. States could also cover other services (e.g., respiratory therapy) at their option.

B. SECURE CHOICE INSURANCE PARTNERSHIP

Part of Title XXI would require states to participate in a public-private partnership to assist individuals with income below 300 percent of the FPL purchase private long-term-care insurance. Under this program States must subsidize individuals with income below 300 percent of the FPL who purchase a qualified long-term-care insurance policy.

Individuals who are able to purchase private long-term-care insurance would be encouraged to purchase a "qualified" policy. The state and Federal governments would subsidize benefits under qualified policies, depending on the individual's income. The government subsidy would make qualified insurance policies more affordable for individuals with income between below 300 percent of the FPL. Qualified policies would also guarantee, for all who purchase them, enhanced asset protection above that permitted under Title XXI.

Qualified policies would provide coverage for nursing facility services and a mix of home and community-based services. Services would be limited to those appropriate to meet the person's ADL-related needs as determined by a qualified case manager.

C. TAX CLARIFICATION

Finally, this bill clarifies that all long-term-care services (medical care and personal care) are treated as medical expenses under the tax law. This means that:

1. long-term-care expenses and insurance premiums would be tax deductible (above 7.5 percent of AGI);

2. Payments under long-term-care insurance policies would not be taxable when received; and,

3. Employer-paid long-term-care insurance would be a tax-free employee fringe benefit.

The bill also clarifies that insurance companies can deduct their reserves set aside to pay benefits under long-term-care policies.

Finally, the bill specifies consumer protection standards for long-term-care insurance policies. Policies that do not meet these standards would be denied the favorable tax treatment described above.

By Mr. BRADLEY (for himself and Mr. LEAHY):

S. 1601. A bill to amend chapter 4 of title 39, United States Code, to grant State governments the discretion to assign mailing addresses to sites within their jurisdiction; to the Committee on Governmental Affairs.

STATE ADDRESS DESIGNATION ACT

Mr. BRADLEY. Mr. President, I rise today to introduce with Mr. LEAHY the State Address Designation Act, which would permit States to establish consistent mailing addresses for municipalities. Identical legislation has been introduced in the House by Congressman SAXTON. This legislation will improve emergency services in many small townships in my State and around the country.

Under current law, the Postal Service has taken responsibility for determining mailing addresses. The postal address, which is based on postal delivery routes and the location of nearby post officer, is often vague and confusing. It may have nothing to do with the community in which an individual or family actually lives. This creates many problems for communities, particularly those in rural areas. In particular, it has delayed the implementation of 911 emergency services in those areas.

There have already been cases where emergency personnel were delayed in arriving on the scene of a serious accident because an insufficient home address—a postal address—was the only address available to the rescue squad. For example, a constituent of mine in Southhampton Township, NJ, who was badly burned in an accident did not receive prompt medical attention because emergency personnel had trouble finding the man's home. The postal address was insufficient for the rescue squad to rapidly respond to the call for help. Some communities have been unable to complete the implementation of a 911 system until they can address the problem of potentially incorrect addresses.

The current system sacrifices community identity for the sake of the bureaucratic efficiency of ZIP Codes. In areas where a small town is served by another town's post office, the name of the larger municipality may serve as the smaller town's town name on its mailing address. Many municipalities in New Jersey suffer from this identity crisis. An example, Mr. President, is Little Egg Harbor Township, which is losing its identity because the entire township has a mailing address of Tuckerton—simply because they are served by a post office in Tuckerton Borough. The South Jersey community of Westhampton is served by five larger neighboring towns; imagine, a town of 6,000 has five different town names for mail delivery purposes. Confusion abounds. Residents of Springfield in Burlington County, NJ, think of themselves as living in Springfield, but for post office purposes, they live in Jobstown, or Juliustown, or Mount Holly, or Pemberton, or Wrightstown, or Columbus, or Burlington, or Bordentown. But not Springfield.

Every home should have a single address. That address should serve the Postal Service, emergency services, the census, and the purpose of local identity. There should be nothing controversial about this idea. The Postal Service has an important mandate, which is to deliver mail to every home at the lowest cost, but local emergency services also have an important mandate, as does the Census Bureau. There must be one authority that designates a municipal address, and it could be the municipality itself, or it could be the State. In this bill, it is the State.

This legislation is similar to a bill that Congressman SAXTON and I have introduced in past Congresses, but the previous bill would have allowed municipalities to designate their own boundaries. This bill requires the Postal Service to acknowledge municipal boundaries designated and recognized by the State. This would address concerns expressed by the Postal Service that any cluster of homes might declare itself a municipality and force the Postal Service to adjust its sorting equipment. More importantly, it responds to the situation in New Jersey, where a State pilot project establishing a single address for every home in Burlington County has been thwarted by the Postal Service's insistence on conducting long and costly surveys of customer preference before acknowledging that the township of Springfield is, in fact, the township of Springfield.

Mr. President, some have argued that this legislation would wreak havoc with the Nation's post offices. I disagree. This legislation does not require the establishment of separate post offices or changes in mail delivery routes. It would not require any zip codes to change or post offices to relocate. It simply puts the authority to designate town addresses in the hands of a single political unit—the State. I would like to thank Senator LEAHY, whose State has experienced many of the same problems, for joining me in introducing this legislation, and I urge my colleagues, including those whose constituents may not yet have encountered the problems that postal addressing can cause, to give consideration to this small but important piece of legislation.

ADDITIONAL COSPONSORS

S. 455

At the request of Mr. HATFIELD, the name of the Senator from Hawaii [Mr. INOUYE] was added as a cosponsor of S. 455, a bill to amend title 31, United States Code, to increase Federal payments to units of general local government for entitlement lands, and for other purposes.

S. 732

At the request of Mr. KENNEDY, the name of the Senator from Arkansas [Mr. BUMPERS] was added as a cosponsor of S. 732, a bill to provide for the immunization of all children in the United States against vaccine-preventable diseases, and for other purposes.

S. 973

At the request of Mr. DORGAN, the names of the Senator from South Dakota [Mr. DASCHLE] and the Senator from Nebraska [Mr. EXON] were added as cosponsors of S. 973, a bill to require the Federal Communications Commission to evaluate and publicly report on the violence contained in television programs, and for other purposes.

S. 1087

At the request of Mr. KOHL, the name of the Senator from South Carolina [Mr. THURMOND] was added as a cosponsor of S. 1087, a bill to amend title 18, United States Code, to prohibit the possession of a handgun or ammunition by, or the private transfer of a handgun or ammunition to, a juvenile.

S. 1118

At the request of Mr. HATFIELD, the names of the Senator from Washington [Mr. GORTON] and the Senator from Washington [Mrs. MURRAY] were added as cosponsors of S. 1118, a bill to establish an additional National Education Goal relating to parental participation in both the formal and informal education of their children, and for other purposes.

S. 1256

At the request of Mr. DOLE, the name of the Senator from Colorado [Mr. CAMPBELL] was added as a cosponsor of S. 1256, a bill to amend the Foreign Assistance Act of 1961 to examine the status of the human rights of people with disabilities worldwide.

S. 1329

At the request of Mr. D'AMATO, the names of the Senator from Alabama [Mr. SHELBY], the Senator from Maryland [Ms. MIKULSKI], the Senator from Wyoming [Mr. WALLOP], the Senator from New York [Mr. MOYNIHAN], the Senator from Pennsylvania [Mr. SPECTER], and the Senator from California [Mrs. BOXER] were added as cosponsors of S. 1329, a bill to provide for an investigation of the whereabouts of the United States citizens and others who have been missing from Cyprus since 1974.

S. 1333

At the request of Mr. KENNEDY, the name of the Senator from Wyoming [Mr. SIMPSON] was added as a cosponsor of S. 1333, a bill to improve the admissions process at airports and other ports of entry and to strengthen criminal sanctions for alien smuggling investigatory authority of the Immigration and Naturalization Service.

S. 1350

At the request of Mr. INOUYE, the name of the Senator from Arkansas [Mr. PRYOR] was added as a cosponsor of S. 1350, a bill to amend the Earthquake Hazards Reduction Act of 1977 to provide for an expanded Federal program of hazard mitigation and insurance against the risk of catastrophic natural disasters, such as hurricanes, earthquakes, and volcanic eruptions, and for other purposes.

S. 1356

At the request of Mr. HATCH, the name of the Senator from Utah [Mr. BENNETT] was added as a cosponsor of S. 1356, a bill to restore order, deter crime, and make our neighborhoods and communities safer and more secure places in which to live and work.

S. 1408

At the request of Mr. LOTT, the names of the Senator from Mississippi [Mr. COCHRAN], and the Senator from Alabama [Mr. SHELBY] were added as cosponsors of S. 1408, a bill to repeal the increase in tax on Social Security benefits.

S. 1439

At the request of Mr. LIEBERMAN, the names of the Senator from California [Mrs. FEINSTEIN], and the Senator from California [Mrs. BOXER] were added as cosponsors of S. 1439, a bill to provide for the application of certain employment protection laws to the Congress, and for other purposes.

S. 1447

At the request of Mr. BRYAN, the names of the Senator from Missouri [Mr. DANFORTH], and the Senator from Nebraska [Mr. EXON] were added as cosponsors of S. 1447, a bill to modify the disclosures required in radio advertisements for consumer leases, loans and savings accounts.

S. 1469

At the request of Mr. DORGAN, the name of the Senator from South Dakota [Mr. DASCHLE] was added as a cosponsor of S. 1469, a bill to require air carriers to provide 90 days' notice to the Secretary of Transportation, the appropriate State agencies, and affected communities prior to the termination, suspension, or significant reduction of air service.

S. 1500

At the request of Mr. LIEBERMAN, the names of the Senator from California [Mrs. BOXER], the Senator from Pennsylvania [Mr. WOFFORD], and the Senator from Kansas [Mrs. KASSEBAUM] were added as cosponsors of S. 1500, a bill to amend the Job Training Partnership Act to establish a program to assist discharged members of the Armed Forces in obtaining training and employment as managers and employees with public housing authorities and management companies.

S. 1522

At the request of Mrs. FEINSTEIN, the name of the Senator from New York [Mr. D'AMATO] was added as a cosponsor of S. 1522, a bill to direct the United States Sentencing Commission to promulgate guidelines or amend existing guidelines to provide sentencing enhancements of not less than 3 offense levels for hate crimes.

S. 1589

At the request of Mrs. BOXER, the names of the Senator from Illinois [Mr. SIMON], and the Senator from Arkansas [Mr. BUMPERS] were added as cosponsors of S. 1589, a bill to amend title 18, United States Code, to prohibit any State motor vehicle department from disclosing certain personal information about a person doing business with such department.

SENATE JOINT RESOLUTION 52

At the request of Mr. PACKWOOD, the name of the Senator from Nevada [Mr. BRYAN] was added as a cosponsor of Senate Joint Resolution 52, a joint resolution to designate the month of November 1993 and 1994 as "National Hospice Month."

SENATE CONCURRENT RESOLUTION 20

At the request of Mr. LIEBERMAN, the name of the Senator from Pennsylvania [Mr. WOFFORD] was added as a cosponsor of Senate Concurrent Resolution 20, a concurrent resolution relative to Taiwan's Membership in the United Nations.

AMENDMENT NO. 1089

At the request of Mr. NICKLES the names of the Senator from Texas [Mrs. HUTCHISON], the Senator from Mississippi [Mr. LOTT], the Senator from Florida [Mr. MACK], the Senator from Indiana [Mr. COATS], the Senator from Georgia [Mr. COVERDELL], the Senator from Utah [Mr. HATCH], the Senator from Montana [Mr. BURNS], the Senator from Arizona [Mr. MCCAIN], and the Senator from Delaware [Mr. ROTH] were added as cosponsors of Amendment No. 1089 proposed to H.R. 3167, a bill to extend the emergency unemployment compensation program, to establish a system of worker profiling, and for other purposes.

SENATE RESOLUTION 159—RELATIVE TO THE DEPARTMENT OF LABOR

Mr. COVERDELL (for himself, Mr. KEMPTHORNE, Mrs. HUTCHISON, and Mr. NICKLES) submitted the following resolution; which was considered and agreed to:

S. RES. 159

Whereas Federal regulation of State and local governments has become increasingly extensive and intrusive in recent years;

Whereas such regulation has, in many instances, adversely affected the ability of State and local governments to achieve their independent responsibilities and meet their established priorities;

Whereas such regulation has forced State and local governments to use existing revenue sources or generate new property tax revenues to enable them to adhere to Federal mandates;

Whereas the resulting excessive fiscal burdens on State and local governments also undermine the ability of State and local governments to attain the goals of Federal regulations;

Whereas over 1,000 mayors through the United States Conference of Mayors recognized October 27, 1993, as National Unfunded Federal Mandates Day to call the attention of Congress to the fiscal emergency facing local governments as a result of the onslaught of Federal unfunded mandates;

Whereas support was given to the National Unfunded Federal Mandates Day by the National Association of Counties, the International City and County Management Association, the National Governors' Association, the National Conference of State Legislatures, and the Council of State Governments;

Whereas the report of The National Performance Review, issued September 7, 1993, states that "the President should issue a directive limiting the use of unfunded mandates by the Administration," and recommends that "Congress refrain from this practice"; and

Whereas the States must have adequate resources to implement effectively any new requirements placed on them by Federal laws and regulations: Now, therefore, be it

Resolved, That it is the sense of the Senate that the Department of Labor should provide adequate resources to the States to cover the costs of developing and implementing the worker profiling system and should provide the Governors with adequate flexibility to ensure that the funds appropriated will be made available to provide reemployment services for profiled claimants.

AMENDMENTS SUBMITTED

UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1993

GRAMM (AND OTHERS) AMENDMENT NO. 1090

Mr. GRAMM (for himself, Mr. GRASSLEY, Mr. MCCAIN, and Mrs. HUTCHISON) proposed an amendment to the bill (H.R. 3167) to extend the emergency unemployment compensation program, to establish a system of worker profiling, and for other purposes; as follows:

On page 10, line 16, strike "1994".'; and insert in lieu thereof the following: "1994".

SEC. . REDUCTION OF FEDERAL FULL-TIME EQUIVALENT POSITIONS.

(A) DEFINITION.—For purposes of this section, the term "agency" means an Executive agency as defined under section 105 of title 5, United States Code, but does not include the General Accounting Office.

(b) LIMITATIONS OF FULL-TIME EQUIVALENT POSITIONS.—The President, through the Office of Management and Budget (in consultation with the Office of Personnel Management), shall ensure that the total number of full-time equivalent positions in all agencies shall not exceed—

(1) 2,095,182 during fiscal year 1994;
(2) 2,044,100 during fiscal year 1995;
(3) 2,003,846 during fiscal year 1996;
(4) 1,963,593 during fiscal year 1997;
(5) 1,923,339 during fiscal year 1998; and
(6) 1,883,086 during fiscal year 1999.

(c) MONITORING AND NOTIFICATION.—The Office of Management and Budget, after consultation with the Office of Personnel Management, shall—

(1) continuously monitor all agencies and make a determination on the first date of each quarter of each applicable fiscal year of whether the requirements under subsection (b) are met; and

(2) notify the President and the Congress on the first date of each quarter of each applicable fiscal year of any determination that any requirement of subsection (b) is not met.

(d) COMPLIANCE.—If at any time during a fiscal year, the Office of Management and Budget notifies the President and the Congress that any requirement under subsection (b) is not met, no agency may hire any employee for any position in such agency until the Office of Management and Budget notifies the President and the Congress that the total number of full-time equivalent positions for all agencies equals or is less than the applicable number required under subsection (b).

(e) WAIVER.—Any provision of this section may be waived upon—

(1) a determination by the President of the existence of war or a national security requirement; or

(2) the enactment of a joint resolution upon an affirmative vote of three-fifths of the Members of each House of the Congress duly chosen and sworn.

PENSION ANNUITANTS PROTECTION ACT OF 1993

METZENBAUM (AND KASSEBAUM) AMENDMENT NO. 1091

Mr. MITCHELL (for Mr. METZENBAUM, for himself and Mrs. KASSEBAUM) proposed an amendment to the bill (S. 1312) to amend the Employee Retirement Income Security Act of 1974 in order to provide for the availability of remedies for certain former pension plan participants and beneficiaries; as follows:

On page 2, line 1, before the word "semicolon" and "'or" after the".

On page 2, line 7, delete "(A)".

On page 2, line 19, after "vided" add "or to be provided".

On page 3, lines 8–9, delete "other than the relief authorized in section 2 of this Act".

NOTICES OF HEARINGS

COMMITTEE ON INDIAN AFFAIRS

Mr. INOUYE. Mr. President, I would like to announce that the Committee on Indian Affairs will be holding an oversight hearing on Thursday, October 28, 1993, beginning at 9:30 a.m. in 485 Russell Senate Office Building on Public Law 101–630, the Indian Child Protection and Family Violence Prevention Act.

Those wishing additional information should contact the Committee on Indian Affairs at 224–2251.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. JOHNSTON. Mr. President, I would like to announce for the public that a hearing has been scheduled before the full Committee on Energy and Natural Resources.

The hearing will take place Wednesday, November 3, 1993, at 9:30 a.m. in room 366 of the Senate Dirksen Office Building in Washington, DC.

The purpose of the hearing is to receive testimony from Martha Krebs, nominee to be Director of the Department of Energy's Office of Energy Research.

For further information, please contact Rebecca Murphy at (202) 224–7562.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet at 6:30 p.m. on Wednesday, October 27, 1993, in closed session, to discuss matters relating to the conference on H.R. 2401, the National Defense Authorization Act for fiscal year 1994.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ARMED SERVICES

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet on Thursday, October 28, 1993, at 12 p.m. in closed session, to discuss the shipbuilding initiative related to conference with the House on H.R. 2401, the National Defense Authorization Act for fiscal year 1994.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate, Thursday, October 28, 1993, at 10 a.m. to mark up S. 783, the Consumer Reporting Reform Act of 1993; and S. 1405, the National Flood Insurance Reform Act of 1993.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on October 28, 1993, at 10 a.m. on the nomination of Jane M. Wales of Virginia, Robert T. Watson of California, and M.R.C. Greenwood of California to be Associate Directors of the Office of Science and Technology Policy [OSTP].

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate, 2 p.m., October 28, 1993, to receive testimony on nuclear safety assistance to Russia and Eastern Europe.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate, 9:30 a.m., October 28, 1993, to receive testimony concerning the administration's national action plan to reduce greenhouse gases.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Finance be permitted to meet today at 10 a.m. to hear testimony from Secretary of Health and Human Services Donna Shalala on the administration's health care proposal.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations, be authorized to meet during the session of the Senate on Thursday, October 28, 1993, at 10 a.m. to hold a nomination hearing on John Holum, to be Director of the U.S. Arms Control and Disarmament Agency.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENT AFFAIRS

Mr. MITCHELL. Mr. President, I ask unanimous consent on behalf of the Government Affairs Committee for authority to meet for markup on Thursday, October 28, on the nomination of: Joseph Swerdzewski, to be General Counsel, Federal Labor Relations Authority.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Indian Affair be authorized to meet on Thursday, October 28, 1993, beginning at 9:30 a.m., in 485 Russell Senate Office Building on Public Law 101–630, the Indian Child Protection and Family Violence Prevention Act.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to hold a business meeting during the session of the Senate on Thursday, October 28, 1993.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Thursday, October 28, 1993, at 9:30 a.m., to hold a hearing on the nomination of Michael F. DiMario, of Maryland, to be Public Printer. This confirmation hearing will be followed by a hearing on Senate Joint Resolution 143 and Senate Joint Resolution 144, providing for the appointments of Frank Anderson Shrontz and Manuel Luis Ibanez, respectively, as citizen regents of the Smithsonian Institution.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON VETERANS' AFFAIRS

Mr. MITCHELL. Mr. President, the Committee on Veterans' Affairs would like to request unanimous consent to hold a markup on pending legislation, followed immediately by a hearing on the nominations of Eugene A. Brickhouse to be Assistant Secretary for Human Resources and Administration, and Kathy Elena Jurado to be Assistant Secretary for Public and Intergovernmental Affairs. The markup and the hearing will be held in room 418 of the Russell Senate Office Building at 2 p.m. on Thursday, October 28, 1993.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Thursday, October 28, 1993, at 3 p.m. to hold an open hearing on NAFTA.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOL

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Subcommittee on Children, Family, Drugs and Alcoholism, Committee on Labor and Human Resources, be authorized to meet for a hearing on "Witness to Domestic Violence: Protecting Our Kids," October 28, 10 a.m.

In addition, I ask unanimous consent that the Committee on Labor and Human Resources be authorized to meet for a hearing on "S. 1115: Implications of the Fair Labor Standards Act for Inmates, Correctional Institutions, Private Industry and Labor," October 28, 2:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON CLEAN AIR AND NUCLEAR REGULATION

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Subcommittee on Clean Air and Nuclear Regulation, Committee on Environment and Public Works, be authorized to meet during the session of the Senate on Thursday, October 28, beginning at 10 a.m., to conduct a markup of S. 1162, a bill to authorize the Nuclear Regulatory Commission [NRC] for fiscal years 1994 and 1995, and S. 1165 and S. 1166, bills concerning the NRC's legislative authority.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON SCIENCE, TECHNOLOGY AND SPACE

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Science, Technology and Space Subcommittee of the Committee on Commerce, Science and Transportation be authorized to meet on October 28, 1993, at 10:30 a.m. on NASA's relevance to the economy.

The PRESIDING OFFICER. Without objection, it is so ordered.

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, be authorized to meet during the session of the Senate on Thursday, October 28, 1993, to hold a hearing on abuses in Federal student grant programs.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

COMMUNITY COMES TOGETHER TO FIND LOST GIRLS

• Ms. MIKULSKI. Mr. President, I rise today to recognize an incredible outpouring of support and community spirit in my State's Garrett and Allegany Counties. Late Monday afternoon, October 18, two young girls, 8 and 9 years old, wandered away from a children's home in eastern Garrett County. These young girls wandered into the nearby woods and became lost. The reason I rise today is to tell a good story, a story with a happy ending, where members of the community came together and gave of themselves to find these two lost girls.

Upon realization of the lost girls, members of the Maryland State Police and Maryland Rangers immediately began a search covering a massive geographic area. This search went all through the night, and by the time it had concluded, scores of local agencies and citizens were involved. Search parties were formed. Local business people closed their shops to help. The massive search included: the Maryland Department of Resources Police from the Billmeyer Work Center, Rangers from New Germany State Park, Deep Creek Lake State Park, Savage River State Forest, Potomac Garrett State Forest and Herrington Manor State Forest, the Maryland State Police including members of the McHenry Barracks, the Cumberland Barracks, the K9–1 Unit from Jessup, and the Aviation Division in Cumberland, the Mt. Nebo Forestry Service, the Cumberland Forestry service, the Western Maryland Crime Search Team, the Northern Garrett County Rescue Squad, the Frostburg Ambulance Service, volunteers from local fire companies including Grantsville, Eastern Garrett/Finzel,

Accident, Bittinger, Swanton, Deer Park, Oakland, Lonaconing, Frostburg, Clarysville, and Corrigansville. Even the local Grantsville Subway Shop got involved by sending doughnuts and subs to feed the volunters.

Mr. President, thanks to the tireless efforts of a community bound together, determined to help, the young girls were found in the woods unharmed the next afternoon. I honor and commend the people of Garrett and Allegany Counties for their commitment to their fellow citizens, and their commitment to the lives of two young Marylanders with much more to give to this world.

Particular thanks goes to Rangers John Frank, Rick Lewis, and Joe Stevens, DNR Public Communications Officer Gary Yoder, State Police Maj. W. Raymond Presley and Lt. Charles Hinnant, Troopers Rodeheaver and Tindal, and the Medivac Helicopter Team. These Marylanders went above and beyond the call of duty to help their fellow citizens.•

REMARKS BY ENERGY SECRETARY O'LEARY

• Mr. JOHNSTON. Mr. President, on October 25 the Associated Press carried a report from London on remarks by Energy Secretary Hazel O'Leary during her attendance at an annual conference on oil and money.

That wire service account unfortunately generated a great deal of confusion and concern with regard to the administration's policy toward domestic oil and gas production. Subsequently I discussed this matter with Secretary O'Leary and am satisfied that her remarks were, indeed, misrepresented.

I am reassured by the statement of clarification issued by the Secretary on October 26. I ask that her statement be reprinted in the RECORD and commend it to the attention of my colleagues.

The statement follows:

[From DOE News, Oct. 26, 1993]

The following is a response from Secretary of Energy Hazel R. O'Leary to an October 26 Associated Press wire service news story by Dirk Beveridge:

"This statement will clarify this Department's and Administration's policy toward the domestic energy industry. As one of the Secretaries of Energy with an extensive knowledge of and background in domestic gas and oil matters, I clearly recognize that independent producers are responsible for the production of more than 60 percent of the gas in this country and more than 37 percent of its oil. Natural gas is a critical element in the President's energy strategy, and independents are a major source for new supplies, comprising more than 80 percent of all new oil and gas discoveries in the United States. Since taking office in January of this year, the Department has launched several initiatives aimed at creating markets for the domestic industry.

I have also proposed to dramatically increase the Department's research and development efforts for gas and oil to levels far in excess of any other Administration in order to make gas and oil exploration and production more economic. The domestic natural gas and oil industry is a high tech, high wage business that we will attempt to encourage in order to take full advantage of our domestic resources and of export markets for exploration and production technology and equipment.

"Next month, the Administration will release its domestic natural gas and oil initiative. I launched this initiative before the Louisiana State Legislature in April and stated the urgency to create a climate which would encourage increased domestic exploration and production. Most importantly, I have stated many times previously, and did so again yesterday, that it is this Secretary's obligation to educate the American public of the critical importance of this industry to the Nation's economic and national security. We have learned many times that the Congress and the public will not support policies which benefit producers and the Nation until they believe it is in the Nation's interest to do so. In partnership with the industry, it is my job to educate the American public of the vital importance of this industry so as to implement beneficial policies.

I have met with many of my colleagues from the independent community several times since taking office to discuss ideas which will benefit the industry and the public, most recently in Oklahoma two weeks ago. I look forward to continuing this dialogue with my colleagues in the independent community to develop policies which create an economic climate that allows these business leaders the opportunity to make rational investment decisions which will increase product and jobs."•

NOMINATION OF JANET NAPOLITANO

• Mr. LOTT. Mr. President, the nomination of Janet Napolitano to be U.S. attorney from Arizona fundamentally challenges the Senate to consider carefully our constitutional responsibilities. Article II, section 2 gives to the Senate the duty of advice and consent to nominations which may be made by the President. To make a judgment on any nominee requires that the Senate know that the person be of high moral character and competence. To make a decision without all of the pertinent information available would be to shirk our constitutional responsibility.

In the nomination of Janet Napolitano, we are faced with a situation which does not allow us to answer all of the questions, and to determine absolutely that there is no problem in her background. She has asserted attorney-client privilege in the matter of her representation of Anita Hill. This claim is subject to question on technical grounds. The memorandum which follows ought to be read by every Senator before any action is taken on this nomination. It details why the assertion made by Ms. Napolitano is questionable.

It also reviews the responsibility of the Senate to require information on which to judge a candidate before advice and consent are given to appointive office. During the consideration of the nominations of Chief Justice Rehnquist and Justice Scalia in 1986, a claim of executive privilege withholding information on the nominees' tenure in the executive branch was exerted by the White House. In that case an agreement was made to give the Judiciary Committee the information that they needed. The Senate made the point that the duty of advice and consent was more important than the claim of executive privilege. Senator KENNEDY noted that the information was needed to fulfill Senate responsibilities. He said the agreement was "a very substantial victory for the Constitution and the constitutional process." I hope we are able to realize a similar victory for the Constitution in this case.

I ask that the following memorandum be included in the RECORD at this point.

The memorandum follows:

MEMORANDUM

In response to questions about her conduct during an October 11, 1991 interview of Judge Susan Hoerchner by lawyers for the Senate Judiciary Committee, Janet Napolitano has invoked on behalf of Judge Hoerchner the so-called "pooled information" or "joint defense" extension of the attorney-client privilege. Ms. Napolitano thus seeks confirmation as United States Attorney for the District of Arizona—the highest ranking federal law enforcement official in the State—despite significant unresolved charges that she suborned false or misleading testimony before the Committee. Neither law nor reason compels the Senate to accept this claim of privilege, and thus abdicate its advice and consent responsibilities, without further investigation.

I. THE ATTORNEY-CLIENT PRIVILEGE DOES NOT APPLY TO CONFIRMATION HEARINGS FOR A PROSPECTIVE UNITED STATES ATTORNEY

A. Congress may reject claims of attorney-client privilege at its discretion

"Attorney-client privilege can not be claimed as a matter of right before a congressional committee." Memorandum Opinion of General Counsel to the Clerk of the House of Representatives on Attorney-Client Privilege (Dec. 11, 1985), *reprinted* in 132 Cong. Rec. H674 (daily ed. Feb. 27, 1986) [hereinafter General Counsel Memorandum]. Older than the Republic itself, this rule finds support in the text of the Constitution; in literally hundreds of years of settled precedent, both legislative and judicial; and in a 1986 memorandum prepared for Congress by Professor Stephen Gillers, who now contends that the Judiciary Committee must accept the claim of attorney-client privilege asserted by Ms. Napolitano.

The Constitution provides explicitly that "Each House may determine the rules of its Proceedings." U.S. Const. Art. I, §5, cl. 2. This grant of authority is qualified by certain constitutional privileges, such as the right against Self-Incrimination. The attorney-client privilege, however, is not secured by the Constitution, but is developed by the judiciary through the common law method. *See, e.g.*, Fed. R. Evid. 501 (federal privilege rules are "governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience"); *Upjohn Co. v.*

United States, 449 U.S. 383, 389 (1981) (attorney-client is a common-law privilege); J. Weinstein & M. Berger, *Weinstein's Evidence* ¶ 503[02], at 503-19 (1993) (same). As the Congressional Research Service has explained, to extend such a common-law privilege to congressional investigations "would, in effect, permit the judiciary to determine congressional procedures and is therefore difficult to reconcile with the constitutional authority granted each House of Congress to determine its own rules." Memorandum From Congressional Research Service to Clerk of the House of Representatives (Feb. 19, 1986), *reprinted in* 132 Cong. Rec. H681 (daily ed. Feb. 27, 1986) [hereinafter CRS Memorandum].

At common law, the courts were bound by the attorney-client privilege, but the Parliament was not. As one distinguished English treatise explains: "A witness is . . . bound to answer all questions which the committee sees fit to put to him, and cannot excuse himself, for example, . . . because the matter was a privileged communication to him, as where a solicitor is called upon to disclose the secrets of his client . . . some of which would be sufficient grounds of excuse in a court of law." E. May, *Treatise on the Law, Privileges, Proceedings and Usage of Parliament* 746-47 (20th ed. 1983). The historical practice in England thus confirms the plain meaning of the Rules of Proceedings Clause: that "Each House" of Congress—not the judiciary—has plenary authority to "determine the rules of its Proceedings."

Professor Gillers himself has endorsed this traditional understanding in prior congressional testimony. In addressing the question "Does the [attorney-client] privilege apply in Congress?," Professor Gillers explained:

"Congress is obligated to observe constitutional privileges, such as the privilege against self-incrimination. It is not obligated to honor subconstitutional privileges created by statute or common law. While it has been suggested that in criminal prosecutions the attorney-client privilege may to some extent be of constitutional dimension, this is not a criminal prosecution. . . .

"Congress has the power to defeat assertion of a statutory or common law privilege even though the privilege would be recognized in court." Memorandum From Stephen Gillers to Rep. Stephen Solarz (Feb. 19, 1986), *reprinted in*, 132 Cong. Rec. H679 (daily ed. Feb. 27, 1986).

The Congress has enacted no rules or statutes recognizing the attorney-client privilege in congressional hearings. As the Subcommittee on Asian and Pacific Affairs on the House Committee on Foreign Relations has explained, "[n]o statute, House rule, or [Committee] rule changes the English rule that attorney-client privilege does not have to be accepted in legislative proceedings; Congress has never decided to impose that restriction on its proceedings." H.R. Rep. No. 462, 99th Cong., 1st Sess. (1985), *reprinted in*, 132 Cong. Rec. H666, at H670 (daily ed. Feb. 27, 1986). "Consistently, Congressional committees have felt enabled to reject the applicability of claims of attorney-client privilege." General Counsel Memorandum, *supra*, at H675. This willingness has been apparent throughout American history.

In the late 19th Century, the House conducted an investigation into financing practices of the Union Pacific Railroad. During hearings, Joseph B. Stewart, counsel for Union Pacific, declined to answer certain questions on the ground of attorney-client privilege. "Unimpressed, the House locked him up" for contempt. T. Taylor, *Grand Inquest: The Story of Congressional Investigations* 45 (1955). The Supreme Court for the District of Columbia upheld the sanction, notwithstanding Stewart's assertion of the privilege. *See Stewart* v. *Blaine*, 8 D.C. (1 MacArth.) 453 (D.C. 1874).

In 1934, the Senate conducted an investigation into the contracting practices of the Postmaster General. During hearings, attorney William P. MacCracken, Jr. resisted a subpoena to produce certain documents on the ground of attorney-client privilege. The Senate ordered MacCraken to produce the documents notwithstanding his assertion of the privilege. *See Jurney* v. *MacCracken*, 294 U.S. 125, 146 (1935). In ensuring litigation, MacCraken abandoned his contention that the privilege applied to congressional hearings, and the Supreme Court noted in passing that the Senate "had authority to require the production of papers as a necessary incident of the power of legislation." *Id.* at 144.

In 1954, both the Senate and the House explicitly rejected proposals to incorporate the attorney-client privilege in their respective Rules. *See* S. Rep. No. 2, 84th Cong., 1st Sess. 27-28 (1954); H.R. Res. 178, 84th Cong., 1st Sess. (1954).

In the late 1970s and early 1980s, the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce repeatedly rejected claims of attorney-client privilege. *See* Attorney-Client Privilege: Memoranda Opinions of the American Law Division, Library of Congress, Committee Print 98-I (98th Cong. June 1983); Hearings on the International Uranium Cartel Before the Subcomm. on Oversight and Investigation of the House Comm. on Interstate and Foreign Commerce, 95th Cong., 1st Sess. Vol. 1 (1977). Committee and Subcommittee Chairman John Dingell explained.

"[T]here is ample support for the view that the availability of the attorney-client privilege is a matter of discretion with the Subcommittee based on analogous judicial authority, coupled with the full investigative prerogatives of Congressional committees acting within their jurisdiction for a valid legislative purpose, the custom, practice and precedents of both Houses of the Congress and the British Parliament, and the consistent practice of the Subcommittee * * *."

In 1986, the Subcommittee on Asian and Pacific Affairs of the House Committee on Foreign Relations conducted an investigation into the real estate holdings of deposed Philippine President Ferdinand Marcos. The Subcommittee rejected claims of attorney-client privilege in part on the "independent" ground that Congress is not bound by the privilege. *See* H.R. Rep. No. 462, *supra*, 132 Cong. Rec. at H669. The Subcommittee noted that *Congress* makes the privilege determinations applicable to legislative proceedings (except for constitutional privileges), and warned that the wholesale application of judicially recognized common-law privileges "would bring key congressional inquires to a halt" Id. at H670.

No judicial decision has questioned Congress's authority to determine the constitutional privilege rules applicable to its own proceedings. On the contrary, the Supreme Court has recognized that "only infrequently have witnesses appearing before congressional committees been afforded the procedural rights normally associated with an adjudicative proceeding." *Hannah* v. *Larche*, 363 U.S. 420, 445 (1960). *See also United States v. Fort*, 443 F.2d 670, 678-82 (D.C. Cir. 1970), *cert. denied*, 403 U.S. 932 (1971). Indeed, the only judicial decision squarely on point upheld the power of Congress to disregard the attorney-client privilege in its own hearings. *See Stewart v. Blaine*, 8 D.C. (1 MacArth.) 453 (D.C. 1874); CRS Memorandum, *supra*, at H681 ("[N]o court has ever questioned the assertion of the prerogative. . . ."). States v. Fort, 443 F.2d 670, 678-82 (D.C. Cir. 1970), *cert. denied*, 403 U.S. 932 (1971). Indeed, the only judicial decision squarely on point upheld the power of Congress to disregard the attorney-client privilege in its own hearings. *See Stewart v. Blaine*, 8 D.C. (1 MacArth.) 453 (D.C. 1874); CRS Memorandum, *supra*, at H681 ("[N]o court has ever questioned the assertion of the prerogative. . . .").

Finally, rejection of the attorney-client privilege in this context reflects sound policy judgments. On the one hand, "the necessity to protect the individual interest in the adversary process is far less compelling in an investigative setting where a legislative committee is not empowered to adjudicate the liberty or property interests of a witness." *Id.* at H682. On the other hand, "complete, untempered importation of the privileges and procedures of the judicial forum is likely to have a paralyzing effect on the investigatory process of the legislature." *Id.*; *see also* H.R. Rep. No. 462, *supra*, 132 Cong. Rec. at H670 (similar).

Neither Ms. Napolitano nor her advocates cite any contrary authority, congressional or judicial. Remarkably, Ms. Napolitano does not even acknowledge, much less attempt to overcome, the grave difficulties of her assertion of attorney-client privilege in the context of a *congressional* proceeding. Instead, she cites decisions governing application of the privilege in *judicial* proceedings and then analyzes her privilege claim as if those decisions were controlling. *See* Answers of Janet Napolitano to Questions Submitted by Senators Simpson and Thurmond, at 1 (Sept. 23, 1993) [hereinafter Napolitano Answers]. At best, her response indicates rather cavalier legal preparation for someone who would become a United States Attorney. The privilege analyses of Professors Hazard and Gillers, which likewise fail to address this issue entirely, are similarly deficient.

For all of these reasons, the Senate is not obligated to accept Ms. Napolitano's claim of attorney-client privilege even if a court, under similar circumstances, would.

B. The Senate should reject claims of attorney-client privilege asserted in the context of confirmation hearings for a prospective United States attorney.

Although congressional committees have discretion to entertain individual claims of attorney-client privilege, the Congress generally has been reluctant to do so, as the above discussion suggests. "[W]here in the particular circumstances an investigation determines that the legislative need for the information outweighs the arguments against production, such production has been required." H.R. Rep. No. 462, *supra*, 132 Cong. Rec. at H669. This is clearly such a case.

The Constitution requires the Senate to provide "Advice and Consent" to appointments by the President of "Officers of the United States." U.S. Const. Art. II, §2, cl. 2. In this context, the "legislative need for the information" is unusually strong. In the *Stewart*, *MacCracken* and Marcos cases, for example, Congress compelled testimony pursuant to its investigations of railroad financing, government contracting, and the acquisition of real estate by foreign potentates—even though the attorney-client privilege

would have protected that same testimony from compelled disclosure in court. The Constitution authorizes, but does not compel, Congress to act in each of these areas. Faced with difficulties in gathering information, Congress might decide to leave problems in these areas for resolution in executive, administrative, judicial, or private fora. The advice-and-consent context is different, however. Only the Senate can perform that function, and it obviously needs all relevant information about a nominee to do so properly.

The importance of the office to which Ms. Napolitano has been nominated only heightens the Senate's need to complete and accurate information about her background and professional integrity:

"The United States Attorney is the representative not of an ordinary party to a controversy, but of a sovereignty whose obligation to govern impartially is as compelling as its obligation to govern at all; and whose interest, therefore, in a criminal prosecution is not that it shall win a case, but that justice shall be done. . . . He may prosecute with earnestness and vigor—indeed, he should do so. But, while he may strike hard blows, he is not at liberty to strike foul ones. It is as much his duty to refrain from improper methods calculated to produce a wrongful conviction as it is to use every legitimate means to bring about a just one."

Berger v. *United States*, 295 U.S. 78, 88 (1935). As Attorney General (later Justice) Jackson explained, a prosecutor must maintain "a detached and impartial view" of all citizens, lest "the real crime" become "that of being unpopular with the predominant or governing group, being attached to the wrong political views, or being personally obnoxious to or in the way of the prosecutor himself." R. Jackson, The Federal Prosecutor, Address Delivered at the Second Annual Conference of United States Attorneys (April 1, 1940). In order to fulfill its advice and consent responsibilities, the Senate must have unimpeded access to all information bearing on whether a prospective United States Attorney will refrain from the "improper methods" condemned in *Berger*, or the partiality decried by Justice Jackson. Evidence that a nominee encouraged false or misleading testimony while in private practice is obviously and highly relevant to this inquiry.

The interests of the witness and the attorney are relatively narrow in the context of confirmation proceedings in general, and this confirmation proceeding in particular. As the Congressional Research Service has explained, "the necessity to protect the individual interest in the adversary process is far less compelling in an investigative setting where a legislative committee is not empowered to adjudicate the liberty or property interests of a witness." CRS Memorandum, *supra*, at H682. The issue here is not whether Ms. Napolitano (or Judge Hoerchner) should be civilly or criminally liable for any wrongdoing that they might have undertaken, but only whether Ms. Napolitano should be confirmed as a United States Attorney. The congressional hearings in this case clearly do not portend any criminal investigation or civil enforcement proceeding—a special context in which Congress has, on occasion, permitted claims of attorney-client privilege. *Compare* N.Y. Times, July 10, 1987, at A8, col. 4 (noting assertion of attorney-client privilege in congressional hearings by Brendon Sullivan on behalf of Oliver North).

In sum, because the Senate's need for all relevant information about Ms. Napolitano's background (if she wishes to proceed with her nomination) clearly outweighs Ms. Napolitano's and Judge Hoerchner's interests against production, the Senate should require Ms. Napolitano to answer its questions notwithstanding her misplaced assertion of attorney-client privilege on behalf of Judge Hoerchner.

II. THE "POOLED INFORMATION" PRIVILEGE ASSERTED BY MS. NAPOLITANO WOULD NOT APPLY EVEN UNDER THE STANDARDS THAT GOVERN JUDICIAL PROCEEDINGS

Ms. Napolitano has asserted that her communications to Judge Hoerchner during the October 11, 1991 Judiciary Committee interview are protected against disclosure by the so-called "pooled information" or "joint defense" extension of the attorney-client privilege. The attorney-client privilege itself is clearly inapposite, because Ms. Napolitano makes no contention that she has ever represented Judge Hoerchner. *See* Napolitano Answers, *supra*, at 2. For several reasons, however, the "pooled information" privilege would not protect Ms. Napolitano against compelled disclosure even assuming (contrary to law) that the standards applicable to judicial proceedings also govern confirmation proceedings.

A. Testimonial privileges must be narrowly construed

Testimonial privileges "contravene the fundamental principle that '"the public has a right to every man's evidence."'" *Trammel v. United States*, 445 U.S. 40, 50 (1980) (citation omitted). Therefore, "they must be strictly construed and accepted 'only to the very limited extent that permitting a refusal to testify or excluding relevant evidence has a public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth.'" *Id.* (citation omitted).

Addressing the attorney-client privilege specifically, the Supreme Court has repeatedly instructed that "'since the privilege has the effect of withholding relevant information from the factfinder, it applies only where necessary to achieve its purpose.'" *United States v. Zolin*, 491 U.S.C. 554, 562 (1989), quoting *Fisher v. United States*, 425 U.S. 391, 403 (1976). As Judge Becker has explained, "[b]ecause the attorney-client privilege obstructs the truth-finding process, it is construed narrowly." *Westinghouse v. Republic of the Philippines*, 951 F.2d 1414, 1423 (3d Cir. 1991). *See also* M. Larkin, *Federal Testimonial Privileges*, §2.01, at 2–4 (1993) ("Since the privilege is generally in derogation of the broad duty of witnesses to disclose the information in their possession, the privilege should ordinarily be confined within the *narrowest possible limits* consistent with its purpose." (emphasis added)). And if the attorney-client privilege itself must be narrowly construed, then, clearly, so too must be the "pooled information" extension of that privilege.

Ms. Napolitano, however, asserts a "pooled information" privilege that is unprecedently broad in three critical respects. Any one of these is enough to defeat her claim of privilege.

B. The "pooled information" privilege requires concerted action not present here

The "pooled information" privilege does not cover any communication between a client and the lawyer of another. Rather, it protects only those communications that are "part of an on-going and joint effort to set up a common defense strategy." *Eisenberg v. Gagnon*, 766 F.2d 770, 787 (3d Cir.), *cert. denied sub nom. Weinstein v. Eisenberg*, 474 U.S. 946 (1985). In *Matter of Bevill, Bresler & Schulman Asset Management Corp.*, 805 F.2d 120 (3d Cir. 1986), the Third Circuit specified the elements of the "pooled information" or "joint defense" privilege:

"In order to establish the existence of a joint defense privilege, the party asserting the privilege must show that (1) the communications were made in the course of a joint defense effort, (2) the statements were designed to further the effort, and (3) the privilege has not been waived."

Id. at 126. *Bevill* thus squarely places the burden of proof on the party invoking the privilege (consistent with privilege law generally), and its three requirements subsume a subsidiary fourth requirement—"that the parties had agreed to pursue a joint defense strategy." *Id.*

Bevill has been widely adopted by the Courts of Appeals. In *United States v. Bay State Ambulance & Hospital Rental Service*, 874 F.2d 20, 28–29 (1st Cir. 1989), the First Circuit quoted *Bevill* verbatim and then rejected a claimed joint defense privilege because its proponent had failed to prove that the relevant communication "was prepared as part of a joint defense." In *United States v. Schwimmer*, 892 F.2d 237, 243 (2d Cir. 1989), the Second Circuit, citing *Bevill*, defined the privilege as applicable "where a joint defense effort or strategy has been decided upon and undertaken by the parties and their respective counsel."

In this case, Ms. Napolitano has not established the necessary agreements among the respective attorneys and clients. There was clearly no agreement between the counsel for Professor Hill and Ron Allen, who served as counsel for Judge Hoerchner. Ms. Napolitano was asked: "Was there any agreement among such counsel?" She responded without qualification: "There was no written agreement among counsel"—a response more charitably read as asserting the absence of any agreement among counsel, written or oral, then as attempting to mislead the Committee (by only partial responsiveness) about the existence of an oral agreement. *See* Napolitano Answers, *supra*, at 3. Moreover, Ms. Napolitano has not alleged that the relevant *clients*, Professor Hill and Judge Hoerchner, agreed upon a "joint defense effort or strategy." Instead, she described Judge Hoerchner only as one of three "corroborating witnesses Professor Hill invited to testify in support of her position." *Id.* That description, however, falls far short of alleging, much less proving, that Professor Hill and Judge Hoerchner had agreed to coordinate their testimony and strategy during the confirmation hearings of Justice Thomas. Finally, even assuming the existence of some agreements between Ms. Napolitano and Mr. Allen, and between Professor Hill and Judge Hoerchner, Ms. Napolitano has not alleged that her communications to Judge Hoerchner during the October 11, 1991 interview were "designed to further" the joint effort.

Professor Geoffrey Hazard speculates that although the transcript of the October 11, 1991 interview "does not indicate one way the other, * * * it may have been that the Attorneys Allen and Napolitano nodded or otherwise silently communicated with each other before Ms. Napolitano spoke." Letter From Professor Geoffrey Hazard to Senator Dennis DeConcini, at 6 (Sept. 28, 1993) [hereinafter Hazard Letter]. That freewheeling speculation, to the extent it is offered to satisfy the *Bevill* elements, is plainly inadequate. The law requires the proponent of the privilege to "show" that the predicate elements do obtain, not to guess how they might.

C. The "pooled information" privilege does not apply outside the context of pending of imminent litigation

Rather than construing the "pooled information" or "joint defense" privilege narrowly, as settled law requires, Ms. Napolitano seeks to establish an unprecedented extension of that privilege outside the context of actual or imminent litigation. She makes no attempt to justify this extension, however—another example of her rather cavalier invocation of the privilege.

A memorandum prepared for Senator Biden, which endorses Ms. Napolitano's invocation of the privilege, identifies in support of the necessary extension exactly three sentences from a single district court opinion decided over 17 years ago, *SMC Corp. v. Xerox Corp.*, 70 F.R.D. 508 (D. Conn.), *appeal dismissed and mandamus denied*, 534 F.2d 1031 (2d Cir. 1976). But *SMC* involved a joint defense privilege asserted *after* litigation had in fact begun, and the Biden Memorandum properly identifies the relevant language from the case as dicta. *See* Memorandum to Senator Biden From Nominations Staff Re. Nomination of Janet Napolitano To Be the U.S. Attorney For the District of Arizona, at 4 (Sept. 28, 1993) [hereinafter Biden Memorandum].

Ms. Napolitano and the Biden Memorandum cite various secondary sources. But to the limited extent that they address the question whether the "pooled information" privilege applies outside the context of actual or imminent litigation, a majority of those sources undercut the position asserted by Ms. Napolitano. *Compare* Revised Uniform Rules of Evidence Rule 502(b)(3) (1974) (privilege applies to a communication by a client "to a lawyer or a representative of a lawyer representing another party *in a pending action* and concerning a matter of common interest therein" (emphasis added)) *and* 2 J. Weinstein, *Weinstein's Evidence* §503(b) [06], at 503–99 (1993) ("'No American case has allowed a [pooled information] privilege . . . in a situation totally unrelated to litigation.'" (citation omitted)) *with* Restatement of the Law Governing Lawyers §126 reporter's note, at 194 (Tentative Draft No. 2) (1989) (proposing to extend privilege beyond the litigation context) [hereinafter Restatement].

The memoranda prepared by Professor Hazard and Professor Gillers, which support Ms. Napolitano's invocation of the privilege, do not even address this issue.

D. No privilege applies because statements by Ms. Napolitano will not reveal privileged communications made by Judge Hoerchner

As classically formulated, the attorney-client privilege extends only to communications from the client to the attorney. *See, e.g., United States v. United Shoe Machinery Corp.*, 89 F. Supp. 357, 358–59 (D. Mass. 1950) (Wyzanski, J.); 8 J. Wigmore, *Evidence* §2292 (McNaughton rev. 1961); *see also* Biden Memorandum, *supra*, at 2. Therefore, communications from the attorney to the client are shielded only if they "rest on confidential information obtained from the client." *In re Sealed Case*, 737 F.2d 94, 99 (D.C. Cir. 1984). But because a claimant must always "present to the court sufficient facts to establish the privilege," as Justice Ginsburg has noted, a claimant in this context "must demonstrate with *reasonable certainty* that the lawyer's communication rested in *significant and inseparable part* on the client's confidential disclosure." *Id.* (emphases added and citation omitted). *See, e.g., American Standard, Inc. v. Pfizer Inc.*, 828 F.2d 734, 745 (Fed. Cir. 1987) (privilege applies to "lawyer-to-client communications that reveal, directly or indirectly, the substance of a confidential communication by the client"); *United States v. (Under Seal)*, 748 F.2d 871, 874 (4th Cir. 1984) (privilege "may also be extended to protect communications by the lawyer to his client . . . if those communications reveal confidential client communications"); *Matter of Fischel*, 557 F.2d 209, 211 (9th Cir. 1977) ("The privilege does not extend, however, beyond the substance of the client's confidential communications to the attorney."); M. Larkin, *supra*, at 2–57 to -58 ("The privilege also protects the legal advice provided by the attorney to the client, but generally only to the extent that disclosure would reveal the substance of the client's confidential communication.").

In this case, Ms. Napolitano has alleged nothing to suggest, much less "demonstrate with reasonable certainty," that the disclosure of statements made by Ms. Napolitano to Judge Hoerchner would also reveal the content of confidential statements made by Judge Hoerchner, on whose behalf she has invoked the privilege, to Ms. Napolitano. Indeed, Ms. Napolitano has not indicated that she had received *any* communication from Judge Hoerchner between October 9, 1991, when she agreed to represent professor Hill, and October 11, 1991, when Ms. Napolitano made the allegedly privileged statements to Judge Hoerchner during the Judiciary Committee interview. On the contrary, a careful reading of Ms. Napolitano's assertions suggests that no such communication took place.

When Ms. Napolitano asked to confer with Judge Hoerchner and her counsel off the record, Judge Hoerchner was testifying about the date of a particular phone call between herself and Professor Hill. In the current confirmation proceedings, the Committee asked Ms. Napolitano: "Prior to and during Hoerchner's testimony before the Judiciary Committee [on October 13, 1991], did you have any discussions with Hoerchner or her representatives about the timing of Hill's call?" Ms. Napolitano answered: "I did have at least one discussion with Judge Hoerchner *after* the interview and prior to her Committee appearance. The conversation took place in a room in the Capitol and, to the best of my recollection, was on Saturday, October 12, 1991." Napolitano Answers, *supra*, at 7-8 (emphasis added). If that response is truthful, then the October 11 statements from Ms. Napolitano to Judge Hoerchner would have *no* possibility to reveal the contents of confidential statements made by Judge Hoerchner to Ms. Napolitano, because no prior conversations between them had occurred.

The Biden, Hazard and Gillers memoranda all fail to address this issue.

III. EVEN IF A "POOLED INFORMATION" PRIVILEGE WERE OTHERWISE AVAILABLE, THE DISPUTED STATEMENTS WOULD BE SUBJECT TO IN CAMERA REVIEW TO DETERMINE WHETHER THE CRIME-FRAUD EXCEPTION SHOULD APPLY

It is hornbook law that the attorney-client privilege "'ceas[es] to operate at a certain point, namely, where the desired advice refers *not to prior wrongdoing*, but to *future wrongdoing*.'" *Zolin*, 491 U.S. at 562–63, quoting 8 J. Wigmore, *supra*, §2298, at 573 (emphasis in Wigmore). *See also* M. Larkin, *supra*, §2.07[1], at 2-138 to -139 ("The privilege does not protect communications made by either the client or the attorney for the purpose of providing or receiving advice or assistance with respect to, in furtherance of, or to induce or to conceal the commission of a present, continuing, or future crime or fraud. . . ."). The crime-fraud exception is fully applicable where the future wrongdoing involves the presentation of false testimony. *See e.g., United States v. Townsley*, 843 F.2d 1070, 1086 (8th Cir. 1988); *United States v. Soudan*, 812 F.2d 920, 925 (5th Cir. 1986), *cert. denied*, 107 S. Ct. 2187 (1987); *United States v. Gordon-Nikkar*, 518 F.2d 972, 975 (5th Cir. 1975).

The crime-fraud exception applies not only to the attorney-client privilege, but to the "pooled information" extension of the privilege. *See, e.g., Haines v. Liggett Group, Inc.*, 975 F.2d 81, 94–97 (3d Cir. 1992). Indeed, the draft Restatement on which Ms. Napolitano principally relies stresses the importance of the crime-fraud exception in this contest, precisely because "the pooled-information rule may increase the risk of illegal collusion." Restatement, *supra*, §126 comment b. The Restatement argues that "the rule does not lead to significantly increased collusion," because it "protects pooling arrangements only for legitimate purpose." *Id.* Thus,

"If the purpose of the participating members of the pool is to further future crimes or frauds, for example to present perjured testimony or other false evidence, the illegal-act exception to the privilege removes its protection entirely." *Id.*

In *Zolin*, the Supreme Court developed three standards for evaluating claims that the crime-fraud exception is applicable. First, the Court held that "*in camera* review may be used to determine whether allegedly privileged attorney-client communications fall within the crime-fraud exception." 491 U.S. at 574. The Court noted that the absence of such review would produce the "absurd result" that crime-fraud claims could almost never be proven. *Id.* at 566. Second, the Court held that the party seeking to establish the crime-fraud exception, in order to obtain an *in camera* review, "must present evidence sufficient to support a *reasonable* belief that *in camera* review *may* yield evidence that establishes the exception's applicability." *Id.* at 574–75 (emphases added). The Court stressed that because "a lesser evidentiary showing is needed to trigger *in camera* review than is required ultimately to overcome the privilege," the applicable standard "need not be a stringent one." *Id.* at 572. Third, the Court held that the threshold showing to obtain *in camera* review may by met by using "*any* relevant evidence"—even unprivileged evidence that is "not 'independent' of the contested communications." *Id.* at 574–75 (emphasis added).

In this case, there is more than enough evidence to meet the low *Zolin* threshold for triggering *in camera* review. According to Judiciary Committee records, the staff "received one phone call from [Judge Hoerchner]—on September 18—who explained that she had one conversation with Professor Hill [in which Professor Hill alleged that she was being sexually harassed]—*in the spring of 1981*." Chronology Released By Senator Biden, *reprinted in* D. Brock, *The Real Anita Hill* 211 (1993) (emphasis added). During the October 11 interview by Judiciary Committee lawyers, moreover, Judge Hoerchner testified that "I remember mainly one telephone call, and I have only been able to guess at the time—sometime before September 1981. That was a time when we spoke fairly regularly by telephone." Transcript of Hoerchner Interview (Oct. 11, 1991), *reprinted in* D. Brock, *supra*, at 212. (In September 1981, Judge Hoerchner moved from Washington, D.C. to California, after which time, according to her own testimony, she enjoyed only "less than sporadic" contact with Professor Hill.) Based on this evidence, Justice Thomas could not have been the person about

whom Professor Hill was then complaining to Judge Hoerchner, because Professor Hill did not even begin working for Thomas until Fall 1981, and does not allege that any harassment occurred during the first three months of her employment.

During the October 11, 1991 interview of Judge Hoerchner, a GOP Staffer apparently recognized the significance of the dates specified by Judge Hoerchner, and began to press her on this point:

Q: And, in an attempt to try to pin down the date a little bit more specifically as to your first phone conversation about the sexual harassment issue in 1981, the year you mentioned, you said the first time you moved out of Washington was September of 1981; is that correct?

A: Right.

Q: Okay. Were you living in Washington at the time you two had this phone conversation?

A: Yes.

Q: So it was prior to September of 1981?

A: Oh, I see what you are saying.

Q: I am just trying for the benefit of everybody to get to the truth, to pin down the——

A: I think I was. Yes. I'm sorry. That isn't something that I can——

Q: Okay.

A: I was living in Washington prior to that time. I'm not sure that was the time of the phone call, but I really think it was.

Q: Okay. You were or were not living in Washington when you think you had this—do you think you were living in Washington or not?

A: I think I was.

Q: So that would make it prior to September of 1981?

A: Yes, if my memory——

Id., reprinted in Napolitano Answers, *Supra*, Exhibit A, at 2. Before Judge Hoerchner could continue with her testimony, Ms. Napolitano interjected: "Can I meet with the witness? Can we talk for just a minute?" *Id.*

After Ms. Napolitano spoke to Judge Hoerchner—the communication that she now asserts to be privileged—Judge Hoerchner claimed not to remember when the relevant conversation with Professor Hill had occurred or where she was living when it did occur. Two days later, Judge Hoerchner testified before the Committee. She again claimed uncertainty about the date of her conversation with Professor Hill, but she asserted confidently, although for the first time, that the alleged harassment occurred *after* Professor Hill had started working for Justice Thomas—by which time Judge Hoerchner had moved to California and ceased to have any regular contact with Professor Hill. Moreover, she positively identified Justice Thomas, which she had declined to do during her October 11 interview, as the alleged harasser:

"I remember, in particular, one conversation I had with Anita. I should say, before telling you about this conversation, that I cannot pin down its date with certainty. I am sure that it was after she started working with Clarence Thomas, because in that conversation, she referred to him as her boss, Clarence."

Testimony of Judge Hoerchner to Senate Judiciary Committee (Oct. 13, 1991), *reprinted in* D. Brock, *supra*, at 215. *Compare* Transcript of Hoerchner Interview (Oct. 11, 1991) *(reprinted in* D. Brock, *supra*, at 209) ("Q: [D]id Anita Hill mention Clarence Thomas' name during that telephone call? A: I *think* she referred to him as Clarence." (emphasis added)).

Based on this sequence of events, a reasonable person could believe that *in camera* review "may yield evidence" to establish the applicability of the crime-fraud exception. *Zolin*, 491 U.S. at 574–75. One reasonable explanation of these events is that Ms. Napolitano interrupted the October 11 interview to warn Judge Hoerchner that her testimony was gravely undermining the allegations of Professor Hill, and to thus encourage changes in that testimony.

Ms. Napolitano responds that her conduct cannot support an inference of improper behavior because "[a]t no point during the questioning was [Judge Hoerchner] able to date with conviction or precision a telephone call which had occurred ten years earlier." Napolitano Answers, *supra*, at 7. That explanation appears doubly misleading, however. First, it fails to account for the fact that Judge Hoerchner did state that the telephone conversation occurred in Spring 1981, without apparent hesitation, during her September 18, 1991 conversation with Judiciary Committee staff. Second, even in her October 11 interview, Judge Hoerchner stated with apparent "conviction" (before speaking with Ms. Napolitano) that the conversation had occurred "sometime before September 1981"—a highly relevant interval that Judge Hoerchner articulated with apparent "conviction" not because she could date a particular conversation with "precision," but because she remembered where she was living ("That was a time when we spoke fairly regularly") when it occurred.

Professor Hazard speculates that Ms. Napolitano might have interrupted the October 11 interview "to help the witness avoid giving inaccurate testimony" by counseling her to state "that she cannot precisely remember, if that is the situation." Hazard Letter, *supra*, at 6. The factual basis for this speculation appears to be that Ms. Napolitano, like Judge Hoerchner, recognized that the "previous dating" of the conversation by Judge Hoerchner "was erroneous if the conversation had occurred while Ms. Hoerchner was still living in Washington." *Id.* at 5. That proposition is simply mistaken. At the point when Ms. Napolitano interrupted the October 11 proceedings, Judge Hoerchner had previously stated that her conversation with Professor Hill had occurred either in the "spring of 1981" (in her September 18 conversation with the judiciary Committee staff) or "sometime before September 1981" (earlier during the October 11 interview itself). Neither of these "previous dating[s]" would be "erroneous if the conversation had occurred while Ms. Hoerchner was still living in Washington."

Perhaps there are innocent explanations of Ms. Napolitano's actions as well, but the purpose of the sufficiency determination under *Zolin* is not to establish conclusively that the crime-fraud exception applies, but only to decide whether a more careful investigation is warranted. Here, that low threshold standard is easily met.

Unless the Senate conducts further investigation, *in camera* or otherwise, the American people will probably never know whether Janet Napolitano intended to encourage false testimony on October 11, 1991, or whether a prospective United States Attorney with the power to prosecute ordinary citizens for aiding and abetting perjury is herself guilty of the same offense. That doubt is unfair to the people of Arizona and, if she is in fact above reproach, unfair to Ms. Napolitano herself. No privilege law prevents the Senate from attempting to resolve it.

IV. JUDGE HOERCHNER'S ASSERTION OF ATTORNEY-CLIENT PRIVILEGE DOES NOT EXCUSE MS. NAPOLITANO FROM ANSWERING QUESTIONS ABOUT HER COMMUNICATIONS WITH WITNESSES OTHER THAN JUDGE HOERCHNER

Members of the Judiciary Committee questioned Ms. Napolitano about her role in advising not only Judge Hoerchner, but also Professor Hill and two other witnesses, Ellen Wells and John Carr. Ms. Napolitano declined to answer questions involving her communications with *any* of these individuals, even though she identifies Judge Hoerchner as the *only* client who has asserted any privilege. Even a proper invocation of privilege by Judge Hoerchner, however, at most would protect communications between *her* and Ms. Napolitano.

Question 12 asked Ms. Napolitano about her discussions with Professor Hill. Ms. Napolitano responded that "[t]he few conversations I had with Professor Hill are covered by the attorney-client privilege; and, therefore, I am precluded from answering these questions." Napolitano Answers, *supra*, at 12. But Judge Hoerchner has no privilege in *these* conversations, and Ms. Napolitano has not asserted any privilege on behalf of Professor Hill. To the contrary, by failing to mention any assertion of privilege by her own client, Ms. Napolitano has implied that Professor Hill is *not* asserting any privilege. Therefore, the Senate certainly should require Ms. Napolitano to answer Question 12.

Questions 13, 15 and 16 likewise asked Ms. Napolitano about her discussions with Professor Hill, Ms. Wells and Mr. Carr. In refusing to answer pertinent portions of these questions, Ms. Napolitano stated that "[i]f the questions are meant to reveal discussions or advice given in meetings with the corroborating witness, the privilege has been asserted and I am bound by the privilege" (Question 13) and that "[a]ny advice I may have given to them is subject to the attorney-client privilege and I am bound by the privilege" (Question 15). Napolitano Answers, *supra*, at 12–13. (Ms. Napolitano asserted no independent justification for her failure to answer pertinent portions of Question 16.) Again, however, the only person Ms. Napolitano has identified as asserting a privilege is Judge Hoerchner, and Ms. Napolitano has not alleged that Judge Hoerchner was involved in any way in her conversations with these other individuals. Therefore, the Senate should require Ms. Napolitano to answer these questions to the extent they relate to her dealings with Professor Hill, Ms. Wells, and Mr. Carr.

Ms. Napolitano's invocation of attorney-client privilege with respect to her communications with Ms. Wells is improper for yet another reason as well. According to Ms. Napolitano herself, "Ellen Wells had no separate representation." Napolitano Answers, *supra*, at 3. The law is clear, however, that "[a] person who is not represented by a lawyer cannot participate as a member of a pooled-information arrangement." Restatement, *supra*, at § 126 comment d. *See also, e.g., Government of Virgin Islands v. Joseph*, 685 F.2d 857, 862 (3d Cir. 1982); Biden Memorandum, *supra*, at 5 n.6. On this additional ground, the Senate should require Ms. Napolitano to answer all questions about her communications with Ms. Wells.●

THE CALENDAR

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Senate proceed en bloc to the immediate consideration of Calendar Nos. 252, 253, 254,

255, 256, 257, and 258; that the resolutions each be deemed read a third time, passed, the preambles be agreed to en bloc, the motions to reconsider be laid upon the table en bloc, and any statements relative to the passage of these items appear at the appropriate place in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

NATIONAL LAW ENFORCEMENT TRAINING WEEK

The Senate proceeded to consider the joint resolution (S.J. Res. 75) designating January 2, 1994, through January 8, 1994, as "National Law Enforcement Training Week," was considered, ordered to be engrossed for a third reading, read the third time and passed.

The preamble was agreed to.

The joint resolution, the preamble are as follows:

S.J. RES. 75

Joint resolution designating January 2, 1994, through January 8, 1994, as "National Law Enforcement Training Week".

Whereas law enforcement training and the sciences related to law enforcement are critical to the immediate and long-term safety and well-being of this Nation because law enforcement professionals provide service and protection to citizens in all sectors of society;

Whereas law enforcement training is a critical component of national efforts to protect the citizens of this Nation from violent crime, to combat the malignancy of illicit drugs, and to apprehend criminals who commit personal property, and business crimes;

Whereas law enforcement training serves the hard working and law abiding citizens of this Nation;

Whereas it is essential that the citizens of this Nation be able to enjoy an inherent right of freedom from fear and learn of the significant contributions that law enforcement trainers have made to assure such right;

Whereas it is vital to build and maintain a highly trained and motivated law enforcement work force that is educated and trained in the skills of law enforcement and the sciences related to law enforcement in order to take advantage of the opportunities that law enforcement provides;

Whereas it is in the national interest to stimulate and encourage the youth of this Nation to understand the significance of law enforcement training in the law enforcement profession and to the safety and security of all citizens;

Whereas it is in the national interest to encourage the youth of this Nation to appreciate the intellectual fascination of law enforcement training; and

Whereas it is in the national interest to make the youth of this Nation aware of career options available in law enforcement and disciplines related to law enforcement: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That January 2, 1994, through January 8, 1994, is designated as "National Law Enforcement Training Week".

NATIONAL MILITARY FAMILIES RECOGNITION DAY

The Senate proceeded to consider the joint resolution (S.J. Res. 115) designating November 22, 1993, as "National Military Families Recognition Day," was considered, ordered to be engrossed for a third reading, read the third time and passed.

The preamble was agreed to.

The joint resolution and its preamble are as follows:

S.J. RES. 115

Whereas the Congress recognizes and supports the Department of Defense policies to recruit, train, equip, retain, and field a military force that is capable of preserving peace and protecting the vital interests of the United States and its allies;

Whereas military families shoulder the responsibility of providing emotional support for their service members;

Whereas, in times of war and military action, military families have demonstrated their patriotism through their steadfast support and commitment to the Nation;

Whereas the emotional and mental readiness of the United States military personnel around the world is tied to the well-being and satisfaction of their families;

Whereas the quality of life that the Armed Forces provide to military families is a key factor in the retention of military personnel;

Whereas the people of the United States are truly indebted to military families for facing adversities, including extended separations from their service members, frequent household moves due to reassignments, and restrictions on their employment and educational opportunities;

Whereas 74 percent of officers and 55 percent of enlisted personnel in the Armed Forces are married;

Whereas families of active duty military personnel (including individuals other than spouses and children) comprise more than one-half of the active duty community of the Armed Forces, and spouses and children of members of the reserve component of the Armed Forces in paid status comprise more than one-half of the individuals constituting the reserve component of the Armed Forces community;

Whereas hundreds of thousands of spouses, children, and other dependents living abroad with members of the Armed Forces face financial hardship and feelings of cultural isolation;

Whereas the significantly reduced global military tensions following the end of the Cold War have resulted in a downsizing of the national defense and a refocusing of national priorities on strengthening the American economy and increasing competitiveness in the global marketplace;

Whereas the Congress is grateful for the sacrifices of military families and is committed to assisting the service members and their families who undergo the transition from active duty to civilian life; and

Whereas military families are devoted to the overall mission of the Department of Defense and have supported the role of the United States as the military leader and protector of the Free World: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That November 22, 1993 is designated as "National Military Families Recognition Day" in appreciation of the commitment and devotion of present and former military families and the sacrifices that such families have made on behalf of the Nation and the President is authorized and requested to issue a proclamation calling on the people of the United States to observe the day with appropriate programs, ceremonies, and activities.

IRISH-AMERICAN HERITAGE MONTH

The Senate proceeded to consider the joint resolution (S.J. Res. 119) to designate the month of March 1994 as "Irish-American Heritage Month," was considered, ordered to be engrossed for a third reading, read the third time and passed.

The preamble was agreed to.

The joint resolution, the preamble are as follows:

S.J. RES. 119

Joint resolution to designate the month of March 1994 as "Irish-American Heritage Month".

Whereas the first Irish emigrants arrived in America as early as 1621;

Whereas 9 of the generals who served in the Continental Army during the American Revolution were Irish born;

Whereas Commodore John Barry of County Wexford, Ireland, served brilliantly in the Continental Navy and is widely regarded as the father of the American Navy;

Whereas James Smith, George Taylor, Matthew Thornton, and Charles Thomson, 4 of the individuals who signed the Declaration of Independence, were Irish born and 9 other signers were of Irish ancestry;

Whereas the contributions of the Irish to America's victory in the American Revolution led Lord Mountjoy to exclaim in the British Parliament that "America was lost by the Irish emigrants";

Whereas beginning at the time of the potato blight and famine in Ireland in 1845, over 700,000 Irish immigrants came to the United States during the 1840's, 900,000 during the 1850's, and over 300,000 in each decade through 1910;

Whereas Irish Americans participated heavily in the industrial and economic development of America during the nineteenth century, building our cities and canals and the railroads that expanded the Nation to the West;

Whereas even today, it is said that under every railroad tie an Irishman is buried;

Whereas the Irish contributed greatly to the development of the labor movement in the United States, including the establishment of the American Miners Association in 1861;

Whereas nearly 150,000 natives of Ireland served in the Union forces during the Civil War;

Whereas more than 500 members of the Irish Brigade were killed while fighting for the Union in the Battle of Antietam on September 17, 1862, a date that has been called the bloodiest day in American history;

Whereas the Irish Brigade fought courageously in several other Civil War battles including Fredericksburg, Chancellorsville, Yorktown, Fair Oaks, Gaines Mill, Allen's Farm, Savage Station, White Oak Bridge, Glendale, Malvern Hill, Gettysburg, and Bristow Station;

Whereas in 1892, Annie Moore from County Cork, Ireland, at age 15 became the first immigrant to pass through Ellis Island;

Whereas Irish Americans have made numerous contributions to the arts and to

sports, as exemplified by the achievements F. Scott Fitzgerald, Eugene O'Neill, Helen Hayes, Georgia O'Keefe, John L. Sullivan, and Connie Mack;

Whereas the first woman to serve as the organizer of the American Federation of Labor was Mary Kennedy O'Sullivan;

Whereas at the beginning of the twentieth century, many of the school teachers in America's largest cities were Irish American women;

Whereas President John F. Kennedy was the first American President to visit Ireland during his term in office;

Whereas Irish Americans, including Kathryn Sullivan, the first American woman to walk in space, and Christa Corrigan McAuliffe, America's first school teacher in space who perished on the Challenger mission, have bravely served as America's pioneers in space;

Whereas more than 200 Irish Americans have been awarded the Congressional Medal of Honor;

Whereas President William Jefferson Clinton is the nineteenth American President of Irish ancestry;

Whereas 37 United States governors and mayors designated March 1993 as "Irish-American Heritage Month"; and

Whereas 44 million Americans are of Irish ancestry: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the month of March 1994 is designated as "Irish-American Heritage Month". The President is authorized and requested to issue a proclamation calling upon the people of the United States to observe this month with appropriate ceremonies and activities.

NATIONAL DRUNK AND DRUGGED DRIVING PREVENTION MONTH

The Senate proceeded to consider the joint resolution (S.J. Res. 122) designating December 1993 as "National Drunk and Drugged Driving Prevention Month," was considered, ordered to be engrossed for a third reading, read the third time and passed.

The preamble was agreed to.

The joint resolution and its preamble are as follows:

S.J. RES. 122

Whereas impaired driving is the most frequently committed violent crime in the United States;

Whereas last year 45 percent of those who died on our Nation's highways were the result of alcohol involved crashes;

Whereas last year nearly eighteen thousand people were killed and one million two hundred thousand were injured in crashes involving alcohol;

Whereas impaired driving continues to cost society some $46,000,000,000 each year in direct costs;

Whereas medical costs associated with impaired driving run approximately $5,500,000,000 a year;

Whereas injury and property damage resulting from impaired driving cause physical, emotional, and economic hardship for hundreds of thousands of adults and young people;

Whereas the ongoing work of citizen activists groups such as Mothers Against Drunk Driving (MADD), Students Against Driving Drunk (SADD), Remove Intoxicated Drivers (RID), and the National Commission Against Drunk Driving continue to promote good prevention efforts which have contributed to a 30 percent reduction in alcohol-related traffic deaths over the past decade;

Whereas a decade of intense public education effort has proved that alcohol-related highway crashes are not accidents and can be prevented;

Whereas comprehensive community-based strategies to further reduce and prevent impaired driving tragedies are known to be effective;

Whereas an increased public awareness of the gravity of the problem of drunk and drugged driving may help to sustain efforts to develop comprehensive solutions at the State and local levels;

Whereas more than seventy public and private sector organizations have joined together to carry out a nationwide public information, education, and enforcement campaign during the December holiday season;

Whereas the Secretary of Transportation has set a goal by the year 1997 to reduce alcohol-related fatalities to 43 percent and MADD has set a goal by the year 2000 to reduce alcohol-related traffic fatalities to 40 percent;

Whereas the Secretary of Health and Human Services has set a goal by the year 2000 for all fifty States to prohibit any allowable blood-alcohol concentration tolerance level for drivers younger than age twenty-one; and

Whereas December is a month of many holidays and celebrations, with more drivers on the roads and an increased number of social functions, is a particularly appropriate time to focus national attention on this critical problem: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the month of December, 1993 is designated as "National Drunk and Drugged Driving Prevention Month", and the President is authorized and requested to issue a proclamation calling upon the people of the United States to observe that month with appropriate activities.

GEOGRAPHY AWARENESS WEEK

The Senate proceeded to consider the joint resolution (S.J. Res. 131) designating the week beginning November 14, 1993, and the week beginning November 13, 1994, each as "Geography Awareness Week," was considered, ordered to be engrossed for a third reading, read the third time and passed.

The preamble was agreed to.

The joint resolution, the preamble are as follows:

S.J. RES. 131

Joint resolution designating the week beginning November 14, 1993, and the week beginning November 13, 1994, each as "Geography Awareness Week".

Whereas geography is the study of people and their planet, offering a framework for understanding ourselves, our interdependence with other peoples, our relationship to the Earth, and world events;

Whereas the United States has both worldwide involvements and influence that demand an understanding of geography, different cultures, and foreign languages;

Whereas a thorough knowledge of geography, different cultures, and foreign languages is essential to maintain the Nation's stature in the international community in matters of business, politics, the environment, and global events;

Whereas a geographic perspective is needed to understand the relationship between human activity and the condition of our planet in this time of increasing environmental problems;

Whereas our Nation's Governors, in the National Education Goals, explicitly identified geography along with English, mathematics, science, and history as the 5 core subjects in which American students should demonstrate competency;

Whereas world standards are being developed as benchmarks for student performance in each of the core subjects identified in the National Education Goals; and

Whereas a knowledge of world geography is essential for citizens of the United States to assume a responsible role in the future of an increasingly interconnected and interdependent world: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the week beginning November 14, 1993, and the week beginning November 13, 1994, each be designated as "Geography Awareness Week", and the President is authorized and requested to issue a proclamation calling upon the people of the United States to observe such weeks with appropriate ceremonies and activities.

NATIONAL CHILDREN'S DAY

The Senate proceeded to consider the joint resolution (S.J. Res. 139) to designate the third Sunday in November of 1993 as "National Children's Day," was considered, ordered to be engrossed for a third reading, read the third time and passed.

The preamble was agreed to.

The joint resolution, and the preamble are as follows:

S.J. RES. 139

Joint Resolution to designate the third Sunday in November of 1993 as "National Children's Day".

Whereas the people of the United States should celebrate children as the most valuable asset of the Nation;

Whereas children represent the future, hope, and inspiration of the United States;

Whereas the children of the United States should not be allowed to feel that their ideas and dreams will be stifled because adults in the United States do not take time to listen;

Whereas many children face crises of grave proportions, especially as they enter adolescent years;

Whereas it is important for parents to spend time listening to their children on a daily basis;

Whereas modern societal and economic demands often pull the family apart;

Whereas encouragement should be given to families to set aside a special time for all family members to remain at home;

Whereas adults in the United States should have an opportunity to reminisce on their youth to recapture some of the fresh insight, innocence, and dreams that they may have lost through the years;

Whereas the designation of a day to commemorate the children of the United States will provide an opportunity to emphasize to children the importance of developing an ability to make the choices necessary to distance themselves from impropriety;

Whereas the designation of a day to commemorate the children of the Nation will

emphasize to the people of the United States the importance of the role of the child within the family;

Whereas the people of the United States should emphasize to children the importance of family life, education, and spiritual qualities; and

Whereas parents, teachers, and community and religious leaders should celebrate the children of the United States, whose questions, laughter, and tears are important to the existence of the United States: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the third Sunday in November of 1993 is designated as "National Children's Day", and the President of the United States is authorized and requested to issue a proclamation calling upon the people of the United States to observe the day with appropriate ceremonies and activities.

NATIONAL WOMEN VETERANS WEEK

The Senate proceeded to consider the joint resolution (S.J. Res. 142) designating the week beginning November 7, 1993, as "National Women Veterans Recognition Week," was considered, ordered to be engrossed for a third reading, read the third time and passed.

The preamble was agreed to.

The joint resolution and its preamble are as follows:

S.J. RES. 142

Joint resolution designating the week beginning November 7, 1993, as "National Women Veterans Recognition Week".

Whereas there are more than 1,200,000 women veterans in the United States representing 4.6 percent of the total veteran population;

Whereas the number of women serving in the United States Armed Forces and the number of women veterans continue to increase;

Whereas women veterans have contributed greatly to the security of the United States through honorable military service, often involving great hardship and danger;

Whereas the special needs of women veterans, especially in the area of health care, have often been overlooked or inadequately addressed by the Federal Government;

Whereas the lack of attention to the special needs of women veterans has discouraged or prevented many women veterans from taking full advantage of the benefits and services to which they are entitled; and

Whereas designating a week to recognize women veterans will help both to promote important gains made by women veterans and to focus attention on the special needs of women veterans: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the week beginning November 7, 1993, is designated as "National Women Veterans Recognition Week", and the President is authorized and requested to issue a proclamation calling upon the people of the United States to observe that week with appropriate ceremonies and activities.

NATIONAL HEALTH INFORMATION MANAGEMENT WEEK

Mr. MITCHELL. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of House Joint Resolution 205, designating National Health Information Management Week, just received from the House; that the resolution be deemed read a third time, passed, the preamble be agreed to, the motion to reconsider be laid upon the table, and any statements relative to the passage of this item appear at the appropriate place in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the joint resolution (H.J. Res. 205) was deemed read a third time and passed.

The preamble was agreed to.

THE SCHEDULE

Mr. MITCHELL. Madam President, as I indicated and as has previously been agreed to by the Senate, the Senate will on Monday take up the matter relating to the resolution by the Ethics Committee regarding Senator PACKWOOD. The Senate will consider that matter for as long as debate continues.

On Tuesday, in accordance with the order just obtained, there will be a cloture vote at 2:15 on the five nominations to which I referred and, if cloture is invoked, there will be 90 minutes of debate on those nominees, and then votes on each of them at the conclusion of the 90 minutes.

It is my intention to proceed to other legislation, including the crime bill, education, and other matters which may be appropriate for consideration following the disposition of the Ethics Committee resolution and the nominations to which I have just referred.

It is also my intention to proceed as soon as possible thereafter to consideration of the rescission and spending cut package and the balanced budget amendment, and that will occur in the near future, following consideration of some of the measures to which I have referred.

I do not intend to make this an exclusive list or be bound with respect to the order of the days but so that Senators can be alert to what is coming. I wanted to make that clear.

Madam President, I now ask unanimous consent that Senators GORTON, SIMPSON, and SARBANES be recognized to address the Senate and that at the conclusion of their remarks the Senate then stand in recess as previously ordered.

Mr. SARBANES. Madam President, I just want to put a couple questions to the majority leader, if I might.

Mr. MITCHELL. I will yield for a question.

Mr. SARBANES. As I understand it, we are going to have another cloture vote on Tuesday; is that correct?

Mr. MITCHELL. That is correct. At 2:15 on Tuesday there will be a cloture vote.

Mr. SARBANES. I listened to the exchange, which is what brought me to the floor, and it was asserted that people who require us to go to cloture votes in order to do business are operating within the rules of the Senate.

I simply want to make the point that they may be operating within the letter of the rules of the Senate but, in my judgment, they are not operating within the spirit of the rules of the Senate, as witnessed by the majority leader's statement about how rarely the filibuster was used in most Congresses since that technique has been available and how frequently it is now being used, almost as a standard course of business.

Of course, what it is doing is thwarting the ability of the institution to come substantively to grips with the issues that are before it.

In this instance, it has even reached the point of holding up nominees for some totally unrelated matter, but it is happening on a whole range of issues that are coming before the Senate that are preventing us from action.

I am frank to tell the majority leader, as to this committee on which I serve that is looking into the procedures of the institution and how we function, one of the things we need to come to grips with is the use of this filibuster. Otherwise, I do not see how the Senate as an institution is going to be able to do the Nation's business.

We are prevented from acting on measures up or down by the use of this filibuster and the requirement of an extraordinary majority.

What has happened now, at least in my perception, is that Members are filibustering and holding up action on particular measures for reasons totally unrelated to that particular issue that is before the Senate. They get angry at some department because they will not take an administrative action they want them to take, and they come out here and slap a hold on an item and then proceed to use a filibuster in order to keep the Senate from acting.

In the end what it does is prevent a majority of the institution from working its will on important legislation.

I do not know how many times in the last Congress a cloture motion had to be filed in order to try to do the job.

I heard one of my colleagues say—"Well, this is all within the rules of the Senate." I just want to make the point. Technically that is correct. But, in effect, what has happened is the rules of the Senate, which allow for a certain course of conduct, in my judgment, are not being used but abused, and they are being abused repeatedly preventing the Senate from doing its business.

The immediate way to get around it is to vote cloture, but my own view is we have to try to address a more fundamental change than that. It is really not fair to the institution. It is certainly not fair to the American people. Of course, the more it is used the more people resort to its use.

I have seen it happen in the course of my service in the Senate. Filibustering has gone from being an extraordinary thing to being a standard weapon and a standard technique. It was never intended to be that. The use of the filibuster in that fashion, in my judgment, is an abuse of the spirit of the rules. It is like any rule or like most rules which require a certain amount of self-restraint in their use. If you do not exercise that self-restraint and you carry it out to the limits, it becomes an abuse, and then you have to try to revise the rules somehow in order to limit the abuse.

I am frank to say I think the Senate has reached that point on this matter.

I thank the majority leader for yielding.

Mr. MITCHELL. Mr. President, I thank my colleague for his comments.

Mr. President, I renew my request.

The PRESIDING OFFICER (Mr. ROCKEFELLER). Without objection, it is so ordered.

Mr. MITCHELL. I modify my request.

I gather the Senator from Maryland is not going to wish to speak.

Mr. SARBANES. The Senator is correct.

Mr. MITCHELL. Mr. President, I ask unanimous consent that the request be modified that it be just Senators GORTON and SIMPSON be recognized and at the conclusion of their remarks the Senate stand in recess, as previously ordered.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SIMPSON. Mr. President, if I might, in response to my friend from Maryland, because I listened to that with whimsical humor. It overtook me, actually, because it is like the old phrase you never discuss the noose in the house of the hangman. I remember so well what happened with many, many of the nominations of President George Bush and President Ronald Reagan, the especially spirited number of hearings conducted by the Senator from Maryland with regard to the issue of contributions and ambassadorships, and things as mundane as that, which were spirited.

But let the Record show that Senator MITCH MCCONNELL, who has been referred to here, at least obliquely and perhaps personally, is at the bedside of his mother. That is where he is today. She is critically ill. He had a hold on these.

It is perfectly appropriate for this leader to bring this forward. But it is also perfectly appropriate to know what the situation is and why. There is always a reason for things in here, and then there is a real reason.

The real reason is because during the past administration there was a great folderol in the State Department as to who did what to whom and who leaked what during the campaign. Then we found the same set of circumstances, except a different administration in place, which was offensive to many, and there this was an instrument. It has nothing to do with the five people on there. It was an instrument to bring it to the attention of this body that you cannot talk out of both sides of one's mouth.

That is how we got here. And now it is going to be resolved. I will vote to invoke cloture. Cloture is a very important tool and it works very well, and it works especially well if you are a member of the minority. And it works especially well if the President is of the other party.

We have not used it much. This Senate gets a great deal done, thanks to the majority leader and the minority leader. We do a ton of business and we do it in a good atmosphere.

So it is fascinating to me that, when one little bump comes up, suddenly I am reminded and refreshed of how it really was for a lot of years when someone else was on the other side. It is a fascinating business.

Mr. MITCHELL. Mr. President, I, of course, as do all Senators, regret that Senator MCCONNELL's mother is ill and that has necessitated his absence. I did not bring up that fact in the discussion.

The reality is that we have been working on this for a few weeks now. After the delay of that period, I made a commitment to these nominees that I would bring this matter forward this week. I communicated, both to staff and directly with the Republican leader, that I made a commitment and I felt that I must honor that commitment that we proceed to try to bring this to a conclusion.

Most unfortunately, Senator MCCONNELL had to leave today because of the illness of his mother, and that is understandable.

The solution that we have reached, of course, means that we will not take these up and get to the debate until next Tuesday afternoon, which thereby permits me to honor the commitment I made to the nominees that we would bring this matter up this week and also permit time for Senator MCCONNELL to return and to be present during the debate.

So, I just wanted to make that point clear, that I am, of course, conscious of his circumstance and join all Senators in expressing our deepest sympathy and regret. I believe that this resolution permits both to occur; that the commitment to bring it up is honored, and time is permitted for him to return, and that time will be possible anyway under the cloture rules.

Mr. President, before I yield to the Senator from Maryland, I have one further unanimous-consent request that I would like to make.

PENSION ANNUITANTS PROTECTION ACT OF 1993

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Labor Committee be discharged from further consideration of S. 1312, the Pension Annuitants Protection Act of 1993, and that the Senate then proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:.

A bill (S. 1312) to amend the Employee Retirement Income Security Act of 1974 in order to provide for the availability of remedies for certain former pension plan participants and beneficiaries.

The Senate proceeded to consider the bill.

AMENDMENT NO. 1091

Mr. MITCHELL. Mr. President, on behalf of Senators METZENBAUM and KASSEBAUM, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report

The legislative clerk read as follows:

The Senator from Maine [Mr. MITCHELL], for Mr. METZENBAUM, for himself and Mrs. KASSEBAUM, proposes an amendment numbered 1091.

Mr. MITCHELL. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection it is so ordered.

The amendment is as follows:

On page 2, line 1, before the word "semicolon" add ""or" after the".

On page 2, line 7, delete "(A)".

On page 2, line 19, after "vided" add "or to be provided".

On page 3, lines 8–9, delete "other than the relief authorized in section 2 of this Act".

The PRESIDING OFFICER. Is there debate on the amendment?

If not, the question is on agreeing to the amendment.

The amendment (No. 1091) was agreed to.

• Mr. DURENBERGER. Before the Senate considers S. 1312, I would like to ask a point of clarification from the sponsor of the bill, my colleague from Ohio, Senator METZENBAUM. As you know, S. 1312 seeks to make clear that parties bringing suit under ERISA for fiduciary breach in the purchase of insurance annuities, including the Department of Labor, may seek and recover appropriate relief. Is it your intention or the intention of this bill to specify the type of remedies to be awarded by a court?

Mr. METZENBAUM. No that is not my intention. The purpose of this bill is to make clear that the Department of Labor and private parties may seek appropriate relief for violations of ERISA. This bill does not seek to tell plaintiffs what type of relief they should seek or to approve or disapprove of particular remedies that have been

sought. It is my hope that private parties will seek and courts will fashion remedies appropriate to undo whatever harm has been caused by a violation of the law.

Mr. DURENBERGER. I thank my colleague for his explanation. I would also like to express my view that under this legislation courts should use their powers and discretion to tailor remedies in ways that fully protect workers and retirees but do not unduly burden employers.●

The PRESIDING OFFICER. If there is no further debate, the question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading, was read the third time, and passed, as follows:

S. 1312

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Pension Annuitants Protection Act of 1993".

SEC. 2. CIVIL ENFORCEMENT OF ERISA.

Section 502(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)) is amended—

(1) by striking the "or" after the semicolon at the end of paragraph (5),

(2) by striking the period at the end of paragraph (6) and inserting "; or", and

(3) by adding at the end the following new paragraph:

"(7) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.".

SEC. 3. WAIVER OR REDUCTION OF CIVIL PENALTY.

Section 502(l)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(l)(3)(B)) is amended by inserting "(or to provide the relief ordered pursuant to subsection (a)(7))" after "to restore all losses to the plan".

SEC. 4. EFFECT ON OTHER PROVISIONS.

Nothing in this Act shall be construed to limit the legal standing of individuals to bring a civil action as participants or beneficiaries under section 502(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)), and nothing in this Act shall affect the responsibilities, obligations, or duties imposed upon fiduciaries by title I of the Employee Retirement Income Security Act of 1974.

SEC. 5. EFFECTIVE DATE.

The amendments made by this Act shall apply to any legal proceeding pending, or brought, on or after May 31, 1993.

Mr. MITCHELL. Mr. President, I move to reconsider the vote by which the bill was passed.

Mr. SIMPSON. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

THE FILIBUSTER PROBLEM

Mr. SARBANES. Mr. President, I simply say to my good friend, the distinguished Senator from Wyoming, that I came to the floor to speak on the filibuster problem, not particularly as it related to the specific issue of these nominees—and I am certainly sympathetic to the situation in which Senator MCCONNELL finds himself—but I really came over upon hearing a colleague on the other side who said, "Well, look, the use of the filibuster is within the rules and people who use the filibuster"—as they are continuously doing it—"are simply functioning within the rules."

The point I want to make is that, while that is technically within the letter of the rules, I think it is outside the spirit of the rules.

What has happened is that the filibuster—and the Senator himself just said it is a very effective use by the minority—in effect, what the minority does by consistently using it, as they have done in this Congress on virtually every measure of major consequence, is they prevent the institution from coming to grips with these issues unless they can produce a supermajority.

That is exactly what happened to the President's jobs stimulus program. We were never able to vote on it because the filibuster rule was used in order to thwart the ability of the majority to move forward with it.

When the distinguished Senator's father served in the Senate, the filibuster was hardly ever used. Members were prepared, in the end, to allow these issues to go to a vote and be voted up or down and let the majority of the institution prevail. That is no longer being allowed.

The filibuster is being used virtually as a standard technique on any measure of consequence that has any controversy associated with it.

It is my very strongly held view that this is not a use of the rules, this is an abuse of the rules. What it is doing is, in effect, undercutting the ability of the U.S. Senate to act as an institution that can come face to face with issues that are before the country.

One only has to look at the number of times that the filibuster has been used and cloture has had to be invoked in recent years.

What happens, of course, is that, in the end, if the filibuster is going to be used, every Member starts using it.

I am interested to hear the Senator's statement, because the filibuster traditionally was never used as sort of a standard technique by the minority party to thwart the ability of the Senate to come to grips with issues. But that is now what is happening.

I think we all need to step back from this and take a look at what is occurring. If you have any concern for the Senate as an institution in this democracy, with an ability, to substantively act on measures and come to grips with them, I think you have to recognize that the filibuster now has become a major stumbling block to the effective functioning of the Senate. I think we are going to have to start considering what to do about it.

The traditional argument that is made for its use is it prevents hasty action. And that is not an argument without some merit. But what is happening here is it is not only preventing hasty action, it is preventing any action at all.

The question then really arises as to whether we ought not to consider reforming this rule in such a way that it allows for some delay in considering matters. But, in the end, you cannot be thwarted from considering the matter. I think that is a matter that we are going to have to come to grips with at some point if this rule continues to be abused in the manner in which it has been taking place in recent times.

Mr. SIMPSON. Mr. President, I do enjoy my colleague from Maryland. He is one of the brightest people in this Chamber and speaks with great passion.

But, as I say, I get a whimsical, almost wry response and feeling when I remember how it was when the President of the United States was in the other party.

But I think the record will show that this Congress has been very, very productive. One need only to look at what we have dealt with and what we have passed.

Simply because there are still some lingering emotions about a singular time when we stiffed the other side of the aisle with regard to the activity that the Senator referred to is no reason at all to believe that that is the way that this place works.

The record does not disclose anything more than that this has been a very productive session, because of the Senator from Maine, the majority leader, and the Senator from Kansas, the minority leader, who understand each other perfectly, who work in an arena of trust and partisanship. And that is the way it works.

But what has happened, and the reason the filibuster is a little more applied in these latter days is because in committee, with all the horses, the Republicans will put in an amendment and suddenly, with no debate or cursory debate, suddenly—whammo. That is it. School is out. We are not going to deal with your amendment in committee. And there has been a lot of that stiffing going on in this session.

So if you want to talk about real life, that is part of it.

So you stiff the minority in committee, and you know what they are going to do. We all know what they are going

to do. They are going to come here to the floor of the U.S. Senate, where they have an opportunity to put in their amendment.

So they put in an amendment that no one wanted to deal with in committee because it was too hot, and put the old tootsies right up to the fire. And the majority leader has no other option but to file a cloture motion because nobody wants to deal with that amendment because it might pass.

So let us look at all of it, keep it in perspective and know that this minority, this beleaguered 44, will help this President and have helped him with Somalia; have and will help him with regard to Russian aid while others on the other side of the aisle seem to drag their feet; and will be the vanguard of NAFTA, which is one of the most important things facing the country, and most of the votes will come from the Republicans.

We are here to work. We know why the hold was put on. If we just dealt honestly with things here the American public would understand it more clearly. The hold was put on by the Senator from Kentucky because, during the last administration and during the campaign it was determined that some rascals with the Republicans in the State Department were going through the files to find out personnel issues about people, real people in America, including the candidate for President.

The reason this hold was placed is because the IG had made a report that has to do with the administration looking into the files of personnel in the State Department to find out things about Bush appointees. So let us get it all out there, shovel it out here where we can see it. The IG made his report and we want the report made public as to why the administration was looking into the personnel files of the State Department with regard to Bush appointees. It is called the wheel coming full cycle.

I could quit but my colleague has run off for some more material, I think. I am going to wait. If the Senator from Maryland has any response I will certainly stay and address that. But that is the honest reason as to why this came up. The hold was placed simply because of the hypocrisy of one group saying you can go through the files when you are a Republican and it is no good but if you do it as a Democrat it is all right. That is how we got here.

I will certainly do anything I can to hold the RECORD open and session open, and I will stay so the Senator from Maryland can respond. I think under the order I will go to the Senator from Washington, if the Chair concurs.

The PRESIDING OFFICER. Under the previous order the distinguished Senator from Washington is recognized.

NAFTA AND THE AIRLINES

Mr. GORTON. Mr. President, last spring, with great fanfare, the administration announced the formation of the National Airline Commission. The administration rightly recognized that the aviation industry which had lost tens of thousands of jobs and suffered financial losses totaling over $10 billion during the last 3 years needed a thorough review. A distinguished panel deliberated for 3 months and issued a comprehensive set of recommendations. Unfortunately, since then, these recommendations have either been ignored or repudiated by this administration. This does not serve the aviation industry well and it does not serve this country well.

One of the major findings of the Airline Commission was that the present tax require on airlines defies common sense and good public policy. The Commission pointed out that the industry now pays more than $5 billion a year in Federal user fees and taxes. The Commission recommended that many of these taxes be reduced and that new taxes not be imposed on the industry. Yet before the print was even dry on this fine report, the President signed a bill imposing $1.5 billion in new transportation fuel taxes on the airlines over the next 5 years. Now again, as if this industry has not already borne a heavy enough financial burden, the administration proposes to impose more new fees to pay for NAFTA.

Initially, the administration proposed that in order to pay for revenue that will be lost by reduced tariffs under NAFTA we should double the existing $5 airline customs fee and impose a new $10 fee on passengers traveling to the Caribbean, Mexico, and Canada. These new fees were designed to raise $326 million a year.

Now the administration through a USTR spokeswoman claims that it never really proposed a new $5 fee, but just floated this idea to "see how Congress would react. We wanted some input and we got it." The administration got the input but has not yet got the message—a $5 increase, a $2.50 increase, or now a proposed $1.50 increase are all nonstarters and just not acceptable.

Last week, I received a letter from Ray Vecci, the president of Alaska Airlines—a company that enjoyed 19 years of consecutive profits until last year, when it went into the red. Mr. Vecci's letter explained why any new increases in fees must be rejected. Alaska Airlines currently serves four Mexican cities, Guadalajara, Los Cabos, Mazatlan, and Puerto Vallarta. An additional $10 for every ticket from these cities is more than the entire profit per passenger on these routes. That fee will mean less travel between the United States and Mexico, and more pain for a United States airline that expects to lose money this year.

Two weeks ago, I called our U.S. Trade Representative, Mickey Kantor and spoke with him again last week when the Senate Commerce Committee held a hearing on NAFTA implementing legislation. I told him that while I am a strong supporter of NAFTA, this new tax is entirely inappropriate and is the last thing our beleaguered airline industry can absorb. Many of my colleagues in the House also contacted the President and told him that it would be difficult for them to support any new taxes to pay for NAFTA. While I am encouraged that this message may be having an effect as we are beginning to see some signs of flexibility and reason coming from some administration officials, I am still concerned about the persistence of the airline passenger fee idea, that even now we are being told that we will not know if the administration will propose a new fee until the legislation is written this weekend or early next week.

It is ironic that the administration is considering placing a tax on the airlines for NAFTA since the adoption of NAFTA will have no direct impact on air transportation between the United States, Canada, and Mexico. Unique among industries, air service between the United States and foreign countries depends upon individually negotiated bilaterals. The administration's proposal would place us in the position of violating many of our bilaterals because most of our agreements require that any charges imposed on air carriers be related to airport or air traffic control costs. Clearly, this new fee would be completely unrelated to the present customs user fee which is imposed to pay for international inspectors and equipment.

In a further ironic twist, this new fee which supposedly would pay for worker retraining caused by NAFTA implementation, would likely result in further job losses in the airline industry.

One of my largest constituents in Washington State, the Boeing Co., has felt the pain of our airline industry. When airlines struggle, they stop buying planes, begin deferring orders, and often seek the best possible Government financing, which frequently now comes from Europe. All of these factors combined have caused huge job losses in the aviation manufacturing industry. Thousands of my constituents have lost their jobs.

Yet, the Boeing Co. supports NAFTA and was like the rest of the industry surprised when the administration decided to float a new airline fee. Boeing sees the overall agreement as a way of dismantling trade barriers, and of applying international rules to trade in services and investment. It expects Mexico's aircraft market to grow 25 percent to $10 billion between now and the year 2010. Perhaps most importantly, it sees NAFTA as a crucial precedent for our Nation's trade policy.Without its success, an Uruguay

round that lowers tariffs around the world and limits foreign aircraft manufacturing subsidies will be nearly impossible. NAFTA is one Government initiative that our aerospace industry truly does need.

Now, for all of its talk about helping our aerospace industry, the administration is considering a tax that would cost that industry jobs while defeating an initiative that would offer it some relief. I strongly urge the administration to find another means of financing these lost tariffs, so that I and many others can enthusiastically vote for this agreement, and see it pass.

Mr. SARBANES and Mr. SIMPSON addressed the Chair.

The PRESIDING OFFICER. The acting Republican leader.

Mr. SIMPSON. Mr. President, under the unanimous-consent agreement, I believe I have the floor and I will yield to the Senator from Maryland. The Senator from Montana has a moment of recognition.

But let me say this, and the Senator from Maryland will correct it in his own way or do whatever he wishes. As I spoke about the real reason why we are enmeshed here—and I wish Senator MCCONNELL were here as he could explain it so very much more clearly, but it is my understanding, and I said, the inspector general had made a report and we wanted it to be public to see what this administration was doing looking into the Bush personnel in the State Department.

It is my understanding that Senator MCCONNELL has been anxiously awaiting the inspector general's report and wants to make it public, to find out just exactly what did go on before these nominees went through. The nominees were, unfortunately, held hostage. I know the Senator from Maryland knows how well we do that on both sides of the aisle here in all administrations.

One of these fine people is well known to me, an Ambassador, and I have talked to the Senator's staff and asked why that person could not go forward. Now that person will go forward because I will vote for cloture on Tuesday, and we will move forward.

But you want to understand, Mr. President, that Senator MCCONNELL will continue his quest and the purpose of the quest, that when this report becomes available—and it is apparently not currently available—that, indeed, this Senator, Senator MCCONNELL, and I am sure others on our side of the aisle, will want to know what happened with it and will want it to be fully public so that we do not have any hypocrisy in the treatment of people in the State Department under different administrations.

I wish to get that clearly in the RECORD.

Mr. SARBANES. Will the Senator yield on that point?

Mr. SIMPSON. Yes, indeed.

Mr. SARBANES. I deferred earlier responding to the Senator when he made the statement, because I wanted to be certain of the accuracy. So I went to make a couple of telephone calls.

The Senator from Wyoming stated that the inspector general had made his report and that access to the report, or knowledge about the contents of that report was being denied. I did not think that was correct, but I was not certain of that. I have made a phone call, and what I have been informed is the inspector general has not completed his inquiry or investigation.

Now, of course, the inspector general operates with a degree of independence from the administration and, indeed, from the Congress, as he ought to.

So as I understand it—this is not an issue that I have been involved in, but as I understand it, that report has not been completed. The inspector general is still conducting his investigation. So you do not have a situation in which the inquiry has been completed and the report has been made and information about the findings of the report is being denied to people.

I further understand, I think as a matter of procedure, that if in fact the report turns up matters in which the Justice Department then takes an interest in a criminal sense, then you may have an ongoing problem about access since you would be interfering with a criminal investigation. But, of course, we do not even have the inspector general's report completed, which, as I understood it, from what the Senator said earlier, had been completed but that information about its findings was being denied to us. I do not think that is where we are.

I understand that is the Senator's understanding as I listened to his last statement. And I deferred earlier responding to him in saying what I have just said because I wanted to be certain that that was the case.

Mr. SIMPSON. Mr. President, that is essentially the case. As I expressed to the Senator from Maryland privately before this last colloquy, indeed, I wanted to correct that record, which I did. I think that that record is now correct.

But I would ask unanimous consent to be printed in the RECORD a letter from the Republican leader and Senator MCCONNELL to the Honorable Warren Christopher with regard to the issue of requesting information because of the media commentary that a State Department person from the White House Liaison Office had searched the records of 160 former political appointees and the protected contents of at least two of those files were publicly disclosed. I think it is rather extraordinary.

Subsequently, Department officials "insisting on anonymity" claimed the file search was "inadvertent."

It is difficult almost to determine what an inadvertent file search is. But since there had been such high old fun with a member of the State Department during the campaign, Senator MCCONNELL particularly wanted some answers to the questions of whether the search was requested or authorized by officials at the State Department acting alone or at the direction of the White House. These were questions asked of Secretary Christopher:

What was the intended use of the documents? Other than reporters at the Washington Post, who received information from these files. Is the individual involved still working at the Department of State?

The letter said:

These questions go to the heart of your administration of the Department of State. We believe they must be answered.

They were not answered, and therefore Senator MCCONNELL, as is his perfect right, placed a hold on these persons, and therefore that hold will now come up for a vote on cloture.

It is unfortunate but many Democrats, during the last administration, put holds on various nominees of the President of the United States, Ronald Reagan and George Bush, not because the nominees were not qualified but because they wanted the administration's attention or they wanted response to a special project or something that was totally unrelated to the nominee's qualifications or abilities.

That is what has happened here. That is what holds are used for. That is why it was a necessity for the leader to go to a cloture motion.

So those are realities just as real as the things the Senator from Maryland has previously discussed.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
Washington, DC, September 9, 1993.

Hon. WARREN CHRISTOPHER,
Secretary, Department of State, Washington, DC.

DEAR SECRETARY CHRISTOPHER: We are writing to request your response to news reports alleging a former Clinton campaign official serving in the White House Liaison Office at the State Department searched the records of 160 former political appointees. The protected contents of at least two of these files were publicly disclosed.

Subsequently, Department officials "insisting on anonymity" claimed the file search was "inadvertent." Nonetheless, the Assistant Secretary for Administration was concerned enough to seal the documentary evidence and forward the matter to the Inspector General. Senior officials in your Department are obviously aware of and publicizing their interpretation of the events in this case.

This situation could reflect the misconduct of an individual former campaign worker or represent evidence of far reaching, politically motivated, illegal activity. We believe it is important that you offer answers to the following questions:

1. Was the search suggested, requested or authorized by officials at the State Department acting alone or at the direction of the

White House, Democratic Party or any other entity?

2. What was the intended use of these documents?

3. Other than reporters at the Washington Post, who received information from these files?

4. Is the individual involved still working at the Department of State?

These questions go to the heart of your administration of the Department of State. We believe they must be answered prior to proceeding with further consideration of the State Department's authorization or appropriations bills. We look forward to your prompt reply.

Sincerely,

ROBERT DOLE,
Republican Leader.
MITCH MCCONNELL,
U.S. Senator.

Mr. SARBANES. I am not suggesting that the filibuster has not been used on both sides. I am suggesting that it is now being abused, and we need to step back and take a look at it and see what we can do so it does not continue to thwart the ability of the institution to do business.

Mr. SIMPSON. I hear my friend. I hear my friend.

Mr. SARBANES. I would strongly make the case, if we could absent ourselves from this back and forth about who hit whom first—we can develop that back—it has now reached the point with where this tactic is really undercutting the ability of the Senate to function as a strong institution in our Democratic system.

Mr. SIMPSON. Mr. President, I would never want to see the Senate get in that position and the public record and the record of this fine session shows that that is not the case. We have moved a tremendous amount of legislation, a tremendous amount.

So it cannot be quite as oblique as portrayed.

Mr. SARBANES. That is for another debate because we can go through the measures and how the filibuster was used and how it thwarted the Senate. But increasingly there is a growing perception across the country that this technique is really preventing the Senate from coming to grips with the Nation's problems and constitutes a form of gridlock which I think undercuts the standing of the Senate as an institution which can respond to the problems of the American people. I think all of us, all 100 of us need to really think this through carefully in an institutional way.

In other words, we have to take ourselves out of a partisan context and be prepared to really confront how the institution ought to operate and whether the repeated use of this tactic, which in effect prevents a majority from finally taking action on measures, is good for the health of the Senate and good for the health of the country.

Mr. SIMPSON. Mr. President, I will join with the Senator from Maryland to dampen our partisan pursuits in that endeavor because he and I both enjoy that aspect of public life. He is very good at it. So am I. And if the Senator from Maryland wants to join in a bipartisan way to do things that make the Senate work better than it has, he and I will, and I shall look forward to that opportunity.

Let me then ask unanimous consent if the Senator from Montana could speak for 1 minute to introduce a remark about a deceased friend. Then I will proceed under the unanimous-consent request with a statement wholly unrelated to this item.

The PRESIDING OFFICER. The unanimous-consent request is granted. The Chair, in his capacity as a Senator from West Virginia, would observe that the preceding conversation between the two Senators has been thoughtful.

The Senator from Montana.

Mr. BURNS. I thank the Chair.

A TRIBUTE TO FRANK DUNKLE

Mr. BURNS. Mr. President, Frank H. Dunkle, former director of the U.S. Fish and Wildlife died in Denver last Saturday. He was aged 69.

He was appointed by President Reagan in 1986 and had a stormy tour of duty as he was the target of environmental groups and congressional critics who said the agency under his leadership paid more attention to politics than protecting the Nation's natural resources. But the record does not bear that out.

According to an Associated Press story out of Helena, MT, he was credited with helping to create the Nation's first national recreational fisheries policy while heading the Federal wildlife agency. He implemented a North American waterfowl management plan and negotiated an agreement with Canada and Mexico to improve conservation of migratory birds and wetland habitats.

He was a native of Oakmont, PA, and served in the U.S. Navy in World War II and Korea. He was a Montana game warden and Yellowstone National Park ranger while working toward bachelor's and master's degrees in wildlife management at Montana State University. He was appointed to the Montana Fish and Game Department in 1963 and played an important role in enacting the State's stream preservation law and began Montana's program of acquiring land for winter game ranges, waterfowl habitat and fishing access.

In 1970, Frank convened the first national grizzly bear conference of State and Federal officials and researchers, the forerunner of the present Grizzly Bear Task Force.

If there ever was a man dedicated to the commonsense approach to our Nation's wildlife and environment, it was Frank Dunkle. I knew him and respected his judgment in such matters. Sure he was a person of controversy but who wasn't in those days of change. He stood his ground when criticism came from all directions and never lost or was swayed from his own judgment. I thank him for his service to my home State of Montana and this United States.

Mr. SIMPSON. Mr. President, I look forward to working with the Senator from Maryland on issues because I do enjoy him as a friend.

THE AARP

Mr. SIMPSON. Mr. President, I rise with some acknowledged trepidation, Mr. President—and on this I shall not extend—in order to express some very deep concerns regarding the activities of the AARP—I can almost feel the Chamber crumbling on my head—the American Association of Retired Persons, the AARP, one of the most enormously influential organizations in our society.

I am most assuredly well aware of the political hazards that one risks when offering up even the mildest criticisms of this mammoth organization. However, I believe my concerns are honest and valid ones, and I would take this opportunity to share them with my Senate colleagues and my fellow Americans.

Perhaps a very good place to start would be with the AARP propaganda machine, as I call it. First note that I am a member of the AARP. I have sent in my $8. I could not resist the blandishments which came to me in the mail when I came to the age of 55. Now the age of admission is 50. All you have to be is 50 to be in the American Association of Retired Persons. So imagine the membership net that they throw out across America.

I recently reviewed the September 1993 issue of the AARP Bulletin—I read these faithfully—the monthly newsletter which the AARP sends to its 34 million members, all paying $8 apiece dues. Figure that up. Big time.

I was immediately intrigued by the front-page headline which said, "AARP Set to Fight Curbs on Benefits." The first sentence of the article reads as follows. "Despite taking a major hit in last month's budget deal, America's elderly are now being targeted for even deeper benefit cuts this fall." What then follows is a lengthy dissertation that makes it sound as if America's senior citizens will be bearing all of the burden of the budget package recently signed into law by the President—and furthermore, that the Congress is getting ready to inflict more pain on older Americans. This is truly a preposterous and phony claim. Not the first time that this organization has espoused such doggerel.

The article then goes dramatically on to quote John Rother, the AARP legislative director, and there is quite a staff there—that will be the subject

of subsequent remarks here on the floor—and their salaries.

He is saying, listen to this, "The situation is grave. * * * Our members should be very concerned and they should be very active." Read that "politically active." Then the gentle readers are directed to a column on the next page where they are urged to write and express their views to their Senators and Representatives.

I have always prided myself on communicating with my Wyoming constituents. I very much appreciate and enjoy reading letters and having phone calls from them. I represent a small State with a small population; indeed, the smallest. So to me it is a person-to-person exercise—so I think it is most unfortunate when these communications suddenly come to me which are prompted solely by inaccurate and deceptive information.

Even though I opposed the President's budget package, I do not believe for 1 minute it has singled out seniors for unfair treatment or a major hit. It troubles me greatly that there are 34 million Americans who are being fed false and misleading information on matters of such critical import for their own understanding.

It is no wonder why so many Americans have such a deep and abiding suspicion and distrust with Congress and their Federal Government. Based upon information that is provided by the AARP Bulletin, one could easily conjecture that Congress was solely made up of evil, uncaring, insensitive, and cruel people; and that seniors are being treated as second-class citizens in this country.

The reality however, as every thoughtful citizen knows, is that we are a very generous and compassionate Nation when it comes to taking care of our senior citizens. That is why we have a national debt of approaching $4.37 trillion—$4,370,000,000,000—and an annual deficit of $300 billion.

So just to set the record straight, let us review the so-called major hit—those are the AARP's words—that the budget package supposedly laid on these senior citizens.

First of all, the growth of Medicare spending was reduced by $55.8 billion over the next 5 years. Those are not cuts. That is the phoniest type of argument.

Do not let the AARP or the media sell you a bill of goods on that. The fiscal year 1992 increase in Medicare spending was 13 percent. The fiscal year 1993 increase is estimated to be 10.9 percent. They are not cuts. We are simply not going to allow the programs to go up as fast as they have in recent years.

When a 13-percent increase is described as a "cut" someone is not telling the truth. And with the exception of $7.8 billion, all of the $55.8 billion in savings are achieved at the expense of health care providers and hospitals. Services and benefits are not reduced in any way. No. None.

The only cost borne by Medicare beneficiaries—the $7.8 billion I just referred to comes from maintaining part B premiums at 25 percent of the cost of the program in fiscal years 1996 through 1998. And all this does is extend the current policies through 1998. There is nothing new about this.

We will hear from the AARP when we should very much consider raising the part B premium participation to 100 percent, because you see right now those who pay part B premiums are paying 25 percent of that premium regardless of their net worth or their income. So Joe Six-Pack is paying the premium, 75 percent of the premium, for someone who is extraordinarily well off. That is wrong. It is silly.

And wait until we try to change it. They will be dropping out of the trees like mayflies in May right onto the water where the trout can leap out. That is their constituency.

So that is something we want to recall with regard to part B premiums. We are going to have to say that those who earn over $100,000 in retirement are going to have to pay all of their part B premium, which will be about $136 a month. They will shriek like a gut shot panther, and these people will probably help them. Remember, right now they are paying about $36 a month for part B premiums. We are going to say, we are going to quadruple that. They are going to pay all of it, which will be about $140, and only if they have about $100,000 in retirement. We will hear from everyone on that. I know we will.

And we will just have to suck up and try to do it right, which will be very difficult because this organization—it will depend on whether they are aboard or not—this organization has the power to destroy the President's health care proposal, or Senator CHAFEE's health care proposal, or Senator BREAUX's health care proposal, or the Democratic proposal, or the Republican proposal.

Now with regard to Social Security, the budget package required that the individual seniors making more than $34,000 a year—this is in retirement—couples making more than $44,000 a year, will now have 85 percent of their Social Security benefits made subject to taxation. That does not mean they will be taxed at 85 percent. Some even write and tell me about that. I do not know where they get that information. It means that 85 percent of their Social Security is exposed to taxes. If they are in the 18 percent bracket, that is not a punitive tax, especially if they are making over $44,000 a year as a couple in retirement. This change in the law will generate $24 billion in revenues over 5 years.

If you were to combine this $24 billion with the $7.8 billion that results from adjusting part B premiums, you then have a total of $31.8 billion that Social Security and Medicare beneficiaries are contributing to deficit reduction. That is what they are coughing up. This may seem like a substantial amount, and it surely is. But it still accounts for only slightly more than 6 percent of the total deficit reduction package, and that, according to the AARP is a major hit on the seniors of America. Bosh.

I think it becomes very clear that the AARP believes that seniors should be largely excluded from participating in any efforts to reduce the Federal budget deficit. Be assured that they always say that they are "very willing to help" do this, and they are willing to help do "their share" and "bear their portion of the burden." Yet, the propaganda they feed out to their vast membership suggests otherwise.

If 6 percent is too much for seniors to contribute toward deficit reduction, then just what is acceptable to the AARP? I think we can find an answer to that question in carefully reviewing the AARP's public policy agenda. This is the AARP's official wish list. Do not miss it. It is 510 pages long. They probably send it to any Member. You can get a copy. This outlines everything the AARP would like the Federal Government to do for senior citizens. And just for starters, they would provide all seniors with expanded health care benefits under Medicare—long-term care coverage and prescription drug coverage—regardless of the person's net worth or income. Seniors of high income status would get these new benefits right along with those who truly cannot afford them.

The AARP would also demand that the Government expand upon housing programs for low-income seniors, energy assistance, food and nutrition assistance, transportation services, counseling, worker training, legal services, and the list goes on and on. Certainly, many of these services are obviously worthwhile, but they would break this Nation financially. The National Taxpayers Union has estimated the cost of these new services, and benefits would exceed $300 billion in this fiscal year alone. I really do believe and think many AARP members would be truly shocked—and even embarrassed—if they knew this broad agenda, this back-breaking agenda, was being proposed in their name and with their dues. By the end of the decade, the costs of these benefits would exceed $600 billion per year—in addition to the cost of everything else we already do for seniors.

As a member of the Senate Special Committee on Aging, I would like to make my colleagues aware of a report that the committee publishes annually. Here it is. It is entitled "Developments in Aging," and it consists of two volumes. Here they are. This report outlines all of the legislative activities

that have taken place in the previous year with respect to aging issues. It also includes comprehensive information on all of the programs, benefits, services, and grants that are available to senior citizens of this country through the Federal Government. It is a marvelous document—heavy, too. I commend it to everyone's attention, "Developments in Aging," a report of the Special Committee, chaired by a wonderful person, Senator DAVID PRYOR, a lovely friend, and the ranking member, BILL COHEN—two very able United States Senators.

So I ask you if you might take a look at that.

In addition, I ask unanimous consent that a separate list of services to seniors compiled by my staff be printed in the RECORD at this point.

There being no objection, the list was ordered to be printed in the RECORD, as follows:

FEDERAL PROGRAMS TARGETED TO SENIORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. Emergency Community Services for the Homeless (93.034), Office of Community Services, Administration for Children and Families, Department of Health and Human Services.

2. Special Programs for the Aging—Title III, Part B—Grants for Supportive Services and Senior Citizens (93.633), Administration on Aging, Office of the Secretary, Department of Health and Human Services.

3. Social Security—Research and Demonstration (SSA Research and Demonstration) (93.812), Social Security Administration, Department of Health and Human Services.

4. Social Security—Retirement Insurance (93.803), Social Security Administration, Department of Health and Human Services.

5. Social Security—Special Benefits for Persons Aged 72 and Over (93.804), Social Security Administration, Department of Health and Human Services.

6. Social Security—Survivors Insurance (93.805), Social Security Administration, Department of Health and Human Services.

7. Special Programs for the Aging—Title VI, Part A—Indian Programs—Grants to Indian Tribes and Part B, Grants to Native Hawaiians (93.655), Administration for Children and Families, Department of Health and Human Services.

8. Supplemental Security Income (93.807), Social Security Administration, Department of Health and Human Services.

9. Special Programs for the Aging—Title IV—Training, Research and Discretionary Projects and Programs (93.668), Administration on Aging, Office of the Secretary, Department of Health and Human Services.

10. Aging Research (93.866), National Institutes of Health, Public Health Service, Department of Health and Human Services.

11. Health Care Financing Research, Demonstrations and Evaluations (HCFA Research) (93.779), Health Care Financing Administration, Department of Health and Human Services.

12. Medicare—Hospital Insurance (Medicare) (93.773), Health Care Financing Administration, Department of Health and Human Services.

13. Medicare—Supplementary Medical Insurance (Medicare) (93.774), Health Care Financing Administration, Department of Health and Human Services.

14. Special Programs for the Aging—Title III, Part A—Long-Term Care Ombudsman Services for Older Individuals (State Grants for Aging Ombudsman Activities) (93.533), Administration on Aging, Office of the Secretary, Department of Health and Human Services.

15. Special Programs for the Aging—Title III, Part D—In-Home Services for Frail Older Individuals (In-Home Services for Frail Older Individuals) (93.641), Administration on Aging, Office of the Secretary, Department of Health and Human Services.

16. Special Programs for the Aging—Title III, Part F—Preventive Health Services (93.555), Administration on Aging, Office of the Secretary, Department of Health and Human Services.)

17. Special Programs for the Aging—Title III, Part G—Prevention of Abuse, Neglect, and Exploitation of Older Individuals (State Grants for Elder Abuse) (93.552), Administration on Aging, Office of the Secretary, Department of Health and Human Services.

18. Low-Income Home Energy Assistance (93.028), Administration for Children and Families, Department of Health and Human Services.

19. Special Programs for the Aging—Title III, Part C—Nutrition Services (93.635), Administration on Aging, Office of the Secretary, Department of Health and Human Services.

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1. Rehabilitation Services—Independent Living Services for Older Blind Individuals (84.77), Office of Special Education and Rehabilitation Services, Department of Education.

DEPARTMENT OF LABOR

1. Senior Community Services Employment Program (SCSEP) (Older Worker Program) (17.235), Employment and Training Administration, Department of Labor.

ENVIRONMENTAL PROTECTION AGENCY

1. Senior Environmental Employment Program, Office of Research and Development, Environmental Protection Agency.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

1. Home Equity Conversion Mortgages (14.183), Housing, Department of Housing and Urban Development.

2. Housing for the Elderly or Handicapped (202) (14.157), Housing, Department of Housing and Urban Development.

3. Congregate Housing Services Program (CHSP) (14.170), Housing, Department of Housing and Urban Development.

4. Mortgage Insurance—Nursing Homes, Intermediate Care Facilities and Board and Care Homes (232 Nursing Homes) (14.129), Housing, Department of Housing and Urban Development.

5. Mortgage Insurance—Rental and Cooperative Housing for Moderate Income Families and Elderly, Market Interest Rate (221)(D)) (3) and (4) Multifamily—Market Rate Housing) (14.135), Housing, Department of Housing and Urban Development.

6. Mortgage Insurance—Rental Housing for the Elderly (231) (14.138), Housing, Department of Housing and Urban Development.

DEPARTMENT OF AGRICULTURE

1. Nutrition Program for the Elderly (Commodities) (NPE) (10.570), Food and Nutrition Service, Department of Agriculture.

DEPARTMENT OF TRANSPORTATION

1. Capital Assistance Program for Elderly Persons and Persons with Disabilities (Elderly and Disabled, Section 16 (B)) (20.513), Federal Transit Administration, Department of Transportation.

VOLUNTEER PROGRAMS

1. Foster Grandparent Program (FGP) (72.001), Action.

2. Retired Senior Volunteer Program (RSVP) (72.002), Action.

3. Senior Companion Program (SCP) (72.008), Action.

4. Service Corps of Retired Executives Association (SCORE) (59.026), Small Business Administration.

5. Tax Counseling for the Elderly (21.006), Internal Revenue Service, Department of the Treasury.

(Mr. WOFFORD assumed the chair.)

Mr. SIMPSON. I think it is also vitally important to acknowledge that the AARP is not just some outfit that is set to look out for the poor and the destitute and disadvantaged, because despite its claim to be a nonprofit organization—and it has been referred to as a money machine in one article—the AARP is an extraordinary, wealthy, and profitable enterprise.

In 1992, the AARP had revenues totaling $386 million—$386 million. Included in this figure is the $102 million that came from membership dues—and that was before they raised their annual dues from $5 to $8. The AARP—I really want to look into this one—also receives $80 million in Federal grants and millions more in postal subsidies, all compliments of the U.S. taxpayers.

In addition, they reported interest income exceeding $37 million in 1992. Interest income. Imagine then, if the yield that is generated here is 6 or 8 percent—and it probably is—then the principal would be $500 million or $600 million. In what? Well, whatever it is, it is called principal in the real world, and you get interest off principal. And if you are getting a yield of $37 million—which I think has been adjusted up to $40 million, and I will have those figures—then imagine what the principal is. I will be exploring those issues in greater detail in weeks ahead—at my political detriment.

Finally, the balance of the AARP's revenues are derived largely from what is described in publications as an $8 billion to $10 billion cash flow—an empire that includes big, big businesses involving health, life, and auto insurance, travel services, mutual funds, a mail order pharmacy, and publications that bring in tens of millions of dollars in advertising revenues—almost $40 million in advertising revenue to this nonprofit organization in the year 1992 alone.

And then the AARP also receives 4 percent of every premium dollar paid to the Prudential Life Insurance Co. on their advertised insurance through AARP. In their magazine, they are even placing their ads for the things they do next to the paid advertisers, and there is an entirely separate examination of that going on by me.

None of this is inherently wrong. After all, this is America. But I think

it is a most curious thing that such a prosperous money making machine has a nonprofit designation. More importantly, I think it is terribly wrong that this organization is communicating false and deceptive information to a large segment of the population. And no one is ever challenging them on their facts. This must stop. Nobody wants to take them on. I can assure you I will pay dearly for this, but I have done a little dragon slaying in my life, and I must say that the hot breath of the dragon has often seared the rest of the hair off this bald dome. I am not going to sit still and watch this continued distortion take place. We in Congress have an obligation to confront the AARP when they stray from the truth. It is not always easy to do that, and it is certainly not politically correct, especially when you are talking about an organization that openly and brazenly boasts about its clout and the millions of votes they represent.

I am encouraged, as is always the case, by a few sturdy souls in my State of Wyoming who have written to me saying "Don't be intimidated by the AARP." I believe that most thoughtful seniors, American citizens, when presented with honest and truthful information and facts, would reject the full blast of propaganda from the AARP. I am also hopeful that the young people in this Nation, and, boy, they better be listening—they will be out picking grit with the chickens in the year 2030, if you leave the AARP to set the national agenda—I am hopeful that the young people in this country are becoming more and more aware and much more politically astute, because they are the ones who will be picking up the tab for the excesses of the AARP agenda.

Let me conclude in emphasizing that my concerns about the AARP—and this will not appear anywhere, but I am saying it because I hope it will—and the manner in which they conduct their business, has nothing at all to do with bashing of senior citizens. I had a 95-year-old father who just died in June. I have a 93-year-old mother. My wife's mother is 93. We are blessed and we take care of them ourselves. One of them is quite able to do that. And yet there are millions or at least hundreds of thousands of people in this country who when their parents or their relatives become aged they suddenly say, "I think we better put the farm in Tommy's name because it just seems like it is important to do that now," and then put that person on title 19. That happens all the time in America.

There is lots of stuff out there, but I am not a basher of senior citizens nor am I trying to diminish the good that is accomplished by AARP. I think it is most admirable that over 400,000 AARP volunteers are involved in community service programs nationwide. I also know that many seniors sincerely benefit from the AARP's driving retraining program. People are frightened at that age, puzzled by driver training, and they help them, as well as consumer affairs information and legal services that the AARP provides in many areas.

These are very worthwhile services, and I will not belittle them in any way, and that is not what I am doing. But I can now hear the hew and cry and see the cartoons, emaciated, gaunt, bald, and slouched "Ichabod Crane" type cartoons like me make remarkable targets for the cartoonist pen.

No, that is not what I am up to. The AARP has every valid right as an organization of American citizens to promote the interests of our Nation's elderly, but they need to be much more careful about their facts and tactics.

I would wish that the AARP would play a more constructive role in the future. With their enormous audience and membership, they have the potential to be ever so helpful to us, especially in this area of health care reform. If they decide to turn, they can be the most destructive force to the President, to the Democrats, to the Republicans, to the House, and to the Senate.

So I hope they will communicate honestly and factually with their membership. I, for one, will continue to observe them very closely, and I am doing some serious research, and I will have much more to say on some of their other activities in the coming weeks.

I thank the Chair and I thank the staff because I have been a bit long, but I do not usually transgress upon the Chamber in that fashion.

RECESS UNTIL TOMORROW AT 10:30 A.M.

The PRESIDING OFFICER. Under the previous order the Senate stands in recess until 10:30 a.m., Friday, October 29.

Thereupon, the Senate, at 7:14 p.m., recessed until tomorrow, Friday, October 29, 1993, at 10:30 a.m.

EXTENSIONS OF REMARKS

HEALTH SECURITY ACT

HON. DAVID E. BONIOR
OF MICHIGAN
IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. BONIOR. Mr. Speaker, I submit for the benefit of all Members and the American people, the President's health security plan, which I strongly support:

HEALTH SECURITY ACT

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUBTITLES.

(a) SHORT TITLE.—This Act may be cited as the "Health Security Act".

(b) TABLE OF TITLES AND SUBTITLES IN ACT.—The following are the titles and subtitles contained in this Act:

TITLE I—HEALTH CARE SECURITY

Subtitle A—Universal Coverage and Individual Responsibility
Subtitle B—Benefits
Subtitle C—State Responsibilities
Subtitle D—Health Alliances
Subtitle E—Health Plans
Subtitle F—Federal Responsibilities
Subtitle G—Employer Responsiblities
[Subtitle H—Reserved]
[Subtitle I—Reserved]
Subtitle J—General Definitions; Miscellaneous Provisions

TITLE II—NEW BENEFITS

Subtitle A—Medicare Outpatient Prescription Drug Benefit
Subtitle B—Long-Term Care

TITLE III—PUBLIC HEALTH INITIATIVES

Subtitle A—Workforce Priorities Under Federal Payments
Subtitle B—Academic Health Centers
Subtitle C—Health Research Initiatives
Subtitle D—Core Functions of Public Health Programs; National Initiatives Regarding Preventive Health
Subtitle E—Health Services for Medically Underserved Populations
Subtitle F—Mental Health; Substance Abuse
Subtitle G—Comprehensive School Health Education; School-Related Health Services
Subtitle H—Public Health Service Initiatives Fund
Subtitle I—Coordination With COBRA Continuation Coverage

TITLE IV—MEDICARE AND MEDICAID

Subtitle A—Medicare and the Alliance System
Subtitle B—Savings in Medicare Program
Subtitle C—Medicaid
Subtitle D—Increase in SSI Personal Needs Allowance

TITLE V—QUALITY AND CONSUMER PROTECTION

Subtitle A—Quality Management and Improvement
Subtitle B—Information Systems, Privacy, and Administrative Simplification
Subtitle C—Remedies and Enforcement
Subtitle D—Medical Malpractice
Subtitle E—Fraud and Abuse
Subtitle F—McCarran-Ferguson Reform

TITLE VI—PREMIUM CAPS; PREMIUM-BASED FINANCING; AND PLAN PAYMENTS

Subtitle A—Premium Caps
Subtitle B—Premium-Related Financings
Subtitle C—Payments to Regional Alliance Health Plans

TITLE VII—REVENUE PROVISIONS

Subtitle A—Financing Provisions
Subtitle B—Tax Treatment of Employer-Provided Health Care
Subtitle C—Employment Status Provisions
Subtitle D—Tax Treatment of Funding of Retiree Health Benefits
Subtitle E—Coordination With COBRA Continuing Care Provisions
Subtitle F—Tax Treatment of Organizations Providing Health Care Services and Related Organizations
Subtitle G—Tax Treatment of Long-term Care Insurance and Services
Subtitle H—Tax Incentives for Health Services Providers
Subtitle I—Miscellaneous Provisions

TITLE VIII—HEALTH AND HEALTH-RELATED PROGRAMS OF THE FEDERAL GOVERNMENT

Subtitle A—Military Health Care Reform
Subtitle B—Department of Veterans Affairs
Subtitle C—Federal Employees Health Benefits Program
Subtitle D—Indian Health Service
Subtitle E—Amendments to the Employee Retirement Income Security Act of 1974
Subtitle F—Special Fund for WIC Program

TITLE IX—AGGREGATE GOVERNMENT PAYMENTS TO REGIONAL ALLIANCES

Subtitle A—Aggregate State Payments
Subtitle B—Aggregate Federal Alliance Payments
Subtitle C—Borrowing Authority to Cover Cash-Flow Shortfalls

TITLE X—COORDINATION OF MEDICAL PORTION OF WORKERS COMPENSATION AND AUTOMOBILE INSURANCE

Subtitle A—Workers Compensation Insurance
Subtitle B—Automobile Insurance
Subtitle C—Commission on Integration of Health Benefits
Subtitle D—Federal Employees' Compensation Act
Subtitle E—Davis-Bacon Act and Service Contract Act
Subtitle F—Effective Dates

TITLE XI—TRANSITIONAL INSURANCE REFORM

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) Under the current health care system in the United States—

(A) individuals risk losing their health care coverage when they move, when they lose or change jobs, when they become seriously ill, or when the coverage becomes unaffordable;

(B) continued escalation of health care costs threatens the economy of the United States, undermines the international competitiveness of the Nation, and strains Federal, State, and local budgets;

(C) an excessive burden of forms, paperwork, and bureaucratic procedures confuses consumers and overwhelms health care providers;

(D) fraud and abuse sap the strength of the health care system; and

(E) health care is a critical part of the economy of the United States and interstate commerce, consumes a significant percentage of public and private spending, and affects all industries and individuals in the United States.

(2) Under any reform of the health care system—

(A) health insurance and high quality health care should be secure, uninterrupted, and affordable for all individuals in the United States;

(B) comprehensive health care benefits that meet the full range of health needs, including primary, preventive, and specialized care, should be available to all individuals in the United States;

(C) the current high quality of health care in the United States should be maintained;

(D) individuals in the United States should be afforded a meaningful opportunity to choose among a range of health plans, health care providers, and treatments;

(E) regulatory and administrative burdens should be reduced;

(F) the rapidly escalating costs of health care should be contained without sacrificing high quality or impeding technological improvements;

(G) competition in the health care industry should ensure that health plans and health care providers are efficient and charge reasonable prices;

(H) a partnership between the Federal Government and each State should allow the State and its local communities to design an effective, high-quality system of care that serves the residents of the State;

(I) all individuals should have a responsibility to pay their fair share of the costs of health care coverage;

(J) a health care system should build on the strength of the employment-based coverage arrangements that now exist in the United States;

(K) the penalties for fraud and abuse should be swift and severe; and

(L) an individual's medical information should remain confidential and should be protected from unauthorized disclosure and use.

SEC. 3. PURPOSES.

The purposes of this Act are as follows:

(1) To guarantee comprehensive and secure health care coverage.

(2) To simplify the health care system for consumers and health care professionals.

(3) To control the cost of health care for employers, employees, and others who pay for health care coverage.

(4) To promote individual choice among health plans and health care providers.

(5) To ensure high quality health care.

(6) To encourage all individuals to take responsibility for their health care coverage.

TITLE I—HEALTH CARE SECURITY

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Subtitle B—Benefits

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Subtitle A—Universal Coverage and Individual Responsibility
PART 1—UNIVERSAL COVERAGE

SEC. 1001. ENTITLEMENT TO HEALTH BENEFITS.

(a) IN GENERAL.—In accordance with this part, each eligible individual is entitled to the comprehensive benefit package under subtitle B through the applicable health plan in which the individual is enrolled consistent with this title.

(b) HEALTH SECURITY CARD.—Each eligible individual is entitled to a health security card to be issued by the alliance or other entity that offers the applicable health plan in which the individual is enrolled.

(c) ELIGIBLE INDIVIDUAL DEFINED.—In this Act, the term "eligible individual" means an individual who is residing in the United States and who is—

(1) a citizen or national of the United States;

(2) an alien permanently residing in the United States under color of law (as defined in section 1902(1)); or

(3) a long-term nonimmigrant (as defined in section 1902(19)).

(d) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—Subject to section 1012(a), a medicare-eligible individual is entitled to health benefits under the medicare program instead of the entitlement under subsection (a).

(e) TREATMENT OF PRISONERS.—A prisoner (as defined in section 1902(26)) is entitled to health care services provided by the authority responsible for the prisoner instead of the entitlement under subsection (a).

SEC. 1002. INDIVIDUAL RESPONSIBILITIES.

(a) IN GENERAL.—In accordance with this Act, each eligible individual (other than a medicare-eligible individual)—

(1) must enroll in an applicable health plan for the individual, and

(2) must pay any premium required, consistent with this Act, with respect to such enrollment.

(b) LIMITATION ON DISENROLLMENT.—No eligible individual shall be disenrolled from an applicable health plan until the individual—

(1) is enrolled under another applicable health plan, or

(2) becomes a medicare-eligible individual.

SEC. 1003. PROTECTION OF CONSUMER CHOICE.

Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services.

(2) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care services not included within the comprehensive benefit package.

(3) An individual who is not an eligible individual from purchasing health insurance (other than through a regional alliance).

(4) Employers from providing coverage for benefits in addition to the comprehensive benefit package (subject to part 2 of subtitle E).

SEC. 1004. APPLICABLE HEALTH PLAN PROVIDING COVERAGE.

(a) SPECIFICATION OF APPLICABLE HEALTH PLAN.—Except as otherwise provided:

(1) GENERAL RULE: REGIONAL ALLIANCE HEALTH PLANS.—The applicable health plan for a family is a regional alliance health plan for the alliance area in which the family resides.

(2) CORPORATE ALLIANCE HEALTH PLANS.—In the case of a family member that is eligible to enroll in a corporate alliance health plan under section 1311(c), the applicable health plan for the family is such a corporate alliance health plan.

(b) CHOICE OF PLANS FOR CERTAIN GROUPS.—

(1) MILITARY PERSONNEL AND FAMILIES.—For military personnel and families who elect a Uniformed Services Health Plan of the Department of Defense under section 1073a(d) of title 10, United States Code, as inserted by section 8001(a) of this Act, that plan shall be the applicable health plan.

(2) VETERANS.—For veterans and families who elect to enroll in a veterans health plan under section 1801 of title 38, United States Code, as inserted by section 8101(a) of this Act, that plan shall be the applicable health plan.

(3) INDIANS.—For those individuals who are eligible to enroll, and who elect to enroll, in a health program of the Indian Health Service under section 8302(b), that program shall be the applicable health plan.

SEC. 1005. TREATMENT OF OTHER NONIMMIGRANTS.

(a) UNDOCUMENTED ALIENS INELIGIBLE FOR BENEFITS.—An undocumented alien is not eligible to obtain the comprehensive benefit package through enrollment in a health plan pursuant to this Act.

(b) DIPLOMATS AND OTHER FOREIGN GOVERNMENT OFFICIALS.—Subject to conditions established by the National Health Board in consultation with the Secretary of State, a nonimmigrant under subparagraph (A) or (G) of section 101(a)(15) of the Immigration and Nationality Act may obtain the comprehensive benefit package through enrollment in the regional alliance health plan for the alliance area in which the nonimmigrant resides.

(c) RECIPROCAL TREATMENT OF OTHER NONIMMIGRANTS.—With respect to those classes of individuals who are lawful nonimmigrants but who are not long-term nonimmigrants (as defined in section 1902(19)) or described in subsection (b), such individuals may obtain

such benefits through enrollment with regional alliance health plans only in accordance with such reciprocal agreements between the United States and foreign states as may be entered into.

SEC. 1006. EFFECTIVE DATE OF ENTITLEMENT.

(a) REGIONAL ALLIANCE ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—In the case of regional alliance eligible individuals residing in a State, the entitlement under this part (and requirements under section 1002) shall not take effect until the State becomes a participating State (as defined in section 1200).

(2) TRANSITIONAL RULE FOR CORPORATE ALLIANCES.—

(A) IN GENERAL.—In the case of a State that becomes a participating State before the general effective date (as defined in subsection (c)) and for periods before such date, under rules established by the Board, an individual who is covered under an employee benefit plan (described in subparagraph (C)) based on the individual (or the individual's spouse) being a qualifying employee of a qualifying employer, the individual shall not be treated under this Act as a regional alliance eligible individual.

(B) QUALIFYING EMPLOYER DEFINED.—In subparagraph (A), the term "qualifying employer" means an employer that—

(i) is described in section 1311(b)(1)(A), or is participating in a multiemployer plan described in section 1311(b)(1)(B) or arrangement described in section 1311(b)(1)(C), and

(ii) provides such notice to the regional alliance involved as the Board specifies.

(C) BENEFITS PLAN DESCRIBED.—A plan described in this subparagraph is an employee benefit plan that—

(i) provides (through insurance or otherwise) the comprehensive benefit package, and

(ii) provides an employer contribution of at least 80 percent of the premium (or premium equivalent) for coverage

(b) CORPORATE ALLIANCE ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—In the case of corporate alliance eligible individuals, the entitlement under this part shall not take effect until the general effective date.

(2) TRANSITION.—For purposes of this Act and before the general effective date, in the case of an eligible individual who resides in a participating State, the individual is deemed a regional alliance eligible individual until the individual becomes a corporate alliance eligible individual, unless paragraph (2)(A) applies to the individual.

(c) GENERAL EFFECTIVE DATE DEFINED.—In this Act, the term "general effective date" means January 1, 1998.

PART 2—TREATMENT OF FAMILIES AND SPECIAL RULES

SEC. 1011. GENERAL RULE OF ENROLLMENT OF FAMILY IN SAME HEALTH PLAN.

(a) IN GENERAL.—Except as provided in this part or otherwise, all members of the same family (as defined in subsection (b)) shall be enrolled in the same applicable health plan.

(b) FAMILY DEFINED.—In this Act, unless otherwise provided, the term "family"—

(1) means, with respect to an eligible individual who is not a child (as defined in subsection (c)), the individual; and

(2) includes the following persons (if any):

(A) The individual's spouse if the spouse is an eligible individual.

(B) The individual's children (and, if applicable, the children of the individual's spouse) if they are eligible individuals.

(c) CLASSES OF FAMILY ENROLLMENT; TERMINOLOGY.—

(1) IN GENERAL.—In this Act, each of the following is a separate class of family enrollment under this Act:

(A) Coverage only of an individual (referred to in this Act as the "individual" class of enrollment).

(B) Coverage of a married couple without children (referred to in this Act as the "couple-only" class of enrollment).

(C) Coverage of an unmarried individual and one or more children (referred to in this Act as the "single parent" class of enrollment).

(D) Coverage of a married couple and one or more children (referred to in this Act as the "dual parent" class of enrollment).

(2) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this Act:

(A) FAMILY.—The term "family", with respect to a class of enrollment, refers to enrollment in a class of enrollment described in subparagraph (B), (C), or (D) of paragraph (1).

(B) COUPLE.—The term "couple", with respect to a class of enrollment, refers to enrollment in a class of enrollment described in subparagraph (B) or (D) of paragraph (1).

(d) SPOUSE; MARRIED; COUPLE.—

(1) IN GENERAL.—In this Act, the terms "spouse" and "married" mean, with respect to a person, another individual who is the spouse of the person or married to the person, as determined under applicable State law.

(2) COUPLE.—The term "couple" means an individual and the individual's spouse.

(e) CHILD DEFINED.—

(1) IN GENERAL.—In this Act, except as otherwise provided, the term "child" means an eligible individual who (consistent with paragraph (3))—

(A) is under 18 years of age (or under 24 years of age in the case of a full-time student), and

(B) is a dependent of an eligible individual.

(2) APPLICATION OF STATE LAW.—Subject to paragraph (3), determinations of whether a person is the child of another person shall be made in accordance with applicable State law.

(3) NATIONAL RULES.—The National Health Board may establish such national rules respecting individuals who will be treated as children as the Board determines to be necessary. Such rules shall be consistent with the following principles:

(A) STEP AND FOSTER CHILD.—A child includes a step child or foster child who is an eligible individual living with an adult in a regular parent-child relationship.

(B) DISABLED CHILD.—A child includes an unmarried dependent eligible individual regardless of age who is incapable of self-support because of mental or physical disability which existed before age 21.

(C) CERTAIN 3-GENERATION FAMILIES.—A child includes the grandchild of an individual, if the parent of the grandchild is a child and the parent and grandchild are living with the grandparent.

(D) TREATMENT OF EMANCIPATED MINORS AND MARRIED INDIVIDUALS.—An emancipated minor or married individual shall not be treated as a child.

(f) ADDITIONAL RULES.—The Board shall provide for such additional exceptions and special rules, including rules relating to—

(1) families in which members are not residing in the same area,

(2) the treatment of individuals who are under 19 years of age and who are not a dependent of an eligible individual, and

(3) changes in family composition occurring during a year,

as the Board finds appropriate.

SEC. 1012. TREATMENT OF CERTAIN FAMILIES.

(a) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS WHO ARE QUALIFIED EMPLOYEES OR SPOUSES OF QUALIFIED EMPLOYEES.—

(1) IN GENERAL.—Except as specifically provided, in the case of an individual who is an individual described in paragraph (2) with respect to 2 consecutive months in a year (and it is anticipated would be in the following month), the individual shall not be treated as a medicare-eligible individual under this Act during the following month and the remainder of the year.

(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph with respect to a month is a medicare-eligible individual (determined without regard to paragraph (1)) who is a qualifying employee or the spouse or family member of a qualifying employee in the month.

(3) EXCEPTION.—Paragraph (1) shall not apply, in the case of an individual, if the individual described in paragraph (2) terminates qualifying employment in the month preceding the first month in which paragraph (1) applies. The previous sentence shall apply until with respect to qualifying employment occurring before such first month.

(b) SEPARATE TREATMENT FOR CERTAIN GROUPS OF INDIVIDUALS.—In the case of a family that includes one or more individuals in a group described in subsection (c)—

(1) all the individuals in each such group within the family shall be treated as a separate family, and

(2) all the individuals not described in any such group shall be treated collectively as a separate family.

(c) GROUPS OF INDIVIDUALS DESCRIBED.—Each of the following is a group of individuals described in this subsection:

(1) AFDC recipients (as defined in section 1902(3)).

(2) Disabled SSI recipients (as defined in section 1902(13)).

(3) SSI recipients who are not disabled SSI recipients.

(4) Electing veterans (as defined in subsection (d)(1)).

(5) Active duty military personnel (as defined in subsection (d)(2)).

(6) Electing Indians (as defined in subsection (d)(3)).

(7) Prisoners (as defined in section 1902(26)).

(d) SPECIAL RULES.—In this Act:

(1) ELECTING VETERANS.—

(A) DEFINED.—Subject to subparagraph (B), the term "electing veteran" means a veteran who makes an election to enroll with a health plan of the Department of Veterans Affairs under chapter 18 of title 38, United States Code.

(B) FAMILY EXCEPTION.—Subparagraph (A) shall not apply with respect to coverage under a health plan referred to in such subparagraph if, for the area in which the electing veteran resides, such health plan offers coverage to family members of an electing veteran and the veteran elects family enrollment under such plan (instead of individual enrollment).

(2) ACTIVE DUTY MILITARY PERSONNEL.—

(A) IN GENERAL.—Subject to subparagraph (B), the term "active duty military personnel" means an individual on active duty in the Uniformed Services of the United States.

(B) EXCEPTION.—If an individual described in subparagraph (A) elects family coverage under section 1073a(d)(1) of title 10, United States Code, then paragraph (5) of subsection (c) shall not apply with respect to such coverage.

(3) ELECTING INDIANS.—

(A) IN GENERAL.—Subject to subparagraph (B), the term "electing Indian" means an eligible individual who makes an election under section 8302(b) of this Act.

(B) FAMILY ELECTION FOR ALL INDIVIDUALS ELIGIBLE TO ELECT.—No such election shall be made with respect to an individual in a family (as defined without regard to this section) unless such election is made for all eligible individuals (described in section 8302(a)) who are family members of the family.

(4) MULTIPLE CHOICE.—Eligible individuals who are permitted to elect coverage under more than one health plan or program referred to in this subsection may elect which of such plans or programs will be the applicable health plan under this Act.

(e) QUALIFYING STUDENTS.—

(1) IN GENERAL.—In the case of a qualifying student (described in paragraph (2)), the individual may elect to enroll in a regional alliance health plan offered by the regional alliance for the area in which the school is located.

(2) QUALIFYING STUDENT.—In paragraph (1), the term "qualifying student" means an individual who—

(A) but for this subsection would receive coverage under a health plan as a child of another person, and

(B) is a full-time student at a school in an alliance area that is different from the alliance area (or, in the case of a corporate alliance, such coverage area as the Board may specify) providing the coverage described in subparagraph (A).

(3) PAYMENT RULES.—

(A) CONTINUED TREATMENT AS FAMILY.—Except as provided in subparagraph (B), nothing in this subsection shall be construed as affecting the payment liabilities between families and health alliances or between health alliances and health plans.

(B) TRANSFER PAYMENT.—In the case of an election under paragraph (1), the health plan described in paragraph (2)(A) shall make payment to the health plan referred to in paragraph (1) in accordance with rules specified by the Board.

(f) SPOUSES LIVING IN DIFFERENT ALLIANCE AREAS.—The Board shall provide for such special rules in applying this Act in the case of a couple in which the spouses reside in different alliance areas as the Board finds appropriate.

SEC. 1013. MULTIPLE EMPLOYMENT SITUATIONS.

(a) MULTIPLE EMPLOYMENT OF AN INDIVIDUAL.—In the case of an individual who—

(1)(A) is not married or (B) is married and whose spouse is not a qualifying employee (as defined in section 6121(c)(1)),

(2) is not a child, and

(3) who is a qualifying employee both of a regional alliance employer and of a corporate alliance employer (or of 2 corporate alliance employers),

the individual may elect the applicable health plan to be either a regional alliance health plan (for the alliance area in which the individual resides) or a corporate alliance health plan (for an employer employing the individual).

(b) MULTIPLE EMPLOYMENT WITHIN A FAMILY.—

(1) MARRIED COUPLE WITH EMPLOYMENT WITH A REGIONAL ALLIANCE EMPLOYER AND WITH A CORPORATE ALLIANCE EMPLOYER.—In the case of a married individual—

(A) who is a qualifying employee of a regional alliance employer and whose spouse is an qualifying employee of a corporate alliance employer, or

(B) who is a qualifying employee of a corporate alliance employer and whose spouse is an qualifying employee of a regional alliance employer,

the individual and the individual's spouse may elect the applicable health plan to be either a regional alliance health plan (for the alliance area in which the couple resides) or a corporate alliance health plan (for an employer employing the individual or the spouse).

(2) MARRIED COUPLE WITH DIFFERENT CORPORATE ALLIANCE EMPLOYERS.—In the case of a married individual—

(A) who is a qualifying employee of a corporate alliance employer, and

(B) whose spouse is a qualifying employee of a different corporate alliance employer,

the individual and the individual's spouse may elect the applicable health plan to be a corporate alliance health plan for an employer employing either the individual or the spouse.

SEC. 1014. TREATMENT OF RESIDENTS OF STATES WITH STATEWIDE SINGLE-PAYER SYSTEMS.

(a) UNIVERSAL COVERAGE.—Notwithstanding the previous provisions of this title, except as provided in part 2 of subtitle C, in the case of an individual who resides in a State that has a Statewide single-payer system under section 1223, universal coverage shall be provided consistent with section 1222(3).

(b) INDIVIDUAL RESPONSIBILITIES.—In the case of an individual who resides in a single-payer State, the responsibilities of such individual under such system shall supersede the obligations of the individual under section 1002.

Subtitle B—Benefits

PART 1—COMPREHENSIVE BENEFIT PACKAGE

SEC. 1101. PROVISION OF COMPREHENSIVE BENEFITS BY PLANS.

(a) IN GENERAL.—The comprehensive benefit package shall consist of the following items and services (as described in part 2), subject to the cost sharing requirements described in part 3, the exclusions described in part 4, and the duties and authority of the National Health Board described in part 5:

(1) Hospital services (described in section 1111).

(2) Services of health professionals (described in section 1112).

(3) Emergency and ambulatory medical and surgical services (described in section 1113).

(4) Clinical preventive services (described in section 1114).

(5) Mental health and substance abuse services (described in section 1115).

(6) Family planning services and services for pregnant women (described in section 1116).

(7) Hospice care (described in section 1117).

(8) Home health care (described in section 1118).

(9) Extended care services (described in section 1119).

(10) Ambulance services (described in section 1120).

(11) Outpatient laboratory, radiology, and diagnostic services (described in section 1121).

(12) Outpatient prescription drugs and biologicals (described in section 1122).

(13) Outpatient rehabilitation services (described in section 1123).

(14) Durable medical equipment and prosthetic and orthotic devices (described in section 1124).

(15) Vision care (described in section 1125).

(16) Dental care (described in section 1126).

(17) Health education classes (described in section 1127).

(18) Investigational treatments (described in section 1128).

(b) NO OTHER LIMITATIONS OR COST SHARING.—The items and services in the comprehensive benefit package shall not be subject to any duration or scope limitation or any deductible, copayment, or coinsurance amount that is not required or authorized under this Act.

(c) HEALTH PLAN.—Unless otherwise provided in this subtitle, for purposes of this subtitle, the term "health plan" has the meaning given such term in section 1400.

PART 2—DESCRIPTION OF ITEMS AND SERVICES COVERED

SEC. 1111. HOSPITAL SERVICES.

(a) COVERAGE.—The hospital services described in this section are the following items and services:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) 24-hour a day hospital emergency services.

(b) LIMITATION.—The hospital services described in this section do not include hospital services provided for the treatment of a mental or substance abuse disorder (which are subject to section 1115), except for medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is not covered under such section).

(c) DEFINITIONS.—For purposes of this subtitle:

(1) HOSPITAL.—The term "hospital" has the meaning given such term in section 1861(e) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(1), a facility of the uniformed services under title 10, United States Code, that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in section 1861(e);

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in section 1861(e); and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(3), a facility operated by the Indian Health Service that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in section 1861(e).

(2) INPATIENT HOSPITAL SERVICES.—The term "inpatient hospital services" means items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when provided to an inpatient of a hospital. The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient hospital services when provided to an inpatient of a hospital.

SEC. 1112. SERVICES OF HEALTH PROFESSIONALS.

(a) COVERAGE.—The items and services described in this section are—

(1) inpatient and outpatient health professional services, including consultations, that are provided in—

(A) a home, office, or other ambulatory care setting; or

(B) an institutional setting; and

(2) services and supplies (including drugs and biologicals which cannot be self-administered) furnished as an incident to such health professional services, of kinds which are commonly furnished in the office of a health professional and are commonly either rendered without charge or included in the bill of such professional.

(b) LIMITATION.—The items and services described in this section do not include items or services that are described in any other section of this part. An item or service that is described in section 1114 but is not provided consistent with a periodicity schedule for such item or service specified in such section or under section 1153 may be covered under this section if the item or service otherwise meets the requirements of this section.

(c) DEFINITIONS.—Unless otherwise provided in this Act, for purposes of this Act:

(1) HEALTH PROFESSIONAL.—The term "health professional" means an individual who provides health professional services.

(2) HEALTH PROFESSIONAL SERVICES.—The term "health professional services" means professional services that—

(A) are lawfully provided by a physician; or

(B) would be described in subparagraph (A) if provided by a physician, but are provided by another person who is legally authorized to provide such services in the State in which the services are provided.

SEC. 1113. EMERGENCY AND AMBULATORY MEDICAL AND SURGICAL SERVICES.

The emergency and ambulatory medical and surgical services described in this section are the following items and services provided by a health facility that is not a hospital and that is legally authorized to provide the services in the State in which they are provided:

(1) 24-hour a day emergency services.

(2) Ambulatory medical and surgical services.

SEC. 1114. CLINICAL PREVENTIVE SERVICES.

(a) COVERAGE.—The clinical preventive services described in this section are—

(1) an item or service for high risk populations (as defined by the National Health Board) that is specified and defined by the Board under section 1153, but only when the item or service is provided consistent with any periodicity schedule for the item or service promulgated by the Board;

(2) except as modified by the National Health Board under section 1153, an age-appropriate immunization, test, or clinician visit specified in one of subsections (b) through (h) that is provided consistent with any periodicity schedule for the item or service specified in the applicable subsection or by the National Health Board under section 1153; and

(3) an immunization, test, or clinician visit that is provided to an individual during an age range other than the age range for such immunization, test, or clinician visit that is specified in one of subsections (b) through (h), but only when provided consistent with any requirements for such immunizations, tests, and clinician visits established by the National Health Board under section 1153.

(b) INDIVIDUALS UNDER 3.—For an individual under 3 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are age-appropriate immunizations for the following illnesses:

(A) Diphtheria.

(B) Tetanus.

(C) Pertussis.

(D) Polio.

(E) Haemophilus influenzae type B.

(F) Measles.

(G) Mumps.

(H) Rubella.

(I) Hepatitis B.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) 1 hematocrit.

(B) 2 blood tests to screen for blood lead levels for individuals who are at risk for lead exposure.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit for an individual who is newborn and 7 other clinician visits.

(c) INDIVIDUALS AGE 3 TO 5.—For an individual at least 3 years of age, but less than 6 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are age-appropriate immunizations for the following illnesses:

(A) Diphtheria.

(B) Tetanus.

(C) Pertussis.

(D) Polio.

(E) Measles.

(F) Mumps.

(G) Rubella.

(2) TESTS.—The tests specified in this subsection are 1 urinalysis.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 3 clinician visits.

(d) INDIVIDUALS AGE 6 TO 19.—For an individual at least 6 years of age, but less than 20 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are age-appropriate immunizations for the following illnesses:

(A) Tetanus.

(B) Diphtheria.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Papanicolaou smears and pelvic exams for females who have reached childbearing age and are at risk for cervical cancer every 3 years, but—

(i) annually until 3 consecutive negative smears have been obtained; and

(ii) annually for females who are at risk for fertility related infectious illnesses.

(B) Annual screening for chlamydia and gonorrhea for females who have reached childbearing age and are at risk for fertility related infectious illnesses.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 5 clinician visits.

(e) INDIVIDUALS AGE 20 TO 39.—For an individual at least 20 years of age, but less than 40 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Papanicolaou smears and pelvic exams for females every 3 years, but—

(i) annually if an abnormal smear has been obtained, until 3 consecutive negative smears have been obtained; and

(ii) annually for females who are at risk for fertility related infectious illnesses.

(B) Annual screening for chlamydia and gonorrhea for females who are at risk for fertility related infectious illnesses.

(C) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every 3 years.

(f) INDIVIDUALS AGE 40 TO 49.—For an individual at least 40 years of age, but less than 50 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Papanicolaou smears and pelvic exams for females every 2 years, but—

(i) annually if an abnormal smear has been obtained, until 3 consecutive negative smears have been obtained; and

(ii) annually for females who are at risk for fertility related infectious illnesses.

(B) Annual screening for chlamydia and gonorrhea for females who are at risk for fertility related infectious illnesses.

(C) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every 2 years.

(g) INDIVIDUALS AGE 50 TO 65.—For an individual at least 50 years of age, but less than 65 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Papanicolaou smears and pelvic exams for females every 2 years.

(B) Mammograms for females every 2 years.

(C) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every 2 years.

(h) INDIVIDUALS AGE 65 OR OLDER.—For an individual at least 65 years of age who is enrolled under a health plan:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are as follows:

(A) Booster immunizations against tetanus and diphtheria every 10 years.

(B) Age-appropriate immunizations for the following illnesses:

(i) Influenza.

(ii) Pneumococcal invasive disease.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Papanicolaou smears and pelvic exams for females who are at risk for cervical cancer every 2 years.

(B) Mammograms for females every 2 years.

(C) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every year.

(i) CLINICIAN VISIT.—For purposes of this section, the term "clinician visit" includes the following health professional services (as defined in section 1112(c)):

(1) A complete medical history.

(2) An appropriate physical examination.

(3) Risk assessment.

(4) Targeted health advice and counseling, including nutrition counseling.

(5) The administration of age-appropriate immunizations and tests specified in subsections (b) through (h).

(j) IMMUNIZATIONS AND TESTS NOT ADMINISTERED DURING CLINICIAN VISIT.—Notwithstanding subsection (i)(5), the clinical preventive services described in this section include an immunization or test described in this section that is administered to an individual consistent with any periodicity schedule for the immunization or test during the age range specified for the immunization or test, and any administration fee for such immunization or test, even if the immunization or test is not administered during a clinician visit.

SEC. 1115. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

(a) COVERAGE.—The mental health and substance abuse services that are described in this section are the following items and services for eligible individuals, as defined in section 1001(c), who satisfy the eligibility requirements in subsection (b):

(1) Inpatient and residential mental health and substance abuse treatment.

(2) Intensive nonresidential mental health and substance abuse treatment.

(3) Outpatient mental health and substance abuse treatment, including case management, screening and assessment, crisis services, and collateral services.

(b) ELIGIBILITY.—The eligibility requirements referred to in subsection (a) are as follows:

(1) INPATIENT, RESIDENTIAL, NONRESIDENTIAL, AND OUTPATIENT TREATMENT.—An eligible individual is eligible to receive coverage for inpatient and residential mental health and substance abuse treatment, intensive nonresidential mental health and substance abuse treatment, or outpatient mental health and substance abuse treatment (except case management and collateral services) if the individual—

(A) has, or has had during the 1-year period preceding the date of such treatment, a diagnosable mental or substance abuse disorder; and

(B) is experiencing, or is at significant risk of experiencing, functional impairment in family, work, school, or community activities.

For purposes of this paragraph, an individual who has a diagnosable mental or substance abuse disorder, is receiving treatment for such disorder, but does not satisfy the functional impairment criterion in subparagraph (B) shall be treated as satisfying such criterion if the individual would satisfy such criterion without such treatment.

(2) CASE MANAGEMENT.—An eligible individual is eligible to receive coverage for case management if—

(A) the health plan in which the individual is enrolled has elected to offer case management and determines that the individual should receive such services; and

(B) the individual is eligible to receive coverage for, and is receiving, outpatient mental health and substance abuse treatment.

(3) SCREENING AND ASSESSMENT AND CRISIS SERVICES.—All eligible individuals enrolled under a health plan are eligible to receive coverage for outpatient mental health and substance abuse treatment consisting of screening and assessment and crisis services.

(4) COLLATERAL SERVICES.—An eligible individual is eligible to receive coverage for outpatient mental health and substance abuse treatment consisting of collateral services if the individual is a family member (as defined in section 1011(b)) of an individual who is receiving inpatient and residential mental health and substance abuse treatment, intensive nonresidential mental health and substance abuse treatment, or outpatient mental health and substance abuse treatment.

(c) INPATIENT AND RESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "inpatient and residential mental health and substance abuse treatment" means the items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when provided with respect to a diagnosable mental or substance abuse disorder to—

(A) an inpatient of a hospital, psychiatric hospital, residential treatment center, residential detoxification center, crisis residential program, or mental health residential treatment program; or

(B) a resident of a therapeutic family or group treatment home or community residential treatment and recovery center for substance abuse.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient and residential mental health and substance abuse treatment when provided to such an inpatient or resident.

(2) LIMITATIONS.—Coverage for inpatient and residential mental health and substance abuse treatment is subject to the following limitations:

(A) LEAST RESTRICTIVE SETTING.—Such treatment is covered only when—

(i) provided to an individual in the least restrictive inpatient or residential setting that is effective and appropriate for the individual; and

(ii) less restrictive intensive nonresidential or outpatient treatment would be ineffective or inappropriate.

(B) LICENSED FACILITY.—Such treatment is only covered when provided by a facility described in paragraph (1) that is legally authorized to provide the treatment in the State in which the facility is located.

(C) DAY LIMITS.—Subject to subparagraph (D), such treatment is covered for each period beginning on the date an episode of inpatient or residential treatment begins and ending on the date the episode ends, except that, prior to January 1, 2001, such treatment is not covered after such an episode exceeds 30 days unless the individual receiving treatment poses a threat to their own life or the life of another individual. Whether such a threat exists shall be determined by a health professional designated by the health plan in which the individual receiving treatment is enrolled. For purposes of this subtitle, an episode of inpatient and residential mental health and substance abuse treatment shall be considered to begin on the date an individual is admitted to a facility for such treatment and to end on the date the individual is discharged from the facility.

(D) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment in all settings is subject to an aggregate annual limit of 60 days.

(E) INPATIENT HOSPITAL TREATMENT FOR SUBSTANCE ABUSE.—Substance abuse treatment, when provided to an inpatient of a hospital or psychiatric hospital, is covered under this section only for medical detoxification associated with withdrawal from alcohol or drugs.

(d) INTENSIVE NONRESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "intensive nonresidential mental health and substance abuse treatment" means diagnostic or therapeutic items or services provided with respect to a diagnosable mental or substance abuse disorder to an individual—

(A) participating in a partial hospitalization program, a day treatment program, a psychiatric rehabilitation program, or an ambulatory detoxification program; or

(B) receiving home-based mental health services or behavioral aide mental health services.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as intensive nonresidential mental health and substance abuse treatment when provided to such an individual.

(2) LIMITATIONS.—Coverage for intensive nonresidential mental health and substance abuse treatment is subject to the following limitations:

(A) DISCRETION OF PLAN.—A health plan may cover intensive nonresidential mental health and substance abuse treatment at its discretion.

(B) TREATMENT PURPOSES.—Such treatment is covered only when provided—

(i) to avert the need for, or as an alternative to, treatment in residential or inpatient settings;

(ii) to facilitate the earlier discharge of an individual receiving inpatient or residential care;

(iii) to restore the functioning of an individual with a diagnosable mental health or substance abuse disorder; or

(iv) to assist the individual to develop the skills and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

(C) ANNUAL LIMIT.—

(i) IN GENERAL.—Prior to January 1, 2001, such treatment in all settings is subject to an aggregate annual limit of 120 days.

(ii) RELATIONSHIP TO OTHER ANNUAL LIMITS.—For each 2 days of intensive nonresidential mental health and substance abuse treatment provided to an individual, the number of treatment days available to the individual before the annual aggregate limit on inpatient and residential mental health and substance abuse treatment described in subsection (c)(2)(D) is exceeded shall be reduced by 1 day. The preceding sentence shall not apply after an individual has received 60 days of intensive nonresidential mental health and substance abuse treatment in a year.

(iii) ADDITIONAL DAYS.—A maximum of 60 additional days of intensive nonresidential mental health and substance abuse treatment may be provided to an individual if a health professional designated by the health plan in which the individual receiving treatment is enrolled determines that such additional treatment is medically necessary or appropriate.

(D) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for intensive nonresidential mental health and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, that substitute for inpatient and residential mental health and substance abuse treatment (up to 60 days) may be applied toward the annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle.

(e) OUTPATIENT TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "outpatient mental health and substance abuse treatment" means the following services provided with respect to a diagnosable mental or substance abuse disorder in an outpatient setting:

(A) Screening and assessment.

(B) Diagnosis.

(C) Medical management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

(2) LIMITATIONS.—Coverage for outpatient mental health and substance abuse treatment is subject to the following limitations:

(A) HEALTH PROFESSIONAL SERVICES.—Such treatment is covered only when it constitutes health professional services (as defined in section 1112(c)(2)).

(B) SUBSTANCE ABUSE COUNSELING.—Substance abuse counseling and relapse prevention is covered only when provided by a substance abuse treatment provider who—

(i) is legally authorized to provide such services in the State in which the services are provided; and

(ii) provides no items or services other than substance abuse counseling and relapse prevention, medical management, or laboratory and diagnostic tests for individuals with substance abuse disorders.

(C) ANNUAL LIMITS.—

(i) PYCHOTHERAPY AND COLLATERAL SERVICES.—Prior to January 1, 2001, psychotherapy and collateral services are subject to annual limits of 30 visits for each type of service. Additional visits may be covered, at the discretion of the health plan in which the individual receiving treatment is enrolled, to prevent hospitalization or to facilitate earlier hospital release, for which the annual aggregate limit on inpatient and residential mental health and substance abuse treatment described in subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits.

(ii) SUBSTANCE ABUSE.—At the discretion of the health plan in which an individual receiving outpatient substance abuse treatment is enrolled, the annual aggregate limit on inpatient and residential mental health and substance abuse treatment described in subsection (c)(2)(D) may be reduced by 1 day for each 4 outpatient visits. Within 12 months after inpatient and residential treatment or intensive nonresidential treatment, 30 visits in group therapy shall be covered for substance abuse counseling and relapse prevention. For individuals who were not initially treated in an inpatient, residential, or intensive nonresidential setting, additional visits shall be covered for which the annual aggregate limit on inpatient and residential mental health and substance abuse treatment described in subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits.

(D) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for outpatient mental health and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle.

(E) DETOXIFICATION.—Outpatient detoxification shall be provided only in the context of a treatment program. If the first detoxification treatment is unsuccessful, subsequent treatments are covered if a health professional designated by the health plan in which the individual receiving treatment is enrolled determines that there is a substantial chance of success.

(f) OTHER DEFINITIONS.—For purposes of this subtitle:

(1) CASE MANAGEMENT.—The term "case management" means services that assist individuals in gaining access to needed medical, social, educational, and other services.

(2) DIAGNOSABLE MENTAL OR SUBSTANCE ABUSE DISORDER.—The term "diagnosable mental or substance abuse disorder" means a disorder that is listed in any authoritative text specifying diagnostic criteria for mental or substance abuse disorders that is identified by the National Health Board.

(3) PSYCHIATRIC HOSPITAL.—The term "psychiatric hospital" has the meaning given such term in section 1861(f) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(1), a facility of the uniformed services under title 10, United States Code, that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital;

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital; and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(3), a facility operated by the Indian Health Service that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital.

SEC. 1116. FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.

The services described in this section are the following items and services:

(1) Voluntary family planning services.

(2) Contraceptive devices that—

(A) may only be dispensed upon prescription; and

(B) are subject to approval by the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act.

(3) Services for pregnant women.

SEC. 1117. HOSPICE CARE.

The hospice care described in this section is the items and services described in paragraph (1) of section 1861(dd) of the Social Security Act, as defined in paragraphs (2), (3), and (4)(A) of such section (with the exception of paragraph (2)(A)(iii)), except that all references to the Secretary of Health and Human Services in such paragraphs shall be treated as references to the National Health Board.

SEC. 1118. HOME HEALTH CARE.

(a) COVERAGE.—The home health care described in this section is—

(1) the items and services described in section 1861(m) of the Social Security Act; and

(2) home infusion drug therapy services described in section 1861(ll) of the Social Security Act (as added by section 2006).

(b) LIMITATIONS.—Coverage for home health care is subject to the following limitations:

(1) INPATIENT TREATMENT ALTERNATIVE.—Such care is covered only as an alternative to inpatient treatment in a hospital, skilled nursing facility, or rehabilitation facility after an illness or injury.

(2) REEVALUATION.—At the end of each 60-day period of home health care, the need for continued care shall be reevaluated by the person who is primarily responsible for providing the home health care. Additional periods of care are covered only if such person determines that the requirement in paragraph (1) is satisfied.

SEC. 1119. EXTENDED CARE SERVICES.

(a) COVERAGE.—The extended care services described in this section are the items and services described in section 1861(h) of the Social Security Act when provided to an inpatient of a skilled nursing facility or a rehabilitation facility.

(b) LIMITATIONS.—Coverage for extended care services is subject to the following limitations:

(1) HOSPITAL ALTERNATIVE.—Such services are covered only as an alternative to inpatient treatment in a hospital after an illness or injury.

(2) ANNUAL LIMIT.—Such services are subject to an aggregate annual limit of 100 days.

(c) DEFINITIONS.—For purposes of this subtitle:

(1) REHABILITATION FACILITY.—The term "rehabilitation facility" means an institution (or a distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to individuals for rehabilitation from illness or injury.

(2) SKILLED NURSING FACILITY.—The term "skilled nursing facility" means an institution (or a distinct part of an institution) which is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care; or

(B) rehabilitation services to residents for rehabilitation from illness or injury.

SEC. 1120. AMBULANCE SERVICES.

(a) COVERAGE.—The ambulance services described in this section are the following items and services:

(1) Ground transportation by ambulance.

(2) Air transportation by an aircraft equipped for transporting an injured or sick individual.

(3) Water transportation by a vessel equipped for transporting an injured or sick individual.

(b) LIMITATIONS.—Coverage for ambulance services is subject to the following limitations:

(1) MEDICAL INDICATION.—Ambulance services are covered only in cases in which the use of an ambulance is indicated by the medical condition of the individual concerned.

(2) AIR TRANSPORT.—Air transportation is covered only in cases in which there is no other method of transportation or where the use of another method of transportation is contra-indicated by the medical condition of the individual concerned.

(3) WATER TRANSPORT.—Water transportation is covered only in cases in which there is no other method of transportation or where the use of another method of transportation is contra-indicated by the medical condition of the individual concerned.

SEC. 1121. OUTPATIENT LABORATORY, RADIOLOGY, AND DIAGNOSTIC SERVICES.

The items and services described in this section are laboratory, radiology, and diagnostic services provided upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility.

SEC. 1122. OUTPATIENT PRESCRIPTION DRUGS AND BIOLOGICALS.

(a) COVERAGE.—The items described in this section are the following:

(1) Covered outpatient drugs described in section 1861(t) of the Social Security Act (as amended by section 2001(b))—

(A) except that, for purposes of this section, a medically accepted indication with respect to the use of a covered outpatient drug includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(i) the drug has been approved by the Food and Drug Administration; and

(ii) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations,

the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the National Health Board, unless the Board has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia; or

(iii) such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this clause by the Board; and

(B) notwithstanding any exclusion from coverage that may be made with respect to such a drug under title XVIII of such Act pursuant to section 1862(a)(18) of such Act.

(2) Blood clotting factors when provided on an outpatient basis.

(b) REVISION OF COMPENDIA LIST.—The National Health Board may revise the list of compendia in subsection (a)(1)(A)(ii) designated as appropriate for identifying medically accepted indications for drugs.

(c) BLOOD CLOTTING FACTORS.—For purposes of this subtitle, the term "blood clotting factors" has the meaning given such term in section 1861(s)(2)(I) of the Social Security Act.

SEC. 1123. OUTPATIENT REHABILITATION SERVICES.

(a) COVERAGE.—The outpatient rehabilitation services described in this section are—

(1) outpatient occupational therapy;

(2) outpatient physical therapy; and

(3) outpatient speech pathology services for the purpose of attaining or restoring speech.

(b) LIMITATIONS.—Coverage for outpatient rehabilitation services is subject to the following limitations:

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS.—Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury.

(2) REEVALUATION.—At the end of each 60-day period of outpatient rehabilitation services, the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that functioning is improving.

SEC. 1124. DURABLE MEDICAL EQUIPMENT AND PROSTHETIC AND ORTHOTIC DEVICES.

(a) COVERAGE.—The items and services described in this section are—

(1) durable medical equipment, including accessories and supplies necessary for repair and maintenance of such equipment;

(2) prosthetic devices (other than dental) which replace all or part of the function of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices;

(3) accessories and supplies which are used directly with a prosthetic device to achieve the therapeutic benefits of the prosthesis or to assure the proper functioning of the device;

(4) leg, arm, back, and neck braces;

(5) artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition; and

(6) fitting and training for use of the items described in paragraphs (1) through (5).

(b) LIMITATION.—An item or service described in this section is covered only if it improves functional ability or prevents further deterioration in function.

(c) DURABLE MEDICAL EQUIPMENT.—For purposes of this subtitle, the term "durable medical equipment" has the meaning given such term in section 1861(n) of the Social Security Act.

SEC. 1125. VISION CARE.

(a) COVERAGE.—The vision care described in this section is diagnosis and treatment for defects in vision.

(b) LIMITATION.—Eyeglasses and contact lenses are covered only for individuals less than 18 years of age.

SEC. 1126. DENTAL CARE.

(a) COVERAGE.—The dental care described in this section is the following:

(1) Emergency dental treatment, including simple extractions, for acute infections, bleeding, and injuries to natural teeth and oral structures for conditions requiring immediate attention to prevent risks to life or significant medical complications, as specified by the National Health Board.

(2) Prevention and diagnosis of dental disease, including oral dental examinations, radiographs, dental sealants, fluoride application, and dental prophylaxis.

(3) Treatment of dental disease, including routine fillings, prosthetics for genetic defects, periodontal maintenance, and endodontic services.

(4) Space maintenance procedures to prevent orthodontic complications.

(5) Interceptive orthodontic treatment to prevent severe malocclusion.

(b) LIMITATIONS.—Coverage for dental care is subject to the following limitations:

(1) PREVENTION AND DIAGNOSIS.—Prior to January 1, 2001, the items and services described in subsection (a)(2) are covered only for individuals less than 18 years of age. On or after such date, such items and services are covered for all eligible individuals enrolled under a health plan, except that dental sealants are not covered for individuals 18 years of age or older.

(2) TREATMENT OF DENTAL DISEASE.—Prior to January 1, 2001, the items and services described in subsection (a)(3) are covered only for individuals less than 18 years of age. On or after such date, such items and services are covered for all eligible individuals enrolled under a health plan, except that endodontic services are not covered for individuals 18 years of age or older.

(3) SPACE MAINTENANCE.—The items and services described in subsection (a)(4) are covered only for individuals at least 3 years of age, but less than 13 years of age and—

(A) are limited to posterior teeth;

(B) involve maintenance of a space or spaces for permanent posterior teeth that would otherwise be prevented from normal eruption if the space were not maintained; and

(C) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

(4) INTERCEPTIVE ORTHODONTIC TREATMENT.—Prior to January 1, 2001, the items and services described in subsection (a)(5) are not covered. On or after such date, such items and services are covered only for individuals at least 6 years of age, but less than 12 years of age.

SEC. 1127. HEALTH EDUCATION CLASSES.

(a) COVERAGE.—Subject to subsection (b), the items and services described in this section are health education and training classes to encourage the reduction of behavioral risk factors and to promote healthy activities. Such education and training classes may include smoking cessation, nutrition counseling, stress management, support groups, and physical training classes.

(b) DISCRETION OF PLAN.—A health plan may offer education and training classes at its discretion.

(c) CONSTRUCTION.—This section shall not be construed to include or limit education or training that is provided in the course of the delivery of health professional services (as defined in section 1112(c)).

SEC. 1128. INVESTIGATIONAL TREATMENTS.

(a) COVERAGE.—Subject to subsection (b), the items and services described in this subsection are qualifying investigational treatments that are administered for a life-threatening disease, disorder, or other health condition (as defined by the National Health Board).

(b) DISCRETION OF PLAN.—A health plan may cover an investigational treatment described in subsection (a) at its discretion.

(c) ROUTINE CARE DURING INVESTIGATIONAL TREATMENTS.—The comprehensive benefit package includes an item or service described in any other section of this part, subject to the limitations and cost sharing requirements applicable to the item or service, when the item or service is provided to an individual in the course of an investigational treatment, if—

(1) the treatment is a qualifying investigational treatment; and

(2) the item or service would have been provided to the individual even if the individual were not receiving the investigational treatment.

(d) DEFINITIONS.—For purposes of this subtitle:

(1) QUALIFYING INVESTIGATIONAL TREATMENT.—The term "qualifying investigational treatment" means a treatment—

(A) the effectiveness of which has not been determined; and

(B) that is under clinical investigation as part of an approved research trial.

(2) APPROVED RESEARCH TRIAL.—The term "approved research trial" means—

(A) a research trial approved by the Secretary of Health and Human Services, the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health; or

(B) a peer-reviewed and approved research program, as defined by the Secretary of Health and Human Services, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for the treatment to be medically necessary or appropriate.

PART 3—COST SHARING

SEC. 1131. COST SHARING.

(a) IN GENERAL.—Each health plan shall offer to individuals enrolled under the plan one of the following cost sharing schedules, which schedule shall be offered to all such enrollees:

(1) lower cost sharing (described in section 1132);

(2) higher cost sharing (described in section 1133); or

(3) combination cost sharing (described in section 1134).

(b) COST SHARING FOR LOW-INCOME FAMILIES.—For provisions relating to reducing cost sharing for certain low-income families, see section 1371.

(c) DEDUCTIBLES, COST SHARING, AND OUT-OF-POCKET LIMITS ON COST SHARING.—

(1) APPLICATION ON AN ANNUAL BASIS.—The deductibles and out-of-pocket limits on cost

sharing for a year under the schedules referred to in subsection (a) shall be applied based upon expenses incurred for items and services furnished in the year.

(2) INDIVIDUAL AND FAMILY GENERAL DEDUCTIBLES.—

(A) INDIVIDUAL.—Subject to subparagraph (B), with respect to an individual enrolled under a health plan (regardless of the class of enrollment), any individual general deductible in the cost sharing schedule offered by the plan represents the amount of countable expenses (as defined in subparagraph (C)) that the individual may be required to incur in a year before the plan incurs liability for expenses for such items and services furnished to the individual.

(B) FAMILY.—In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 1011(c)(2)(A)), the individual general deductible under subparagraph (A) shall not apply to countable expenses incurred by any member of the individual's family in a year at such time as the family has incurred, in the aggregate, countable expenses in the amount of the family general deductible for the year.

(C) COUNTABLE EXPENSE.—In this paragraph, the term "countable expense" means, with respect to an individual for a year, an expense for an item or service covered by the comprehensive benefit package that is subject to the general deductible and for which, but for such deductible and other cost sharing under this subtitle, a health plan is liable for payment. The amount of countable expenses for an individual for a year under this paragraph shall not exceed the individual general deductible for the year.

(3) COINSURANCE AND COPAYMENTS.—After a general or separate deductible that applies to an item or service covered by the comprehensive benefit package has been satisfied for a year, subject to paragraph (4), coinsurance and copayments are amounts that an individual may be required to pay with respect to the item or service.

(4) INDIVIDUAL AND FAMILY LIMITS ON COST SHARING.—

(A) INDIVIDUAL.—Subject to subparagraph (B), with respect to an individual enrolled under a health plan (regardless of the class of enrollment), the individual out-of-pocket limit on cost sharing in the cost sharing schedule offered by the plan represents the amount of expenses that the individual may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost sharing with respect to items or services covered by the comprehensive benefit package that are provided to the individual, except as provided in subsections (d)(2)(D) and (e)(2)(D) of section 1115.

(B) FAMILY.—In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 1011(c)(2)(A)), the family out-of-pocket limit on cost sharing in the cost sharing schedule offered by the plan represents the amount of expenses that members of the individual's family, in the aggregate, may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost sharing with respect to items or services covered by the comprehensive benefit package that are provided to any member of the individual's family, except as provided in subsections (d)(2)(D) and (e)(2)(D) of section 1115.

SEC. 1132. LOWER COST SHARING.

(a) IN GENERAL.—The lower cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) may not include a deductible;

(2) shall have—

(A) an annual individual out-of-pocket limit on cost sharing of $1500; and

(B) an annual family out-of-pocket limit on cost sharing of $3000;

(3) except as provided in paragraph (4)—

(A) shall prohibit payment of any coinsurance; and

(B) subject to section 1152, shall require payment of the copayment for an item or service (if any) that is specified for the item or service in the table under section 1135; and

(4) shall require payment of coinsurance for an out-of-network item or service (as defined in section 1402(f)) in an amount that is a percentage (determined under subsection (b)) of the applicable payment rate for the item or service established under section 1322(c), but only if the item or service is subject to coinsurance under the higher cost sharing schedule described in section 1133.

(b) OUT-OF-NETWORK COINSURANCE PERCENTAGE.—

(1) IN GENERAL.—The National Health Board shall determine a percentage referred to in subsection (a)(4). The percentage—

(A) may not be less than 20 percent; and

(B) shall be the same with respect to all out-of-network items and services that are subject to coinsurance, except as provided in paragraph (2).

(2) EXCEPTION.—The National Health Board may provide for a percentage that is greater than a percentage determined under paragraph (1) in the case of an out-of-network item or service for which the coinsurance is greater than 20 percent of the applicable payment rate under the higher cost sharing schedule described in section 1133.

SEC. 1133. HIGHER COST SHARING.

The higher cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) shall have an annual individual general deductible of $200 and an annual family general deductible of $400 that apply with respect to expenses incurred for all items and services in the comprehensive benefit package except—

(A) an item or service with respect to which a separate individual deductible applies under paragraph (2), (3), or (4); or

(B) an item or service described in paragraph (5), (6), or (7) with respect to which a deductible does not apply;

(2) shall require an individual to incur expenses during each episode of inpatient and residential mental health and substance abuse treatment (described in section 1115) equal to the cost of one day of such treatment before the plan provides benefits for such treatment to the individual;

(3) shall require an individual to incur expenses in a year for outpatient prescription drugs and biologicals (described in section 1122) equal to $250 before the plan provides benefits for such items to the individual;

(4) shall require an individual to incur expenses in a year for dental care described in section 1126, except the items and services for prevention and diagnosis of dental disease described in section 1126(a)(2), equal to $50 before the plan provides benefits for such care to the individual;

(5) may not require any deductible for clinical preventive services (described in section 1114);

(6) may not require any deductible for clinician visits and associated services related to prenatal care or 1 post-partum visit under section 1116;

(7) may not require any deductible for the items and services for prevention and diagnosis of dental disease described in section 1126(a)(2);

(8) shall have—

(A) an annual individual out-of-pocket limit on cost sharing of $1500; and

(B) an annual family out-of-pocket limit on cost sharing of $3000;

(9) shall prohibit payment of any copayment; and

(10) subject to section 1152, shall require payment of the coinsurance for an item or service (if any) that is specified for the item or service in the table under section 1135.

SEC. 1134. COMBINATION COST SHARING.

(a) IN GENERAL.—The combination cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) shall have—

(A) an annual individual out-of-pocket limit on cost sharing of $1500; and

(B) an annual family out-of-pocket limit on cost sharing of $3000; and

(2) otherwise shall require different cost sharing for in-network items and services than for out-of-network items and services.

(b) IN-NETWORK ITEMS AND SERVICES.—With respect to an in-network item or service (as defined in section 1402(f)(1)), the combination cost sharing schedule that is offered by a health plan—

(1) may not apply a deductible;

(2) shall prohibit payment of any coinsurance; and

(3) shall require payment of a copayment in accordance with the lower cost sharing schedule described in section 1132.

(c) OUT-OF-NETWORK ITEMS AND SERVICES.—With respect to an out-of-network item or service (as defined in section 1402(f)(2)), the combination cost sharing schedule that is offered by a health plan—

(1) shall require an individual and a family to incur expenses before the plan provides benefits for the item or service in accordance with the deductibles under the higher cost sharing schedule described in section 1133;

(2) shall prohibit payment of any copayment; and

(3) shall require payment of coinsurance in accordance with such schedule.

SEC. 1135. TABLE OF COPAYMENTS AND COINSURANCE.

(a) IN GENERAL.—The following table specifies, for different items and services, the copayments and coinsurance referred to in sections 1132 and 1133:

Copayments and Coinsurance for Items and Services

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient hospital services	1111	No copayment	20 percent of applicable payment rate

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Outpatient hospital services	1111	$10 per visit	20 percent of applicable payment rate
Hospital emergency room services	1111	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Services of health professionals	1112	$10 per visit	20 percent of applicable payment rate
Emergency services other than hospital emergency room services	1113	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Ambulatory medical and surgical services	1113	$10 per visit	20 percent of applicable payment rate
Clinical preventive services	1114	No copayment	No coinsurance
Inpatient and residential mental health and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental health and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate
Outpatient mental health and substance abuse treatment (except psychotherapy, collateral services, and case management)	1115	$10 per visit	20 percent of applicable payment rate
Outpatient psychotherapy and collateral services	1115	$25 per visit until January 1, 2001, and $10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter
Case management	1115	No copayment	No coinsurance
Family planning and services for pregnant women (except clinician visits and associated services related to prenatal care and 1 post-partum visit)	1116	$10 per visit	20 percent of applicable payment rate
Clinician visits and associated services related to prenatal care and 1 post-partum visit	1116	No copayment	No coinsurance
Hospice care	1117	No copayment	20 percent of applicable payment rate
Home health care	1118	No copayment	20 percent of applicable payment rate
Extended care services	1119	No copayment	20 percent of applicable payment rate
Ambulance services	1120	No copayment	20 percent of applicable payment rate
Outpatient laboratory, radiology, and diagnostic services	1121	No copayment	20 percent of applicable payment rate
Outpatient prescription drugs and biologicals	1122	$5 per prescription	20 percent of applicable payment rate
Outpatient rehabilitation services	1123	$10 per visit	20 percent of applicable payment rate
Durable medical equipment and prosthetic and orthotic devices	1124	No copayment	20 percent of applicable payment rate
Vision care	1125	$10 per visit (No additional charge for 1 set of necessary eyeglasses for an individual less than 18 years of age)	20 percent of applicable payment rate
Dental care (except space maintenance procedures and interceptive orthodontic treatment)	1126	$10 per visit	20 percent of applicable payment rate
Space maintenance procedures and interceptive orthodontic treatment	1126	$20 per visit	40 percent of applicable payment rate
Health education classes	1127	All cost sharing rules determined by plans	All cost sharing rules determined by plans
Investigational treatment for life-threatening condition	1128	All cost sharing rules determined by plans	All cost sharing rules determined by plans

(b) APPLICABLE PAYMENT RATE.—For purposes of this section, the term "applicable payment rate", when used with respect to an item or service, means the applicable payment rate for the item or service established under section 1322(c).

SEC. 1136. INDEXING DOLLAR AMOUNTS RELATING TO COST SHARING.

(a) IN GENERAL.—Any deductible, copayment, out-of-pocket limit on cost sharing, or other amount expressed in dollars in this subtitle for items or services provided in a year after 1994 shall be such amount increased by the percentage specified in subsection (b) for the year.

(b) PERCENTAGE.—The percentage specified in this subsection for a year is equal to the product of the factors described in subsection (d) for the year and for each previous year after 1994.

(c) ROUNDING.—Any increase (or decrease) under subsection (a) shall be rounded, in the case of an amount specified in this subtitle of—

(1) $200 or less, to the nearest multiple of $1,

(2) more than $200, but less $500, to the nearest multiple of $5, or

(3) $500 or more, to the nearest multiple of $10.

(d) FACTOR.—

(1) IN GENERAL.—The factor described in this subsection for a year is 1 plus the general health care inflation factor (as specified in section 6001(a)(3) and determined under paragraph (2)) for the year.

(2) DETERMINATION.—In computing such factor for a year, the percentage increase in the CPI for a year (referred to in section 6001(b)) shall be determined based upon the percentage increase in the average of the CPI for the 12-month period ending with August 31 of the previous year over such average for the preceding 12-month period.

PART 4—EXCLUSIONS

SEC. 1141. EXCLUSIONS.

(a) MEDICAL NECESSITY.—The comprehensive benefit package does not include—

(1) an item or service (other than services referred to in paragraph (2)) that is not medically necessary or appropriate; or

(2) an item or service that the National Health Board may determine is not medically necessary or appropriate in a regulation promulgated under section 1154.

(b) ADDITIONAL EXCLUSIONS.—The comprehensive benefit package does not include the following items and services:

(1) Custodial care, except in the case of hospice care under section 1117.

(2) Surgery and other procedures performed solely for cosmetic purposes and hospital or other services incident thereto, unless—

(A) required to correct a congenital anomaly; or

(B) required to restore or correct a part of the body that has been altered as a result of—

(i) accidental injury;

(ii) disease; or

(iii) surgery that is otherwise covered under this subtitle.

(3) Hearing aids.

(4) Eyeglasses and contact lenses for individuals at least 18 years of age.

(5) In vitro fertilization services.

(6) Sex change surgery and related services.

(7) Private duty nursing.

(8) Personal comfort items, except in the case of hospice care under section 1117.

(9) Any dental procedures involving orthodontic care, inlays, gold or platinum fillings, bridges, crowns, pin/post retention, dental implants, surgical periodontal procedures, or the preparation of the mouth for the fitting or continued use of dentures, except as specifically described in section 1126.

PART 5—ROLE OF THE NATIONAL HEALTH BOARD

SEC. 1151. DEFINITION OF BENEFITS.

(a) IN GENERAL.—The National Health Board may promulgate such regulations or establish such guidelines as may be necessary to assure uniformity in the application of the comprehensive benefit package across all health plans.

(b) FLEXIBILITY IN DELIVERY.—The regulations or guidelines under subsection (a) shall permit a health plan to deliver covered items and services to individuals enrolled under the plan using the providers and methods that the plan determines to be appropriate.

SEC. 1152. ACCELERATION OF EXPANDED BENEFITS.

(a) IN GENERAL.—Subject to subsection (b), at any time prior to January 1, 2001, the National Health Board, in its discretion, may by regulation expand the comprehensive benefit package by—

(1) adding any item or service that is added to the package as of January 1, 2001; and

(2) requiring that a cost sharing schedule described in part 3 of this subtitle reflect (wholly or in part) any of the cost sharing requirements that apply to the schedule as of January 1, 2001.

No such expansion shall be effective except as of January 1 of a year.

(b) CONDITION.—The Board may not expand the benefit package under subsection (a) which is to become effective with respect to a year, by adding any item or service or altering any cost sharing schedule, unless the Board estimates that the additional increase in per capita health care expenditures resulting from the addition or alteration, for each regional alliance for the year, will not cause any regional alliance to exceed its per capita target (as determined under section 6003(a)).

SEC. 1153. AUTHORITY WITH RESPECT TO CLINICAL PREVENTIVE SERVICES.

(a) IN GENERAL.—With respect to clinical preventive services described in section 1114, the National Health Board—

(1) shall specify and define specific items and services as clinical preventive services for high risk populations and shall establish and update a periodicity schedule for such items and services;

(2) shall update the periodicity schedules for the age-appropriate immunizations, tests, and clinician visits specified in subsections (b) through (h) of such section;

(3) shall establish rules with respect to coverage for an immunization, test, or clinician visit that is not provided to an individual during the age range for such immunization, test, or clinician visit that is specified in one of subsections (b) through (h) of such section; and

(4) may otherwise modify the items and services described in such section, taking into account age and other risk factors, but may not modify the cost sharing for any such item or service.

(b) CONSULTATION.—In performing the functions described in subsection (a), the National Health Board shall consult with experts in clinical preventive services.

SEC. 1154. ESTABLISHMENT OF STANDARDS REGARDING MEDICAL NECESSITY.

The National Health Board may promulgate such regulations as may be necessary to carry out section 1141(a)(2) (relating to the exclusion of certain services that are not medically necessary or appropriate).

PART 6—ADDITIONAL PROVISIONS RELATING TO HEALTH CARE PROVIDERS

SEC. 1161. OVERRIDE OF RESTRICTIVE STATE PRACTICE LAWS.

No State may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals.

SEC. 1162. PROVISION OF ITEMS OR SERVICES CONTRARY TO RELIGIOUS BELIEF OR MORAL CONVICTION.

A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

Subtitle C—State Responsibilities

SEC. 1200. PARTICIPATING STATE.

(a) IN GENERAL.—For purposes of the approval of a State health care system by the Board under section 1511, a State is a "participating State" if the State meets the applicable requirements of this subtitle.

(b) SUBMISSION OF SYSTEM DOCUMENT.—

(1) IN GENERAL.—In order to be approved as a participating State under section 1511, a State shall submit to the National Health Board a document (in a form and manner specified by the Board) that describes the State health care system that the State is establishing (or has established).

(2) DEADLINE.—If a State is not a participating State with a State health care system in operation by January 1, 1998, the provisions of subpart B of part 2 of subtitle F (relating to Federal operation of a State health care system) shall take effect.

(3) SUBMISSION OF INFORMATION SUBSEQUENT TO APPROVAL.—A State approved as a participating State under section 1511 shall submit to the Board an annual update to the State health care system not later than February 15 of each year following the first year for which the State is a participating State that contains—

(A) such information as the Board may require to determine that the system shall meet the applicable requirements of subtitle C for the succeeding year; and

(B) such information as the Board may require to determine that the State operated the system during the previous year in accordance with the Board's approval of the system for such previous year.

PART 1—GENERAL STATE RESPONSIBILITIES

SEC. 1201. GENERAL STATE RESPONSIBILITIES.

The responsibilities for a participating State are as follows:

(1) REGIONAL ALLIANCES.—Establishing one or more regional alliances (in accordance with section 1202).

(2) HEALTH PLANS.—Certifying health plans (in accordance with section 1203).

(3) FINANCIAL SOLVENCY OF PLANS.—Assuring the financial solvency of health plans (in accordance with section 1204).

(4) ADMINISTRATION.—Designating an agency or official charged with coordinating the State responsibilities under Federal law.

(5) WORKERS COMPENSATION AND AUTOMOBILE INSURANCE.—Conforming State laws to meet the requirements of title X (relating to medical benefits under workers compensation and automobile insurance).

(6) OTHER RESPONSIBILITIES.—Carrying out other responsibilities of participating States specified under this Act.

SEC. 1202. STATE RESPONSIBILITIES WITH RESPECT TO ALLIANCES.

(a) ESTABLISHMENT OF ALLIANCES.—

(1) IN GENERAL.—A participating State shall—

(A) establish and maintain one or more regional alliances in accordance with this section and subtitle D, and ensure that such alliances meet the requirements of this Act; and

(B) designate alliance areas in accordance with subsection (b).

(2) DEADLINE.—A State may not be a participating State for a year unless the State has established such alliances by March 1 of the previous year.

(b) ALLIANCE AREAS.—

(1) IN GENERAL.—In accordance with this subsection, each State shall designate a geographic area assigned to each regional alliance. Each such area is referred to in this Act as an "alliance area".

(2) POPULATION REQUIRED.—

(A) IN GENERAL.—Each alliance area shall encompass a population large enough to ensure that the alliance has adequate market share to negotiate effectively with health plans providing the comprehensive benefit package to eligible individuals who reside in the area.

(B) TREATMENT OF CONSOLIDATED METROPOLITAN STATISTICAL AREAS.—An alliance area that includes a Consolidated Metropolitan Statistical Area within a State is presumed to meet the requirements of subparagraph (A).

(3) SINGLE ALLIANCE IN EACH AREA.—No geographic area may be assigned to more than one regional alliance.

(4) BOUNDARIES.—In establishing boundaries for alliance areas, the State may not discriminate on the basis of or otherwise take into account race, ethnicity, language, religion, national origin, socio-economic status, disability, or perceived health status.

(5) TREATMENT OF METROPOLITAN AREAS.—The entire portion of a metropolitan statistical area located in a State shall be included in the same alliance area.

(6) NO PORTIONS OF STATE PERMITTED TO BE OUTSIDE ALLIANCE AREA.—Each portion of the State shall be assigned to a regional alliance under this subsection.

(c) STATE COORDINATION OF REGIONAL ALLIANCES.—One or more States may allow or require two or more regional alliances to coordinate their operations, whether such alliances are in the same or different States. Such coordination may include adoption of joint operating rules, contracting with health plans, enforcement activities, and establishment of fee schedules for health providers.

(d) ASSISTANCE IN COLLECTION OF AMOUNTS OWED TO ALLIANCES.—Each State shall assure that the amounts owed to regional alliances in the State are collected and paid to such alliances.

(e) ASSISTANCE IN ELIGIBILITY VERIFICATIONS.—

(1) IN GENERAL.—Each State shall assure that the determinations of eligibility for cost sharing assistance (and premium discounts and cost sharing reductions for families) are made by regional alliances in the State on the basis of the best information available to the alliances and the State.

(2) PROVISION OF INFORMATION.—Each State shall use the information available to the State under section 6103(l)(7)(D)(x) of the Internal Revenue Code of 1986 to assist regional alliances in verifying such eligibility status.

(f) SPECIAL REQUIREMENTS FOR ALLIANCES WITH SINGLE-PAYER SYSTEM.—If the State operates an alliance-specific single-payer system (as described in part 2), the State shall assure that the regional alliance in which the system is operated meets the requirements for such an alliance described in section 1224(b).

(g) PAYMENT OF SHORTFALLS FOR CERTAIN ADMINISTRATIVE ERRORS.—Each participating State is financially responsible, under section 9201(c)(2), for administrative errors described in section 9201(e)(2).

SEC. 1203. STATE RESPONSIBILITIES RELATING TO HEALTH PLANS.

(a) CRITERIA FOR CERTIFICATION.—

(1) IN GENERAL.—For purposes of this section, a participating State shall establish and publish the criteria that are used in the certification of health plans under this section.

(2) REQUIREMENTS.—Such criteria shall be established with respect to—

(A) the quality of the plan,

(B) the financial stability of the plan,

(C) the plan's capacity to deliver the comprehensive benefit package in the designated service area,

(D) other applicable requirements for health plans under parts 1, 3, and 4 of subtitle E, and

(E) other requirements imposed by the State consistent with this part.

(b) CERTIFICATION OF HEALTH PLANS.—A participating State shall certify each plan as a regional alliance health plan that it determines meet the criteria for certification established and published under subsection (a).

(c) MONITORING.—A participating State shall monitor the performance of each State-certified regional alliance health plan to ensure that it continues to meet the criteria for certification.

(d) LIMITATIONS ON AUTHORITY.—A participating State may not—

(1) discriminate against a plan based on the domicile of the entity offering of the plan; and

(2) regulate premium rates charged by health plans, except as may be required under title VI (relating to the enforcement of cost containment rules for plans in the State) or as may be necessary to ensure that plans meet financial solvency requirements under section 1408.

(e) ASSURING ADEQUATE ACCESS TO A CHOICE OF HEALTH PLANS.—

(1) GENERAL ACCESS.—

(A) IN GENERAL.—Each participating State shall ensure that—

(i) each regional alliance eligible family has adequate access to enroll in a choice of regional alliance health plans providing services in the area in which the individual resides, including (to the maximum extent practicable) adequate access to a plan whose premium is at or below the weighted average premium for plans in the regional alliance, and

(ii) each such family that is eligible for a premium discount under section 6104(b) is provided a discount in accordance with such section (including an increase in such discount described in section 6104(b)(2)).

(B) AUTHORITY.—In order to carry out its responsibility under subparagraph (A), a participating State may require, as a condition of entering into a contract with a regional alliance under section 1321, that one or more certified regional alliance health plans cover all (or selected portions) of the alliance area.

(2) ACCESS TO PLANS USING CENTERS OF EXCELLENCE.—Each participating State may require, as a condition of entering into a contract with a regional alliance under section 1321, that one or more certified health plans provide access (through reimbursement, contracts, or otherwise) of enrolled individuals to services of centers of excellence (as designated by the State in accordance with rules promulgated by the Secretary).

(3) USE OF INCENTIVES TO ENROLL AND SERVE DISADVANTAGED GROUPS.—A State may provide—

(A) for an adjustment to the risk-adjustment methodology under section 1542(c) and other financial incentives to regional alliance health plans to ensure that such plans enroll individuals who are members of disadvantaged groups, and

(B) for appropriate extra services, such as outreach to encourage enrollment and transportation and interpreting services to ensure access to care, for certain population groups that face barriers to access because of geographic location, income levels, or racial or cultural differences.

(f) COORDINATION OF WORKERS' COMPENSATION SERVICES AND AUTOMOBILE INSURANCE.—Each participating State shall comply with the responsibilities regarding workers' compensation and automobile insurance specified in title X.

(g) IMPLEMENTATION OF MANDATORY REINSURANCE SYSTEM.—If the risk adjustment and reinsurance methodology developed under section 1541 includes a mandatory reinsurance system, each participating State shall establish a reinsurance program consistent with such methodology and any additional standards established by the Board.

(h) REQUIREMENTS FOR PLANS OFFERING SUPPLEMENTAL INSURANCE.—Notwithstanding any other provision of this Act a State may not certify a regional alliance health plan under this section if—

(1) the plan (or any entity with which the plan is affiliated under such rules as the Board may establish) offers a supplemental health benefit policy (as defined in section 1421(a)(1)) that fails to meet the applicable requirements for such a policy under part 2 of subtitle E (without regard to the State in which the policy is offered); or

(2) the plan offers a cost sharing policy (as defined in section 1421(a)(2)) that fails to meet the applicable requirements for such a policy under part 2 of subtitle E.

SEC. 1204. FINANCIAL SOLVENCY; FISCAL OVERSIGHT; GUARANTY FUND.

(a) CAPITAL STANDARDS.—A participating State shall establish capital standards for health plans that meet minimum Federal requirements established by the National Health Board under section 1505(i).

(b) REPORTING AND AUDITING REQUIREMENTS.—Each participating State shall define financial reporting and auditing requirements and requirements for fund reserves adequate to monitor the financial status of plans.

(c) GUARANTY FUND.—

(1) ESTABLISHMENT.—Each participating State shall ensure that there is a guaranty fund that meets the requirements established by the Board under section 1505(j)(2), in order to provide financial protection to health care providers and others in the case of a failure of a regional alliance health plan.

(2) ASSESSMENTS TO PROVIDE FUNDS.—In the case of a failure of one or more regional alliance health plans, the State may require each regional alliance health plan within the State to pay an assessment to the State in an amount not to exceed 2 percent of the premiums of such plans paid by or on behalf of regional alliance eligible individuals during a year for so long as necessary to generate sufficient revenue to cover any outstanding claims against the failed plan.

(d) PROCEDURES IN EVENT OF PLAN FAILURE.—

(1) IN GENERAL.—A participating State shall assure that, in the event of the failure of a regional alliance health plan in the State, eligible individuals enrolled in the plan will be assured continuity of coverage for the comprehensive benefit package.

(2) DESIGNATION OF STATE AGENCY.—A participating State shall designate an agency of State government that supervises or assumes control of the operation of a regional alliance health plan in the case of the failure of the plan.

(3) PROTECTIONS FOR HEALTH CARE PROVIDERS AND ENROLLEES.—Each participating State shall assure that in the case of a plan failure—

(A) the guaranty fund shall pay health care providers for items and services covered under the comprehensive benefit package for enrollees of the plan for which the plan is otherwise obligated to make payment;

(B) after making all payments required to be made to providers under subparagraph (A), the guaranty fund shall make payments for the operational, administrative, and other costs and debts of the plan (in accordance with requirements imposed by the State based on rules promulgated by the Board);

(C) such health care providers have no legal right to seek payment from eligible individuals enrolled in the plan for any such covered items or services (other than the enrollees' obligations under cost sharing arrangements); and

(D) health care providers are required to continue caring for such eligible individuals until such individuals are enrolled in a new health plan.

(4) PLAN FAILURE.—For purposes of this section, the failure of a health plan means the current or imminent inability to pay claims.

SEC. 1205. RESTRICTIONS ON FUNDING OF ADDITIONAL BENEFITS.

If a participating State provides benefits (either directly or through regional alliance health plans or otherwise) in addition to those covered under the comprehensive benefit package, the State may not provide for payment for such benefits through funds provided under this Act.

PART 2—REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

SEC. 1221. SINGLE-PAYER SYSTEM DESCRIBED.

The Board shall approve the application of a State to operate a single-payer system if the Board finds that the system—

(1) meets the requirements of section 1222;

(2) meets the requirements for a Statewide single-payer system under section 1223, in the case of a system offered throughout a State; and

(3) meets the requirements for an alliance-specific single-payer system under section 1224, in the case of a system offered in a single alliance of a State.

SEC. 1222. GENERAL REQUIREMENTS FOR SINGLE-PAYER SYSTEMS.

Each single-payer system shall meet the following requirements:

(1) ESTABLISHMENT BY STATE.—The system is established under State law, and State law provides for mechanisms to enforce the requirements of the plan.

(2) OPERATION BY STATE.—The system is operated by the State or a designated agency of the State.

(3) ENROLLMENT OF ELIGIBLE INDIVIDUALS.—

(A) MANDATORY ENROLLMENT OF ALL REGIONAL ALLIANCE INDIVIDUALS.—The system provides for the enrollment of all eligible individuals residing in the State (or, in the case of an alliance-specific single-payer system, in the alliance area) for whom the applicable health plan would otherwise be a regional alliance health plan.

(B) OPTIONAL ENROLLMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—At the option of the State, the system may provide for the enrollment of medicare-individuals residing in the State (or, in the case of an alliance-specific single-payer system, in the alliance area) if the Secretary of Health and Human Services has approved an application submitted by the State under section 1893 of the Social Security Act (as added by section 4001(a)) for the integration of medicare beneficiaries into plans of the State. Nothing in this subparagraph shall be construed as requiring that a State have a single-payer system in order to provide for such integration.

(C) OPTIONAL ENROLLMENT OF CORPORATE ALLIANCE INDIVIDUALS IN STATEWIDE PLANS.—At the option of the State, a Statewide single-payer system may provide for the enrollment of individuals residing in the State who are otherwise eligible to enroll in a corporate alliance health plan under section 1311.

(D) OPTIONS INCLUDED IN STATE SYSTEM DOCUMENT.—A State may not exercise any of the options described in subparagraphs (A) or (B) for a year unless the State included a description of the option in the submission of its system document to the Board for the year under section 1200(b).

(E) EXCLUSION OF CERTAIN INDIVIDUALS.—A single-payer system may not require the enrollment of electing veterans, active duty military personnel, and electing Indians (as defined in 1012(d)).

(4) DIRECT PAYMENT TO PROVIDERS.—

(A) IN GENERAL.—With respect to providers who furnish items and services included in the comprehensive benefit package to individuals enrolled in the system, the State shall make payments directly to such providers and assume (subject to subparagraph (B)) all financial risk associated with making such payments.

(B) CAPITATED PAYMENTS PERMITTED.—Nothing in subparagraph (A) shall be construed to prohibit providers furnishing items and services under the system from receiving payments from the plan on a capitated, at-risk basis based on prospectively determined rates.

(5) PROVISION OF COMPREHENSIVE BENEFIT PACKAGE.—

(A) IN GENERAL.—The system shall provide for coverage of the comprehensive benefit package, including the cost sharing provided under the package (subject to subparagraph (B)), to all individuals enrolled in the system.

(B) IMPOSITION OF REDUCED COST SHARING.—The system may decrease the cost sharing otherwise provided in the comprehensive benefit package with respect to any class of individuals enrolled in the system or any class of services included in the package, so long as the system does not increase the cost sharing otherwise imposed with respect to any other class of individuals or services.

(6) COST CONTAINMENT.—The system shall provide for mechanisms to ensure, in a manner satisfactory to the Board, that—

(A) per capita expenditures for items and services in the comprehensive benefit package under the system for a year (beginning with the first year) do not exceed an amount equivalent to the regional alliance per capita premium target that is determined under section 6003 (based on the State being a single regional alliance) for the year;

(B) the per capita expenditures described in subparagraph (A) are computed and effectively monitored; and

(C) automatic, mandatory, nondiscretionary reductions in payments to health care providers will be imposed to the extent required to assure that such per capita expenditures do not exceed in the applicable target referred to in subparagraph (A).

(7) REQUIREMENTS GENERALLY APPLICABLE TO HEALTH PLANS.—The system shall meet the requirements applicable to a health plan under section 1400(a), except that—

(A) the system does not have the authority provided to health plans under section 1402(a)(2) (relating to permissible limitations on the enrollment of eligible individuals on the basis of limits on the plan's capacity);

(B) the system is not required to meet the requirements of section 1404(a) (relating to restrictions on the marketing of plan materials); and

(C) the system is not required to meet the requirements of section 1408 (relating to plan solvency).

SEC. 1223. SPECIAL RULES FOR STATES OPERATING STATEWIDE SINGLE-PAYER SYSTEM.

(a) IN GENERAL.—In the case of a State operating a Statewide single-payer system—

(1) the State shall operate the system throughout the State through a single alliance;

(2) except as provided in subsection (b), the State shall meet the requirements for participating States under part 1; and

(3) the State shall assume the functions described in subsection (c) that are otherwise required to be performed by regional alliances in participating States that do not operate a Statewide single-payer system.

(b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR PARTICIPATING STATES.—In the case of a State operating a Statewide single-payer system, the State is not required to meet the following requirements otherwise applicable to participating States under part 1:

(1) ESTABLISHMENT OF ALLIANCES.—The requirements of section 1202 (relating to the establishment of alliances).

(2) HEALTH PLANS.—The requirements of section 1203 (relating to health plans), other than the requirement of subsection (f) of such section (relating to coordination of workers' compensation services and automobile liability insurance).

(3) FINANCIAL SOLVENCY.—The requirements of section 1204 (relating to the financial solvency of health plans in the State).

(c) ASSUMPTION BY STATE OF CERTAIN REQUIREMENTS APPLICABLE TO REGIONAL ALLIANCES.—A State operating a Statewide single-payer system shall be subject to the following requirements otherwise applicable to regional alliances in other participating States:

(1) ENROLLMENT; ISSUANCE OF HEALTH SECURITY CARDS.—The requirements of subsections (a) and (c) of section 1323 and section 1324 shall apply to the State, eligible individuals residing in the State, and the single-payer system operated by the State in the same manner as such requirements apply to a regional alliance, alliance eligible individuals, and regional alliance plans.

(2) REDUCTIONS IN COST SHARING FOR LOW-INCOME INDIVIDUALS.—The requirement of section 1371 shall apply to the State in the same manner as such requirement applies to a regional alliance.

(3) DATA COLLECTION; QUALITY.—The requirements of section 1327(a) shall apply to the State and the single-payer system operated by the State in the same manner as such requirement applies to a regional alliance and health plans offered through a regional alliance.

(4) ANTI-DISCRIMINATION; COORDINATION.—The requirements of section 1328 shall apply to the State in the same manner as such requirements apply with respect to a regional alliance.

(d) FINANCING.—

(1) IN GENERAL.—A State operating a Statewide single-payer system shall provide for the financing of the system using, at least in part, a payroll-based financing system that requires employers to pay at least the amount that the employers would be required to pay if the employers were subject to the requirements of subtitle B of title VI.

(2) USE OF FINANCING METHODS.—Such a State may use, consistent with paragraph (1), any other method of financing.

(e) SINGLE-PAYER STATE DEFINED.—In this Act, the term "single-payer State" means a State with a Statewide single-payer system in effect that has been approved by the Board in accordance with this part.

SEC. 1224. SPECIAL RULES FOR ALLIANCE-SPECIFIC SINGLE-PAYER SYSTEMS.

(a) IN GENERAL.—In the case of a State operating an alliance-specific single-payer system—

(1) the State shall meet the requirements for participating States under part 1, except that in establishing the regional alliance through which the system is offered, the requirement of section 1202(a)(1)(A) shall not apply to the extent necessary for the alliance to meet the requirements of section 1242; and

(2) the regional alliance in which the system is operated shall meet the requirements of subsection (b).

(b) REQUIREMENTS FOR ALLIANCE IN WHICH SYSTEM OPERATES.—A regional alliance in which an alliance-specific single payer system is operated shall meet the requirements

applicable to regional alliances under subtitle D, except that the alliance is not required to meet the following requirements of such subtitle:

(1) CONTRACTS WITH HEALTH PLANS.—The requirements of section 1321 (relating to contracts with health plans).

(2) CHOICE OF HEALTH PLANS OFFERED.—The requirements of subsections (a) or (b) of section 1322 (relating to offering a choice of health plans to eligible enrollees).

(4) ESTABLISHMENT OF PROCESS FOR CONSUMER COMPLAINTS.—The requirements of section 1326(a) (relating to the establishment of a process for the hearing and resolution of consumer complaints against plans offered through the alliance).

(5) ADDRESSING NEEDS OF AREAS WITH INADEQUATE HEALTH SERVICES.—The regional alliance does not have any of the authorities described in subsections (a) and (b) of section 1329 (relating to adjusting payments to plans and encouraging the establishment of new plans).

Subtitle D—Health Alliances

SEC. 1300. HEALTH ALLIANCE DEFINED.

In this Act, the term "health alliance" means a regional alliance (as defined in section 1301) and a corporate alliance (as defined in section 1311).

PART 1—ESTABLISHMENT OF REGIONAL AND CORPORATE ALLIANCES

Subpart A—Regional Alliances

SEC. 1301. REGIONAL ALLIANCE DEFINED.

In this Act, the term "regional alliance" means a non-profit organization, an independent state agency, or an agency of the State which—

(1) meets the applicable organizational requirements of this subpart, and

(2) is carrying out activities consistent with part 2.

SEC. 1302. BOARD OF DIRECTORS.

(a) IN GENERAL.—A regional alliance must be governed by a Board of Directors appointed consistent with the provisions of this title. All powers vested in a regional alliance under this Act shall be vested in the Board of Directors.

(b) MEMBERSHIP.—

(1) IN GENERAL.—Such a Board of Directors shall consist of—

(A) members who represent employers whose employees purchase health coverage through the alliance, including self-employed individuals who purchase such coverage; and

(B) members who represent individuals who purchase such coverage, including employees who purchase such coverage.

(2) EQUAL REPRESENTATION OF EMPLOYERS AND CONSUMERS.—The number of members of the Board described under subparagraph (A) of paragraph (1) shall be the same as the number of members described in subparagraph (B) of such paragraph.

(c) NO CONFLICT OF INTEREST PERMITTED.—An individual may not serve as a member of the Board of Directors if the individual is one of the following (or an immediate family member of one of the following):

(1) A health care provider.

(2) An individual who is an employee or member of the Board of Directors of, has a substantial ownership in, or derives substantial income from, a health care provider, health plan, pharmaceutical company, or a supplier of medical equipment, devices, or services.

(3) A person who derives substantial income from the provision of health care.

(4)(A) A member or employee of an association, law firm, or other institution or organization that represents the interests of one or more health care providers, health plans or others involved in the health care field, or (B) an individual who practices as a professional in an area involving health care.

SEC. 1303. PROVIDER ADVISORY BOARDS FOR REGIONAL ALLIANCES.

Each regional alliance must establish a provider advisory board consisting of representatives of health care providers and professionals who provide covered services through health plans offered by the alliance.

Subpart B—Corporate Alliances

SEC. 1311. CORPORATE ALLIANCE DEFINED; INDIVIDUALS ELIGIBLE FOR COVERAGE THROUGH CORPORATE ALLIANCES; ADDITIONAL DEFINITIONS.

(a) CORPORATE ALLIANCE DEFINED.—In this Act, the term "corporate alliance" means an eligible sponsor (as defined in subsection (b)) if—

(1) the sponsor elects, in a form and manner specified by the Secretary of Labor consistent with this subpart, to be treated as a corporate alliance under this title and such election has not been terminated under section 1313; and

(2) the sponsor has filed with the Secretary of Labor a document describing how the sponsor shall carry out activities as such an alliance consistent with part 3.

(b) ELIGIBLE SPONSORS.—

(1) IN GENERAL.—In this subpart, each of the following is an eligible sponsor of a corporate alliance:

(A) LARGE EMPLOYER.—An employer that—

(i) is a large employer (as defined in subsection (e)(3)) as of the date of an election under subsection (a)(1), and

(ii) is not an excluded employer described in paragraph (2).

(B) PLAN SPONSOR OF A MULTIEMPLOYER PLAN.—A plan sponsor described in section 3(16)(B)(iii) of Employee Retirement Income Security Act of 1974, but only with respect to a group health plan that is a multiemployer plan (as defined in subsection (e)(4)) maintained by the sponsor and only if—

(i) such plan offered health benefits as of September 1, 1993, and

(ii) as of both September 1, 1993, and January 1, 1996, such plan has more than 5,000 active participants in the United States, or the plan is affiliated with a national labor agreement covering more than 5,000 employees.

(C) RURAL ELECTRIC COOPERATIVE AND RURAL TELEPHONE COOPERATIVE ASSOCIATION.—A rural electric cooperative or a rural telephone cooperative association, but only with respect to a group health plan that is maintained by such cooperative or association (or members of such cooperative or association) and only if such plan—

(i) offered health benefits as of September 1, 1993, and

(ii) as of both September 1, 1993, and January 1, 1996, has more than 5,000 full-time employees in the United States entitled to health benefits under the plan.

(2) EXCLUDED EMPLOYERS.—For purposes of paragraph (1)(A), any of the following are excluded employers described in this paragraph:

(A) An employer whose primary business is employee leasing.

(B) The Federal government (other than the United States Postal Service).

(C) A State government, a unit of local government, and an agency or instrumentality of government, including any special purpose unit of government.

(c) INDIVIDUALS ELIGIBLE TO ENROLL IN CORPORATE ALLIANCE HEALTH PLANS.—For purposes of part 1 of subtitle A, subject to subsection (d)—

(1) LARGE EMPLOYER ALLIANCES.—

(A) FULL-TIME EMPLOYEES.—Each eligible individual who is a full-time employee of a large employer that has an election in effect as a corporate alliance is eligible to enroll in a corporate alliance health plan offered by such corporate alliance.

(B) ONE-TIME OPTION TO EXEMPT EMPLOYEES IN SMALL ESTABLISHMENTS.—At the time of making an election to become a corporate alliance under this subpart, a large employer may exercise an option to make ineligible for enrollment all full-time employees of the employer employed in any establishment of the employer which has (at the time of the election) fewer than 100 full-time employees. The option under this subparagraph may be exercised separately with respect to each establishment of the employer.

(2) MULTIEMPLOYER ALLIANCES.—

(A) PARTICIPANTS.—Each participant and beneficiary (as defined in subparagraph (B)) under a multiemployer plan, with respect to which an eligible sponsor of the plan described in subsection (b)(1)(B) has an election in effect as a corporate alliance, is eligible to enroll in a corporate alliance health plan offered by such corporate alliance.

(B) PARTICIPANT AND BENEFICIARY DEFINED.—In subparagraph (A), the terms "participant" and "beneficiary" have the meaning given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(3) FULL-TIME EMPLOYEES OF RURAL COOPERATIVE ALLIANCES.—Each full-time employee of a rural electric cooperative or rural telephone cooperative association (or of a member of such a cooperative or association) which has an election in effect as a corporate alliance is eligible to enroll in a corporate alliance health plan offered by such corporate alliance.

(4) INELIGIBLE TO ENROLL IN REGIONAL ALLIANCE HEALTH PLAN.—Except as provided in section 1013(b), a corporate alliance eligible individual is not eligible to enroll under a regional alliance health plan.

(d) EXCLUSION OF CERTAIN INDIVIDUALS.—In accordance with rules of the Board, the following individuals shall not be treated as corporate alliance eligible individuals:

(1) AFDC recipients.

(2) SSI recipients.

(3) Individuals who are described in section 1004(b) (relating to veterans, military personnel, and Indians) and who elect an applicable health plan described in such section.

(4) Employees who are seasonal or temporary workers (as defined by the Board), other than such workers who are treated as corporate alliance eligible individuals pursuant to a collective bargaining agreement (as defined by the Secretary of Labor).

(e) DEFINITIONS RELATING TO CORPORATE ALLIANCES.—In this subtitle, except as otherwise provided:

(1) ESTABLISHMENT.—The term "establishment" shall be defined by the Secretary of Labor.

(2) GROUP HEALTH PLAN.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through insurance, reimbursement, or otherwise.

(3) LARGE EMPLOYER.—The term "large employer" means an employer that has more than 5,000 full-time employees in the United

States, not including (subject to section 1312(a)(3)) any employee located at an establishment for which the option described in subsection (c)(1)(B) is in effect. Such term includes the United States Postal Service.

(4) MULTIEMPLOYER PLAN.—The term "multiemployer plan" has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

(5) RURAL ELECTRIC COOPERATIVE.—The term "rural electric cooperative" has the meaning given such term in section 3(40)(A)(iv) of the Employee Retirement Income Security Act of 1974.

(6) RURAL TELEPHONE COOPERATIVE ASSOCIATIONS.—The term "rural telephone cooperative association" has the meaning given such term in section 3(40)(A)(v) of the Employee Retirement Income Security Act of 1974.

SEC. 1312. TIMING OF ELECTIONS.

(a) FOR LARGE EMPLOYERS.—

(1) CURRENT LARGE EMPLOYERS.—

(A) IN GENERAL.—In the case of an employer that is an eligible sponsor described in section 1311(b)(1)(A) as of the most recent January 1 prior to the general effective date, the sponsor's election to be a corporate alliance under such section must be made and filed with the Secretary of Labor not later than the date specified in subparagraph (B).

(B) DEADLINE FOR NOTICE.—The date specified in this subparagraph is January 1 of the second year preceding the general effective date or, in the case of a State that elects to become a participating State before the general effective date, not later than one month later than the date specified for States to provide notice of their intent under section 1202(a)(2).

(2) NEW LARGE EMPLOYERS.—In the case of an employer that is not an eligible sponsor described in section 1311(b)(1)(A) as of the most recent January 1 prior to the general effective date, but first becomes such a sponsor as of a subsequent date, the election to be a corporate alliance under such section must be made and filed with the Secretary of Labor not later than March 1 of the year following the year in such report is submitted.

(3) APPLICATION OF OPTION.—The Secretary of Labor shall promulgate rules regarding how the option described in section 1311(c)(1)(B) will be applied to the determination of whether an employer is a large employer before an election is made under section 1311.

(b) FOR MULTIEMPLOYER PLANS AND RURAL COOPERATIVES.—In the case of an eligible sponsor described in section 1311(b)(1)(B) or (C), the sponsor's election to be a corporate alliance under such section must be made and filed with the Secretary of Labor not later than the second most recent March 1 prior to the general effective date.

(c) EFFECTIVE DATE OF ELECTION.—An election made under subsection (a) or (b) shall be effective for coverage provided under health plans on and after January 1 of the year following the year in which the election is made.

(d) ONE-TIME ELECTION.—If an eligible sponsor fails to make the election on a timely manner under subsection (a) or (b), the sponsor may not make such election at any other time.

SEC. 1313. TERMINATION OF ALLIANCE ELECTION.

(a) TERMINATION FOR INSUFFICIENT NUMBER OF FULL-TIME EMPLOYEES OR PARTICIPANTS.—If a corporate alliance reports under section 1387(c), that there were fewer than 4,800 full-time employees (or, active participants, in the case of one or more plans offered by a corporate alliance which is an eligible sponsor described in section 1311(b)(1)(B)) who are enrolled in a health plan through the alliance, the election under this part with respect to the alliance shall terminate.

(b) TERMINATION FOR FAILURE TO MEET REQUIREMENTS.—

(1) IN GENERAL.—If the Secretary of Labor finds that a corporate alliance has failed substantially to meet the applicable requirements of this subtitle, the Secretary shall terminate the election under this part with respect to the alliance

(2) EXCESS INCREASE IN PREMIUM EQUIVALENT.—If the Secretary of Labor finds that the alliance is in violation of the requirements of section 6022 (relating to prohibition against excess increase in premium expenditures), the Secretary shall terminate the alliance in accordance with such section.

(c) ELECTIVE TERMINATION.—A corporate alliance may terminate an election under this part by filing with the National Health Board and the Secretary of Labor a notice of intent to terminate.

(d) EFFECTIVE DATE OF TERMINATION.—In the case of a termination of an election under this section, in accordance with rules established by the Secretary of Labor—

(1) the termination shall take effect as of the effective date of enrollments in regional alliance health plans made during the next open enrollment period (as provided in section 1323(d)), and

(2) the enrollment of eligible individuals in corporate alliance health plans of the corporate alliance shall be terminated as of such date and such individuals shall be enrolled in other applicable health plans effective on such date.

(e) NOTICE TO BOARD.—If an election with respect to a corporate alliance is terminated pursuant to subsection (a) or subsection (b), the Secretary of Labor shall notify the National Health Board of the termination of the election.

PART 2—GENERAL RESPONSIBILITIES AND AUTHORITIES OF REGIONAL ALLIANCES

SEC. 1321. CONTRACTS WITH HEALTH PLANS.

(a) CONTRACTS WITH PLANS.—

(1) IN GENERAL.—In order to assure the availability of the comprehensive benefit package to eligible individuals residing in the alliance area in a cost-effective manner, except as provided in this section, each regional alliance shall negotiate with any willing State-certified health plan to enter into a contract with the alliance for the enrollment under the plan of eligible individuals in the alliance area. Subject to paragraph (2), a regional alliance shall not enter into any such contract with a health plan that is not a State-certified health plan.

(2) TREATMENT OF CERTAIN PLANS.—Each regional alliance shall enter into a contract under this section with any veterans health plan of the Department of Veterans Affairs and with a Uniformed Services Health Plan of the Department of Defense, that offers the comprehensive benefit package to eligible individuals residing in the alliance area if the appropriate official requests to enter into such a contract.

(b) GENERAL CONDITIONS FOR DENIAL OF CONTRACT BY A REGIONAL ALLIANCE.—A regional alliance is not required under this section to offer a contract with a health plan if—

(1) the alliance finds that the proposed premium exceeds 120 percent of the weighted-average premium within the alliance; or

(2) the plan has failed to comply with requirements under prior contracts with the alliance, including failing to offer coverage for all the services in the comprehensive benefit package in the entire service area of the plan.

SEC. 1322. OFFERING CHOICE OF HEALTH PLANS FOR ENROLLMENT; ESTABLISHMENT OF FEE-FOR-SERVICE SCHEDULE.

(a) IN GENERAL.—Each health alliance must provide to each eligible enrollee with respect to the alliance a choice of health plans among the plans which have contracts in effect with the alliance under section 1321 (in the case of a regional alliance) or section 1341 (in the case of a corporate alliance).

(b) OFFERING OF PLANS BY ALLIANCES.—

(1) IN GENERAL.—Each regional alliance shall include among its health plan offerings at least one fee-for-service plan (as defined in paragraph (2)).

(2) FEE-FOR-SERVICE PLAN DEFINED.—

(A) IN GENERAL.—For purposes of this Act, the term "fee-for-service plan" means a health plan that—

(i) provides coverage for all items and services included in the comprehensive benefit package that are furnished by any lawful health care provider of the enrollee's choice, subject to reasonable restrictions (described in subparagraph (B)), and

(ii) makes payment to such a provider without regard to whether or not there is a contractual arrangement between the plan and the provider.

(B) REASONABLE RESTRICTIONS DESCRIBED.—The reasonable restrictions on coverage permitted under a fee-for-service plan (as specified by the National Health Board) are as follows:

(i) Utilization review.

(ii) Prior approval for specified services.

(iii) Exclusion of providers on the basis of poor quality of care, based on evidence obtainable by the plan.

Clause (ii) shall not be construed as permitting a plan to require prior approval for nonprimary health care services through a gatekeeper or other process.

(c) ESTABLISHMENT OF FEE-FOR-SERVICE SCHEDULE.—

(1) IN GENERAL.—Except in the case of regional alliances of a State that has established a Statewide fee schedule under paragraph (3), each regional alliance shall establish a fee schedule setting forth the payment rates applicable to services furnished during a year to individuals enrolled in fee-for-service plans (or to services furnished under the fee-for-service component of any regional alliance health plan) for use by regional alliance health plans under section 1406(c) and corporate alliance health plans providing services subject to the schedule in the regional alliance area.

(2) NEGOTIATION WITH PROVIDERS.—The fee schedule under paragraph (1) shall be established after negotiations with providers, and (subject to paragraphs (5) and (6)) providers may collectively negotiate the fee schedule with the regional alliance.

(3) USE OF STATEWIDE SCHEDULE.—At the option of a State, the State may establish its own statewide fee schedule which shall apply to all fee-for-service plans offered by regional alliances and corporate alliances in the State instead of alliance-specific schedules established under paragraph (1).

(4) ANNUAL REVISION.—A regional alliance or State (as the case may be) shall annually update the payment rates provided under the fee schedule established pursuant to paragraph (1) or paragraph (3).

(5) ACTIVITIES TREATED AS STATE ACTION OR EFFORTS INTENDED TO INFLUENCE GOVERNMENT

ACTION.—The establishment of a fee schedule under this subsection by a regional alliance of a State shall be considered to be pursuant to a clearly articulated and affirmatively expressed State policy to displace competition and actively supervised by the State, and conduct by providers respecting the establishment of the fee schedule, including collective negotiations by providers with the regional alliance (or the State) pursuant to paragraph (2), shall be considered as efforts intended to influence governmental action.

(6) NO BOYCOTT PERMITTED.—Nothing in this subsection shall be construed to permit providers to threaten or engage in any boycott.

(7) NEGOTIATIONS DEFINED.—In this subsection, "negotiations" are the process by which providers collectively and jointly meet, confer, consult, discuss, share information, among and between themselves in order to agree on information to be provided, presentations to be made, and other such activities with respect to regional alliances (or States) relating to the establishment of the fee schedule (but not including any activity that constitutes engaging in or threatening to engage in a boycott), as well as any and all collective and joint meetings, discussions, presentations, conferences, and consultations between or among providers and any regional alliance (or State) for the purpose of establishing the fee schedule described in this subsection.

(d) PROSPECTIVE BUDGETING OF FEE-FOR-SERVICE.—

(1) IN GENERAL.—The fee schedule established by a regional alliance or a State under subsection (c) may be based on prospective budgeting described in paragraph (2).

(2) PROSPECTIVE BUDGETING DESCRIBED.—Under prospective budgeting—

(A) the regional alliance or State (as the case may be) shall negotiate with health providers annually to develop a budget for the designated fee-for-service plan;

(B) the negotiated budget shall establish spending targets for each sector of health expenditures made by the plan; and

(C) if the regional alliance or State (as the case may be) determines that the utilization of services under the plan is at a level that will result in expenditures under the plan exceeding the negotiated budget, the plan shall reduce the amount of payments otherwise made to providers (through a withhold or delay in payments or adjustments) in such a manner and by such amounts as necessary to assure that expenditures will not exceed the budget.

(3) USE OF PROSPECTIVE BUDGETING EXCLUSIVE.—If a regional alliance or State establishes the fee schedule for fee-for-service plans on the basis of prospective budgeting under this subsection, payment for all services provided by fee-for-service plans in the alliance or State shall be determined on such basis.

SEC. 1323. ENROLLMENT RULES AND PROCEDURES.

(a) IN GENERAL.—Each regional alliance shall assure that each regional alliance eligible individual who resides in the alliance area is enrolled in a regional alliance health plan and shall establish and maintain methods and procedures, consistent with this section, sufficient to assure such enrollment. Such methods and procedures shall assure the enrollment of alliance eligible individuals at the time they first become eligible enrollees in the alliance area, including individuals at the time of birth, at the time they move into the alliance area, and at the time of reaching the age of individual eligibility as an eligible enrollee (and not merely as a family member). Each regional alliance shall establish procedures, consistent with subtitle A, for the selection of a single health plan in which all members of a family are enrolled.

(b) POINT OF SERVICE ENROLLMENT MECHANISM.—

(1) IN GENERAL.—Each regional alliance shall establish a point-of-service enrollment mechanism (meeting the requirements of this subsection) for enrolling eligible individuals who are not enrolled in a health plan of the alliance when the individual seeks health services.

(2) REQUIREMENTS OF MECHANISM.—Under such a mechanism, if an eligible individual seeks to receive services (included in the comprehensive benefit package) from a provider in an alliance area and does not present evidence of enrollment under any applicable health plan, or if the provider has no evidence of the individual's enrollment under any such plan, the following rules shall apply:

(A) NOTICE TO ALLIANCE.—The provider—

(i) shall provide the regional alliance with information relating to the identity of the eligible individual, and

(ii) may request payment from the regional alliance for the furnishing of such services.

(B) INITIAL DETERMINATION OF ELIGIBILITY AND ENROLLMENT STATUS.—The regional alliance shall determine—

(i) if the individual is an alliance eligible individual for the alliance, and

(ii) if the individual is enrolled under an applicable health plan (including a corporate alliance health plan).

(C) TREATMENT OF ALLIANCE ELIGIBLE INDIVIDUALS.—If the regional alliance determines that the individual is an alliance eligible individual with respect to the alliance and—

(i) is enrolled under a regional alliance health plan of the alliance, the alliance shall forward the claim to the health plan involved and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in paragraph (3)(C));

(ii) is not enrolled under a regional alliance health plan of the alliance but is required to be so enrolled in a specific health plan as a family member under section 1021, the alliance shall record the individual's enrollment under such specific plan, shall forward the claim to such plan, and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in paragraph (3)(C)); or

(iii) is not enrolled under such a plan and is not described in clause (ii), the point-of-service enrollment procedures described in paragraph (3) shall apply.

(D) TREATMENT OF INDIVIDUALS ENROLLED UNDER HEALTH PLANS OF OTHER ALLIANCES.—If the regional alliance determines that the individual is not an alliance eligible individual with respect to the alliance but the individual is enrolled—

(i) under a regional alliance health plan of another alliance, the alliance shall forward the claim to the other regional alliance and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in paragraph (3)(C)); or

(ii) under a corporate alliance health plan, the alliance shall forward the claim to the corporate alliance involved and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in section 1383(b)(2)(B)).

(E) TREATMENT OF OTHER ALLIANCE ELIGIBLE INDIVIDUALS NOT ENROLLED IN HEALTH PLAN.—If the regional alliance determines that the individual is not an alliance eligible individual with respect to the alliance and the individual is an alliance eligible individual with respect to another health alliance but is not enrolled in a health plan of such alliance, the regional alliance shall forward the claim to the other alliance involved and shall notify the provider (and the individual) of the forwarding of such claim and the requirement for prompt enrollment of the individual under an applicable health plan of such alliance pursuant to the procedures described in paragraph (3) (in the case of a regional alliance) or in section 1383(b) (in the case of a corporate alliance).

(F) TREATMENT OF ALL OTHER INDIVIDUALS.—The National Board shall promulgate rules regarding the responsibilities of regional alliances relating to individuals whose applicable health plan is not an alliance plan and other individuals the alliance is unable to identify as eligible individuals.

(3) POINT-OF-SERVICE ENROLLMENT PROCEDURES DESCRIBED.—The point-of-service enrollment procedures under this paragraph are as follows:

(A) Not later than 10 days after the date an alliance is notified of the receipt of services by an unenrolled individual, the alliance provides the individual with materials describing health plans offered through the alliance.

(B) The individual shall be provided a period of 30 days in which to enroll in a health plan of the individual's choice. If the individual fails to so enroll during such period, the alliance shall enroll the individual in a health plan of the alliance selected on a random basis.

(C) Using the fee-for-service schedule adopted by the alliance under section, the health plan in which the individual is enrolled under this subparagraph shall reimburse the provider who provided the services referred to in subparagraph (A) to the same extent as if the individual had been enrolled under the plan at the time of provision of the services.

(c) ENROLLMENT OF NEW RESIDENTS.—

(1) IN GENERAL.—Each regional alliance shall establish procedures for enrolling regional alliance eligible individuals who move into the alliance area.

(2) LONG-TERM RESIDENTS.—Such procedures shall assure that regional alliance eligible individuals who intend to reside in the alliance area for longer than 6 months shall register with the regional alliance for the area and shall enroll in a regional alliance health plan offered by the alliance.

(3) SHORT-TERM RESIDENTS.—Such procedures shall permit eligible individuals who intend to reside in the alliance area for more than 3 months but less than 6 months to choose among the following options:

(A) To continue coverage through the health plan in which such individual is previously enrolled, in which case coverage for care in the area of temporary residence may be limited to emergency services and urgent care.

(B) To register with the regional alliance and enroll in a regional alliance health plan offered by the alliance.

(C) To change enrollment in the previous alliance area to enrollment in a health plan of such alliance that provides for coverage on a fee-for-service basis of services provided outside the area of that alliance.

(d) CHANGES IN ENROLLMENT.—

(1) ANNUAL OPEN ENROLLMENT PERIOD TO CHANGE PLAN ENROLLMENT.—Each regional alliance shall hold an annual open enrollment period during which each eligible enrollee in the alliance has the opportunity to choose among health plans offered through the alliance, according to rules to be promulgated by the National Health Board.

(2) DISENROLLMENT FOR CAUSE.—In addition to the annual open enrollment period held under paragraph (1), each regional alliance shall establish procedures under which alliance eligible individuals enrolled in a plan may disenroll from the plan for good cause at any time during a year and enroll in another plan of the alliance. Such procedures shall be implemented in a manner that ensures continuity of coverage for the comprehensive benefit package for such individuals during the year.

(e) ENROLLMENT OF FAMILY MEMBERS.—Each regional alliance shall provide for the enrollment of all family members in the same plan, consistent with part 2 of subtitle A.

(f) OVERSUBSCRIPTION OF PLANS.—

(1) IN GENERAL.—Each regional alliance shall establish a method for establishing enrollment priorities in the case of a health plan that does not have sufficient capacity to enroll all eligible individuals seeking enrollment.

(2) PREFERENCE FOR CURRENT MEMBERS.—Such method shall provide that in the case of such an oversubscribed plan—

(A) individuals already enrolled in the plan are given priority in continuing enrollment in the plan, and

(B) other individuals who seek enrollment during an applicable enrollment period are permitted to enroll in accordance with a random selection method, up to the enrollment capacity of the plan.

(g) TERMINATION OF ENROLLMENT.—

(1) IN GENERAL.—Each regional alliance shall establish special enrollment procedures to permit alliance eligible individuals to change the plan in which they are enrolled in the case of the termination of coverage under a plan, in a manner that ensures the individuals' continuation of coverage for the comprehensive benefit package.

(2) FAILURE OF A CORPORATE ALLIANCE.—Each regional alliance shall establish special enrollment procedures to permit individuals, who become alliance eligible individuals as a result of the failure of a corporate alliance, to enroll promptly in regional alliance health plans in a manner that ensures the individuals' continuation of coverage for the comprehensive benefit package.

(h) LIMITATION ON OFFERING OF COVERAGE TO INELIGIBLE INDIVIDUALS.—A regional alliance may not knowingly offer coverage under a regional alliance health plan or other health insurance or health benefits to an individual who is not an eligible individual. Nothing in this section shall be construed as affecting the ability of a regional alliance health plan or other health plan to offer coverage to such individuals without any financial payment by a regional alliance.

(i) ENFORCEMENT OF ENROLLMENT REQUIREMENT.—In the case of a regional alliance eligible individual who fails to enroll in an applicable health plan as required under section 1002(a)—

(1) the applicable regional alliance shall enroll the individual in a regional alliance health plan (selected by the alliance consistent with this Act and with any rules established by the Board), and

(2) such alliance shall require the payment of twice the amount of the family share of premiums that would have been payable under subtitle B of title VI if the individual had enrolled on a timely basis in the plan, unless the individual has established to the satisfaction of the alliance good cause for the failure to enroll on a timely basis.

SEC. 1324. ISSUANCE OF HEALTH SECURITY CARDS.

A regional alliance is responsible for the issuance of health security cards to regional alliance eligible individuals under section 1001(b).

SEC. 1325. CONSUMER INFORMATION AND MARKETING.

(a) CONSUMER INFORMATION.—

(1) IN GENERAL.—Each regional alliance shall make available to eligible enrollees information, in an easily understood and useful form, that allows such enrollees (and other alliance eligible individuals) to make valid comparisons among health plans offered by the alliance. Such information shall be made available in a brochure, published not less often than annually.

(2) INFORMATION TO BE INCLUDED.—Such information must include, in the same format for each plan, such information as the National Health Board shall require, including at least the following:

(A) The cost of the plan, including premiums and average out-of-pocket expenses.

(B) The characteristics and availability of health care professionals and institutions participating in the plan.

(C) Any restrictions on access to providers and services under the plan.

(D) A summary of the annual quality performance report, established pursuant to section 5005(d)(1), which contains measures of quality presented in a standard format.

(b) MARKETING.—Each regional alliance shall review and approve or disapprove the distribution of any materials used to market health plans offered through the alliance.

SEC. 1326. OMBUDSMAN.

(a) ESTABLISHMENT.—Each regional alliance must establish and maintain an office of an ombudsman to assist consumers in dealing with problems that arise with health plans and the alliance.

(b) OPTIONAL FINANCING THROUGH VOLUNTARY CONTRIBUTION.—At the option of State in which a regional alliance is located, the alliance—

(1) shall permit alliance eligible individuals to designate that one dollar of the premium paid for enrollment in the individual's regional alliance health plan for the operation of the office of the alliance's ombudsman; and

(2) shall apply any such amounts towards the establishment and operation of such office.

SEC. 1327. DATA COLLECTION; QUALITY.

Each regional alliance shall comply with requirements of subtitles A and B of title V (relating to quality, information systems, and privacy), and shall take appropriate steps to ensure that health plans offered through the alliance comply with such requirements.

SEC. 1328. ADDITIONAL DUTIES.

(a) ANTI-DISCRIMINATION.—In carrying out its activities under this part, a health alliance may not discriminate against health plans on the basis of race, gender, ethnicity, religion, mix of health professionals, location of the plan's headquarters, or (except as specifically provided in this part) organizational arrangement.

(b) COORDINATION OF ENROLLMENT ACTIVITIES.—Each regional alliance shall coordinate, in a manner specified by the National Health Board, with other health alliances its activities, including enrollment and disenrollment activities, in a manner that ensures continuous, nonduplicative coverage of alliance eligible individuals in health plans and that minimizes administrative procedures and paperwork.

SEC. 1329. ADDITIONAL AUTHORITIES FOR REGIONAL ALLIANCES TO ADDRESS NEEDS IN AREAS WITH INADEQUATE HEALTH SERVICES; PROHIBITION OF INSURANCE ROLE.

(a) PAYMENT ADJUSTMENT.—In order to ensure that plans are available to all eligible individuals residing in all portions of the alliance area, a regional alliance may adjust payments to plans or use other financial incentives to encourage health plans to expand into areas that have inadequate health services.

(b) ENCOURAGING NEW PLANS.—Subject to subsection (c), in order to encourage the establishment of a new health plan in an area that has inadequate health services, an alliance may—

(1) organize health providers to create such a plan in such an area a new health plan targeted at such an area,

(2) provide assistance with setting up and administering such a plan, and

(3) arrange favorable financing for such a plan.

(c) PROHIBITION OF REGIONAL ALLIANCES BEARING RISK.—A regional alliance may not bear insurance risk.

SEC. 1330. PROHIBITION AGAINST SELF-DEALING AND CONFLICTS OF INTEREST.

(a) PROMULGATION OF STANDARDS.—The Board shall promulgate standards of conduct in accordance with subsection (b) for any administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any regional alliance.

(b) REQUIREMENTS FOR STANDARDS.—The standards of conduct shall referred to in subsection (a) shall set forth—

(1) the types of investment interests, ownership interests, affiliations or other employment that would be improper for an individual described in subsection (a) to hold during the time of the individual's service or employment with an alliance; and

(2) the circumstances that will constitute impermissible conflicts of interest or self-dealing by such employees in performing their official duties and functions for any regional alliance.

(c) CIVIL MONETARY PENALTY.—Any individual who engages in an activity that the individual knows or has reason to know is in violation of the regulations and standards promulgated by the Board pursuant to paragraphs (a) and (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such violation.

PART 3—AUTHORITIES AND RESPONSIBILITIES RELATING TO FINANCING AND INCOME DETERMINATIONS

Subpart A—Collection of Funds

SEC. 1341. INFORMATION AND NEGOTIATION AND ACCEPTANCE OF BIDS.

(a) INFORMATION PROVIDED TO PLANS BEFORE SOLICITING BIDS.—

(1) IN GENERAL.—Each regional alliance shall make available, by April 1 of each year, to each plan that indicates an interest in

submitting a premium bid under section 6004 in the year, information (including information described in paragraph (2)) that the Board specifies as being necessary to enable a plan to estimate, based upon an accepted bid, the amounts payable to such a plan under section 1351.

(2) INFORMATION TO BE INCLUDED.—Such information shall include the following:

(A) The demographic and other characteristics of regional alliance eligible individuals for the regional alliance.

(B) The uniform per capita conversion factor for the regional alliance (established under subsection (b)).

(C) The premium class factors (established by the Board under section 1531).

(D) The regional alliance inflation factor (determined under section 6001(a)).

(E) The risk-adjustment factors and reinsurance methodology and payment amounts (published under subsection (c)) to be used by the regional alliance in computing blended plan per capita rates (in accordance with section 6201).

(F) The plan bid proportion, the AFDC proportion, the SSI proportion, the AFDC per capita premium amount, and the SSI per capita premium amount, for the year, as computed under subtitle D of title VI.

(G) The alliance administrative allowance percentage, computed under section 1352(b).

(b) DETERMINATION OF UNIFORM PER CAPITA CONVERSION FACTOR.—Each regional alliance shall specify, not later than April 1 of each year (beginning with the year before the first year) a uniform per capita conversion factor to be used under section 6102(a)(2) in converting the accepted bid for each plan for the year into the premium for an individual enrollment for such plan for the year. SSI or AFDC recipients shall not be included for purposes of computing the conversion factor.

(c) DETERMINATION OF RISK-ADJUSTMENT FACTORS AND REINSURANCE PAYMENT AMOUNTS.—Each regional alliance shall compute and publish the risk-adjustment factors and reinsurance payment amounts to be used by the regional alliance in computing blended plan per capita rates under section 6201.

(d) SOLICITATION OF BIDS.—Each regional alliance shall solicit and negotiate, consistent with section 6004, with each regional alliance health plan a bid for the payment rate on a per capita basis for the comprehensive benefit package for all alliance eligible individuals in the alliance area.

SEC. 1342. CALCULATION AND PUBLICATION OF GENERAL FAMILY SHARE AND GENERAL EMPLOYER PREMIUM AMOUNTS.

(a) CALCULATION OF COMPONENTS IN GENERAL FAMILY SHARE AND GENERAL EMPLOYER PREMIUMS.—

(1) FAMILY SHARE.—Each regional alliance shall compute the following components of the general family share of premiums:

(A) PLAN PREMIUMS.—For each plan offered, the premium for the plan for each class of family enrollment (including the amount of any family collection shortfall).

(B) ALLIANCE CREDIT.—The alliance credit amount for each class of family enrollment, under section 6103.

(C) EXCESS PREMIUM CREDIT.—The amount of any excess premium credit provided under section 6105 for each class of family enrollment.

(D) CORPORATE ALLIANCE OPT-IN CREDIT.—The amount of any corporate alliance opt-in credit provided under section 6106 for each class of family enrollment.

(2) EMPLOYER PREMIUMS.—Each regional alliance shall compute the following components of the general employer premium payment:

(A) BASE EMPLOYER MONTHLY PREMIUM PER WORKER.—The base employer monthly premium determined under section 6122 for each class of family enrollment.

(B) EMPLOYER COLLECTION SHORTFALL ADD-ON.—The employer collection shortfall add-on computed under section 6125(b).

(b) PUBLICATION.—

(1) FAMILY SHARE.—

(A) IN GENERAL.—Each regional alliance shall publish, before the open enrollment period in each year, the general family share of the premium (as defined in subparagraph (B)) for each class of family enrollment for each regional alliance health plan to be offered by the alliance in the following year.

(B) GENERAL FAMILY SHARE OF PREMIUM DEFINED.—In this subpart, the term "general family share of premium" means the family share of premium under section 6101 computed without regard to section 6104 and without regard to section 6101(b)(2)(C)(v).

(2) EMPLOYER PREMIUM.—

(A) IN GENERAL.—Each regional alliance shall publish, in December before each year (beginning with December before the first year) the general employer premium payment amount (as defined in subparagraph (B)) for each class of family enrollment for the following year.

(B) GENERAL EMPLOYER PREMIUM PAYMENT AMOUNT DEFINED.—In this subpart, the term "general employer premium payment amount" means the employer premium payment under section 6121 computed, as an amount per full-time equivalent worker, without regard to sections 6124, 6125, 6126.

SEC. 1343. DETERMINATION OF FAMILY SHARE FOR FAMILIES.

(a) AMOUNT OF FAMILY SHARE.—The amount charged by a regional alliance to a family for a class of family enrollment (specified under section 1011(c)) under a regional alliance health plan is equal to the family share of premium established under section 6101(a) for the family. Based upon the information described in this section, each regional alliance shall determine the amount required to be paid under section 6101 and under section 6111 for each year for families enrolling in regional alliance health plans.

(b) FAMILY SHARE AMOUNT.—The amount required to be paid under section 6101, with respect to each family, takes into account—

(1) the general family share of premium (as defined in section 1342(b)(1)(B)) for the class of enrollment involved;

(2) any income-related discount provided under section 6104(a)(1) for the family; and

(3) whether or not the family is an SSI or AFDC family.

(c) ALLIANCE CREDIT AMOUNT.—The amount of the alliance credit under section 6111, with respect to each family, takes into account the following:

(1) The number of months of enrollment, and class of enrollment, in regional alliance health plans, used in determining the amount of the alliance credit under section 6103 for the family.

(2) Reductions in liability under section 6111(b) based on employer premium payments based on net earnings from self-employment for the family.

(3) Reductions in liability under section 6112 based on months of employment for the family.

(4) Limitations in liability under section 6113 on the basis of the adjusted family income for the family.

(5) The elimination of liability in the case of certain retirees and qualified spouses and children under section 6114.

(6) The elimination of liability in the case of certain working medicare beneficiaries under section 6115.

(d) ACCESS TO NECESSARY INFORMATION TO MAKE DETERMINATION.—Information required for an alliance to make the determination under subsection (a) shall be based on information obtained or maintained by the alliance in the conduct of its business, including the following:

(1) Information required for income-related determinations shall be obtained under subpart B.

(2) Information on SSI and AFDC recipients under subsection (e).

(3) Information submitted on a monthly and annual basis by employers under section 1602.

(4) Information submitted by self-employed individuals on net earnings from self-employment under section 1602(d).

(5) Applications for premium reductions under section 6114.

(6) Information concerning medicare-eligible individuals under subsection (f).

(7) Any income-related discount provided under section 6104(a)(1) for the family.

(8) Whether or not the family is an SSI or AFDC family.

(e) INFORMATION CONCERNING CASH ASSISTANCE STATUS.—Each participating State and the Secretary shall make available (in a time and manner specified by the Secretary) to each regional alliance such information as may be necessary to determine and verify whether an individual is an AFDC or SSI recipient for a month in a year.

(f) INFORMATION CONCERNING MEDICARE-ELIGIBLE INDIVIDUALS.—

(1) INFORMATION TO REGIONAL ALLIANCES.—The Secretary shall make available to regional alliances (through regional information centers or otherwise) information necessary to determine—

(A) whether an individual is a medicare-eligible individual,

(B) the eligibility of individuals for the special treatment under section 6115,

(C) if medicare-eligible individuals are described in section 1012(a), and

(D) the amounts of payments owed the alliance under section 1895 of the Social Security Act.

(2) INFORMATION TO SECRETARY.—Each regional alliance shall make available to the Secretary (through the national information system under section 5101 or otherwise) information relating to the enrollment of individuals who would be medicare-eligible individuals but for section 1012(a).

(g) ALLIANCE ACCOUNTING SYSTEM.—

(1) IN GENERAL.—Each regional alliance shall establish an accounting system that meets standards established by the Secretary.

(2) SPECIFICS.—Such system shall collect information, on a timely basis for each individual enrolled (and, to the extent required by the Secretary, identified and required to be enrolled) in a regional alliance health plan regarding—

(A) the applicable premium for such enrollment,

(B) family members covered under such enrollment,

(C) the premium payments made by (or on behalf of) the individual for such enrollment,

(D) employer premium payments made respecting the employment of the individual and other employer contributions made respecting such enrollment, and

(E) any government contributions made with respect to such enrollment (including contributions for electing veterans and active duty military personnel).

(3) END-OF-YEAR REPORTING.—Such system shall provide for a report, at the end of each year, regarding the total premiums imposed, and total amounts collected, for individuals enrolled under regional health alliance plans, in such manner as identifies net amounts that may be owed to the regional alliance.

SEC. 1344. NOTICE OF FAMILY PAYMENTS DUE.

(a) FAMILY STATEMENTS.—

(1) NOTICE OF NO AMOUNT OWED.—If the regional alliance determines under section 1343 that a family has paid any family share required under section 6101 and is not required to repay any amount under section 6111 for a year, the alliance shall mail notice of such determination to the family. Such notice shall include a prominent statement that the family is not required to make any additional payment and is not required to file any additional information with the regional alliance.

(2) NOTICE OF AMOUNT OWED.—

(A) IN GENERAL.—If the regional alliance determines that a family has not paid the entire family share required under section 6101 or is required to repay an amount under section 6111 for a year, the alliance shall mail to the family a notice of such determination.

(B) INFORMATION ON AMOUNT DUE.—Such notice shall include detailed information regarding the amount owed, the basis for the computation (including the amount of any reductions that have been made in the family's liability under subtitle B of title VI), and the date the amount is due and the manner in which such amount is payable.

(C) INFORMATION ON DISCOUNTS AND REDUCTIONS AVAILABLE.—Such notice shall include—

(i) information regarding the discounts and reductions available (under sections 6104, 6112, 6113, 6114, and 6115) to reduce or eliminate any liability, and

(ii) a worksheet which may be used to calculate reductions in liability based on income under sections 6104 and 6113.

(3) INCLUSION OF INCOME RECONCILIATION FORM FOR FAMILIES PROVIDED PREMIUM DISCOUNTS.—

(A) IN GENERAL.—A notice under this subsection shall include, in the case of a family that has been provided a premium discount under section 6103 (or section 6113) for the previous year, an income verification statement (described in section 1375) to be completed and returned to the regional alliance (along with any additional amounts owed) by the deadline specified in subsection (b). Such form shall require the submission of such information as Secretary specifies to establish or verify eligiblility for such premium discount.

(B) OTHER FAMILIES.—Any family which has not been provided such a discount but may be eligible for such a discount may submit such an income verification form and, if eligible, receive a rebate of the amount of excess family share paid for the previous year.

(C) ADDITIONAL INFORMATION.—The alliance shall permit a family to provide additional information relating to the amount of such reductions or the income of the family (insofar as it may relate to a premium discount or reduction in liability under section 6104 or 6113).

(4) TIMING OF NOTICE.—Notices under this subsection shall be mailed to each family at least 45 days before the deadline specified in subsection (b).

(b) DEADLINE FOR PAYMENT.—The deadline specified in this subsection for amounts owed for a year is such date as the Secretary may specify, taking into account the dates when the information specified in section 1343 becomes available to compute the amounts owed and the information required to file income reconcilation statements under section 1375. Amounts not paid by such deadline are subject to interest and penalty.

(c) CHANGE IN REGIONAL ALLIANCE.—In the case of a family that during a year changes the regional alliance through which the family obtains coverage under a regional alliance health plan, the Secretary shall establish rules which provide that the regional alliance in which the family last obtained such coverage in a year—

(1) is responsible for recovering amounts due under this subpart for the year (whether or not attributable to periods of coverage obtained through that alliance);

(2) shall obtain such information, through the health information system implemented under section 5201, as the alliance may require in order to compute the amount of any liability owed under this subpart (taking into account any reduction in such amount under this section), and

(3) shall provide for the payment to other regional alliances of such amounts collected as may be attributable to amounts owed for periods of coverage obtained through such alliances.

(d) NO LOSS OF COVERAGE.—In no case shall the failure to pay amounts owed under this subsection result in an individual's or family's loss of coverage under this Act.

(e) DISPUTE RESOLUTION.—Each regional alliance shall establish a fair hearing mechanism for the resolution of disputes concerning amounts owed the alliance under this subpart.

SEC. 1345. COLLECTIONS.

(a) IN GENERAL.—Each regional alliance is responsible for the collection of all amounts owed the alliance (whether by individuals, employers, or others and whether on the basis of premiums owed, incorrect amounts of discounts or premium, cost sharing, or other reductions made, or otherwise), and no amounts are payable by the Federal Government under this Act (including section 9102) with respect to the failure to collect any such amounts. Each regional alliance shall use credit and collection procedures, including the imposition of interest charges and late fees for failure to make timely payment, as may be necessary to collect amounts owed to the alliance. States assist regional alliances in such collection process under section 1202(d).

(b) COLLECTION OF FAMILY SHARE.—

(1) WITHHOLDING.—

(A) IN GENERAL.—In the case of a family that includes a qualifying employee of an employer, the employer shall deduct from the wages of the qualifying employee (in a manner consistent with any rules of the Secretary of Labor) the amount of the family share of the premium for the plan in which the family is enrolled.

(B) MULTIPLE EMPLOYMENT.—In the case of a family that includes more than one qualifying employee, the family shall choose the employer to which subparagraph (A) will apply.

(C) PAYMENT.—Amounts withheld under this paragraph shall be maintained in a manner consistent with standards established by the Secretary of Labor and paid to the regional alliance involved in a manner consistent with the payment of employer premiums under subsection (c).

(D) SATISFACTION OF LIABILITY.—An amount deducted from wages of a qualifying employee by an employer is deemed to have been paid by the employee and to have satisfied the employee's obligation under subsection (a) to the extent of such amount.

(2) OTHER METHODS.—In the case of a family that does not include a qualifying employee, the regional alliance shall require payment to be made prospectively and such payment may be required to be made not less frequently than monthly. The Secretary may issue regulations in order to assure the timely and accurate collection of the family share due.

(c) TIMING AND METHOD OF PAYMENT OF EMPLOYER PREMIUMS.—

(1) FREQUENCY OF PAYMENT.—Payment of employer premiums under section 6121 for a month shall be made not less frequently than monthly (or quarterly in the case of such payments made by virtue of section 6126). The Secretary of Labor may establish a method under which employers that pay wages on a weekly or biweekly basis are permitted to make such employer payments on such a weekly or biweekly basis.

(2) ELECTRONIC TRANSFER.—A regional alliance may require those employers that have the capacity to make payments by electronic transfer to make payments under this section by electronic transfer.

(d) ASSISTANCE.—

(1) EMPLOYER COLLECTIONS.—The Secretary of Labor shall provide regional alliances with such technical and other assistance as may promote the efficient collection of all amounts owed such alliances under this Act by employers. Such assistance may include the assessment of civil monetary penalties, not to exceed $5,000 or three times the amount of the liability owed, whichever is greater, in the case of repeated failure to pay (as specified in rules of the Secretary of Labor).

(2) FAMILY COLLECTIONS.—Except as provided in paragraph (1), the Secretary shall provide regional alliances with such technical and other assistance as may promote the efficient collection of other amounts owed such alliances under this Act. Such assistance may include the assessment of civil monetary penalties, not to exceed $5,000 or three times the amount of the liability owed, whichever is greater, in the case of repeated failure to pay (as specified in rules of the Secretary).

(e) RECEIPT OF MISCELLANEOUS AMOUNTS.—For payments to regional alliances by—

(1) States, see subtitle A of title IX, and

(2) the Federal Government, see subtitle B of such title and section 1895 of the Social Security Act (as added by section 4003).

SEC. 1346. COORDINATION AMONG REGIONAL ALLIANCES.

(a) IN GENERAL.—The regional alliance which offers the regional alliance health plan in which a family is enrolled in December of each year (in this section referred to as the "final alliance") is responsible for the collection of any amounts owed under this subpart, without regard to whether the family resided in the alliance area during the entire year.

(b) PROVISION OF INFORMATION IN THE CASE OF CHANGE OF RESIDENCE.—In the case of a family that moves from one alliance area to another alliance area during a year, each regional alliance (other than the final alliance) is responsible for providing to the final alliance (through the national information system under section 5101 or otherwise) such information as the final alliance may require in order to determine the liability (and reductions in liability under section 6112) attributable to alliance credits provided by such regional alliance.

(c) DISTRIBUTION OF PROCEEDS.—In accordance with rules established by the Secretary, in consultation with the Secretary of Labor, the final alliance shall provide for the distribution of amounts collected under this subpart with respect to families in a year in an equitable manner among the regional alliances that provided health plan coverage to the families in the year.

(d) EXPEDITING PROCESS.—In order to reduce paperwork and promote efficiency in the collection of amounts owed regional alliances under this subpart, the Secretary may require or permit regional alliances to share such information (through the national information system under section 5101 or otherwise) as the Secretary determines to be cost-effective, subject to such confidentiality restrictions as may otherwise apply.

(e) STUDENTS.—In the case of a qualifying student who makes an election described in section 1012(e)(2)) (relating to certain full-time students who are covered under the plan of a parent but enrolled in a health plan offered by a different regional alliance from the one in which the parent is enrolled), the regional alliance that offered the plan to the parent shall provide for transfers of an appropriate portion of the premium (determined in accordance with procedures specified by the Board) to the other regional alliance in order to compensate that alliance for the provision of such coverage.

(f) PAYMENTS OF CERTAIN AMOUNTS TO CORPORATE ALLIANCES.—In the case of a married couple in which one spouse is a qualifying employee of a regional alliance employer and the other spouse is a qualifying employee of a corporate alliance employer, if the couple is enrolled with a corporate alliance health plan the regional alliance (which receives employer premium payments from such regional alliance employer with respect to such employee) shall pay to the corporate alliance the amounts so paid (or would be payable by the employer if section 6123 did not apply).

Subpart B—Payments

SEC. 1351. PAYMENT TO REGIONAL ALLIANCE HEALTH PLANS.

(a) COMPUTATION OF BLENDED PLAN PER CAPITA PAYMENT AMOUNT.—For purposes of making payments to plans under this section, each regional alliance shall compute, under section 6201(a), a blended plan per capita payment amount for each regional alliance health plan for enrollment in the alliance for a year.

(b) AMOUNT OF PAYMENT TO PLANS.—

(1) IN GENERAL.—Subject to subsection (e) and section 6121(b)(5)(B), each regional alliance shall provide for payment to each regional alliance health plan, in which an alliance eligible individual is enrolled, an amount equal to the net blended rate (described in paragraph (2)) adjusted (consistent with subsection (c)) to take into account the relative actuarial risk associated with the coverage with respect to the individual.

(2) NET BLENDED RATE.—The net blended rate described in this paragraph is the blended plan per capita payment amount (determined under section 6201(a)), reduced by—

(A) the consolidated set aside percentage specified under subsection (d), and

(B) any plan payment reduction imposed under section 6011 for the plan for the year.

(c) APPLICATION OF RISK ADJUSTMENT AND REINSURANCE METHODOLOGY.—Each regional alliance shall use the risk adjustment methodology developed under section 1541 in making payments to regional alliance health plans under this section, except as provided in section 1542.

(d) CONSOLIDATED SET ASIDE PERCENTAGE.—The consolidated set aside percentage, for a regional alliance for a year, is the sum of—

(1) the administrative allowance percentage for the regional alliance, computed by the alliance under section 1352(b); and

(2) 1.5 percentage points.

Amounts attributable to paragraph (2) are paid to the Federal Government (for academic health centers and graduate medical education) under section 1353.

(e) TREATMENT OF VETERANS, MILITARY, AND INDIAN HEALTH PLANS AND PROGRAMS.—

(1) VETERANS HEALTH PLAN.—In applying this subtitle (and title VI) in the case of a regional alliance health plan that is a veterans health plan of the Department of Veterans Affairs, the following rules apply:

(A) For purposes of applying subtitle A of title VI, families enrolled under the plan shall not be taken into account.

(B) The provisions of subtitle A of title VI shall not apply to the plan, other than such provisions as require the plan to submit a per capita amount for each regional alliance area on a timely basis, which amount shall be treated as the final accepted bid of the plan for the area for purposes of subtitle B of such title and this section. This amount shall not be subject to negotiation and not subject to reduction under section 6011.

(C) For purposes of computing the blended plan per capita payment amount under this section, the AFDC and SSI proportions (under section 6202(a)) are deemed to be 0 percent.

(2) UNIFORMED SERVICES HEALTH PLAN.—In applying this subtitle (and title VI) in the case of a regional alliance health plan that is a Uniformed Services Health Plan of the Department of Defense, the following rules apply:

(A) For purposes of applying subtitle A of title VI, families enrolled under the plan shall not be taken into account.

(B) The provisions of subtitle A of title VI shall not apply to the plan, other than such provisions as require the plan to submit a per capita amount on a timely basis, which amount shall be treated as the final accepted bid of the plan for the area involved for purposes of subtitle B of such title and this section. This amount shall not be subject to negotiation and not subject to reduction under section 6011. The Board, in consultation with the Secretary of Defense, shall establish rules relating to the area (or areas) in which such a bid shall apply.

(C) For purposes of computing the blended plan per capita payment amount under this section, the AFDC and SSI proportions (under section 6202(a)) are deemed to be 0 percent.

(3) INDIAN HEALTH PROGRAMS.—In applying this subtitle (and title VI) in the case of a health program of the Indian Health Service, the following rules apply:

(A) Except as provided in this paragraph, the plan shall not be considered or treated to be a regional alliance health plan and for purposes of applying title VI, families enrolled under the program shall not be taken into account.

(B) In accordance with rules established by the Secretary, regional alliances shall act as agents for the collection of employer premium payments (including payments of corporate alliance employers) required under subtitle B of title VI with respect to qualifying employees who are enrolled under a health program of the Indian Health Service. The Secretary shall permit such alliances to retain a nominal fee to compensate them for such collection activities. In applying this subparagraph, the family share of premium for such employees is deemed to be zero for electing Indians (as defined in section 1012(d)(3)) and for other employees is the amount of the premium established under section 8306(b)(4)(A), employees are deemed to be residing in the area of residence (or area of employment), as specified under rules of the Secretary, and the class of enrollment shall be such class (or classes) as specified under rules of the Secretary.

SEC. 1352. ALLIANCE ADMINISTRATIVE ALLOWANCE PERCENTAGE.

(a) SPECIFICATION BY ALLIANCE.—Before obtaining bids under 6004 from health plans for a year, each regional alliance shall establish the administrative allowance for the operation of regional alliance in the year.

(b) ADMINISTRATIVE ALLOWANCE PERCENTAGE.—Subject to subsection (c), the regional alliance shall compute an administrative allowance percentage for each year equal to—

(1) the administrative allowance determined under subsection (a) for the year, divided by

(2) the total of the amounts payable to regional alliance health plans under section 1343 (as estimated by the alliance and determined without regard to section 1343(d)).

(c) LIMITATION TO 2½ PERCENT.—In no case shall an administrative allowance percentage exceed 2.5 percent.

SEC. 1353. PAYMENTS TO THE FEDERAL GOVERNMENT FOR ACADEMIC HEALTH CENTERS AND GRADUATE MEDICAL EDUCATION.

Each regional alliance shall make payment to the Secretary each year of an amount equal to the reduction in payments by the alliance to regional alliance health plans resulting from the consolidated set aside percentage under section 1351(d) including the 1.5 percentage points under paragraph (2) of such section.

Subpart C—Financial Management

SEC. 1361. MANAGEMENT OF FINANCES AND RECORDS.

(a) IN GENERAL.—Each regional alliance shall comply with standards established under section 1571(b) (relating to the management of finances, maintenance of records, accounting practices, auditing procedures, and financial reporting) and under section 1591(d) (relating to employer payments).

(b) SPECIFIC PROVISIONS.—In accordance with such standards—

(1) FINANCIAL STATEMENTS.—

(A) IN GENERAL.—Each regional alliance shall publish periodic audited financial statements.

(B) ANNUAL FINANCIAL AUDIT.—

(i) IN GENERAL.—Each regional alliance shall have an annual financial audit conducted by an independent auditor in accordance with generally accepted auditing standards.

(ii) PUBLICATION.—A report on each such audit shall be made available to the public at nominal cost.

(iii) REQUIRED ACTIONS FOR DEFICIENCIES.—If the report from such an audit does not bear an unqualified opinion, the alliance shall take such steps on a timely basis as may be necessary to correct any material deficiency identified in the report.

(C) ELIGIBILITY ERROR RATES.—Each regional alliance shall make eligibility determinations for premium discounts, liability reductions, and cost sharing reductions under sections 6104 and 6123, section 6113, and section 1371, respectively, in a manner that maintains the error rates below an applicable maximum permissible error rate specified by the Secretary (or the Secretary of

Labor with respect to section 6123). In specifying such a rate, the Secretary shall take into account maximum permissible error rates recognized by the Federal Government under comparable State-administered programs.

(2) SAFEGUARDING OF FUNDS.—Each regional alliance shall safeguard family, employer, State, and Federal government payments to the alliance in accordance with fiduciary standards and shall hold such payments in financial institutions and instruments that meet standards recognized or established by the Secretary, in consultation with the Secretaries of Labor and the Treasury and taking into account current Federal laws and regulations relating to fiduciary responsibilities and financial management of public funds.

(3) CONTINGENCIES.—Each regional alliance shall provide that any surplus of funds resulting from an estimation discrepancy described in section 9201(b)(1)(D), up to a reasonable amount specified by the Secretary, shall be held in a contingency fund established by the alliance and used to fund any future shortfalls resulting from such a discrepancy.

(4) AUDITING OF EMPLOYER PAYMENTS.—

(A) IN GENERAL.—Each regional alliance is responsible for auditing the records of regional alliance employers to assure that employer payments (including the payment of amounts withheld) were made in the appropriate amount as provided under subpart A of part 2 of subtitle B of title VI.

(B) EMPLOYERS WITH EMPLOYEES RESIDING IN DIFFERENT ALLIANCE AREAS.—In the case of a regional alliance employer which has employees who reside in more than one alliance area, the Secretary of Labor, in consultation with the Secretary, shall establish a process for the coordination of regional alliance auditing activities among the regional alliances involved.

(C) APPEAL.—In the case of an audit conducted by a regional alliance on an employer under this paragraph, an employer or other regional alliance that is aggrieved by the determination in the audit is entitled to review of such audit by the Secretary of Labor in a manner to be provided by such Secretary.

Subpart D—Reductions in Cost Sharing; Income Determinations

SEC. 1371. REDUCTION IN COST SHARING FOR LOW-INCOME FAMILIES.

(a) REDUCTION.—

(1) IN GENERAL.—Subject to subsection (b), in the case of a family that is enrolled in a regional alliance health plan and that is either (A) an AFDC or SSI family or (B) is determined under this subpart to have family adjusted income below 150 percent of the applicable poverty level, the family is entitled to a reduction in cost sharing in accordance with this section.

(2) TIMING OF REDUCTION.—The reduction in cost sharing shall only apply to items and services furnished after the date the application for such reduction is approved under section 1372(c) and before the date of termination of the reduction under this subpart, or, in the case of an AFDC or SSI family, during the period in which the family is such a family.

(3) INFORMATION TO PROVIDERS AND PLANS.—Each regional alliance shall provide, through electronic means and otherwise, health care providers and regional alliance health plans with access to such information as may be necessary in order to provide for the cost sharing reductions under this section.

(b) LIMITATION.—No reduction in cost sharing shall be available for families residing in an alliance area if the regional alliance for the area determines that there are sufficient low-cost plans (as defined in section 6104(b)(3)) that are lower or combination cost sharing plans available in the alliance area to enroll AFDC and SSI families and families with family adjusted income below 150 percent of the applicable poverty level.

(c) AMOUNT OF COST SHARING REDUCTION.—

(1) IN GENERAL.—Subject to paragraph (2), the reduction in cost sharing under this section shall be such reduction as will reduce cost sharing to the level of a lower or combination cost sharing plan.

(2) ADDITIONAL REDUCTION FOR AFDC AND SSI FAMILIES.—In the case of an AFDC or SSI family, in applying paragraph (1) (other than with respect to hospital emergency room services for which there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act) there shall be substituted, for $5, $10, $20, and $25 in the table in section 1135(a), 20 percent of such respective amounts. The dollar amounts substituted by the previous sentence shall be subject to adjustment in the same manner under section 1136 as the dollar amounts otherwise specified in such section.

(d) ADMINISTRATION.—

(1) IN GENERAL.—In the case of an approved family (as defined in section 1372(b)(3)) enrolled in a regional alliance health plan, the regional alliance shall pay the plan for cost sharing reductions (other than cost sharing reductions under subsection (c)(2)) provided under this section and included in payments made by the plan to its providers.

(2) ESTIMATED PAYMENTS, SUBJECT TO RECONCILIATION.—Such payment shall be made initially on the basis of reasonable estimates of cost sharing reductions incurred by such a plan with respect to approved families and shall be reconciled not less often than quarterly based on actual claims for items and services provided.

(e) NO COST SHARING FOR INDIANS AND CERTAIN VETERANS AND MILITARY PERSONNEL.—The provisions of section 6104(a)(3) shall apply to cost sharing reductions under this section in the same manner as such provisions apply to premium discounts under section 6104.

SEC. 1372. APPLICATION PROCESS FOR COST SHARING REDUCTIONS.

(a) APPLICATION.—

(1) IN GENERAL.—A regional alliance eligible family may apply for a determination of the family adjusted income of the family, for the purpose of establishing eligibility for cost sharing reductions under section 1371.

(2) FORM.—An application under this section shall include such information as may be determined by the regional alliance (consistent with rules developed by the Secretary) and shall include at least information about the family's employment status and income.

(b) TIMING.—

(1) IN GENERAL.—An application under this section may be filed at such times as the Secretary may provide, including during any open enrollment period, at the time of a move, or after a change in life circumstances (such as unemployment or divorce) affecting class of enrollment or amount of family share or repayment amount.

(2) CONSIDERATION.—Each regional alliance shall approve or disapprove an application under this section, and notify the applicant of such decision, within such period (specified by the Secretary) after the date of the filing of the application.

(3) APPROVED FAMILY DEFINED.—In this section and section 1371, the term "approved family" means a family for which an application under this section is approved, until the date of termination of such approval under this section.

(c) APPROVAL OF APPLICATION.—

(1) IN GENERAL.—A regional alliance shall approve an application of a family under this section filed in a month if the application demonstrates that that family adjusted income of the family (as defined in subsection (d) and determined under paragraph (2)) is (or is expected to be) less than 150 percent of the applicable poverty level.

(2) USE OF CURRENT INCOME.—In making the determination under paragraph (1), a regional alliance shall take into account the income for the previous 3-month period and current wages from employment (if any), consistent with rules specified by the Secretary.

(d) FAMILY ADJUSTED INCOME.—

(1) IN GENERAL.—Except as provided in paragraph (4), in this Act the term "family adjusted income" means, with respect to a family, the sum of the adjusted incomes (as defined in paragraph (2)) for all members of the family (determined without regard to section 1012).

(2) ADJUSTED INCOME.—In paragraph (1), the term "adjusted income" means, with respect to an individual, adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

(A) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

(B) increased by the amount of interest received or accrued by the individual which is exempt from tax.

(3) PRESENCE OF ADDITIONAL DEPENDENTS.—At the option of an individual, a family may include (and not be required to separate out) the income of other individuals who are claimed as dependents of the family for income tax purposes, but such individuals shall not be counted as part of the family for purposes of determining the size of the family.

(e) REQUIREMENT FOR PERIODIC CONFIRMATION AND VERIFICATION AND NOTICES.—

(1) CONFIRMATION AND VERIFICATION REQUIREMENT.—The continued eligibility of a family for cost sharing reductions under this section is conditioned upon the family's eligibility being—

(A) confirmed periodically by the regional alliance, and

(B) verified (through the filing of a new application under this section) by the regional alliance at the time income reconciliation statements are required to be filed under section 1375.

(2) RULES.—The Secretary shall issue rules related to the manner in which alliances confirm and verify eligibility under this section.

(3) NOTICES OF CHANGES IN INCOME AND EMPLOYMENT STATUS.—

(A) IN GENERAL.—Each approved family shall promptly notify the regional alliance of any material increase in the family adjusted income (as defined by the Secretary).

(B) RESPONSE.—If a regional alliance receives notice under subparagraph (A) (or from an employer under section 1602(b)(3)(A)(i)) or otherwise receives information indicating a potential significant change in the family's employment status or increase in adjusted family income, the regional alliance shall promptly take steps necessary to reconfirm the family's eligibility.

(f) TERMINATION OF COST SHARING REDUCTION.—The regional alliance shall, after notice to the family, terminate the reduction of cost sharing under this subpart for an approved family if the family fails to provide

for confirmation or verification or notice required under subsection (c) on a timely basis or the alliance otherwise determines that the family is no longer eligible for such reduction. The previous sentence shall not prevent the family from subsequently reapplying for cost sharing reduction under this section.

(g) TREATMENT OF AFDC AND SSI RECIPIENTS.—

(1) NO APPLICATION REQUIRED.—AFDC and SSI families are not required to make an application under this section.

(2) NOTICE REQUIREMENT.—Each State (and the Secretary) shall notify each regional alliance, in a manner specified by the Secretary, of the identity (and period of eligibility under the AFDC or SSI programs) of each AFDC and SSI recipient, unless such a recipient elects (in a manner specified by the Secretary) not to accept the reduction of cost sharing under this section.

SEC. 1373. APPLICATION FOR PREMIUM REDUCTIONS AND REDUCTION IN LIABILITIES TO ALLIANCES.

(a) IN GENERAL.—Any regional alliance eligible family may apply for a determination of the family adjusted income of the family, for the purpose of establishing eligibility for a premium discount under section 6104 or a reduction in liability under section 6113.

(b) TIMING.—Such an application may be filed at such times as an application for a cost sharing reduction may be filed under section 1372(b) and also may be filed after the end of the year to obtain a rebate for excess premium payments made during a year.

(c) APPROVAL OF APPLICATION.—

(1) IN GENERAL.—A regional alliance shall approve an application of a family under this section filed in a month—

(A) for a premium discount under section 6104, if the application demonstrates that family adjusted income of the family (as determined under paragraph (2)) is (or is expected to be) less than 150 percent of the applicable poverty level, or

(B) for a reduction in liability under section 6113, if the application demonstrates that the wage-adjusted income (as defined in subsection 6113(d)) of the family (as determined under paragraph (2)) is (or is expected to be) less than 250 percent of the applicable poverty level.

(2) USE OF CURRENT INCOME.—In making the determination under paragraph (1), a regional alliance shall take into account the income for the previous 3-month period and current wages from employment (if any) and the statement of estimated income for the year (filed under section 1374(c)), consistent with rules specified by the Secretary.

(d) REQUIREMENT FOR PERIODIC CONFIRMATION AND VERIFICATION AND NOTICES.—The provisions of section (e) of section 1372 shall apply under this section in the same manner as it applies under such section, except that any reference to family adjusted income is deemed a reference to wage-adjusted income.

SEC. 1374. GENERAL PROVISIONS RELATING TO APPLICATION PROCESS.

(a) DISTRIBUTION OF APPLICATIONS.—Each regional alliance shall distribute applications under this subpart directly to consumers and through employers, banks, and designated public agencies.

(b) TO WHOM APPLICATION MADE.—Applications under this subpart shall be filed, by person or mail, with a regional alliance or an agency designated by the State for this purpose. The application may be submitted with an application to enroll with a health plan under this subtitle or separately.

(c) INCOME STATEMENT.—Each application shall include a declaration of estimated annual income for the year involved.

(d) FORM AND CONTENTS.—An application for a discount or reduction under this subpart shall be in a form and manner specified by the Secretary and shall require the provision of information necessary to make the determinations required under this subpart.

(e) FREQUENCY OF APPLICATIONS.—

(1) IN GENERAL.—An application under this subpart may be filed at any time during the year (including, in the case of section 1373, during the reconciliation process).

(2) CORRECTION OF INCOME.—Nothing in paragraph (1) shall be construed as preventing an individual or family from, at any time, submitting an application to reduce the amount of premium reduction or reduction of liability under this subpart based upon an increase in income from that stated in the previous application.

(e) TIMING OF REDUCTIONS AND DISCOUNTS.—

(1) IN GENERAL.—Subject to reconciliation under section 1375, premium discounts and cost sharing reductions under this subpart shall be applied to premium payments required (and for expenses incurred) after the date of approval of the application under this subpart.

(2) AFDC AND SSI RECIPIENTS.—In the case of an AFDC or SSI family, in applying paragraph (1), the date of approval of benefits under the AFDC or SSI program shall be considered the date of approval of an application under this subpart.

(f) VERIFICATION.—The Secretary shall provide for verification, on a sample basis or other basis, of the information supplied in applications under this part. This verification shall be separate from the reconciliation provided under section 1375.

(g) HELP IN COMPLETING APPLICATIONS.—Each regional alliance shall assist individuals in the filing of applications and income reconciliation statements under this subpart.

(h) PENALTIES FOR INACCURATE INFORMATION.—

(1) INTEREST FOR UNDERSTATEMENTS.—Each individual who knowingly understates income reported in an application to a regional alliance under this subpart or otherwise makes a material misrepresentation of information in such an application shall be liable to the alliance for excess payments made based on such understatement or misrepresentation, and for interest on such excess payments at a rate specified by the Secretary.

(2) PENALTIES FOR MISREPRESENTATION.—In addition to the liability established under paragraph (1), each individual who knowingly misrepresents material information in an application under this subpart to a regional alliance shall be liable to the State in which the alliance is located for $2,000 or, if greater, three times the excess payments made based on such misrepresentation. The State shall provide for the transfer of a significant portion of such amount to the regional alliance involved.

SEC. 1375. END-OF-YEAR RECONCILIATION FOR PREMIUM DISCOUNT AND REPAYMENT REDUCTION WITH ACTUAL INCOME.

(a) IN GENERAL.—In the case of a family whose application for a premium discount or reduction of liability for a year has been approved before the end of the year under this subpart, the family shall, subject to subsection (c) and by the deadline specified in section 1344(b) file with the regional alliance an income reconciliation statement to verify the family's adjusted income or wage-adjusted income, as the case may be, for the previous year. Such a statement shall contain such information as the Secretary may specify. Each regional alliance shall coordinate the submission of such statements with the notice and payment of family payments due under section 1344.

(b) RECONCILIATION OF PREMIUM PREMIUM DISCOUNT AND LIABILITY ASSISTANCE BASED ON ACTUAL INCOME.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to a family, the regional alliance shall compute the amount of premium discount or reduction in liability that should have been provided under section 6104 or section 6113 with respect for the family for the year involved. If the amount of such discount or liability reduction computed is—

(1) greater than the amount that has been provided, the family is liable to the regional alliance to pay (directly or through an increase in future family share of premiums or other payments) a total amount equal to the amount of the excess payment, or

(2) less than the amount that has been provided, the regional alliance shall pay to the family (directly or through a reduction in future family share of premiums or other payments) a total amount equal to the amount of the deficit.

(c) NO RECONCILIATION FOR AFDC AND SSI FAMILIES; NO RECONCILIATION FOR COST SHARING REDUCTIONS.—No reconciliation statement is required under this section—

(1) with respect to cost sharing reductions provided under section 1372, or

(2) for a family that only claims a premium discount or liability reduction under this subpart on the basis of being an AFDC or SSI family.

(d) DISQUALIFICATION FOR FAILURE TO FILE.—In the case of any family that is required to file a statement under this section in a year and that fails to file such a statement by the deadline specified, members of the family shall not be eligible for premium reductions under section 6104 or reductions in liability under section 6113 until such statement is filed. A regional alliance, using rules established by the Secretary, shall waive the application of this subsection if the family establishes, to the satisfaction of the alliance under such rules, good cause for the failure to file the statement on a timely basis.

(e) PENALTIES FOR FALSE INFORMATION.—Any individual that provides false information in a statement under subsection (a) is subject to the same liabilities as are provided under section 1374(h) for a misrepresentation of material fact described in such section.

(f) NOTICE OF REQUIREMENT.—Each regional alliance (directly or in coordination with other regional alliances) shall provide for written notice, at the end of each year, of the requirement of this section to each family which had received premium discount or reduction in liability under this subpart in any month during the preceding year and to which such requirement applies.

(g) TRANSMITTAL OF INFORMATION; VERIFICATION.—

(1) IN GENERAL.—Each participating State shall transmit annually to the Secretary such information relating to the income of families for the previous year as the Secretary may require to verify such income under this subpart.

(2) VERIFICATION.—Each participating State may use such information as it has available to it to assist regional alliances in verifying income of families with applications filed under this subpart. The Secretary of the Treasury may, consistent with section 6103 of the Internal Revenue Code of 1986,

permit return information to be disclosed and used by a participating State in verifying such income but only in accordance with such section and only if the information is not directly disclosed to a regional alliance.

(h) CONSTRUCTION.—Nothing in this section shall be construed as authorizing reconciliation of any cost sharing reduction provided under this subpart.

PART 4—RESPONSIBILITIES AND AUTHORITIES OF CORPORATE ALLIANCES

SEC. 1381. CONTRACTS WITH HEALTH PLANS.

(a) CONTRACTS WITH PLANS.—Subject to section 1382, each corporate alliance may—

(1) offer to individuals eligible to enroll under section 1311(c) coverage under an appropriate self-insured health plan (as defined in section 1400(b)), or

(2) negotiate with a State-certified health plan to enter into a contract with the plan for the enrollment of such individuals under the plan,

or do both.

(b) TERMS OF CONTRACTS WITH STATE-CERTIFIED HEALTH PLANS.—Contracts under this section between a corporate alliance and a State-certified health plan may contain such provisions (not inconsistent with the requirements of this title) as the alliance and plan may provide, except that in no case does such contract remove the obligation of the sponsor of the corporate alliance to provide for health benefits to corporate alliance eligible individuals consistent with this part.

SEC. 1382. OFFERING CHOICE OF HEALTH PLANS FOR ENROLLMENT.

(a) IN GENERAL.—Each corporate alliance must provide to each eligible enrollee with respect to the alliance a choice of health plans among the plans which have contracts with the alliance under section 1381.

(b) OFFERING OF PLANS BY ALLIANCES.—A corporate alliance shall include among its health plan offerings for any eligible enrollee at least 3 health plans to enrollees, of which the alliance must offer—

(1) at least one fee-for-service plan (as defined in section 1322(b)(3)); and

(2) at least two health plans that are not fee-for-service plans.

SEC. 1383. ENROLLMENT; ISSUANCE OF HEALTH SECURITY CARD.

(a) IN GENERAL.—

(1) ENROLLMENT OF ALLIANCE ELIGIBLE INDIVIDUALS.—Each corporate alliance shall assure that each alliance eligible individual with respect to the alliance is enrolled in a corporate alliance health plan offered by the alliance, and shall establish and maintain methods and procedures consistent with this section sufficient to assure such enrollment. Such methods and procedures shall assure the enrollment of such individuals at the time they first become alliance eligible individuals with respect to the alliance.

(2) ISSUANCE OF HEALTH SECURITY CARDS.—A corporate alliance is responsible for the issuance of health security cards to corporate alliance eligible individuals under section 1001(b).

(b) RESPONSE TO POINT-OF-SERVICE NOTICES.—If a corporate alliance is notified under section 1323(b)(2) regarding an individual who has received services and appears to be an alliance eligible individual—

(1) the alliance shall promptly ascertain the individual's eligibility as an alliance eligible individual; and

(2) if the alliance determines that the individual is an alliance eligible individual—

(A) the alliance shall promptly provide for the enrollment of the individual in a health plan offered by the alliance (and notify the Secretary of Labor of such enrollment), and

(B) the alliance shall forward the claim for payment for the services to the health plan in which the individual is so enrolled and the plan shall make payment to the provider for such claim (in a manner consistent with requirements of the Secretary of Labor).

(c) ANNUAL OPEN ENROLLMENT; ENROLLMENT OF FAMILY MEMBERS; OVERSUBSCRIPTION OF PLANS.—The provisions of subsections (d) through (f) of section 1323 shall apply to a corporate alliance in the same manner as such provisions apply to a regional alliance.

(d) TERMINATION.—

(1) IN GENERAL.—The provisions of section 1323(g)(1) shall apply to a corporate alliance in the same manner as such provisions apply to a regional alliance.

(2) FAILURE TO PAY PREMIUMS.—If a corporate alliance fails to make premium payments to a health plan, the plan, after reasonable written notice to the alliance and the Secretary of Labor, may terminate coverage (and any contract with the alliance under this subpart). If such coverage is terminated the corporate alliance is responsible for the prompt enrollment of alliance eligible individuals whose coverage is terminated in another corporate alliance health plan.

(e) CORPORATE ALLIANCE TRANSITION.—Each corporate alliance must provide coverage—

(1) as of the first day of any month in which an individual first becomes a corporate alliance eligible individual, and

(2) through the end of the month in the case of a corporate alliance eligible individual who loses such eligibility during the month.

SEC. 1384. COMMUNITY-RATED PREMIUMS WITHIN PREMIUM AREAS.

(a) APPLICATION OF COMMUNITY-RATED PREMIUMS.—The premiums charged by a corporate alliance for enrollment in a corporate alliance health plan (not taking into account any employer premium payment required under section 6131) shall vary only by class of family enrollment (specified in section 1011(c)) and by premium area.

(b) DESIGNATION OF PREMIUM AREAS.—

(1) DESIGNATION.—Each corporate alliance shall designate premium areas to be used for the imposition of premiums (and calculation of employer premium payments) under this Act.

(2) CONDITIONS.—The boundaries of such areas shall reasonably reflect labor market areas or health care delivery areas and shall be consistent with rules the Secretary of Labor establishes (consistent with paragraph (3)) so that within such areas there are not substantial differences in average per capita health care expenditures.

(3) ANTI-REDLINING.—The provisions of paragraphs (4) and (5) of section 1202(b) (relating to redlining and metropolitan statistical areas) shall apply to the establishment of premium areas in the same manner as they apply to the establishment of the boundaries of regional alliance areas.

(c) APPLICATIONS OF CLASSES OF ENROLLMENT.—

(1) IN GENERAL.—The premiums shall be applied under this section based on class of family enrollment and shall vary based on such class in accordance with factors specified by the corporate alliance.

(2) BASIS FOR FACTORS.—Such factors shall be the same in each premium and shall take into account such appropriate considerations (including the considerations the Board takes into account in the establishment of premium class factors under section 1531 and the costs of regional alliance health plans providing the comprehensive benefit package for families enrolled in the different classes) as the alliance considers appropriate, consistent with rules the Secretary of Labor establishes.

(d) SPECIAL TREATMENT OF MULTIEMPLOYER ALLIANCES.—The Secretary of Labor shall provide for such exceptions to the requirements of this section in the case of a corporate alliance with a sponsor described in section 1311(b)(1)(B) as may be appropriate to reflect the unique and historical relationship between the employers and employees under such alliances.

SEC. 1385. ASSISTANCE FOR LOW-WAGE FAMILIES.

Each corporate alliance shall make an additional contribution towards the enrollment in health plans of the alliance by certain low-wage families in accordance with section 6131(b)(2).

SEC. 1386. CONSUMER INFORMATION AND MARKETING; DATA COLLECTION AND QUALITY; ADDITIONAL DUTIES.

The provisions of sections 1325(a), 1327(a), 1328(a), and 1328(b) shall apply to a corporate alliance in the same manner as such provisions apply to a regional alliance.

SEC. 1387. PLAN AND INFORMATION REQUIREMENTS.

(a) IN GENERAL.—A corporate alliance shall provide a written submission to the Secretary of Labor (in such form as the Secretary may require) detailing how the corporate alliance will carry out its activities under this part.

(b) ANNUAL INFORMATION.—A corporate alliance shall provide to the Secretary of Labor each year, in such form and manner as the Secretary may require, such information as the Secretary may require in order to monitor the compliance of the alliance with the requirements of this part.

(c) ANNUAL NOTICE OF EMPLOYEES OR PARTICIPANTS.—

(1) CORPORATE ALLIANCE.—Each corporate alliance shall submit to the Secretary of Labor, by not later than March 1 of each year, information on the number of full-time employees or participants obtaining coverage through the alliance as of January 1 of that year.

(2) EMPLOYERS THAT BECOME LARGE EMPLOYERS.—Each employer that is not a corporate alliance but employs 5,000 full-time employees as of January 1 of a year, shall submit to the Secretary of Labor, by not later than March 1 of the year, information on the number of such employees.

SEC. 1388. MANAGEMENT OF FUNDS; RELATIONS WITH EMPLOYEES.

(a) MANAGEMENT OF FUNDS.—The management of funds by a corporate alliance shall be subject to the applicable fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, together with the applicable enforcement provisions of part 5 of subtitle B of title I of such Act.

(b) MANAGEMENT OF FINANCES AND RECORDS; ACCOUNTING SYSTEM.—Each corporate alliance shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify.

SEC. 1389. COST CONTROL.

Each corporate alliance shall control covered expenditures in a manner that meets the requirements of part 2 of subtitle A of title VI.

SEC. 1390. PAYMENTS BY CORPORATE ALLIANCE EMPLOYERS TO CORPORATE ALLIANCES.

(a) LARGE EMPLOYER ALLIANCES.—In the case of a corporate alliance with a sponsor

described in section 1311(b)(1)(A), the sponsor shall provide for the funding of benefits, through insurance or otherwise, consistent with section 6131, the applicable solvency requirements of sections 1395 and 1396, and any rules established by the Secretary of Labor.

(b) OTHER ALLIANCES.—In the case of a corporate alliance with a sponsor described in subparagraph (B) or (C) of section 1311(b)(1), a corporate alliance employer shall make payment of the employer premiums required under section 6131 under rules established by the corporate alliance, which rules shall be consistent with rules established by the Secretary of Labor.

SEC. 1391. COORDINATION OF PAYMENTS.

(a) PAYMENTS OF CERTAIN AMOUNTS TO REGIONAL ALLIANCES.—In the case of a married couple in which one spouse is a qualifying employee of a regional alliance employer and the other spouse is a qualifying employee of a corporate alliance employer, if the couple is enrolled with a regional alliance health plan the corporate alliance (which receives employer premium payments from such corporate alliance employer with respect to such employee) shall pay to the regional alliance the amounts so paid.

(b) PAYMENTS OF CERTAIN AMOUNTS TO CORPORATE ALLIANCES.—In the case of a married couple in which one spouse is a qualifying employee of a corporate alliance employer and the other spouse is a qualifying employee of another corporate alliance employer, the corporate alliance of the corporate alliance health plan in which the couple is not enrolled shall pay to the corporate alliance of the plan in which the couple is enrolled any employer premium payments received from such corporate alliance employer with respect to such employee.

SEC. 1392. APPLICABILITY OF ERISA ENFORCEMENT MECHANISMS FOR ENFORCEMENT OF CERTAIN REQUIREMENTS.

The provisions of sections 502 (relating to civil enforcement) and 504 (relating to investigative authority) of the Employee Retirement Income Security Act of 1974 shall apply to enforcement by the Secretary of Labor of this part in the same manner and to same extent as such provisions apply to enforcement of title I of such Act.

SEC. 1393. APPLICABILITY OF CERTAIN ERISA PROTECTIONS TO ENROLLED INDIVIDUALS.

The provisions of sections 510 (relating to interference with rights protected under Act) and 511 (relating to coercive interference) of the Employee Retirement Income Security Act of 1974 shall apply, in relation to the provisions of this Act, with respect to individuals enrolled under corporate alliance health plans in the same manner and to the same extent as such provisions apply, in relation to the provisions of the Employee Retirement Income Security Act of 1974, with respect to participants and beneficiaries under employee welfare benefit plans covered by title I of such Act.

SEC. 1394. DISCLOSURE AND RESERVE REQUIREMENTS.

(a) IN GENERAL.—The Secretary of Labor shall ensure that each corporate alliance health plan which is a self-insured plan maintains plan assets in trust as provided in section 403 of the Employee Retirement Income Security Act of 1974—

(1) without any exemption under section 403(b)(4) of such Act, and

(2) in amounts which the Secretary determines are sufficient to provide at any time for payment to health care providers of all outstanding balances owed by the plan at such time.

The requirements of the preceding sentence may be met through letters of credit, bonds, or other appropriate security to the extent provided in regulations of the Secretary.

(b) DISCLOSURE.—Each self-insured corporate alliance health plan shall notify the Secretary at such time as the financial reserve requirements of this section are not being met. The Secretary may assess a civil money penalty of not more than $100,000 against any corporate alliance for any failure to provide such notification in such form and manner and within such time periods as the Secretary may prescribe by regulation.

SEC. 1395. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT CORPORATE ALLIANCE HEALTH PLANS.

(d) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary of Labor determines that a corporate alliance health plan which is a self-insured plan will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of the Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint the Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the covered individuals or health care providers or to avoid any unreasonable deterioration of the financial condition of the plan or any unreasonable increase in the liability of the Corporate Alliance Insolvency Fund. The trusteeship of the Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

(b) POWERS AS TRUSTEE.—The Secretary of Labor, upon appointment as trustee under subsection (a), shall have the power—

(1) to do any act authorized by the plan, this Act, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

(4) to do such other acts as the Secretary deems necessary to continue operation of the plan without increasing the potential liability of the Corporate Alliance Insolvency Fund, if such acts may be done under the provisions of the plan,

(5) to require the corporate alliance, the plan administrator, any contributing employer, and any employee organization representing covered individuals to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

(6) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

(7) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

(8) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

(9) to terminate the plan and liquidate the plan assets in accordance with applicable provisions of this Act and other provisions of law, to restore the plan to the responsibility of the corporate alliance, or to continue the trusteeship,

(10) to provide for the enrollment of individuals covered under the plan in an appropriate regional alliance health plan, and

(11) to do such other acts as may be necessary to comply with this Act or any order of the court and to protect the interests of enrolled individuals and health care providers.

(b) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

(1) the plan administrator,

(2) each enrolled individual,

(3) each employer who may be liable for contributions to the plan, and

(4) each employee organization which, for purposes of collective bargaining, represents enrolled individuals.

(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this Act or part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or as may be otherwise ordered by the court, the Secretary of Labor, upon appointment as trustee under this subsection, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of such part 4.

(e) OTHER PROCEEDINGS.—An application by the Secretary of Labor under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(f) JURISDICTION OF COURT.—

(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this subsection, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this subsection, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under paragraph (1) such court shall stay, and upon appointment by it of the Secretary of Labor as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsoring alliance, or property of such plan or alliance, and any other suit against any receiver, conservator, or trustee of the plan, the sponsoring alliance, or property of the plan or alliance. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsoring alliance or any other suit against the plan or the alliance.

(2) VENUE.—An action under this subsection may be brought in the judicial district where the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

(g) PERSONNEL.—In accordance with regulations of the Secretary of Labor, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary

in connection with the Secretary's service as trustee under this subsection.

SEC. 1396. GUARANTEED BENEFITS UNDER TRUSTEESHIP OF THE SECRETARY.

(a) IN GENERAL.—Subject to subsection (b), the Secretary shall guarantee the payment of all benefits under a corporate alliance health plan which is a self-insured plan while such plan is under the Secretary's trusteeship under section 1396.

(b) LIMITATIONS.—Any increase in the amount of benefits under the plan resulting from a plan amendment which was made, or became effective, whichever is later, within 180 days (or such other reasonable time as may be prescribed in regulations of the Secretary of Labor) before the date of the Secretary's appointment as trustee of the plan shall be disregarded for purposes of determining the guarantee under this section.

(c) CORPORATE ALLIANCE HEALTH PLAN INSOLVENCY FUND.—

(1) ESTABLISHMENT.—The Secretary of Labor shall establish a Corporate Alliance Health Plan Insolvency Fund (hereinafter in this section referred to as the "Fund") from which the Secretary shall make payment of all guaranteed benefits under this section.

(2) RECEIPTS AND DISBURSEMENTS.—

(A) RECEIPTS.—The Fund shall be credited with—

(i) funds borrowed under paragraph (4),

(ii) assessments collected under section 1397, and

(iii) earnings on investment of the fund.

(B) DISBURSEMENTS.—The Fund shall be available—

(i) for making such payments as the Secretary determines are necessary to pay benefits guaranteed under this section,

(ii) to repay the Secretary of the Treasury such sums as may be borrowed (together with interest thereon) under paragraph (4), and

(iii) to pay the operational and administrative expenses of the Fund.

(3) BORROWING AUTHORITY.—At the direction of the Secretary of Labor, the Fund may, to the extent necessary to carry out the purposes of paragraph (1), issue to the Secretary of the Treasury notes or other obligations, in such forms and denominations, bearing such maturities, and subject to such terms and conditions as may be prescribed by the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of such notes or other obligations by the Fund. The Secretary of the Treasury shall purchase any notes or other obligations issued by the Fund under this paragraph, and for that purpose the Secretary of the Treasury may use as a public debt transaction the proceeds from the sale of any securities issued under chapter 31 of title 31, United States Code and the purposes for which securities may be issued under such chapter are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by such Secretary under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States.

(4) INVESTMENT AUTHORITY.—Whenever the Secretary of Labor determines that the moneys of the Fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States, but, until all borrowings under paragraph (4) have been repaid, the obligations in which such excess moneys are invested may not yield a rate of return in excess of the rate of interest payable on such borrowings.

SEC. 1397. IMPOSITION AND COLLECTION OF PERIODIC ASSESSMENTS ON SELF-INSURED CORPORATE ALLIANCE PLANS.

(a) IMPOSITION OF ASSESSMENTS.—Upon a determination that additional receipts to the Fund are necessary in order to enable the Fund to repay amounts borrowed by the Fund under section 1396(c)(3) while maintaining a balance sufficient to ensure the solvency of the Fund, the Secretary may impose assessments under this section. The Secretary shall prescribe from time to time such schedules of assessment rates and bases for the application of such rates as may be necessary to provide for such repayments.

(b) UNIFORMITY OF ASSESSMENTS.—The assessment rates prescribed by the Secretary for any period shall be uniform for all plans, except that the Secretary may vary the amount of such assessments by category, or waive the application of such assessments by category, taking into account differences in the financial solvency of, and financial reserves maintained by, plans in each category.

(c) LIMITATION ON AMOUNT OF ASSESSMENT.—The total amount assessed against a corporate alliance health plan under this section during a year may not exceed 2 percent of the total premiums paid to the plan with respect to corporate alliance eligible individuals enrolled with the plan during the year.

(d) PAYMENT OF ASSESSMENTS.—

(1) OBLIGATION TO PAY.—The designated payor of each plan shall pay the assessments imposed by the Secretary of Labor under this section with respect to that plan when they are due. Assessments under this section are payable at the time, and on an estimated, advance, or other basis, as determined by the Secretary. Assessments shall continue to accrue until the plan's assets are distributed pursuant to a termination procedure or the Secretary is appointed to serve as trustee of the plan under section 1395.

(2) LATE PAYMENT CHARGES AND INTEREST.—

(A) LATE PAYMENT CHARGES.—If any assessment is not paid when it is due, the Secretary may assess a late payment charge of not more than 100 percent of the assessment payment which was not timely paid.

(B) WAIVERS.—Subparagraph (A) shall not apply to any assessment payment made within 60 days after the date on which payment is due, if before such date, the designated payor obtains a waiver from the Secretary of Labor based upon a showing of substantial hardship arising from the timely payment of the assessment. The Secretary may grant a waiver under this subparagraph upon application made by the designated payor, but the Secretary may not grant a waiver if it appears that the designated payor will be unable to pay the assessment within 60 days after the date on which it is due.

(C) INTEREST.—If any assessment is not paid by the last date prescribed for a payment, interest on the amount of such assessment at the rate imposed under section 6601(a) of the Internal Revenue Code of 1986 shall be paid for the period from such last date to the date paid.

(e) CIVIL ACTION UPON NONPAYMENT.—If any designated payor fails to pay an assessment when due, the Secretary of Labor may bring a civil action in any district court of the United States within the jurisdiction of which the plan assets are located, the plan is administered, or in which a defendant resides or is found, for the recovery of the amount of the unpaid assessment, any late payment charge, and interest, and process may be served in any other district. The district courts of the United States shall have jurisdiction over actions brought under this subsection by the Secretary without regard to the amount in controversy.

(f) GUARANTEE HELD HARMLESS.—The Secretary of Labor shall not cease to guarantee benefits on account of the failure of a designated payor to pay any assessment when due.

(g) DESIGNATED PAYOR DEFINED.—

(1) IN GENERAL.—For purposes of this section, the term "designated payor" means—

(A) the employer or plan administrator in any case in which the eligible sponsor of the corporate alliance health plan is described in subparagraph (A) or (D) of section 1311(b)(1); and

(B) the contributing employers or the plan administrator in any case in which the eligible sponsor of the corporate alliance health plan is described in subparagraph (B) or (C) of section 1311(b)(1).

(2) CONTROLLED GROUPS.—If an employer is a member of a controlled group, each member of such group shall be jointly and severally liable for any assessments required to be paid by such employer. For purposes of the preceding sentence, the term "controlled group" means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.

Subtitle E—Health Plans

SEC. 1400. HEALTH PLAN DEFINED.

(a) IN GENERAL.—In this Act, the term "health plan" means a plan that provides the comprehensive benefit package and meets the requirements of parts 1, 3, and 4.

(b) APPROPRIATE SELF-INSURED HEALTH PLAN.—In this Act, the term "appropriate self-insured health plan" means a group health plan (as defined in section 3(42) of the Employee Retirement Income Security Act of 1974) with respect to which the applicable requirements of title I of the Employee Retirement Income Security Act of 1974 are met and which is a self-insured plan.

(c) STATE-CERTIFIED HEALTH PLAN.—In this Act, the term "State-certified health plan" means a health plan that has been certified by a State under section 1203(a) (or, in the case in which the Board is exercising certification authority under section 1522(e), that has been certified by the Board).

(d) APPLICABLE REGULATORY AUTHORITY DEFINED.—In this subtitle, the term "applicable regulatory authority" means—

(1) with respect to a self-insured health plan, the Secretary of Labor, or

(2) with respect to a State-certified health plan, the State authority responsible for certification of the plan.

PART 1—REQUIREMENTS RELATING TO COMPREHENSIVE BENEFIT PACKAGE

SEC. 1401. APPLICATION OF REQUIREMENTS.

No plan shall be treated under this Act as a health plan—

(1) unless the plan is a self-insured plan or a State-certified plan; or

(2) on and after the effective date of a finding by the applicable regulatory authority that the plan has failed to comply with such applicable requirements.

SEC. 1402. REQUIREMENTS RELATING TO ENROLLMENT AND COVERAGE.

(a) NO UNDERWRITING.—

(1) IN GENERAL.—Subject to paragraph (2), each health plan offered by a regional alliance or a corporate alliance must accept for enrollment every alliance eligible individual who seeks such enrollment. No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics, such as health status, anticipated need for health care, age, occupation, or affiliation with any person or entity.

(2) CAPACITY LIMITATIONS.—With the approval of the applicable regulatory authority, a health plan may limit enrollment because of the plan's capacity to deliver services or to maintain financial stability. If such a limitation is imposed, the limitation may not be imposed on a basis referred to in paragraph (1).

(b) NO LIMITS ON COVERAGE; NO PRE-EXISTING CONDITION LIMITS.—A health plan may not—

(1) terminate, restrict, or limit coverage for the comprehensive benefit package in any portion of the plan's service area for any reason, including nonpayment of premiums;

(2) cancel coverage for any alliance eligible individual until that individual is enrolled in another applicable health plan;

(3) exclude coverage of an alliance eligible individual because of existing medical conditions;

(4) impose waiting periods before coverage begins; or

(5) impose a rider that serves to exclude coverage of particular eligible individuals.

(c) ANTI-DISCRIMINATION.—

(1) IN GENERAL.—No health plan may engage (directly or through contractual arrangements) in any activity, including the selection of a service area, that has the effect of discriminating against an individual on the basis of race, national origin, gender, income, health status, or anticipated need for health services.

(2) SELECTION OF PROVIDERS FOR PLAN NETWORK.—In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health plan may not engage in any practice that has the effect of discriminating against a provider—

(A) based on the race, national origin, or gender of the provider; or

(B) based on the income, health status, or anticipated need for health services of a patient of the provider.

(3) NORMAL OPERATION OF HEALTH PLAN.—Except in the case of intentional discrimination, it shall not be a violation of this subsection, or of any regulation issued under this subsection, for any person to take any action otherwise prohibited under this subsection, if the action is necessary to the normal operation of the health plan.

(4) REGULATIONS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue regulations in an accessible form to carry out this subsection.

(d) REQUIREMENTS FOR PLANS OFFERING LOWER COST SHARING.—Each health plan that offers enrollees the lower cost sharing schedule referred to in section 1131—

(1) shall apply such schedule to all items and services in the comprehensive benefit package;

(2) shall offer enrollees the opportunity to obtain coverage for out-of-network items and services (as described in subsection (f)(2)); and

(3) notwithstanding section 1403, in the case of an enrollee who obtains coverage for such items and services, may charge an alternative premium to take into account such coverage.

(e) TREATMENT OF COST SHARING.—Each health plan, in providing benefits in the comprehensive benefit package—

(1) shall include in its payments to providers, such additional reimbursement as may be necessary to reflect cost sharing reductions to which individuals are entitled under section 1371, and

(2) shall maintain such claims or encounter records as may be necessary to audit the amount of such additional reimbursements and the individuals for which such reimbursement is provided.

(f) IN-NETWORK AND OUT-OF-NETWORK ITEMS AND SERVICES DEFINED.—

(1) IN-NETWORK ITEMS AND SERVICES.—For purposes of this Act, the term "in-network", when used with respect to items or services described in this subtitle, means items or services provided to an individual enrolled under a health plan by a health care provider who is a member of a provider network of the plan (as defined in paragraph (3)).

(2) OUT-OF-NETWORK ITEMS AND SERVICES.—For purposes of this Act, the term "out-of network", when used with respect to items or services described in this subtitle, means items or services provided to an individual enrolled under a health plan by a health care provider who is not a member of a provider network of the plan (as defined in paragraph (3)).

(3) PROVIDER NETWORK DEFINED.—A "provider network" means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services in the comprehensive benefit package to individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(g) RELATION TO DETENTION.—A health plan is not required to provide any reimbursement to any detention facility for services performed in that facility for detainees in the facility.

SEC. 1403. COMMUNITY RATING.

(a) REGIONAL ALLIANCE HEALTH PLANS.—Each regional alliance health plan may not vary the premium imposed with respect to residents of an alliance area, except as may be required under section 6102(a) with respect to different types of individual and family coverage under the plan.

(b) CORPORATE ALLIANCE HEALTH PLANS.—Each corporate alliance health plan may not vary the premium imposed with respect to individuals enrolled in the plan, except as may be required under section 1364 with respect to different types of individual and family coverage under the plan.

SEC. 1404. MARKETING OF HEALTH PLANS; INFORMATION.

(a) REGIONAL ALLIANCE MARKETING RESTRICTIONS.—

(1) IN GENERAL.—The contract entered into between a regional alliance and a regional alliance health plan shall prohibit the distribution by the health plan of marketing materials within the regional alliance that contain false or materially misleading information and shall provide for prior approval by the regional alliance of any marketing materials to be distributed by the plan.

(2) ENTIRE MARKET.—A health plan offered by a health alliance may not distribute marketing materials to an area smaller than the entire area served by the plan.

(3) PROHIBITION OF TIE-INS.—A regional alliance health plan, and any agency of such a plan, may not seek to influence an individual's choice of plans in conjunction with the sale of any other insurance.

(b) INFORMATION AVAILABLE.—

(1) IN GENERAL.—Each regional alliance health plan must provide to the regional alliance and make available to alliance eligible individuals and health care professionals complete and timely information concerning the following:

(A) Costs.

(B) The identity, locations, qualifications, and availability of participating providers.

(C) Procedures used to control utilization of services and expenditures.

(D) Procedures for assuring and improving the quality of care.

(E) Rights and responsibilities of enrollees.

(F) Information on the number of plan members who disenroll from the plan.

(2) PROHIBITION AGAINST CERTIFICATION OF PLANS PROVIDING INACCURATE INFORMATION.—No regional alliance health plan may be a State-certified health plan under this title if the State determines that the plan submitted materially inaccurate information under paragraph (1).

(c) ADVANCE DIRECTIVES.—Each self-insured health plan and each State-certified health plan shall meet the requirement of section 1866(f) of the Social Security Act (relating to maintaining written policies and procedures respecting advance directives) in the same manner as such requirement relates to organizations with contracts under section 1876 of such Act.

SEC. 1405. GRIEVANCE PROCEDURE.

(a) IN GENERAL.—Each health plan must establish a grievance procedure for enrollees to use in pursuing complaints. Such procedure shall be consistent with subtitle C of title V.

(b) ADDITIONAL REMEDIES.—If the grievance procedure fails to resolve an enrollee's complaint—

(1) in the case of an enrollee of a regional alliance health plan, the enrollee has the option of seeking assistance from the office of the ombudsman for the regional alliance established under section 1326(a), and

(2) the enrollee may pursue additional legal remedies, including those provided under subtitle C of title V.

SEC. 1406. HEALTH PLAN ARRANGEMENTS WITH PROVIDERS.

(a) REQUIREMENT.—Each health plan must enter into such agreements with health care providers or have such other arrangements as may be necessary to assure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled with the plan.

(b) EMERGENCY AND URGENT CARE SERVICES.—

(1) IN GENERAL.—Each health plan must cover emergency and urgent care services provided to enrollees, without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan.

(2) PAYMENT AMOUNTS.—In the case of emergency and urgent care provided to an enrollee outside of a health plan's service area, the payment amounts of the plan shall be based on the fee for service rate schedule established by the regional alliance for the alliance area where the services were provided.

(c) APPLICATION OF FEE SCHEDULE.—

(1) IN GENERAL.—Subject to paragraph (2), each regional alliance health plan or corporate alliance health plan that provides for payment for services on a fee-for-service basis shall make such payment in the

amounts provided under the fee schedule established by the regional alliance under section 1322(c) (or, in the case of a plan offered in a State that has established a Statewide fee schedule under section 1322(c)(3), under such Statewide fee schedule).

(2) REDUCTION FOR PROVIDERS VOLUNTARILY REDUCING CHARGES.—If a provider under a health plan voluntarily agrees to reduce the amount charged to an individual enrolled under the plan, the plan shall reduce the amount otherwise determined under the fee schedule applicable under paragraph (1) by the proportion of the reduction in such amount charged.

(3) REDUCTION FOR NONCOMPLYING PLAN.—Each regional alliance health plan that is a noncomplying plan shall provide for reductions in payments under the fee schedule to providers that are not participating providers in accordance with section 6012(b).

(d) PROHIBITION AGAINST BALANCE BILLING; REQUIREMENT OF DIRECT BILLING.—

(1) PROHIBITION OF BALANCE BILLING.—A provider may not charge or collect from an enrollee a fee in excess of the applicable payment amount under the applicable fee schedule under subsection (c), and the health plan and its enrollees are not legally responsible for payment of any amount in excess of such applicable payment amount for items and services covered under the comprehensive benefits package.

(2) DIRECT BILLING.—A provider may not charge or collect from an enrollee amounts that are payable by the health plan (including any cost sharing reduction assistance payable by the plan) and shall submit charges to such plan in accordance with any applicable requirements of part 1 of subtitle B of title V (relating to health information systems).

(3) COVERAGE UNDER AGREEMENTS WITH PLANS.—The agreements or other arrangements entered into under subsection (a) between a health plan and the health care providers providing the comprehensive benefit package to individuals enrolled with the plan shall prohibit a provider from engaging in balance billing described in paragraph (1).

(e) IMPOSITION OF PARTICIPATING PROVIDER ASSESSMENT IN CASE OF A NONCOMPLYING PLAN.—Each health plan shall provide that if the plan is a noncomplying plan for a year under section 6012, payments to participating providers shall be reduced by the applicable network reduction percentage under such section.

SEC. 1407. PREEMPTION OF CERTAIN STATE LAWS RELATING TO HEALTH PLANS.

(a) LAWS RESTRICTING PLANS OTHER THAN FEE-FOR-SERVICE PLANS.—Except as may otherwise be provided in this section, no State law shall apply to any services provided under a health plan that is not a fee-for-service plan (or a fee-for-service component of a plan) if such law has the effect of prohibiting or otherwise restricting plans from—

(1) except as provided in section 1203, limiting the number and type of health care providers who participate in the plan;

(2) requiring enrollees to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan;

(3) requiring enrollees to obtain a referral for treatment by a specialized physician or health institution;

(4) establishing different payment rates for participating providers and providers outside the plan;

(5) creating incentives to encourage the use of participating providers; or

(6) requiring the use single-source suppliers for pharmacy, medical equipment, and other health products and services.

(b) PREEMPTION OF STATE CORPORATE PRACTICE ACTS.—Any State law related to the corporate practice of medicine and to provider ownership of health plans or other providers shall not apply to arrangements between health plans that are not fee-for-service plans and their participating providers.

(c) PARTICIPATING PROVIDER DEFINED.—In this title, a "participating provider" means, with respect to a health plan, a provider of health care services who is a member of a provider network of the plan (as described in section 1402(f)(3)).

SEC. 1408. FINANCIAL SOLVENCY.

Each regional alliance health plan must—

(1) meet or exceed minimum capital requirements established by States under section 1204(a);

(2) in the case of a plan operating in a State, must participate in the guaranty fund established by the State under section 1204(c); and

(3) meet such other requirements relating to fiscal soundness as the State may establish (subject to the establishment of any alternative standards by the Board).

SEC. 1409. REQUIREMENT FOR OFFERING COST SHARING POLICY.

Each regional alliance health plan shall offer a cost sharing policy (as defined in section 1421(b)(2)) to each eligible family enrolled under the plan.

SEC. 1410. QUALITY ASSURANCE.

Each health plan shall comply with such quality assurance requirements as are imposed under subtitle A of title V with respect to such a plan.

SEC. 1411. PROVIDER VERIFICATION.

Each health plan shall—

(1) verify the credentials of practitioners and facilities;

(2) ensure that all providers participating in the plan meet applicable State licensing and certification standards;

(3) oversee the quality and performance of participating providers, consistent with section 1410; and

(4) investigate and resolve consumer complaints against participating providers.

SEC. 1412. CONSUMER DISCLOSURES OF UTILIZATION MANAGEMENT PROTOCOLS.

Each health plan shall disclose to enrollees (and prospective enrollees) the protocols used by the plan for controlling utilization and costs.

SEC. 1413. CONFIDENTIALITY, DATA MANAGEMENT, AND REPORTING.

(a) IN GENERAL.—Each health plan shall comply with the confidentiality, data management, and reporting requirements imposed under subtitle B of title V.

(b) TREATMENT OF ELECTRONIC INFORMATION.—

(1) ACCURACY AND RELIABILITY.—Each health plan shall take such measures as may be necessary to ensure that health care information in electronic form that the plan, or a member of a provider network of the plan, collects for or transmits to the Board under subtitle B of title V is accurate and reliable.

(2) PRIVACY AND SECURITY.—Each health plan shall take such measures as may be necessary to ensure that health care information described in paragraph (1) is not distributed to any individual or entity in violation of a standard promulgated by the Board under part 2 of subtitle B of title V.

SEC. 1414. PARTICIPATION IN REINSURANCE SYSTEM.

Each regional alliance health plan of a State that has established a reinsurance system under section 1203(g) shall participate in the system in the manner specified by the State.

PART 2—REQUIREMENTS RELATING TO SUPPLEMENTAL INSURANCE

SEC. 1421. IMPOSITION OF REQUIREMENTS ON SUPPLEMENTAL INSURANCE.

(a) IN GENERAL.—An entity may offer a supplemental insurance policy but only if—

(1) in the case of a supplemental health benefit policy (as defined in subsection (b)(1)), the entity and the policy meet the requirements of section 1422; and

(2) in the case of a cost sharing policy (as defined in subsection (b)(2)), the entity and the policy meet the requirements of section 1423.

(b) POLICIES DEFINED.—

(1) SUPPLEMENTAL HEALTH BENEFIT POLICY.—

(A) IN GENERAL.—In this part, the term "supplemental health benefit policy" means a health insurance policy or health benefit plan offered to an alliance-eligible individual which provides—

(i) coverage for services and items not included in the comprehensive benefit package, or

(ii) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope provided under such title,

or both.

(B) EXCLUSIONS.—Such term does not include the following:

(i) A cost sharing policy (as defined in paragraph (2)).

(ii) A long-term care insurance policy (as defined in section 2304(10)).

(iii) Insurance that limits benefits with respect to specific diseases (or conditions).

(iv) Hospital or nursing home indemnity insurance.

(v) A medicare supplemental policy (as defined in section 1882(g) of the Social Security Act).

(vi) Insurance with respect to accidents.

(2) COST SHARING POLICY.—In this part, the term "cost sharing policy" means a health insurance policy or health benefit plan offered to an alliance-eligible individual which provides coverage for deductibles, coinsurance, and copayments imposed as part of the comprehensive benefit package under title II, whether imposed under a higher cost sharing plan or with respect to out-of-network providers.

SEC. 1422. STANDARDS FOR SUPPLEMENTAL HEALTH BENEFIT POLICIES.

(a) PROHIBITING DUPLICATION OF COVERAGE.—

(1) IN GENERAL.—No health plan, insurer, or any other person may offer—

(A) to any eligible individual a supplemental health benefit policy that duplicates any coverage provided in the comprehensive benefit package; or

(B) to any medicare-eligible individual a supplemental health benefit policy that duplicates any coverage provided under part B of the medicare program.

(2) EXCEPTION FOR MEDICARE-ELIGIBLE INDIVIDUALS.—For purposes of this subsection, for the period in which an individual is a medicare-eligible individual and also is an alliance-eligible individual (and is enrolled under a regional alliance or corporate alliance health plan), paragraph (1)(A) (and not paragraph (1)(B)) shall apply.

(b) NO LIMITATION ON INDIVIDUALS OFFERED POLICY.—

(1) IN GENERAL.—Except as provided in paragraph (2), each entity offering a supplemental health benefit policy must accept for

enrollment every individual who seeks such enrollment, subject to capacity and financial limits.

(2) EXCEPTION FOR CERTAIN OFFERORS.—Paragraph (1) shall not apply to any supplemental health benefit policy offered to an individual only on the basis of—

(A) the individual's employment (in the case of a policy offered by the individual's employer); or

(B) the individual's membership or enrollment in a fraternal, religious, professional, educational, or other similar organization.

(c) RESTRICTIONS ON MARKETING ABUSES.—Not later than January 1, 1996, the Board shall develop (in consultation with the States) minimum standards that prohibit marketing practices by entities offering supplemental health benefit policies that involve:

(1) Providing monetary incentives for or tying or otherwise conditioning the sale of the policy to enrollment in a regional alliance health plan of the entity.

(2) Using or disclosing to any party information about the health status or claims experience of participants in a regional alliance health plan for the purpose of marketing such a policy.

(d) CIVIL MONETARY PENALTY.—An entity that knowingly and willfully violates any provision of this section with respect to the offering of a supplemental health benefit policy to any individual shall be subject to a civil monetary penalty (not to exceed $10,000) for each such violation.

SEC. 1423. STANDARDS FOR COST SHARING POLICIES.

(a) RULES FOR OFFERING OF POLICIES.—Subject to subsection (f), a cost sharing policy may be offered to an individual only if—

(1) the policy is offered by the regional alliance health plan in which the individual is enrolled;

(2) the regional alliance health plan offers the policy to all individuals enrolled in the plan;

(3) the plan offers each such individual a choice of a policy that provides standard coverage and a policy that provides maximum coverage (in accordance with standards established by the Board); and

(4) the policy is offered only during the annual open enrollment period for regional alliance health plans (described in section 1323(d)(1)).

(b) PROHIBITION OF COVERAGE OF COPAYMENTS.—Each cost sharing policy may not provide any benefits relating to any copayments established under the schedule of copayments and coinsurance under section 1135.

(c) EQUIVALENT COVERAGE FOR ALL SERVICES.—Each cost sharing policy must provide coverage for items and services in the comprehensive benefit package to the same extent as the policy provides coverage for all items and services in the package.

(d) REQUIREMENTS FOR PRICING.—

(1) IN GENERAL.—The price of any cost sharing policy shall—

(A) be the same for each individual to whom the policy is offered;

(B) take into account any expected increase in utilization resulting from the purchase of the policy by individuals enrolled in the regional alliance health plan; and

(C) not result in a loss-ratio of less than 90 percent.

(2) LOSS-RATIO DEFINED.—In paragraph (1)(C), a "loss-ratio" is the ratio of the premium returned to the consumer in payout relative to the total premium collected.

(e) LOSS OF STATE CERTIFICATION FOR REGIONAL ALLIANCE HEALTH PLANS FAILING TO MEET STANDARDS.—A State may not certify a regional alliance health plan that offers a cost sharing policy unless the plan and the policy meet the standards described in this section.

(f) SPECIAL RULES FOR FEHBP SUPPLEMENTAL PLANS.—Subsection (a) shall not apply to an FEHBP supplemental plan described in section 8203(f)(1), but only if the plan meets the following requirements:

(1) The plan must be offered to all individuals to whom such a plan is required to be offered under section 8204.

(2) The plan must offer each such individual a choice of a policy that provides standard coverage and a policy that provides maximum coverage (in accordance with standards established by the Board under subsection (a)(3)).

(3) The plan is offered only during the annual open enrollment period for regional alliance health plans (described in section 1323(d)(1)).

(4)(A) The price of the plan shall include an amount, established in accordance with rules established by the Board in consultation with the Office of Personnel Management, that takes into account any expected increase in utilization of the items and services in the comprehensive benefit package resulting from the purchase of the plan by individuals enrolled in a regional alliance health plan.

(B) The plan provides for payment, in a manner specified by the Board in the case of an individual enrolled in the plan and in a regional alliance health plan, to the regional alliance health plan of an amount equivalent to the additional amount described in subparagraph (A).

PART 3—REQUIREMENTS RELATING TO ESSENTIAL COMMUNITY PROVIDERS

SEC. 1431. HEALTH PLAN REQUIREMENT.

(a) IN GENERAL.—Subject to section 1432, each health plan shall, with respect to each electing essential community provider (as defined in subsection (d), other than a provider of school health services) located within the plan's service area, either—

(1) enter into a written provider participation agreement (described in subsection (b)) with the provider, or

(2) enter into a written agreement under which the plan shall make payment to the provider in accordance with subsection (c).

(b) PARTICIPATION AGREEMENT.—A participation agreement between a health plan and an electing essential community provider under this subsection shall provide that the health plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers participating in the health plan with respect to each of the following:

(1) The scope of services for which payment is made by the plan to the provider.

(2) The rate of payment for covered care and services.

(3) The availability of financial incentives to participating providers.

(4) Limitations on financial risk provided to other participating providers.

(5) Assignment of enrollees to participating providers.

(6) Access by the provider's patients to providers in medical specialties or subspecialties participating in the plan.

(c) PAYMENTS FOR PROVIDERS WITHOUT PARTICIPATION AGREEMENTS.—

(1) IN GENERAL.—Payment in accordance with this subsection is payment based, as elected by the electing essential community provider, either—

(A) on the fee schedule developed by the applicable health alliance (or the State) under section 1322(c), or

(B) on payment methodologies and rates used under the applicable Medicare payment methodology and rates (or the most closely applicable methodology under such program as the Secretary of Health and Human Services specifies in regulations).

(2) NO APPLICATION OF GATE-KEEPER LIMITATIONS.—Payment in accordance with this subsection may be subject to utilization review, but may not be subject to otherwise applicable gate-keeper requirements under the plan.

(d) ELECTION.—

(1) IN GENERAL.—In this part, the term "electing essential community provider" means, with respect to a health plan, an essential community provider that elects this subpart to apply to the health plan.

(2) FORM OF ELECTION.—An election under this subsection shall be made in a form and manner specified by the Secretary, and shall include notice to the health plan involved. Such an election may be made annually with respect to a health plan, except that the plan and provider may agree to make such an election on a more frequent basis.

(e) SPECIAL RULE FOR PROVIDERS OF SCHOOL HEALTH SERVICES.—A health plan shall pay, to each provider of school health services located in the plan's service area an amount determined by the Secretary for such services furnished to enrollees of the plan.

SEC. 1432. SUNSET OF REQUIREMENT.

(a) IN GENERAL.—Subject to subsection (d), the requirement of section 1431 shall only apply to health plans offered by a health alliance during the 5-year period beginning with the first year in which any regional alliance health plan is offered by the alliance.

(b) STUDIES.—In order to prepare recommendations under subsection (c), the Secretary shall conduct studies regarding essential community providers, including studies that assess—

(1) the definition of essential community provider,

(2) the sufficiency of the funding levels for providers, for both covered and uncovered benefits under this Act,

(3) the effects of contracting requirements relating to such providers on such providers, health plans, and enrollees,

(4) the impact of the payment rules for such providers, and

(5) the impact of national health reform on such providers.

(c) RECOMMENDATIONS TO CONGRESS.—The Secretary shall submit to Congress, by not later than March 1, 2001, specific recommendations respecting whether, and to what extent, section 1431 should continue to apply to some or all essential community providers. Such recommendations may include a description of the particular types of such providers and circumstances under which such section should continue to apply.

(d) CONGRESSIONAL CONSIDERATION.—

(1) IN GENERAL.—Recommendations submitted under subsection (c) shall apply under this part (and may supersede the provisions of subsection (a)) unless a joint resolution (described in paragraph (2)) disapproving such recommendations is enacted, in accordance with the provisions of paragraph (3), before the end of the 60-day period beginning on the date on which such recommendations were submitted. For purposes of applying the preceding sentence and paragraphs (2) and

(3), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

(2) JOINT RESOLUTION OF DISAPPROVAL.—A joint resolution described in this paragraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the Secretary submits recommendations under subsection (c) and—

(A) which does not have a preamble;

(B) the matter after the resolving clause of which is as follows: "That Congress disapproves the recommendations of the Secretary of Health and Human Services concerning the continued application of certain essential community provider requirements under section 1431 of the Health Security Act, as submitted by the Secretary on _____.", the blank space being filled in with the appropriate date; and

(C) the title of which is as follows: "Joint resolution disapproving recommendations of the Secretary of Health and Human Services concerning the continued application of certain essential community provider requirements under section 1431 of the Health Security Act, as submitted by the Secretary on _____.", the blank space being filled in with the appropriate date.

(3) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to paragraph (4), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in paragraph (2) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(4) SPECIAL RULES.—For purposes of applying paragraph (3) with respect to such provisions—

(A) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of recommendations under subsection (c)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Majority Leader of the Senate at the time of submission of recommendations under subsection (c)); and

(B) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the Secretary submits recommendations under subsection (c).

PART 4—REQUIREMENTS RELATING TO WORKERS' COMPENSATION AND AUTOMOBILE MEDICAL LIABILITY COVERAGE

SEC. 1441. REFERENCE TO REQUIREMENTS RELATING TO WORKERS COMPENSATION SERVICES.

Each health plan shall meet the applicable requirements of part 2 of subtitle A of title VIII (relating to provision of workers compensation services to enrollees).

SEC. 1442. REFERENCE TO REQUIREMENTS RELATING TO AUTOMOBILE MEDICAL LIABILITY SERVICES.

Each health plan shall meet the applicable requirements of part 2 of subtitle B of title VIII (relating to provision of automobile medical liability services to enrollees).

Subtitle F—Federal Responsibilities

PART 1—NATIONAL HEALTH BOARD

Subpart A—Establishment of National Health Board

SEC. 1501. CREATION OF NATIONAL HEALTH BOARD; MEMBERSHIP.

(a) IN GENERAL.—There is hereby created in the Executive Branch a National Health Board.

(b) COMPOSITION.—The Board is composed of 7 members appointed by the President, by and with the advice and consent of the Senate.

(c) CHAIR.—The President shall designate one of the members as chair. The chair serves a term concurrent with that of the President. The chair may serve a maximum of 3 terms. The chair shall serve as the chief executive officer of the Board.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (4), the term of each member of the Board, except the chair, is 4 years and begins when the term of the predecessor of that member ends.

(2) INITIAL TERMS.—The initial terms of the members of the Board (other than the chair) first taking office after the date of the enactment of this Act, shall expire as designated by the President, two at the end of one year, two at the end of two years, and two at the end of three years.

(3) REAPPOINTMENT.—A member (other than the chair) may be reappointed for one additional term.

(4) CONTINUATION IN OFFICE.—Upon the expiration of a term of office, a member shall continue to serve until a successor is appointed and qualified.

(e) VACANCIES.—

(1) IN GENERAL.—Whenever a vacancy shall occur, other than by expiration of term, a successor shall be appointed by the President as provided above, by and with the consent of the Senate, to fill such vacancy, and is appointed for the remainder of the term of the predecessor.

(2) NO IMPAIRMENT OF FUNCTION.—A vacancy in the membership of the Board does not impair the right of the remaining members to exercise all of the powers of the Board.

(3) ACTING CHAIR.—The Board may designate a Member to Act as chair during any period in which there is no chair designated by the President.

(f) MEETINGS; QUORUM.—

(1) MEETINGS.—At meetings of the Board the chair shall preside, and in the absence of the chair, the Board shall elect a member to act as chair pro tempore.

(2) QUORUM.—Four members of the Board shall constitute a quorum thereof.

SEC. 1502. QUALIFICATIONS OF BOARD MEMBERS.

(a) CITIZENSHIP.—Each member of the Board shall be a citizen of the United States.

(b) BASIS OF SELECTION.—Board members will be selected on the basis of their experience and expertise in relevant subjects, including the practice of medicine, health care financing and delivery, state health systems, consumer protection, business, law, and delivery of care to vulnerable populations.

(c) EXCLUSIVE EMPLOYMENT.—During the term of appointment, Board members shall serve as employees of the Federal Government and shall hold no other employment.

(d) PROHIBITION OF CONFLICT OF INTEREST.—A member of the Board may not have a pecuniary interest in or hold an official relation to any health care plan, health care provider, insurance company, pharmaceutical company, medical equipment company, or other affected industry. Before entering upon the duties as a member of the Board, the member shall certify under oath compliance with this requirement.

(e) POST-EMPLOYMENT RESTRICTIONS.—After leaving the Board, former members are subject to post-employment restrictions applicable to comparable Federal employees.

(f) COMPENSATION OF BOARD MEMBERS.—Each member of the Board (other than the chair) shall receive an annual salary at the annual rate payable from time to time for level IV of the Executive Schedule. The chair of the Board, during the period of service as chair, shall receive an annual salary at the annual rate payable from time to time for level III of the Executive Schedule.

SEC. 1503. GENERAL DUTIES AND RESPONSIBILITIES.

(a) COMPREHENSIVE BENEFIT PACKAGE.—

(1) INTERPRETATION.—The Board shall interpret the comprehensive benefit package, adjust the delivery of preventive services under section 1153, and take such steps as may be necessary to assure that the comprehensive benefit package is available on a uniform national basis to all eligible individuals.

(2) RECOMMENDATIONS.—The Board may recommend to the President and the Congress appropriate revisions to such package. Such recommendations may reflect changes in technology, health care needs, health care costs, and methods of service delivery.

(b) ADMINISTRATION OF COST CONTAINMENT PROVISIONS.—The Board shall oversee the cost containment requirements of subtitle A of title VI and certify compliance with such requirements.

(c) COVERAGE AND FAMILIES.—The Board shall develop and implement standards relating to the eligibility of individuals for coverage in applicable health plans under subtitle A of title I and may provide such additional exceptions and special rules relating to the treatment of family members under section 1012 as the Board finds appropriate.

(d) QUALITY MANAGEMENT AND IMPROVEMENT.—The Board shall establish and have ultimate responsibility for a performance-based system of quality management and improvement as required by section 5001.

(e) INFORMATION STANDARDS.—The Board shall develop and implement standards to establish national health information system to measure quality as required by section 5101.

(f) PARTICIPATING STATE REQUIREMENTS.—Consistent with the provisions of subtitle C, the Board shall—

(1) establish requirements for participating States,

(2) monitor State compliance with those requirements,

(3) provide technical assistance,

in a manner that ensures access to the comprehensive benefit package for all eligible individuals.

(g) DEVELOPMENT OF PREMIUM CLASS FACTORS.—The Board shall establish premium class factors under subpart D of this part.

(h) DEVELOPMENT OF RISK-ADJUSTMENT METHODOLOGY.—The Board shall develop a methodology for the risk-adjustment of premium payments to regional alliance health plans in accordance with part 3 of this subtitle.

(i) ENCOURAGING THE REASONABLE PRICING OF BREAKTHROUGH DRUGS.—The Board shall establish the Breakthrough Drug Committee in accordance with subpart F of this part.

(j) FINANCIAL REQUIREMENTS.—The Board shall establish minimum capital requirements and requirements for guaranty funds under subpart G of this part.

(k) STANDARDS FOR HEALTH PLAN GRIEVANCE PROCEDURES.—The Board shall establish standards for health plan grievance procedures that are used by enrollees in pursuing complaints.

SEC. 1504. ANNUAL REPORT.

(a) IN GENERAL.—The Board shall prepare and send to the President and Congress an annual report addressing the overall implementation of the new health care system.

(b) MATTERS TO BE INCLUDED.—The Board shall include in each annual report under this section the following:

(1) Information on Federal and State implementation.

(2) Data related to quality improvement.

(3) Recommendations or changes in the administration, regulation and laws related to health care and coverage.

(4) A full account of all actions taken during the previous year.

SEC. 1505. POWERS.

(a) STAFF; CONTRACT AUTHORITY.—The Board shall have authority, subject to the provisions of the civil-service laws and chapter 51 and subchapter III of chapter 53 of title 5, United States Code, to appoint such officers and employees as are necessary to carry out its functions. To the extent provided in advance in appropriations Acts, the Board may contract with any person (including an agency of the Federal Government) for studies and analysis as required to execute its functions. Any employee of the Executive Branch may be detailed to the Board to assist the Board in carrying out its duties.

(b) ESTABLISHMENT OF ADVISORY COMMITTEES.—The Board may establish advisory committees.

(c) ACCESS TO INFORMATION.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out its functions, to the extent such information is otherwise available to a department or agency of the United States. Upon request of the chair, the head of that department or agency shall furnish that information to the Board.

(d) DELEGATION OF AUTHORITY.—Except as otherwise provided in this Act, the Board may delegate any function to such officers and employees as the Board may designate and may authorize such successive redelegations of such functions with the Board as the Board deems to be necessary or appropriate. No delegation of functions by the Board shall relieve the Board of responsibility for the administration of such functions.

(e) RULEMAKING.—The National Health Board is authorized to establish such rules as may be necessary to carry out this Act.

SEC. 1506. FUNDING.

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Board such sums as may be necessary for fiscal years 1994, 1995, 1996, 1997, and 1998.

(b) SUBMISSION OF BUDGET.—Under the procedures of chapter 11 of title 31, United States Code, the budget for the Board for a fiscal year shall be reviewed by the Director of the Office of Management and Budget and submitted to the Congress as part of the President's submission of the Budget of the United States for the fiscal year.

Subpart B—Responsibilities Relating to Review and Approval of State Systems

SEC. 1511. FEDERAL REVIEW AND ACTION ON STATE SYSTEMS.

(a) APPROVAL OF STATE SYSTEMS BY NATIONAL BOARD.—

(1) IN GENERAL.—The National Health Board shall approve a State health care system for which a document is submitted under section 1200(a) unless the Board finds that the system (as set forth in the document) does not (or will not) provide for the State meeting the responsibilities for participating States under this Act.

(2) REGULATIONS.—The Board shall issue regulations, not later than July 1, 1995, prescribing the requirements for State health care systems under parts 2 and 3 of subtitle C, except that in the case of a document submitted under section 1201(a) before the date of issuance of such regulations, the Board shall take action on such document notwithstanding the fact that such regulations have not been issued.

(3) NO APPROVAL PERMITTED FOR YEARS PRIOR TO 1996.—The Board may not approve a State health care system under this part for any year prior to 1996.

(b) REVIEW OF COMPLETENESS OF DOCUMENTS.—

(1) IN GENERAL.—If a State submits a document under subsection (a)(1), the Board shall notify the State, not later than 7 working days after the date of submission, whether or not the document is complete and provides the Board with sufficient information to approve or disapprove the document.

(2) ADDITIONAL INFORMATION ON INCOMPLETE DOCUMENT.—If the Board notifies a State that the State's document is not complete, the State shall be provided such additional period (not to exceed 45 days) as the Board may by regulation establish in which to submit such additional information as the Board may require. Not later than 7 working days after the State submits the additional information, the Board shall notify the State respecting the completeness of the document.

(c) ACTION ON COMPLETED DOCUMENTS.—

(1) IN GENERAL.—The Board shall make a determination (and notify the State) on whether the State's document provides for implementation of a State system that meets the applicable requirements of subtitle C—

(A) in the case of a State that did not require the additional period described in subsection (b)(2) to file a complete document, not later than 90 days after notifying a State under subsection (b) that the State's document is complete, or

(B) in the case of a State that required the additional period described in subsection (b)(2) to file a complete document, not later than 90 days after notifying a State under subsection (b) that the State's document is complete.

(2) PLANS DEEMED APPROVED.—If the Board does not meet the applicable deadline for making a determination and providing notice established under paragraph (1) with respect to a State's document, the Board shall be deemed to have approved the State's document for purposes of this Act.

(d) OPPORTUNITY TO RESPOND TO REJECTED DOCUMENT.—

(1) IN GENERAL.—If (within the applicable deadline under subsection (c)(1)) the Board notifies a State that its document does not provide for implementation of a State system that meets the applicable requirements of subtitle C, the Board shall provide the State with a period of 30 days in which to submit such additional information and assurances as the Board may require.

(2) DEADLINE FOR RESPONSE.—Not later than 30 days after receiving such additional information and assurances, the Board shall make a determination (and notify the State) on whether the State's document provides for implementation of a State system that meets the applicable requirements of subtitle C.

(3) PLAN DEEMED APPROVED.—If the Board does not meet the deadline established under paragraph (2) with respect to a State, the Board shall be deemed to have approved the State's document for purposes of this Act.

(e) APPROVAL OF PREVIOUSLY TERMINATED STATES.—If the Board has approved a State system under this part for a year but subsequently terminated the approval of the system under section 1513, the Board shall approve the system for a succeeding year if the State—

(1) demonstrates to the satisfaction of the Board that the failure that formed the basis for the termination no longer exists, and

(2) provides reasonable assurances that the types of actions (or inactions) which formed the basis for such termination will not recur.

(f) REVISIONS TO STATE SYSTEM.—

(1) SUBMISSION.—A State may revise a system approved for a year under this section, except that such revision shall not take effect unless the State has submitted to the Board a document describing such revision and the Board has approved such revision.

(2) ACTIONS ON AMENDMENTS.—Not later than 60 days after a document is submitted under paragraph (1), the Board shall make a determination (and notify the State) on whether the implementation of the State system, as proposed to be revised, meets the applicable requirements of subtitle C. If the Board fails to meet the requirement of the preceding sentence, the Board shall be deemed to have approved the implementation of the State system as proposed to be revised.

(3) REJECTION OF AMENDMENTS.—Subsection (d) shall apply to an amendment submitted under this subsection in the same manner as it applies to a completed document submitted under subsection (b).

(g) NOTIFICATION OF NON-PARTICIPATING STATES.—If a State fails to submit a document for a State system by the deadline referred to in section 1200, or such a document is not approved under subsection (c), the Board shall immediately notify the Secretary of Health and Human Services and the Secretary of the Treasury of the State's failure for purposes of applying subpart B in that State.

SEC. 1512. FAILURE OF PARTICIPATING STATES TO MEET CONDITIONS FOR COMPLIANCE.

(a) IN GENERAL.—In the case of a participating State, if the Board determines that the operation of the State system under subtitle C fails to meet the applicable requirements of this Act, sanctions shall apply against the State in accordance with subsection (b).

(b) TYPE OF SANCTION APPLICABLE.—The sanctions applicable under this part are as follows:

(1) If the Board determines that the State's failure does not substantially jeopardize the ability of eligible individuals in the State to obtain coverage for the comprehensive benefit package—

(A) the Board may order a regional alliance in the State to comply with applicable requirements of this Act and take such additional measures to assure compliance with such requirements as the Board may impose, if the Board determines that the State's failure relates to a requirement applicable to a regional alliance in the State, or

(B) if the Board does not take the action described in subparagraph (A) (or if the Board takes the action and determines that the action has not remedied the violation that led to the imposition of the sanction), the Board shall notify the Secretary of

Health and Human Services, who shall reduce payments with respect to the State in accordance with section 1513.

(2) If the Board determines that the failure substantially jeopardizes the ability of eligible individuals in the State to obtain coverage for the comprehensive benefit package—

(A) the Board shall terminate its approval of the State system; and

(B) the Board shall notify the Secretary of Health and Human Services, who shall assume the responsibilities described in section 1522.

(c) TERMINATION OF SANCTION.—

(1) COMPLIANCE BY STATE.—A State against which a sanction is imposed may submit information at any time to the Board to demonstrate that the failure that led to the imposition of the sanction has been corrected.

(2) TERMINATION OF SANCTION.—If the Board determines that the failure that led to the imposition of a sanction has been corrected—

(A) in the case of the sanction described in subsection (b)(1)(A), the Board shall notify the regional alliance against which the sanction is imposed; or

(B) in the case of any other sanction described in subsection (b), the Board shall notify the Secretary of Health and Human Services.

(d) PROTECTION OF ACCESS TO BENEFITS.—The Board and the Secretary of Health and Human Services shall exercise authority to take actions under this section with respect to a State only in a manner that assures the continuous coverage of eligible individuals under regional alliance health plans.

SEC. 1513. REDUCTION IN PAYMENTS FOR HEALTH PROGRAMS BY SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—Upon receiving notice from the Board under section 1512(b)(1)(B), the Secretary of Health and Human Services shall reduce the amount of any of the payments described in subsection (b) that would otherwise be made to individuals and entities in the State by such amount as the Secretary determines to be appropriate.

(b) PAYMENTS DESCRIBED.—The payments described in this subsection are as follows:

(1) Payments to academic health centers in the State under subtitle B of title III for medical education training programs funds.

(2) Payments to individuals and entities in the State for health research activities under section 301 and title IV of the Public Health Service Act.

(3) Payments to hospitals in the State under part 4 of subtitle E of title III (relating to payments to hospitals serving vulnerable populations)

SEC. 1514. REVIEW OF FEDERAL DETERMINATIONS.

Any State or alliance affected by a determination by the Board under this subpart may appeal such determination in accordance with section 5231.

SEC. 1515. FEDERAL SUPPORT FOR STATE IMPLEMENTATION.

(a) PLANNING GRANTS.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall make available to each State a planning grant to assist a State in the development of a health care system to become a participating State under subtitle C.

(2) FORMULA.—The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $50,000,000 in each of fiscal years 1995 and 1996.

(b) GRANTS FOR START-UP SUPPORT.—

(1) IN GENERAL.—The Secretary shall make available to States, upon their enacting of enabling legislation to become participating States, grants to assist in the establishment of regional alliances.

(2) FORMULA.—The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) STATE MATCHING FUNDS REQUIRED.—Funds are payable to a State under this subsection only if the State provides assurances, satisfactory to the Secretary, that amounts of State funds (at least equal to the amount made available under this subsection) are expended for the purposes described in paragraph (1).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $313,000,000 for fiscal year 1996, $625,000,000 for fiscal year 1997, and $313,000,000 for fiscal year 1998.

(c) FORMULA.—

(1) IN GENERAL.—The Board shall develop a formula for the distribution of

Subpart C—Responsibilities in Absence of State Systems

SEC. 1521. APPLICATION OF SUBPART.

(a) INITIAL APPLICATION.—This subpart shall apply with respect to a State as of January 1, 1998, unless—

(1) the State submits a document for a State system under section 1511(a)(1) by July 1, 1997, and

(2) the Board determines under section 1511 that such system meets the requirements of part 1 of subtitle C.

(b) TERMINATION OF APPROVAL OF SYSTEM OF PARTICIPATING STATE.—In the case of a participating State for which the Board terminates approval of the State system under section 1512(2), this subpart shall apply with respect to the State as of such date as is appropriate to assure the continuity of coverage for the comprehensive benefit package for eligible individuals in the State.

SEC. 1522. FEDERAL ASSUMPTION OF RESPONSIBILITIES IN NON-PARTICIPATING STATES.

(a) NOTICE.—When the Board determines that this subpart will apply to a State for a calendar year, the Board shall notify the Secretary of Health and Human Services.

(b) ESTABLISHMENT OF REGIONAL ALLIANCE SYSTEM.—Upon receiving notice under subsection (a), the Secretary shall take such steps, including the establishment of regional alliances, and compliance with other requirements applicable to participating States under subtitle C, as are necessary to ensure that the comprehensive benefit package is provided to eligible individuals in the State during the year.

(c) REQUIREMENTS FOR ALLIANCES.—Subject to section 1523, any regional alliance established by the Secretary pursuant to this section must meet all the requirements applicable under subtitle D to a regional alliance established and operated by a participating State, and the Secretary shall have the authority to fulfill all the functions of such an alliance.

(d) ESTABLISHMENT OF GUARANTY FUND.—

(1) ESTABLISHMENT.—The Secretary must ensure that there is a guaranty fund that meets the requirements established by the Board under section 1562, in order to provide financial protection to health care providers and others in the case of a failure of a regional alliance health plan under a regional alliance established and operated by the Secretary under this section.

(2) ASSESSMENTS TO PROVIDE GUARANTY FUNDS.—In the case of a failure of one or more regional alliance health plans under a regional alliance established and operated by the Secretary under this section, the Secretary may require each regional alliance health plan under the alliance to pay an assessment to the Secretary in an amount not to exceed 2 percent of the premiums of such plans paid by or on behalf of regional alliance eligible individuals during a year for so long as necessary to generate sufficient revenue to cover any outstanding claims against the failed plan.

SEC. 1523. IMPOSITION OF SURCHARGE ON PREMIUMS UNDER FEDERALLY-OPERATED SYSTEM.

(a) IN GENERAL.—If this subpart applies to a State for a calendar year, the premiums charged under the regional alliance established and operated by the Secretary in the State shall be equal to premiums that would otherwise be charged under a regional alliance established and operated by the State, increased by 15 percent. Such 15 percent increase shall be used to reimburse the Secretary for any administrative or other expenses incurred as a result of establishing and operating the system.

(b) TREATMENT OF SURCHARGE AS PART OF PREMIUM.—For purposes of determining the compliance of a State for which this subpart applies in a year with the requirements for budgeting under subtitle A of title VI for the year, the 15 percent increase described in subsection (a) shall be treated as part of the premium for payment to a regional alliance.

SEC. 1524. RETURN TO STATE OPERATION.

(a) APPLICATION PROCESS.—After the establishment and operation of an alliance system by the Secretary in a State under section 1522, the State may at any time apply to the Board for the approval of a State system in accordance with the procedures described in section 1511.

(b) TIMING.—If the Board approves the system of a State for which the Secretary has operated an alliance system during a year, the Secretary shall terminate the operation of the system, and the State shall establish and operate its approved system, as of January 1 of the first year beginning after the Board approves the State system. The termination of the Secretary's system and the operation of the State's system shall be conducted in a manner that assures the continuous coverage of eligible individuals in the State under regional alliance health plans.

Subpart D—Establishment of Class Factors for Charging Premiums

SEC. 1531. PREMIUM CLASS FACTORS.

(a) IN GENERAL.—For each of the classes of family enrollment (as specified in section 1011(c)), for purposes of title VI, the Board shall establish a premium class factor that reflects, subject to subsection (b), the relative actuarial value of the comprehensive benefit package of the class of family enrollment compared to such value of such package for individual enrollment.

(b) CONDITIONS.—In establishing such factors, the factor for the class of individual enrollment shall be 1 and the factor for the class of family enrollment of coverage of a married couple without children shall be 2.

Subpart E—Risk Adjustment and Reinsurance Methodology for Payment of Plans

SEC. 1541. DEVELOPMENT OF A RISK ADJUSTMENT AND REINSURANCE METHODOLOGY.

(a) DEVELOPMENT.—

(1) INITIAL DEVELOPMENT.—Not later than April 1, 1995, the Board shall develop a risk adjustment and reinsurance methodology in accordance with this subpart.

(2) IMPROVEMENTS.—The Board shall make such improvements in such methodology as may be appropriate to achieve the purposes described in subsection (b)(1).

(b) METHODOLOGY.—

(1) PURPOSES.—Such methodology shall provide for the adjustment of payments to regional alliance health plans for the purposes of—

(A) assuring that payments to such plans reflect the expected relative utilization and expenditures for such services by each plan's enrollees compared to the average utilization and expenditures for regional alliance eligible individuals, and

(B) protecting health plans that enroll a disproportionate share of regional alliance eligible individuals with respect to whom expected utilization of health care services (included in the comprehensive benefit package) and expected health care expenditures for such services are greater than the average level of such utilization and expenditures for regional alliance eligible individuals.

(2) FACTORS TO BE CONSIDERED.—In developing such methodology, the Board shall take into account the following factors:

(A) Demographic characteristics.

(B) Health status.

(C) Geographic area of residence.

(D) Socio-economic status.

(E) Subject to paragraph (5), (i) the proportion of enrollees who are SSI recipients and (ii) the proportion of enrollees who are AFDC recipients.

(F) Any other factors determined by the Board to be material to the purposes described in paragraph (1).

(3) ZERO SUM.—The methodology shall assure that the total payments to health plans by the regional alliance after application of the methodology are the same as the amount of payments that would have been made without application of the methodology.

(4) PROSPECTIVE ADJUSTMENT OF PAYMENTS .—The methodology, to the extent possible and except in the case of a mandatory reinsurance system described in subsection (b), shall be applied in manner that provides for the prospective adjustment of payments to health plans.

(5) TREATMENT OF SSI/AFDC ADJUSTMENT.—The Board is not required to apply the factor described in clause (i) or (ii) of paragraph (2)(E) if the Board determines that the application of the other risk adjustment factors described in paragraph (2) is sufficient to adjust premiums to take into account the enrollment in plans of AFDC recipients and SSI recipients.

(6) SPECIAL CONSIDERATION FOR MENTAL ILLNESS.—In developing the methodology under this section, the Board shall give consideration to the unique problems of adjusting payments to health plans with respect to individuals with mental illness.

(7) SPECIAL CONSIDERATION FOR VETERANS, MILITARY, AND INDIAN HEALTH PLANS.—In developing the methodology under this section, the Board shall give consideration to the special enrollment and funding provisions relating to plans described in section 1004(b).

(8) ADJUSTMENT TO ACCOUNT FOR USE OF ESTIMATES.—Subject to section 1346(b)(3) (relating to establishment of regional alliance reserve funds), if the total payments made by a regional alliance to all regional alliance health plans in a year under section 1324(c) exceeds, or is less than, the total of such payments estimated by the alliance in the application of the methodology under this subsection, because of a difference between—

(A) the alliance's estimate of the distribution of enrolled families in different risk categories (assumed in the application of risk factors under this subsection in making payments to regional alliance health plans), and

(B) the actual distribution of such enrolled families in such categories,

the methodology under this subsection shall provide for an adjustment in the application of such methodology in the second succeeding year in a manner that would reduce, or increase, respectively, by the amount of such excess (or deficit) the total of such payments made by the alliance to all such plans.

(b) MANDATORY REINSURANCE.—

(1) IN GENERAL.—The methodology developed under this section may include a system of mandatory reinsurance, but may not include a system of voluntary reinsurance.

(2) REQUIREMENT IN CERTAIN CASES.—If the Board determines that an adequate system of prospective adjustment of payments to health plans to account for the health status of individuals enrolled by regional alliance health plans cannot be developed (and ready for implementation) by the date specified in subsection (a)(1), the Board shall include a mandatory reinsurance system as a component of the methodology. The Board may thereafter reduce or eliminate such a system at such time as the Board determines that an adequate prospective payment adjustment for health status has been developed and is ready for implementation.

(3) REINSURANCE SYSTEM.—The Board, in developing the methodology for a mandatory reinsurance system under this subsection, shall—

(A) provide for health plans to make payments to state-established reinsurance programs for the purpose of reinsuring part or all of the health care expenses for items and services included in the comprehensive benefit package for specified classes of high-cost enrollees or specified high-cost treatments or diagnoses; and

(B) specify the manner of creation, structure, and operation of the system in each State, including—

(i) the manner (which may be prospective or retrospective) in which health plans make payments to the system, and

(ii) the type and level of reinsurance coverage provided by the system.

(c) CONFIDENTIALITY OF INFORMATION.—The methodology shall be developed in a manner consistent with privacy standards promulgated under section 5102(a). In developing such standards, the Board shall take into account any potential need of alliances for certain individually identifiable health information in order to carry out risk-adjustment and reinsurance activities under this Act, but only to the minimum extent necessary to carry out such activities and with protections provided to minimize the identification of the individuals to whom the information relates.

SEC. 1542. INCENTIVES TO ENROLL DISADVANTAGED GROUPS.

The Board shall establish standards under which States may provide (under section 1203(e)(3)) for an adjustment in the risk-adjustment methodology developed under section 1541 in order to provide a financial incentive for regional alliance health plans to enroll individuals who are members of disadvantaged groups.

SEC. 1543. ADVISORY COMMITTEE.

(a) IN GENERAL.—The Board shall establish an advisory committee to provide technical advice and recommendations regarding the development and modification of the risk adjustment and reinsurance methodology developed under this part.

(b) COMPOSITION.—Such advisory committee shall consist of 15 individuals and shall include individuals who are representative of health plans, regional alliances, consumers, experts, employers, and health providers.

SEC. 1544. RESEARCH AND DEMONSTRATIONS.

The Secretary shall conduct and support research and demonstration projects to develop and improve, on a continuing basis, the risk adjustment and reinsurance methodology under this subpart.

SEC. 1545. TECHNICAL ASSISTANCE TO STATES AND ALLIANCES.

The Board shall provide technical assistance to States and regional alliances in implementing the methodology developed under this subpart.

Subpart F—Responsibilities for Financial Requirements

SEC. 1551. CAPITAL STANDARDS FOR REGIONAL ALLIANCE HEALTH PLAN.

(a) IN GENERAL.—The Board shall establish, in consultation with the States, minimum capital requirements for regional alliance health plans, for purposes of section 1203(c).

(b) $500,000 MINIMUM.—Subject to paragraph (3), under such requirements there shall be not less than $500,000 of capital maintained for each plan offered in each alliance area, regardless of whether or not the same sponsor offered more than one of such plans.

(c) ADDITIONAL CAPITAL REQUIREMENTS.—The Board may require additional capital for factors likely to affect the financial stability of health plans, including the following:

(1) Projected plan enrollment and number of providers participating in the plan.

(2) Market share and strength of competition.

(3) Extent and nature of risk-sharing with participating providers and the financial stability of risk-sharing providers.

(4) Prior performance of the plan, risk history, and liquidity of assets.

(d) DEVELOPMENT OF STANDARDS BY NAIC.—The Board may request the National Association of Insurance Commissioners to develop model standards for the additional capital requirements described in subsection (c) and to present such standards to the Board not later than July 1, 1995. The Board may accept such standards as the standards to be applied under subsection (c) or modify the standards in any manner it finds appropriate.

SEC. 1552. STANDARD FOR GUARANTY FUNDS.

(a) IN GENERAL.—In consultation with the States, the Board shall establish standards for guaranty funds established by States under section 1204(c).

(b) GUARANTY FUND STANDARDS.—The standards established under subsection (a) for a guaranty fund shall include the following:

(1) Each fund must have a method to generate sufficient resources to pay health providers and others in the case of a failure of a health plan (as described in section 1204(d)(4)) in order to meet obligations with respect to—

(A) services rendered by the health plan for the comprehensive benefit package, including any supplemental coverage for cost sharing provided by the health plan, and

(B) services rendered prior to health plan insolvency and services to patients after the insolvency but prior to their enrollment in other health plans.

(2) The fund is liable for all claims against the plan by health care providers with respect to their provision of items and services covered under the comprehensive benefit package to enrollees of the failed plan. Such claims, in full, shall take priority over all

other claims. The fund also is liable, to the extent and in the manner provided in accordance with rules established by the Board, for other claims, including other claims of such providers and the claims of contractors, employees, governments, or any other claimants.

(3) The fund stands as a creditor for any payments owed the plan to the extent of the payments made by the fund for obligations of the plan.

(4) The fund has authority to borrow against future assessments (payable under section 1204(c)(2)) in order to meet the obligations of failed plans participating in the fund.

PART 2—RESPONSIBILITIES OF DEPARTMENT OF HEALTH AND HUMAN SERVICES

Subpart A—General Responsibilities

SEC. 1571. GENERAL RESPONSIBILITIES OF SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—Except as otherwise specifically provided under this Act (or with respect to administration of provisions in the Internal Revenue Code of 1986 or in the Employee Retirement Income Security Act of 1974), the Secretary of Health and Human Services shall administer and implement all of the provisions of this Act, except those duties delegated to the National Health Board, any other executive agency, or to any State.

(b) FINANCIAL MANAGEMENT STANDARDS.—The Secretary, in consultation with the Secretaries of Labor and the Treasury, shall establish, for purposes of section 1361, standards relating to the management of finances, maintenance of records, accounting practices, auditing procedures, and financial reporting for health alliances. Such standards shall take into account current Federal laws and regulations relating to fiduciary responsibilities and financial management of funds.

(c) AUDITING REGIONAL ALLIANCE PERFORMANCE.—The Secretary shall perform periodic financial and other audits of regional alliances to assure that such alliances are carrying out their responsibilities under this Act consistent with this Act. Such audits shall include audits of alliance performance in the areas of—

(1) assuring enrollment of all regional alliance eligible individuals in health plans,

(2) management of premium and cost sharing discounts and reductions provided; and

(3) financial management of the alliance, including allocation of collection shortfalls.

SEC. 1572. ADVISORY COUNCIL ON BREAKTHROUGH DRUGS.

(a) IN GENERAL.—The Secretary shall appoint an Advisory Council on Breakthrough Drugs (in this section referred to as the "Council") that will examine the reasonableness of launch prices of new drugs that represent a breakthrough or significant advance over existing therapies.

(b) DUTIES.—(1) At the request of the Secretary, or a member of the Council, the Council shall make a determination regarding the reasonableness of launch prices of a breakthrough drug. Such a determination shall be based on:

(A) prices of other drugs in the same therapeutic class;

(B) cost information supplied by the manufacturer;

(C) prices of the drug in countries specified in section 302(b)(4)(A) of the Federal Food, Drug, and Cosmetic Act; and

(D) projected prescription volume, economies of scale, product stability, special manufacturing requirements and research costs.

(2) The Secretary shall review the determinations of the Council and publish the results of such review along with the Council's determination (including minority opinions) as a notice in the Federal Register.

(c) MEMBERSHIP.—The Council shall consist of a chair and 12 other persons, appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Council shall include a representative from the pharmaceutical industry, consumer organizations, physician organizations, the hospital industry, and the managed care industry. Other individuals appointed by the Secretary shall be recognized experts in the fields of health care economics, pharmacology, pharmacy and prescription drug reimbursement. Only one member of the Council may have direct or indirect financial ties to the pharmaceutical industry.

(d) TERM OF APPOINTMENTS.—Appointments shall be for a term of 3 years, except that the Secretary may provide initially for such shorter terms as will ensure that the terms of not more than 5 members expire in any one year.

(e) COMPENSATION.—Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursements under the Social Security Act.

(f) NO TERMINATION.—Notwithstanding the provisions of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise specified in law.

Subpart B—Certification of Essential Community Providers

SEC. 1581. CERTIFICATION.

(a) IN GENERAL.—For purposes of this Act, the Secretary shall certify as an "essential community provider" any health care provider or organization that—

(1) is within any of the categories of providers and organizations specified in section 1582(a), or

(2) meets the standards for certification under section 1583(a).

(b) TIMELY ESTABLISHMENT OF PROCESS.—The Secretary shall take such actions as may be necessary to permit health care providers and organizations to be certified as essential community providers in a State before the beginning of the first year for the State.

SEC. 1582. CATEGORIES OF PROVIDERS AUTOMATICALLY CERTIFIED.

(a) IN GENERAL.—The categories of providers and organizations described in this subsection are as follows:

(1) MIGRANT HEALTH CENTERS.—A recipient or subrecipient of a grant under section 329 of the Public Health Service Act.

(2) COMMUNITY HEALTH CENTERS.—A recipient or subrecipient of a grant under section 330 of the Public Health Service Act.

(3) HOMELESS PROGRAM PROVIDERS.—A recipient or subrecipient of a grant under section 340 of the Public Health Service Act.

(4) PUBLIC HOUSING PROVIDERS.—A recipient or subrecipient of a grant under section 340A of the Public Health Service Act.

(5) FAMILY PLANNING CLINICS.—A recipient or subrecipient of a grant under title X of the Public Health Service Act.

(6) INDIAN HEALTH PROGRAMS.—A service unit of the Indian Health Service, a tribal organization, or an urban Indian program, as defined in the Indian Health Care Improvement Act.

(7) AIDS PROVIDERS UNDER RYAN WHITE ACT.—A public or private nonprofit health care provider that is a recipient or subrecipient of a grant under title XXIII of the Public Health Service Act.

(8) MATERNAL AND CHILD HEALTH PROVIDERS.—A public or private nonprofit entity that provides prenatal care, pediatric care, or ambulatory services to children, including children with special health care needs, and that receives funding for such care or services under title V of the Social Security Act.

(9) FEDERALLY QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC.—A Federally-qualified health center or a rural health clinic (as such terms are defined in section 1861(aa) of the Social Security Act.

(10) PROVIDER OF SCHOOL HEALTH SERVICES.—A provider of school health services that receives funding for such services under subtitle G of title III.

(11) COMMUNITY PRACTICE NETWORK.—A community practice networking receiving development funds under subtitle E of title III.

(b) SUBRECIPIENT DEFINED.—In this subpart, the term "subrecipient" means, with respect to a recipient of a grant under a particular authority, an entity that—

(1) is receiving funding from such a grant under a contract with the principal recipient of such a grant, and

(2) meets the requirements established to be a recipient of such a grant.

(c) HEALTH PROFESSIONAL DEFINED.—In this subpart, the term "health professional" means a physician, nurse, nurse practitioner, certified nurse midwife, physician assistant, psychologist, dentist, pharmacist, and other health care professional recognized by the Secretary.

SEC. 1583. STANDARDS FOR ADDITIONAL PROVIDERS.

(a) STANDARDS.—The Secretary shall publish standards for the certification of additional categories of health care providers and organizations as essential community providers, including the categories described in subsection (b). Such a health care provider or organization shall not be certified unless the Secretary determines, under such standards, that health plans operating in the area served by the applicant would not be able to assure adequate access to items and services included in the comprehensive benefit package.

(b) CATEGORIES TO BE INCLUDED.—The categories described in this subsection are as follows:

(1) HEALTH PROFESSIONALS.—Health professionals—

(A) located in an area designated as a health professional shortage area (under section 332 of the Public Health Service Act), or

(B) providing a substantial amount of health services (as determined in accordance with standards established by the Secretary) to a medically underserved population (as designated under section 330 of such Act).

(2) INSTITUTIONAL PROVIDERS.—Public and private nonprofit hospitals and other institutional health care providers located in such an area or providing health services to such a population.

(3) OTHER PROVIDERS.—Other public and private nonprofit agencies and organizations that—

(A) are located in such an area or providing health services to such a population, and

(B) provide health care and services essential to residents of such an area or such populations.

SEC. 1584. CERTIFICATION PROCESS; REVIEW; TERMINATION OF CERTIFICATIONS.

(a) CERTIFICATION PROCESS.—

(1) PUBLICATION OF PROCEDURES.—The Secretary shall publish, not later than 6 months

after the date of the enactment of this Act, the procedures to be used by health care professionals, providers, agencies, and organizations seeking certification under this subpart, including the form and manner in which an application for such certification is to be made.

(2) TIMELY DETERMINATION.—The Secretary shall make a determination upon such an application not later than 60 days (or 15 days in the case of a certification for an entity described in section 1582) after the date the complete application has been submitted. The determination on an application for certification of an entity described in section 1582 shall only involve the verification that the entity is an entity described in such section.

(b) REVIEW OF CERTIFICATIONS.—The Secretary shall periodically review whether professionals, providers, agencies, and organizations certified under this subpart continue to meet the requirements for such certification.

(c) TERMINATION OR DENIAL OF CERTIFICATION.—

(1) PRELIMINARY FINDING.—If the Secretary preliminarily finds that an entity seeking certification under this section does not meet the requirements for such certification or such an entity certified under this subpart fails to continue to meet the requirements for such certification, the Secretary shall notify the entity of such preliminary finding and permit the entity an opportunity, under subtitle E of title V, to rebut such findings.

(2) FINAL DETERMINATION.—If, after such opportunity, the Secretary continues to find that such an entity continues to fail to meet such requirements, the Secretary shall terminate the certification and shall notify the entity, regional alliances, and corporate alliances of such termination and the effective date of the termination.

SEC. 1585. NOTIFICATION OF HEALTH ALLIANCES AND PARTICIPATING STATES.

(a) IN GENERAL.—Not less often than annually the Secretary shall notify each participating State and each health alliance of essential community providers that have been certified under this subpart.

(b) CONTENTS.—Such notice shall include sufficient information to permit each health alliance to notify health plans of the identity of each entity certified as an essential community provider, including—

(1) the location of the provider within each plan's service area,

(2) the health services furnished by the provider, and

(3) other information necessary for health plans to carry out part 3 of subtitle E.

PART 3—SPECIFIC RESPONSIBILITIES OF SECRETARY OF LABOR.

SEC. 1591. RESPONSIBILITIES OF SECRETARY OF LABOR.

(a) IN GENERAL.—The Secretary of Labor is responsible—

(1) under subtitle D of title I, for the enforcement of requirements applicable to employers under regional health alliances (including requirements relating to payment of premiums) and the administration of corporate health alliances;

(2) under subtitle E of title I, with respect to elections by eligible sponsors to become corporate alliances and the termination of such elections;

(3) under section 1395, for the temporary assumption of the operation of self-insured corporate alliance health plans that are insolvent;

(4) under section 1396, for the establishment and administration of Corporate Alliance Health Plan Insolvency Fund;

(5) for carrying out any other responsibilities assigned to the Secretary under this Act; and

(6) for administering title I of the Employee Retirement Income Security Act of 1974 as it relates to group health plans maintained by corporate alliances.

(b) AGREEMENTS WITH STATES.—The Secretary of Labor may enter into agreements with States in order to enforce responsibilities of employers and corporate alliances, and requirements of corporate alliance health plans, under subtitle B of title I of the Employee Retirement Income Security Act of 1974.

(c) CONSULTATION WITH BOARD.—In carrying out activities under this Act with respect to corporate alliances, corporate alliance health plans, and employers, the Secretary of Labor shall consult with the National Health Board.

(d) EMPLOYER-RELATED REQUIREMENTS.—

(1) IN GENERAL.—The Secretary of Labor, in consultation with the Secretary, shall be responsible for assuring that employers—

(A) make payments of any employer premiums (and withhold and make payment of the family share of premiums with respect to qualifying employees) as required under this Act, including auditing of regional alliance collection activities with respect to such payments,

(B) submit timely reports as required under this Act, and

(C) otherwise comply with requirements imposed on employers under this Act.

(2) AUDIT AND SIMILAR AUTHORITIES.—The Secretary of Labor—

(A) may carry out such audits (directly or through contract) and such investigations of employers and health alliances,

(B) may exercise such authorities under section 504 of Employee Retirement Income Security Act of 1974 (in relation to activities under this Act),

(C) may, with the permission of the Board, provide (through contract or otherwise) for such collection activities (in relation to amounts owed to regional alliances and for the benefit of such alliances), and

(D) may impose such civil penalties under section 1347(c),

as may be necessary to carry out such Secretary's responsibilities under this section.

(e) AUTHORITY.—The Secretary of Labor is authorized to issue such regulations as may be necessary to carry out responsibilities of the Secretary under this Act.

Subtitle G—Employer Responsibilities

SEC. 1601. PAYMENT REQUIREMENT.

(a) IN GENERAL.—Each employer shall provide for payments required under section 6121 or 6131 in accordance with the applicable provisions of this Act.

(b) EMPLOYERS IN SINGLE-PAYER STATES.—In the case of an employer with respect to employees who reside in a single-payer State, the responsibilities of such employer under such system shall supersede the obligations of the employer under subsection (a), except as the Board may provide.

SEC. 1602. REQUIREMENT FOR INFORMATION REPORTING.

(a) REPORTING OF END-OF-YEAR INFORMATION TO QUALIFYING EMPLOYEES.—

(1) IN GENERAL.—Each employer shall provide to each individual who was a qualifying employee of the employer during any month in the previous year information described in paragraph (2) with respect to the employee.

(2) INFORMATION TO BE SUPPLIED.—The information described in this paragraph, with respect to a qualifying employee, is the following (as specified by the Secretary):

(A) REGIONAL ALLIANCE INFORMATION.—With respect to each regional alliance through which the individual obtained health coverage:

(i) The total number of months of full-time equivalent employment (as determined for purposes of section 6121(d)) for each class of enrollment.

(ii) The amount of wages attributable to qualified employment and the amount of covered wages (as defined in paragraph (4)).

(iii) The total amount deducted from wages and paid for the family share of the premium.

(iv) Such other information as the Secretary of Labor may specify.

(B) CORPORATE ALLIANCE INFORMATION.—With respect to a qualifying employee who obtains coverage through a corporate alliance health plan:

(i) The total number of months of full-time equivalent employees (as determined under section 1901(b)(2)) for each class of enrollment.

(ii) Such other information as the Secretary of Labor may specify.

(3) ALLIANCE SPECIFIC INFORMATION.—In the case of a qualifying employee with respect to whom an employer made employer premium payments during the year to more than one regional alliance, the information under this subsection shall be reported separately with respect to each such alliance.

(4) COVERED WAGES DEFINED.—In this section, the term "covered wages" means wages paid an employee of an employer during a month in which the employee was a qualifying employee of the employer.

(b) REPORTING OF INFORMATION FOR USE OF REGIONAL ALLIANCES.—

(1) IN GENERAL.—Each employer (including corporate alliance employers) shall provide under subsection (f) on behalf of each regional alliance information described in paragraph (2) on an annual basis, information described in paragraph (3) on a monthly basis, and information described in paragraph (4) on a one-time basis, with respect to the employment of qualified employees in each year, month, or other time, respectively.

(2) INFORMATION TO BE SUPPLIED ON AN ANNUAL BASIS.—The information described in this paragraph, with respect to an employer, is the following (as specified by the Secretary of Labor).

(A) REGIONAL ALLIANCE INFORMATION.—With respect to each regional alliance to which employer premium payments were payable in the year:

(i) For each qualifying employee in the year—

(I) The total number of months of full-time equivalent employment (as determined for purposes of section 6121(d)) for the employee for each class of enrollment.

(II) The total amount deducted from wages and paid for the family share of the premium of the qualifying employee.

(ii) The total employer premium payment made under section 6121 for the year with respect to the employment of all qualifying employees residing in the alliance area and, in the case of an employer that has obtained (or seeks to obtain) a premium discount under section 6123, the total employer premium payment that would have been owed for such employment for the year but for such section.

(iii) The number of full-time equivalent employees (determined under section 6121(d)) for each class of family enrollment in the year (and for each month in the year in the case of an employer that has obtained or is

seeking a premium discount under section 6123).

(iv) In the case of an employer to which section 6124 applies in a year, such additional information as the Secretary of Labor may require for purposes of that section.

(v) The amounts paid (and payable) pursuant to section 6125.

(vi) The amount of covered wages for each qualified employee.

(3) INFORMATION ON A MONTHLY BASIS.—

(A) IN GENERAL.—The information described in this paragraph for a month for an employer is such information as the Secretary of Labor may specify regarding—

(i) the identity of each eligible individual who changed qualifying employee status with respect to the employer in the month; and

(ii) in the case of such an individual described in subparagraph (B)(i)—

(I) the regional alliance for the alliance area in which the individual resides, and

(II) the individual's class of family enrollment.

(B) CHANGES IN QUALIFYING EMPLOYEE STATUS DESCRIBED.—For purposes of subparagraph (A), an individual is considered to have changed qualifying employee status in a month if the individual either (i) is a qualifying employee of the employer in the month and was not a qualifying employee of the employer in the previous month, or (ii) is not a qualifying employee of the employer in the month but was a qualifying employee of the employer in the previous month.

(4) INITIAL INFORMATION.—Each employer, at such time before the first year in which qualifying employees of the employer are enrolled in regional alliance health plans as the Board may specify, shall provide for the reporting of such information relating to employment of eligible individuals as the Board may specify.

(c) RECONCILIATION OF EMPLOYER PREMIUM PAYMENTS.—

(1) PROVISION OF INFORMATION.—Each employer (whether or not the employer claimed (or claims) an employer premium discount under section 6123 for a year) that is liable for employer premium payments to a regional alliance for any month in a year shall provide the alliance with such information as the alliance may require (consistent with rules of the Secretary of Labor) to determine the appropriate amount of employer premium payments that should have been made for all months in the year (taking into account any employer premium discount under section 6123 for the employer).

(2) DEADLINE.—Such information shall be provided not later than the beginning of February of the following year with the payment to be made for that month.

(3) RECONCILIATION.—

(A) CONTINUING EMPLOYERS.—Based on such information, the employer shall adjust the amount of employer premium payment made in the month in which the information is provided to reflect the amount by which the payments in the previous year were greater or less than the amount of payments that should have been made.

(B) DISCONTINUING EMPLOYERS.—In the case of a person that ceases to be an employer in a year, such adjustment shall be made in the form of a payment to, or from, the alliance involved.

(4) SPECIAL TREATMENT OF SELF-EMPLOYED INDIVIDUALS.—Except as the Secretary of Labor may provide, individuals who are employers only be virtue of the operation of section 6126 shall have employer premium payments attributable to such section reconciled (in the manner previously described in this subsection) under the process for the collection of the family share of premiums under section 1344 rather than under this subsection.

(d) SPECIAL RULES FOR SELF-EMPLOYED.—

(1) IN GENERAL.—In the case of an individual who is treated as an employer under section 6126, the individual shall provide, under subsection (f) on behalf of each regional alliance, information described in paragraph (2) with respect to net earnings from self-employment income of the individual in each year.

(2) INFORMATION TO BE SUPPLIED.—The information described in this paragraph, with respect to an individual, is such information as may be necessary to compute the amount payable under section 6131 by virtue of section 6126.

(e) FORM.—Information shall be provided under this subsection in such electronic or other form as the Secretary specifies. Such specifications shall be done in a manner that, to the maximum extent practicable, simplifies administration for small employers.

(f) INFORMATION CLEARINGHOUSE FUNCTIONS.—

(1) DESIGNATION.—The Board shall provide for the use of the regional centers (which are part of the electronic data network under section 5103) to perform information clearinghouse functions under this section with respect to employers and regional and corporate alliances.

(2) FUNCTIONS.—The functions referred to in paragraph (1) shall include—

(A) receipt of information submitted by employers under subsection (b) on an annual (or one-time) basis,

(B) from the information received, transmittal of information required to regional alliances,

(C) such other functions as the Board specifies.

(g) DEADLINE.—Information required to be provided by an employer for a year under this section—

(1) to a qualifying employee shall be provided not later than the date the employer is required under law to provide for statements under section 6051 of the Internal Revenue Code of 1986 for that year, or

(2) to a health alliance (through a regional center) shall be provided not later than the date by which information is required to be filed with the Secretary pursuant to agreements under section 232 of the Social Security Act for that year.

(h) NOTICE TO CERTAIN INDIVIDUALS WHO ARE NOT EMPLOYEES.—

(1) IN GENERAL.—A person that carries on a trade or business shall notify in writing each individual described in paragraph (2) that the person is not obligated to make any employer health care premium payment (under section 6121) in relation to the services performed by the individual for the person.

(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph, with respect to a person, is an individual who normally performs services for the person in the person's trade or business for more than 40 hours per month but who is not an employee of the person (within the meaning of section 1901(a)).

(3) TIMING; EFFECTIVE DATE.—Such notice shall be provided within a reasonable time after the individual begins performing services for the person, except that in no event is such a notice required to be provided with respect to services performed before January 1, 1998.

(4) EXCEPTIONS.—The Secretary shall issue regulations providing exceptions to the notice requirement of paragraph (1) with respect to individuals performing services on an irregular, incidental, or casual basis.

(5) MODEL NOTICE.—The Secretary shall publish a model notice that is easily understood by the average reader and that persons may use to satisfy the requirements of paragraph (1).

SEC. 1603. REQUIREMENTS RELATING TO NEW EMPLOYEES.

(a) COMPLETION OF ENROLLMENT INFORMATION FORM.—At the time an individual is hired as a qualifying employee of a regional alliance employer, the employer shall obtain from the individual the following information (pursuant to rules established by the Secretary of Labor):

(1) The identity of the individual.

(2) The individual's alliance area of residence and whether the individual has moved from another alliance area.

(3) The class of family enrollment applicable to the individual.

(4) The health plan (and health alliance) in which the individual is enrolled at that time.

(5) If the individual has moved from another alliance area, whether the individual intends to enroll in a regional alliance health plan.

(b) TRANSMITTAL OF INFORMATION TO ALLIANCE.—

(1) IN GENERAL.—Each employer shall transmit the information obtained under subsection (a) to the regional alliance for the alliance area in which the qualifying employee resides (or will reside at the time of initial employment).

(2) DEADLINE.—Such information shall be transmitted within 30 days of the date of hiring of the employee.

(3) FORM.—Information under this section may be forwarded in electronic form to a regional alliance.

(c) PROVISION OF ENROLLMENT FORM AND INFORMATION.—In the case of an individual described in subsection (a)(5), the employer shall provide the individual, at the time of hiring, with—

(1) such information regarding the choice of, and enrollment in, regional alliance health plans, and

(2) such enrollment form,

as the regional alliance provides to the employer.

SEC. 1604. AUDITING OF RECORDS.

Each regional alliance employer shall maintain such records, and provide the regional alliance for the area in which the employer maintains the principal place of employment (as specified by the Secretary of Labor) with access to such records, as may be necessary to verify and audit the information reported under this subtitle.

SEC. 1605. PROHIBITION OF CERTAIN EMPLOYER DISCRIMINATION.

No employer may discriminate with respect to an employee on the basis of the family status of the employee or on the basis of the class of family enrollment selected with respect to the employee.

SEC. 1606. PROHIBITION ON SELF-FUNDING OF COST SHARING BENEFITS BY REGIONAL ALLIANCE EMPLOYERS.

(a) PROHIBITION.—A regional alliance employer (and a corporate alliance employer with respect to employees who are regional alliance eligible individuals) may provide benefits to employees that consist of the benefits included in a cost sharing policy (as defined in section 1421(b)(2)) only through a contribution toward the purchase of a cost sharing policy which is funded primarily through insurance.

(b) INDIVIDUAL AND EMPLOYER RESPONSIBILITIES.—In the case of an individual who resides in a single-payer State and an employer with respect to employees who reside in such a State, the responsibilities of such individual and employer under such system shall supersede the obligations of the individual and employer under part 2 of this subtitle.

SEC. 1607. EQUAL VOLUNTARY CONTRIBUTION REQUIREMENT.

(a) IN GENERAL.—An employer may not discriminate in the wages or compensation paid, or other terms or conditions of employment, with respect to an employee based on the health plan (or premium of such a plan) in which the employee is enrolled.

(b) REBATE REQUIRED IN CERTAIN CASES.—

(1) IN GENERAL.—Subject to paragraph (3), if—

(A) an employer makes available a voluntary premium payment on behalf of an employee towards the enrollment of the employee in a health plan, and

(B) the premium for the plan selected is less than the sum of the amounts of the employer premium payment (required under part 3) and the voluntary premium payment,

the employer must rebate to the employee an amount equal to the difference described in subparagraph (B).

(2) REBATES.—

(A) IN GENERAL.—Any rebate provided under paragraph (1) shall be treated, for purposes of the Internal Revenue Code of 1986, as wages described in section 3121(a) of such Act.

(B) TREATMENT OF MULTIPLE FULL-TIME EMPLOYMENT IN A FAMILY.—In the case of—

(i) an individual who is an employee of more than one employer, or

(ii) a couple for which both spouses are employees,

if more than one employer provides for voluntary premium payments, the individual or couple may elect to have paragraph (1) applied with respect to all employment.

(c) EXCEPTION FOR COLLECTIVE BARGAINING AGREEMENT.—Subsections (a) and (b) shall not apply with respect to voluntary employer contributions made pursuant to a bona fide collective bargaining agreement.

(d) CONSTRUCTION.—

(1) Subsection (a) shall not be construed as preventing variations in net wages of an employee to reflect the family share of premiums for the health plan selected, so long as any excess employer payments (as defined in paragraph (2)) are added to the pay of the employee involved.

(2) In paragraph (1), the term "excess employer payments" means, with respect to an employee, the amount by which the voluntary employer contribution toward health care expenses exceeds the family share of premium under section 6101(b) for such enrollment.

(e) VOLUNTARY EMPLOYER CONTRIBUTION DEFINED.—In this section, the term "voluntary employer contribution" means any payment designed to be used exclusively (or primarily) towards the cost of the family share of premiums for a health plan. Such term does not include any employer premiums required to be paid under part 3 of subtitle B of title VI.

SEC. 1608. ENFORCEMENT.

In the case of a person that violates a requirement of this subtitle, the Secretary of Labor may impose a civil money penalty, in an amount not to exceed $10,000, for each violation with respect to each individual.

[Subtitle H—Reserved]

[Subtitle I—Reserved]

Subtitle J—General Definitions; Miscellaneous Provisions

PART 1—GENERAL DEFINITIONS

SEC. 1901. DEFINITIONS RELATING TO EMPLOYMENT AND INCOME.

(a) IN GENERAL.—Except as otherwise specifically provided, in this Act the following definitions and rules apply:

(1) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND WAGES DEFINED.—Except as provided in this section—

(A) the terms "wages" and "employment" have the meanings given such terms under section 3121 of the Internal Revenue Code of 1986,

(B) the term "employee" has the meaning given such term under subtitle C of such Code, and

(C) the term "employer" has the same meaning as the term "employer" as used in such section.

(2) EXCEPTIONS.—For purposes of paragraph (1)—

(A) EMPLOYMENT.—

(i) EMPLOYMENT INCLUDED.—Paragraphs (1), (2), (5), (7) (other than clauses (i) through (iv) of subparagraph (C) and clauses (i) through (v) of subparagraph (F)), (8), (9), (10), (11), (13), (15), (18), and (19) of section 3121(b) of the Internal Revenue Code of 1986 shall not apply.

(ii) EXCLUSION OF INMATES AS EMPLOYEES.—Employment shall not include services performed in a penal institution by an inmate thereof or in a hospital or other health care institution by a patient thereof.

(B) WAGES.—

(i) IN GENERAL.—Paragraph (1) of section 3121(a) of the Internal Revenue Code of 1986 shall not apply.

(ii) TIPS NOT INCLUDED.—The term "wages" does not include cash tips.

(C) EXCLUSION OF EMPLOYEES OUTSIDE THE UNITED STATES.—The term "employee" does not include an individual who does not reside in the United States.

(D) EXCLUSION OF FOREIGN EMPLOYMENT.—The term "employee" does not include an individual—

(i) with respect to service, if the individual is not a citizen or resident of the United States and the service is performed outside the United States, or

(ii) with respect to service, if the individual is a citizen or resident of the United States and the service is performed outside the United States for an employer other than an American employer (as defined in section 3121(h) of the Internal Revenue Code of 1986).

(3) AGGREGATION RULES FOR EMPLOYERS.—For purposes of this Act—

(A) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(B) under regulations of the Secretary of Labor, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under subparagraph (B) shall be based on principles similar to the principles which apply to taxable organizations under subparagraph (A).

(4) EMPLOYER PREMIUM.—The term "employer premium" refers to the premium established and imposed under part 2 of subtitle B of title VI.

(b) QUALIFYING EMPLOYEE; FULL-TIME EMPLOYMENT.—

(1) QUALIFYING EMPLOYEE.—

(A) IN GENERAL.—In this Act, the term "qualifying employee" means, with respect to an employer for a month, an employee (other than a covered child, as defined in subparagraph (C)) who is employed by the employer for at least 40 hours (as determined under paragraph (3)) in the month.

(B) NO SPECIAL TREATMENT OF MEDICARE BENEFICIARIES, SSI RECIPIENTS, AFDC RECIPIENTS, AND OTHERS.—Subparagraph (A) shall apply regardless of whether or not the qualifying employee is a medicare-eligible individual, an SSI recipient, an AFDC recipient, an individual described in section 1004(b), an eligible individual or is authorized to be so employed.

(C) COVERED CHILD DEFINED.—In subparagraph (A), the term "covered child" means an eligible individual who is a child and is enrolled under a health plan as a family member described in section 1011(b)(2)(B).

(2) FULL-TIME EQUIVALENT EMPLOYEES; PART-TIME EMPLOYEES.—

(A) IN GENERAL.—For purposes of this Act, a qualifying employee who is employed by an employer—

(i) for at least 120 hours in a month, is counted as 1 full-time equivalent employee for the month and shall be deemed to be employed on a full-time basis, or

(ii) for at least 40 hours, but less than 120 hours, in a month, is counted as a fraction of a full-time equivalent employee in the month equal to the full-time employment ratio (as defined in subparagraph (B)) for the employee and shall be deemed to be employed on a part-time basis.

(B) FULL-TIME EMPLOYMENT RATIO DEFINED.—For purposes of this Act, the term "full-time employment ratio" means, with respect to a qualifying employee of an employer in a month, the lesser of 1 or the ratio of—

(i) the number of hours of employment such employee is employed by such employer for the month (as determined under paragraph (3)), to

(ii) 120 hours.

(C) FULL-TIME EMPLOYEE.—For purposes of this Act, the term "full-time employee" means, with respect to an employer, an employee who is employed on a full-time basis (as specified in subparagraph (A)) by the employer.

(3) HOURS OF EMPLOYMENT.—

(A) IN GENERAL.—For purposes of this Act, the Board shall specify the method for computing hours of employment for employees of an employer consistent with this paragraph. The Board shall take into account rules used for purposes of applying the Fair Labor Standards Act.

(B) HOURLY WAGE EARNERS.—In the case of an individual who receives compensation (in the form of hourly wages or compensation) for the performance of services, the individual is considered to be "employed" by an employer for an hour if compensation is payable with respect to that hour of employment, without regard to whether or not the employee is actually performing services during such hours.

(4) TREATMENT OF SALARIED EMPLOYEES AND EMPLOYEE PAID ON CONTINGENT OR BONUS ARRANGEMENTS.—In the case of an employee who receives compensation on a salaried basis or on the basis of a commission (or other contigent or bonus basis), rather than an hourly, the Board shall establish rules for the conversion of the compensation to hours of employment, taking into account the minimum monthly compensation levels for

workers employed on a full-time basis under the Fair Labor Standards Act and other factors the Board considers relevant.

(c) DEFINITIONS RELATING TO SELF-EMPLOYMENT.—In this Act:

(1) NET EARNINGS FROM SELF-EMPLOYMENT.—The term "net earnings from self-employment" has the meaning given such term under section 1402(a) of the Internal Revenue Code of 1986.

(2) SELF-EMPLOYED INDIVIDUAL.—The term "self-employed individual" means, for a year, an individual who has net earnings from self-employment for the year.

SEC. 1902. OTHER GENERAL DEFINITIONS.

Except as otherwise specifically provided, in this Act the following definitions apply:

(1) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term "alien permanently residing in the United States under color of law" means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(19) of the Immigration and Nationality Act), and includes any of the following:

(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(B) An alien who is granted asylum under section 208 of such Act.

(C) An alien whose deportation is withheld under section 243(h) of such Act.

(D) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(E) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

(F) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(G) An alien within such other classification of permanent resident aliens as the National Health Board may establish by regulation.

(2) AFDC FAMILY.—The term "AFDC family" means a family composed entirely of one or more AFDC recipients.

(3) AFDC RECIPIENT.—The term "AFDC recipient" means an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act.

(4) ALLIANCE AREA.—The term "alliance area" means the area served by a regional alliance and specified under section 1202(b).

(5) ALLIANCE ELIGIBLE INDIVIDUAL.—The term "alliance eligible individual" means, with respect to a health alliance, an eligible individual with respect to whom the applicable health plan is a health plan offered by or through such alliance and does not include a prisoner.

(6) APPLICABLE HEALTH PLAN.—The term "applicable health plan" means, with respect to an eligible individual, the health plan specified pursuant to section 1004 and part 2 of subtitle A.

(7) COMBINATION COST SHARING PLAN.—The term "combination cost sharing plan" means a health plan that provides combination cost sharing schedule (consistent with section 1134).

(8) COMPREHENSIVE BENEFIT PACKAGE.—The term "comprehensive benefit package" means the package of health benefits provided under subtitle B of title II.

(9) CONSUMER PRICE INDEX; CPI.—The terms consumer price index" and "CPI" mean the Consumer Price Index for all urban consumers (U.S. city average), as published by the Bureau of Labor Statistics.

(10) CORPORATE ALLIANCE ELIGIBLE INDIVIDUAL.—The term "corporate alliance eligible individual" means, with respect to a corporate alliance, an eligible individual with respect to whom the corporate alliance is the applicable health plan.

(11) CORPORATE ALLIANCE EMPLOYER.—The term "corporate alliance employer" means, with respect to a corporate alliance, an employer of an individual who is a participant in a corporate alliance health plan of that alliance.

(12) CORPORATE ALLIANCE HEALTH PLAN.—The term "corporate alliance health plan" means a health plan offered by a corporate alliance under part 2 of subtitle E.

(13) DISABLED SSI RECIPIENT.—The term "disabled SSI recipient" means an individual who—

(A) is an SSI recipient, and

(B) has been determined to be disabled for purposes of the supplemental security income program (under title XVI of the Social Security Act).

(14) ELIGIBLE ENROLLEE.—The term "eligible enrollee" means, with respect to an health plan offered by a health alliance, an alliance eligible individual, but does not include such an individual if the individual is enrolled under such a plan as the family member of another alliance eligible individual.

(15) ESSENTIAL COMMUNITY PROVIDER.—The term "essential community provider" means an entity certified as such a provider under subpart B of part 2 of subtitle F.

(16) FEE-FOR-SERVICE PLAN.—The term "fee-for-service plan" means a health plan described in section 1322(b)(2)(A).

(17) FIRST YEAR.—The term "first year" means, with respect to—

(A) a State that is a participating State in a year before 1998, the year in which the State first is a participating State, or

(B) any other State, 1998.

(18) HIGHER COST SHARING PLAN.—The term "higher cost sharing plan" means a health plan that provides a high cost sharing schedule (consistent with section 1133).

(19) LONG-TERM NONIMMIGRANT.—The term "long-term nonimmigrant" means a nonimmigrant described in subparagraph (E), (H), (I), (J), (K), (L), (M), (N), (O), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act or an alien within such other classification of nonimmigrant as the National Health Board may establish by regulation.

(20) LOWER COST SHARING PLAN.—The term "lower cost sharing plan" means a health plan that provides a lower cost sharing schedule (consistent with section 1132).

(21) MEDICARE PROGRAM.—The term "medicare program" means the health insurance program under title XVIII of the Social Security Act.

(22) MEDICARE-ELIGIBLE INDIVIDUAL.—The term "medicare-eligible individual" means, subject to section 1012(a), an individual who is entitled to benefits under part A of the medicare program.

(23) MOVE.—The term "move" means, respect to an individual, a change of residence of the individual from one alliance area to another alliance area.

(24) NATIONAL HEALTH BOARD; BOARD.—The terms "National Health Board" and "Board" mean the National Health Board established under part 1 of subtitle F of title I.

(25) POVERTY LEVEL.—

(A) IN GENERAL.—The term "applicable poverty level" means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved (as determined under subparagraph (B)) for 1994 adjusted by the percentage increase or decrease described in subparagraph (C) for the year involved.

(B) FAMILY SIZE.—In applying the applicable poverty level to—

(i) an individual enrollment, the family size is deemed to be one person;

(ii) a couple-only enrollment, the family size is deemed to be two persons;

(iii) a single parent enrollment, the family size is deemed to be three persons; or

(iv) a dual parent, the family size is deemed to be four persons.

(C) PERCENTAGE ADJUSTMENT.—The percentage increase or decrease described in this subparagraph for a year is the percentage increase or decrease by which the average CPI for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31, 1993.

(D) ROUNDING.—Any adjustment made under subparagraph (A) for a year shall be rounded to the nearest multiple of $100.

(26) PRISONER.—The term "prisoner" means, as specified by the Board, an eligible individual during a period of imprisonment under Federal, State, or local authority after conviction as an adult.

(27) REGIONAL ALLIANCE ELIGIBLE INDIVIDUAL.—The term "regional alliance eligible individual" means an eligible individual with respect to whom a regional alliance health plan is an applicable health plan.

(28) REGIONAL ALLIANCE EMPLOYER.—The term "regional alliance employer" means an employer that is meeting the requirement of section 1003 other than through an agreement with one or more health alliances.

(29) REGIONAL ALLIANCE HEALTH PLAN.—The term "regional alliance health plan" means a health plan offered by a regional alliance under part 1 of subtitle E of title I.

(30) RESIDE.—

(A) An individual is considered to reside in the location in which the individual maintains a primary residence (as established under rules of the National Health Board).

(B) Under such rules and subject to section 1323(c), in the case of an individual who maintains more than one residence, the primary residence of the individual shall be determined taking into account the proportion of time spent at each residence.

(C) In the case of a couple only one spouse of which is a qualifying employee, except as the Board may provide, the residence of the employee shall be the residence of the couple.

(31) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(32) SSI FAMILY.—The term "SSI family" means a family composed entirely of one or more SSI recipients.

(33) SSI RECIPIENT.—The term "SSI recipient" means an individual—

(A) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act,

(B) who receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93-66; or

(C) who receiving monthly benefits under section 1619(a) of such Act (whether or not pursuant to section 1616(c)(3) of such Act).

(34) STATE.—The term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(35) STATE MEDICAID PLAN.—The term "State medicaid plan" means a plan of medical assistance of a State approved under title XIX of the Social Security Act.

(36) UNDOCUMENTED ALIEN.—The term "undocumented alien" means an alien who is not a long-term nonimmigrant, a diplomat, or described in section 1004(c).

(37) UNITED STATES.—The term "United States" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and Northern Mariana Islands.

PART 2—MISCELLANEOUS PROVISIONS

SEC. 1911. USE OF INTERIM, FINAL REGULATIONS.

In order to permit the timely implementation of the provisions of this Act, the National Health Board, the Secretary of Health and Human Services, the Secretary of Labor are each authorized to issue regulations under this Act on an interim basis that become final on the date of publication, subject to change based on subsequent public comment.

SEC. 1912. SOCIAL SECURITY ACT REFERENCES.

Except as may otherwise be provided, any reference in this title, or in title V or VI, to the Social Security Act shall be to the Social Security Act as in effect on the date of the enactment of this Act.

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Subtitle A—Medicare Outpatient Prescription Drug Benefit

SEC. 2001. COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS.

(a) COVERED OUTPATIENT DRUGS AS MEDICAL AND OTHER HEALTH SERVICES.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) is amended to read as follows:

"(J) covered outpatient drugs;".

(b) DEFINITION OF COVERED OUTPATIENT DRUG.—Section 1861(t) of such Act (42 U.S.C. 1395x(t)), as amended by section 13553(b) of the Omnibus Budget Reconciliation Act of 1993 (hereafter in this subtitle referred to as "OBRA-1993"), is amended—

(1) in the heading, by adding at the end the following: "; Covered Outpatient Drugs";

(2) in paragraph (1), by striking "paragraph (2)" and inserting "the succeeding paragraphs of this subsection"; and

(3) by striking paragraph (2) and inserting the following:

"(2) Except as otherwise provided in paragraph (3), the term 'covered outpatient drug' means any of the following products used for a medically accepted indication (as described in paragraph (4)):

"(A) A drug which may be dispensed only upon prescription and—

"(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

"(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

"(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling;

"(B) A biological product which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(iii) is produced at an establishment licensed under such section to produce such product; and

"(C) Insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"(3) The term 'covered outpatient drug' does not include any product which is intravenously administered in a home setting unless it is a covered home infusion drug (as described in paragraph (5)).

"(4) For purposes of paragraph (2), the term 'medically accepted indication', with respect to the use of an outpatient drug, includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

"(A) the drug has been approved by the Food and Drug Administration; and

"(B)(i) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

"(ii) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this clause by the Secretary.

The Secretary may revise the list of compendia in paragraph (B)(i) designated as appropriate for identifying medically accepted indications for drugs.

"(5)(A) For purposes of paragraph (3), the term 'covered home infusion drug' means a covered outpatient drug dispensed to an individual that—

"(i) is administered intravenously, subcutaneously, epidurally, or through other means determined by the Secretary, using an access device that is inserted in to the body and an infusion device to control the rate of flow of the drug,

"(ii) is administered in the individual's home (including an institution used as his home, other than a hospital under subsection (e) or a skilled nursing facility that meets the requirements of section 1819(a)), and

"(iii)(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or the indication to which the drug is applied, that the drug cannot generally be administered safely and effectively in a home setting, or

"(II) is not an antibiotic drug and the Secretary has determined, for the specific drug or the indication to which the drug is applied, that the drug can generally be administered safely and effectively in a home setting.

"(B) Not later than January 1, 1996, (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home infusion drugs, with respect to which home infusion drug therapy may be provided under this title.".

(c) EXCEPTIONS; EXCLUSIONS FROM COVERAGE.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)), as amended by sections 4034(b)(4) and 4118(b), is amended—

(1) by striking "and" at the end of paragraph (15),

(2) by striking the period at the end of paragraph (16) and inserting "; or", and

(3) by inserting after paragraph (16) the following new paragraph:

"(17) A covered outpatient drug (as described in section 1861(t))—

"(A) when furnished as part of, or as incident to, any other item or service for which payment may be made under this title, or

"(B) which is listed under paragraph (2) of section 1927(d) (other than subparagraph (I) or (J) of such paragraph) as a drug which may be excluded from coverage under a State plan under title XIX and which the Secretary elects to exclude from coverage under this part.

(d) OTHER CONFORMING AMENDMENTS.—(1) Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2), as amended by section 13553 of OBRA-1993—

(i) by striking subparagraphs (O) and (Q),

(ii) by adding "and" at the end of subparagraph (N),

(iii) by striking "; and" at the end of subparagraph (P) and inserting a period, and

(iv) by redesignating subparagraph (P) as subparagraph (O); and

(B) by striking the subsection (jj) added by section 4156(a)(2) of the Omnibus Budget Reconciliation Act of 1990.

(2) Section 1881(b)(1)(C) of such Act (42 U.S.C. 1395rr(b)(1)(C)), as amended by section 13566(a) of OBRA-1993, is amended by striking "section 1861(s)(2)(P)" and inserting "section 1861(s)(2)(O)".

SEC. 2002. PAYMENT RULES AND RELATED REQUIREMENTS FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

"(d) PAYMENT FOR AND CERTAIN REQUIREMENTS CONCERNING COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) IN GENERAL.—Payment shall be made under paragraph (2) only for expenses incurred by an individual for a covered outpatient drug during a calendar year after the individual has incurred expenses in the year for such drugs (during a period in which the individual is entitled to benefits under this part) equal to the deductible amount for that year.

"(B) DEDUCTIBLE AMOUNT.—

"(i) For purposes of subparagraph (A), the deductible amount is—

"(I) for 1996, $250, and

"(II) for any succeeding year, the amount (rounded to the nearest dollar) that the Secretary estimates will ensure that the percentage of the average number of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) during the year who will incur expenses for covered outpatient drugs equal to or greater than such amount will be the same as the percentage for the previous year.

"(ii) The Secretary shall promulgate the deductible amount for 1997 and each succeeding year during September of the previous year.

"(C) SPECIAL RULE FOR DETERMINATION OF EXPENSES INCURRED.—In determining the amount of expenses incurred by an individual for covered outpatient drugs during a year for purposes of subparagraph (A), there shall not be included any expenses incurred with respect to a drug to the extent such expenses exceed the payment basis for such drug under paragraph (3).

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the deductible established under paragraph (1), the amount payable under this part for a covered outpatient drug furnished to an individual during a calendar year shall be equal to—

"(i) 80 percent of the payment basis described in paragraph (3), in the case of an individual who has not incurred expenses for covered outpatient drugs during the year (including the deductible imposed under paragraph (1)) in excess of the out-of-pocket limit for the year under subparagraph (B); and

"(ii) 100 percent of the payment basis described in paragraph (3), in the case of any other individual.

"(B) OUT-OF-POCKET LIMIT DESCRIBED.—

"(i) For purposes of subparagraph (A), the out-of-pocket limit for a year is equal to—

"(I) for 1996, $1000, and

"(II) for any succeeding year, the amount (rounded to the nearest dollar) that the Secretary estimates will ensure that the percentage of the average number of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) during the year who will incur expenses for covered outpatient drugs equal to or greater than such amount will be the same as the percentage for the previous year.

"(ii) The Secretary shall promulgate the out-of-pocket limit for 1997 and each succeeding year during September of the previous year.

"(C) SPECIAL RULE FOR DETERMINATION OF EXPENSES INCURRED.—In determining the amount of expenses incurred by an individual for covered outpatient drugs during a year for purposes of subparagraph (A), there shall not be included any expenses incurred with respect to a drug to the extent such expenses exceed the payment basis for such drug under paragraph (3).

"(3) PAYMENT BASIS.—For purposes of paragraph (2), the payment basis is the lesser of—

"(A) the actual charge for a covered outpatient drug, or

"(B) the applicable payment limit established under paragraph (4).

"(4) PAYMENT LIMITS.—

"(A) PAYMENT LIMIT FOR SINGLE SOURCE DRUGS AND MULTIPLE SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a covered outpatient drug that is a multiple source drug which has a restrictive prescription, or that is single source drug, the payment limit for a payment calculation period is equal to—

"(i) for drugs furnished after 1996, the 90th percentile of the actual charges (computed on the geographic basis specified by the Secretary) for the drug product for the second previous payment calculation period, or

"(ii) the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the per unit estimated acquisition cost for the drug product (determined under subparagraph (C)) for the period,

whichever is less.

"(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug which does not have a restrictive prescription, the payment limit for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the unweighted median of the unit estimated acquisition cost (determined under subparagraph (C)) for the drug products for the period.

"(C) DETERMINATION OF UNIT PRICE.—

"(i) IN GENERAL.—The Secretary shall determine, for the dispensing of a covered outpatient drug product in a payment calculation period, the estimated acquisition cost for the drug product. With respect to any covered outpatient drug product, such cost may not exceed 93 percent of the average manufacturer non-retail price for the drug (as defined in section 1850(f)(2)) during the period.

"(ii) COMPLIANCE WITH REQUEST FOR INFORMATION.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide price information requested to carry out clause (i), or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as they apply to a penalty or proceeding under section 1128A(a). Information gathered pursuant to clause (i) shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part.

"(5) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMIT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the administrative allowance under paragraph (4) is—

"(i) for 1996, $5, and

"(ii) for each succeeding year, the amount for the previous year adjusted by the percentage change in the consumer price index for all urban consumers (U.S. city average)

for the 12-month period ending with June of that previous year.

"(B) REDUCTION FOR MAIL ORDER PHARMACIES.—The Secretary may, after consulting with representatives of pharmacists, individuals enrolled under this part, and of private insurers, reduce the administrative allowances established under subparagraph (A) for any covered outpatient drug dispensed by a mail order pharmacy, based on differences between such pharmacies and other pharmacies with respect to operating costs and other economies.

"(6) ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES.—

"(A) IN GENERAL.—The Secretary shall establish a program to identify (and to educate physicians and pharmacists concerning)—

"(i) instances or patterns of unnecessary or inappropriate prescribing or dispensing practices for covered outpatient drugs,

"(ii) instances or patterns of substandard care with respect to such drugs,

"(iii) potential adverse reactions, and

"(iv) appropriate use of generic products.

"(B) STANDARDS.—In carrying out the program under subparagraph (A), the Secretary shall establish for each covered outpatient drug standards for the prescribing of the drug which are based on accepted medical practice. In establishing such standards, the Secretary shall incorporate standards from such current authoritative compendia as the Secretary may select, except that the Secretary may modify such a standard by regulation on the basis of scientific and medical information that such standard is not consistent with the safe and effective use of the drug.

"(C) DRUG USE REVIEW.—The Secretary may provide for a drug use review program with respect to covered outpatient drugs dispensed to individuals eligible for benefits under this part. Such program may include such elements as the Secretary determines to be necessary to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results, including any elements of the State drug use review programs required under section 1927(g) that the Secretary determines to be appropriate.

"(7) ADMINISTRATIVE IMPROVEMENTS.—The Secretary shall develop, in consultation with representatives of pharmacies and of other interested persons, a standard claims form for covered outpatient drugs in accordance with title V of the Health Security Act.

"(8) DEFINITIONS.—In this subsection:

"(A) MULTIPLE AND SINGLE SOURCE DRUGS.—The terms 'multiple source drug' and 'single source drug' have the meanings of those terms under section 1927(k)(7).

"(B) RESTRICTIVE PRESCRIPTION.—A drug has a 'restrictive prescription' only if—

"(i) in the case of a written prescription, the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that a particular drug product must be dispensed, or

"(ii) in the case of a prescription issued by telephone—

"(I) the physician or other person prescribing the drug (through use of such an appropriate phrase) states that a particular drug product must be dispensed, and

"(II) the physician or other person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation which is in the handwriting of the physician or other person prescribing the drug and which indicates with such appropriate phrase that the particular drug product was required to have been dispensed.

"(C) PAYMENT CALCULATION PERIOD.—The term 'payment calculation period' means the 6-month period beginning with January of each year and the 6-month period beginning with July of each year.".

(b) SUBMISSION OF CLAIMS BY PHARMACIES.—Section 1848(g)(4) of such Act (42 U.S.C. 1395w-4(g)(4)) is amended—

(1) in the heading—

(A) by striking "PHYSICIAN", and

(B) by inserting "BY PHYSICIANS AND SUPPLIERS" after "CLAIMS",

(2) in the matter in subparagraph (A) preceding clause (i)—

(A) by striking "For services furnished on or after September 1, 1990, within 1 year" and inserting "Within 1 year (90 days in the case of covered outpatient drugs)",

(B) by striking "a service" and inserting "an item or service", and

(C) by inserting "or of providing a covered outpatient drug," after "basis," and

(3) in subparagraph (A)(i), by inserting "item or" before "service.

(c) SPECIAL RULES FOR CARRIERS.—

(1) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) of such Act (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

"(D) With respect to activities related to covered outpatient drugs, the Secretary may enter into contracts with carriers under this section to perform the activities on a regional basis.".

(2) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) of such Act (42 U.S.C. 1395u(c)(1)(A)) is amended—

(A) by inserting "(i)" after "(c)(1)(A)",

(B) in the first sentence, by inserting ", except as otherwise provided in clause (ii)," after "under this part, and", and

(C) by adding at the end the following:

"(ii) To the extent that a contract under this section provides for activities related to covered outpatient drugs, the Secretary may provide for payment for those activities based on any method of payment determined by the Secretary to be appropriate.".

(3) USE OF OTHER ENTITIES FOR COVERED OUTPATIENT DRUGS.—Section 1842(f) of such Act (42 U.S.C. 1395u(f)) is amended—

(A) by striking "and" at the end of paragraph (1),

(B) by substituting "; and" for the period at the end of paragraph (2), and,

(C) by adding at the end the following:

"(3) with respect to activities related to covered outpatient drugs, any other private entity which the Secretary determines is qualified to conduct such activities.".

(4) DESIGNATED CARRIERS TO PROCESS CLAIMS OF RAILROAD RETIREES.—Section 1842(g) of such Act (42 U.S.C. 1395u(g)) is amended by inserting "(other than functions related to covered outpatient drugs)" after "functions".

(d) CONTRACTS FOR AUTOMATIC DATA PROCESSING EQUIPMENT.—Actions taken before 1995 that affect contracts related to the processing of claims for covered outpatient drugs (as defined in section 1861(t) of the Social Security Act) shall not be subject to section 111 of the Federal Property and Administrative Services Act of 1949, and shall not be subject to administrative or judicial review.

(e) CONFORMING AMENDMENTS.—

(1)(A) Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)), as amended by section 13544(b)(2) of OBRA-1993, is amended—

(i) by striking "and" at the end of clause (O), and

(ii) by inserting before the semicolon at the end the following: ", and (Q) with respect to covered outpatient drugs, the amounts paid shall be as prescribed by section 1834(d)".

(B) Section 1833(a)(2) of such Act (42 U.S.C. 1395l(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ", except for covered outpatient drugs," after "and (I) of such section".

(2) Section 1833(b)(2) of such Act (42 U.S.C. 1395l(b)(2)) is amended by inserting "or with respect to covered outpatient drugs" before the comma.

(3) The first sentence of section 1842(h)(2) of such Act (42 U.S.C. 1395u(h)(2)) is amended by inserting "(other than a carrier described in subsection (f)(3))" after "Each carrier".

(4) The first sentence of section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) in clause (i), by inserting "section 1834(d), after "section 1833(b),", and

(B) in clause (ii), by inserting ", other than for covered outpatient drugs," after "provider)".

SEC. 2003. MEDICARE REBATES FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Part B of title XVIII of the Social Security Act is amended by adding at the end the following new section:

"REBATES FOR COVERED OUTPATIENT DRUGS

"Sec. 1850. (a) REQUIREMENT FOR REBATE AGREEMENT.—In order for payment to be available under this part for covered outpatient drugs of a manufacturer dispensed on or after January 1, 1996, the manufacturer must have entered into and have in effect a rebate agreement with the Secretary meeting the requirements of subsection (b), and an agreement to give equal access to discounts in accordance with subsection (e).

"(b) TERMS, IMPLEMENTATION, AND ENFORCEMENT OF REBATE AGREEMENT.—

"(1) PERIODIC REBATES.—

"(A) IN GENERAL.—A rebate agreement under this section shall require the manufacturer to pay to the Secretary for each calendar quarter, not later than 30 days after the date of receipt of the information described in paragraph (2) for such quarter, a rebate in an amount determined under subsection (c) for all covered outpatient drugs of the manufacturer described in subparagraph (B).

"(B) DRUGS INCLUDED IN QUARTERLY REBATE CALCULATION.—Drugs subject to rebate with respect to a calendar quarter are drugs which are either—

"(i) dispensed by participating pharmacies during such quarter to individuals (other than individuals enrolled with an eligible organization with a contract under section 1876) eligible for benefits under this part, as reported by such pharmacies to the Secretary, or

"(ii) dispensed by nonparticipating pharmacies to such individuals and included in claims for payment of benefits received by the Secretary during such quarter.

"(2) INFORMATION FURNISHED TO MANUFACTURERS.—

"(A) IN GENERAL.—The Secretary shall report to each manufacturer, not later than 60 days after the end of each calendar quarter, information on the total number, for each covered outpatient drug, of units of each dosage form, strength, and package size dispensed under the plan during the quarter, on the basis of the data reported to the Secretary described in paragraph (1)(B).

"(B) AUDIT.—The Comptroller General may audit the records of the Secretary to the extent necessary to determine the accuracy of

reports by the Secretary pursuant to subparagraph (A). Adjustments to rebates shall be made to the extent determined necessary by the audit to reflect actual units of drugs dispensed.

"(3) PROVISION OF PRICE INFORMATION BY MANUFACTURER.—

"(A) QUARTERLY PRICING INFORMATION.—Each manufacturer with an agreement in effect under this section shall report to the Secretary, not later than 30 days after the last day of each calendar quarter, on the average manufacturer retail price and the average manufacturer non-retail price for each dosage form and strength of each covered outpatient drug for the quarter.

"(B) BASE QUARTER PRICES.—Each manufacturer of a covered outpatient drug with an agreement under this section shall report to the Secretary, by not later than 30 days after the effective date of such agreement (or, if later, 30 days after the end of the base quarter), the average manufacturer retail price, for such base quarter, for each dosage form and strength of each such covered drug.

"(C) VERIFICATION OF AVERAGE MANUFACTURER PRICE.—The Secretary may inspect the records of manufacturers, and survey wholesalers, pharmacies, and institutional purchasers of drugs, as necessary to verify prices reported under subparagraph (A).

"(D) PENALTIES.—

"(i) CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty on a manufacturer with an agreement under this section—

"(I) for failure to provide information required under subparagraph (A) on a timely basis, in an amount up to $10,000 per day of delay;

"(II) for refusal to provide information about charges or prices requested by the Secretary for purposes of verification pursuant to subparagraph (C), in an amount up to $100,000; and

"(III) for provision, pursuant to subparagraph (A) or (B), of information that the manufacturer knows or should know is false, in an amount up to $100,000 per item of information.

Such civil money penalties are in addition to any other penalties prescribed by law. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(ii) TERMINATION OF AGREEMENT.—If a manufacturer with an agreement under this section has not provided information required under subparagraph (A) or (B) within 90 days of the deadline imposed, the Secretary may suspend the agreement with respect to covered outpatient drugs dispensed after the end of such 90-day period and until the date such information is reported (but in no case shall a suspension be for less than 30 days).

"(4) LENGTH OF AGREEMENT.—

"(A) IN GENERAL.—A rebate agreement shall be effective for an initial period of not less than one year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

"(B) TERMINATION.—

"(i) BY THE SECRETARY.—The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall afford a manufacturer an opportunity for a hearing concerning such termination, but such hearing shall not delay the effective date of the termination.

"(ii) BY A MANUFACTURER.—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

"(iii) EFFECTIVE DATE OF TERMINATION.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

"(iv) NOTICE TO PHARMACIES.—In the case of a termination under this subparagraph, the Secretary shall notify pharmacies that are participating suppliers under this part and physician organizations not less than 30 days before the effective date of such termination.

"(c) AMOUNT OF REBATE.—

"(1) BASIC REBATE.—Each manufacturer shall remit a basic rebate to the Secretary for each calendar quarter in an amount, with respect to each dosage form and strength of a covered drug (except as provided under paragraph (4)), equal to the product of—

"(A) the total number of units subject to rebate for such quarter, as described in subsection (b)(1)(B); and

"(B) the greater of—

"(i) the difference between the average manufacturer retail price and the average manufacturer non-retail price,

"(ii) 17 percent of the average manufacturer retail price, or

"(iii) the amount determined pursuant to paragraph (4).

"(2) ADDITIONAL REBATE.—Each manufacturer shall remit to the Secretary, for each calendar quarter, an additional rebate for each dosage form and strength of a covered drug (except as provided under paragraph (4)), in an amount equal to—

"(A) the total number of units subject to rebate for such quarter, as described in subsection (b)(1)(B), multiplied by

"(B) the amount, if any, by which the average manufacturer retail price for covered drugs of the manufacturer exceeds the average manufacturer retail price for the base quarter, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from the end of such base quarter to the month before the beginning of such calendar quarter.

"(3) NEGOTIATED REBATE AMOUNT FOR NEW DRUGS.—

"(A) IN GENERAL.—The Secretary may negotiate with the manufacturer a per-unit rebate amount, in accordance with this paragraph, for any covered outpatient drug (except as provided under paragraph (4)) first marketed after June 30, 1993—

"(i) which is not marketed in any country specified in section 802(b)(4)(A) of the Federal Food, Drug, and Cosmetic Act and for which the Secretary believes the average manufacturer's retail price may be excessive, or

"(ii) which is marketed in one or more of such countries, at prices significantly lower than the average manufacturer retail price.

"(B) MAXIMUM REBATE AMOUNT FOR DRUGS MARKETED IN CERTAIN COUNTRIES.—The rebate negotiated pursuant to this paragraph for a drug described in subparagraph (A)(ii) may be an amount up to the difference between the average manufacturer retail price and any price at which the drug is available to wholesalers in a country specified in such section 802(b)(4)(A).

"(C) FACTORS TO BE CONSIDERED.—In making determinations with respect to the prices of a covered drug described in subparagraph (A) and in negotiating a rebate amount pursuant to this paragraph, the Secretary shall take into consideration, as applicable and appropriate, the prices of other drugs in the same therapeutic class, cost information requested by the Secretary and supplied by the manufacturer or estimated by the Secretary, prescription volumes, economies of scale, product stability, special manufacturing requirements, prices of the drug in countries specified in subparagraph (A)(i) (in the case of a drug described in such subparagraph), and other relevant factors.

"(D) OPTION TO EXCLUDE COVERAGE.—If the Secretary is unable to negotiate with the manufacturer an acceptable rebate amount with respect to a covered outpatient drug pursuant to this paragraph, the Secretary may exclude such drug from coverage under this part.

"(E) EFFECTIVE DATE OF EXCLUSION FROM COVERAGE.—An exclusion of a drug from coverage pursuant to subparagraph (D) shall be effective on and after—

"(i) the date 6 months after the effective date of marketing approval of such drug by the Food and Drug Administration, or

"(ii) (if earlier) the date the manufacturer terminates negotiations with the Secretary concerning the rebate amount.

"(4) NO REBATE REQUIRED FOR GENERIC DRUGS.—Paragraphs (1) through (3) shall not apply with respect to a covered outpatient drug that is not a single source drug or an innovator multiple source drug (as such terms are defined in section 1927(k)).

"(5) DEPOSIT OF REBATES.—The Secretary shall deposit rebates under this section in the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"(d) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by a manufacturer under this section is confidential and shall not be disclosed by the Secretary, except—

"(A) as the Secretary determines to be necessary to carry out this section,

"(B) to permit the Comptroller General to review the information provided, and

"(C) to permit the Director of the Congressional Budget Office to review the information provided.

"(e) AGREEMENT TO GIVE EQUAL ACCESS TO DISCOUNTS.—An agreement under this subsection by a manufacturer of covered outpatient drugs shall guarantee that the manufacturer will offer, to each wholesaler or retailer (or other purchaser representing a group of such wholesalers or retailers) that purchases such drugs on substantially the same terms (including such terms as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other terms effectively reducing the manufacturer's costs) as any other purchaser (including any institutional purchaser) the same price for such drugs as is offered to such other purchaser. In determining a manufacturer's compliance with the previous sentence, there shall not be taken into account terms offered to the Department of Veterans Affairs, the Department of Defense, or any public program.

"(f) DEFINITIONS.—For purposes of this section—

"(1) AVERAGE MANUFACTURER RETAIL PRICE.—The term 'average manufacturer retail price' means, with respect to a covered

outpatient drug of a manufacturer for a calendar quarter, the average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section), but exclusive of nominal prices) paid to the manufacturer for the drug in the United States for drugs distributed to the retail pharmacy class of trade.

"(2) AVERAGE MANUFACTURER NON-RETAIL PRICE.—The term 'average manufacturer non-retail price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the weighted average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section), but exclusive of nominal prices) paid to the manufacturer for the drug in the United States by hospitals and other institutional purchasers that purchase drugs for institutional use and not for resale.

"(3) BASE QUARTER.—The term 'base quarter' means, with respect to a covered outpatient drug of a manufacturer, the calendar quarter beginning April 1, 1993, or (if later) the first full calendar quarter during which the drug was marketed in the United States.

"(4) COVERED DRUG.—The term 'covered drug' includes each innovator multiple source drug and single source drug, as those terms are defined in section 1927(k)(7).

"(5) MANUFACTURER.—The term 'manufacturer' means, with respect to a covered outpatient drug—

"(A) the entity whose National Drug Code number (as issued pursuant to section 510(e) of the Federal Food, Drug, and Cosmetic Act) appears on the labeling of the drug; or

"(B) if the number described in subparagraph (A) does not appear on the labeling of the drug, the person named as the applicant in a human drug application (in the case of a new drug) or the product license application (in the case of a biological product) for such drug approved by the Food and Drug Administration.".

(b) CONFORMING AMENDMENT RELATING TO EXCLUSIONS FROM COVERAGE.—Section 1862(a)(18) of such Act (42 U.S.C. 1395y(a)), as added by section 2001(c), is amended—

(A) by striking "or" at the end of subparagraph (A),

(B) by striking the period at the end of subparagraph (B) and inserting ", or", and

(C) by adding at the end the following new subparagraphs:

"(C) furnished during a year for which the drug's manufacturer does not have in effect a rebate agreement with the Secretary that meets the requirements of section 1850 for the year, or

"(D) excluded from coverage during the year by the Secretary pursuant to section 1850(c)(3)(D) (relating to negotiated rebate amounts for certain new drugs).".

SEC. 2004. COUNSELING BY PARTICIPATING PHARMACIES.

Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following:

"(8) A pharmacy that is a participating supplier under this part shall agree to answer questions of individuals enrolled under this part who receive a covered outpatient drug from the pharmacy regarding the appropriate use of the drug, potential interactions between the drug and other drugs dispensed to the individual, and other matters relating to the dispensing of such drugs.".

SEC. 2005. EXTENSION OF 25 PERCENT RULE FOR PORTION OF PREMIUM ATTRIBUTABLE TO COVERED OUTPATIENT DRUGS.

Section 1839(e) of the Social Security Act (42 U.S.C. 1395r(e)) is amended by adding at the end the following:

"(3) Notwithstanding the provisions of subsection (a), the portion of the monthly premium for each individual enrolled under this part for each month after December 1998 that is attributable to covered outpatient drugs shall be an amount equal to 50 percent of the portion of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month, that is attributable to covered outpatient drugs.".

SEC. 2006. COVERAGE OF HOME INFUSION DRUG THERAPY SERVICES.

(a) IN GENERAL.—Section 1832(a)(2)(A) of the Social Security Act (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting "and home infusion drug therapy services" before the semicolon.

(b) HOME INFUSION DRUG THERAPY SERVICES DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) inserted by section 4156(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as subsection (kk); and

(2) by inserting after such subsection the following new subsection:

"Home Infusion Drug Therapy Services

"(ll)(1) The term 'home infusion drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

"(A) in a place of residence used as the individual's home,

"(B) by a qualified home infusion drug therapy provider (as defined in paragraph (3)) or by others under arrangements with them made by that provider, and

"(C) under a plan established and periodically reviewed by a physician.

"(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively a drug regimen through use of a covered home infusion drug (as defined in subsection (t)(5)), but do not include such covered outpatient drugs.

"(3) The term 'qualified home infusion drug therapy provider' means any entity that the secretary determines meets the following requirements:

"(A) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home infusion drugs.

"(B) The entity maintains clinical records on all patients.

"(C) The entity adheres to written protocols and policies with respect to the provision of items and services.

"(D) The entity makes services available (as needed) seven days a week on a 24-hour basis.

"(E) The entity coordinates all service with the patient's physician.

"(F) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

"(G) The entity assures that only trained personnel provide covered home infusion drugs (and any other service for which training is required to provide the service safely).

"(H) The entity assumes responsibility for the quality of services provided by others under arrangements with the entity.

"(I) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

"(J) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home infusion drug therapy services and the efficient administration of the home infusion drug therapy benefit.".

(c) PAYMENT.—

(1) IN GENERAL.—Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(A) in subsection (a)(2)(B), by striking "or (E)" and inserting "(E), or (F)",

(B) in subsection (a)(2)(D), by striking "and" at the end,

(C) in subsection (a)(2)(E), by striking the semicolon and inserting "; and",

(D) by inserting after subsection (a)(2)(E) the following new subparagraph:

"(F) with resect to home infusion drug therapy services, the amounts described in section 1834(j);",

(E) in the first sentence of subsection (b), by striking "services, (3)" and inserting "services and home infusion drug therapy services, (3)".

(2) AMOUNT DESCRIBED.—Section 1834 of such Act, as amended by section 13544(b)(i) of OBRA-1993, is amended by adding at the end the following new subsection:

"(j) HOME INFUSION DRUG THERAPY SERVICES.—

"(1) IN GENERAL.—With respect to home infusion drug therapy services, payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

"(2) ESTABLISHMENT OF FEE SCHEDULE.—The Secretary shall establish by regulation before the beginning of 1996 and each succeeding year a fee schedule for home infusion drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.".

(3) PROHIBITION ON CERTAIN REFERRALS.—Section 1877(h)(6) of such Act (42 U.S.C. 1395nn(h)(6)), as amended by section 13562(a) of OBRA-1993, is amended by adding at the end the following:

"(L) Home infusion drug therapy services.".

(d) CERTIFICATION.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended—

(1) by striking "and" at the end of subparagraph (E),

(2) by striking the period at the end of subparagraph (F) and inserting "; and", and

(3) by inserting after subparagraph (F) the following:

"(G) in the case of home infusion drug therapy services, (i) such services are or were required because the individual needed such services for the administration of a covered home infusion drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.".

(e) CERTIFICATION OF HOME INFUSION DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) of such Act (42 U.S.C. 1395x(u)) is amended by inserting "home infusion drug therapy provider," after "hospice program,".

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking "and (dd)(2)" and inserting "(dd)(2), and (ll)(3)".

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended—

(A) in the first sentence, by striking "an agency is a hospice program" and inserting "an agency or entity is a hospice program or a home infusion drug therapy provider," after "home health agency, or whether"; and

(B) in the second sentence—

(i) by striking "institution or agency" and inserting "institution, agency, or entity", and

(ii) by striking "or hospice program" and inserting "hospice program, or home infusion drug therapy provider".

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 of such Act (42 U.S.C. 1395w-2) is amended—

(A) in the heading, by adding "AND FOR QUALIFIED HOME INFUSION DRUG THERAPY PROVIDERS" at the end,

(B) in subsection (a), by inserting "or that a qualified home infusion drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(ll)(3)" after "under this part", and

(C) in subsection (b)(2)(A)(iv), by inserting "or home infusion drug therapy services" after "clinical diagnostic laboratory tests".

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 of such Act (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

"(k) With respect to carrying out functions relating to payment for home infusion drug therapy services and covered home infusion drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.".

SEC. 2007. CIVIL MONEY PENALTIES FOR EXCESSIVE CHARGES.

Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7a(a)), as amended by sections 4041(a)(1), 4043(a)(1), and 4043(c), is amended—

(1) by striking ",or" at the end of paragraph (5) and adding a semicolon,

(3) by adding "or" at the end of paragraph (6), and

(4) by inserting after paragraph (6) the following:

"(7) in the case of a pharmacy, presents or causes to be presented to any person a request for payment for covered outpatient drugs (as defined in section 1861(t)) dispensed to an individual enrolled under part B of title XVIII and for which the amount charged by the pharmacy is greater than the amount the pharmacy charges the general public (as determined by the Secretary);".

SEC. 2008. CONFORMING AMENDMENTS TO MEDICAID PROGRAM.

(a) IN GENERAL.—

(1) REQUIRING MEDICARE REBATE AS CONDITION OF COVERAGE.—The first sentence of section 1927(a)(1) of the Social Security Act (42 U.S.C. 1396r-8(a)(1)) is amended—

(A) in the first sentence of paragraph (1), by striking "and paragraph (6)" and inserting ", paragraph (6), and (for calendar quarters beginning on or after January 1, 1996) paragraph (7)"; and

(B) by adding at the end the following new paragraph:

"(7) REQUIREMENT RELATING TO REBATE AGREEMENTS FOR COVERED OUTPATIENT DRUGS UNDER MEDICARE PROGRAM.—A manufacturer meets the requirements of this paragraph for quarters in a year if the manufacturer has in effect an agreement with the Secretary under section 1850 for providing rebates for covered outpatient drugs furnished to individuals under title XVIII during the year.".

(2) NON-DUPLICATION OF REBATES.—Section 1927(b)(1) of the Social Security Act (42 U.S.C. 1396r-8(b)(1)) is amended—

(A) by redesignating subparagraph (B) as subparagraph (C), and

(B) by inserting after subparagraph (A) the following new subparagraph:

"(B) NON-DUPLICATION OF MEDICARE REBATE.—Covered drugs furnished to an individual eligible for benefits under both part B of title XVIII and a State plan under this title shall not be included in the determination of units of covered outpatient drugs subject to rebate under this section.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to quarters beginning on or after January 1, 1996.

SEC. 2009. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to items and services furnished on or after January 1, 1996.

Subtitle B—Long-Term Care

PART 1—STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

SEC. 2101. STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Each State that has a plan for the home and community-based services to individuals with disabilities submitted to and approved by the Secretary under section 2102(b) is entitled to payment in accordance with section 2108.

(b) NO INDIVIDUAL ENTITLEMENT ESTABLISHED.—Nothing in this part shall be construed to create an entitlement in individuals or a requirement that a State with such an approved plan expend the entire amount of funds to which it is entitled in any year.

(c) STATE DEFINED.—In this subpart, the term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 2102. STATE PLANS.

(a) PLAN REQUIREMENTS.—In order to be approved under subsection (b), a State plan for home and community-based services for individuals with disabilities must meet the following requirements (except to the extent provided in subsection (b)(2), relating to phase-in period):

(1) ELIGIBILITY.—

(A) IN GENERAL.—Within the amounts provided by the State (and under section 2108) for such program, the plan shall provide that services under the plan will be available to individuals with disabilities (as defined in section 2103(a)) in the State.

(B) INITIAL SCREENING.—The plan shall provide a process for the initial screening of individuals who appear to have some reasonable likelihood of being an individual with disabilities.

(C) RESTRICTIONS.—The plan may not limit the eligibility of individuals with disabilities based on—

(i) income,

(ii) age,

(iii) geography,

(iv) nature, severity, or category of disability,

(v) residential setting (other than an institutional setting), or

(vi) other grounds specified by the Secretary.

(D) MAINTENANCE OF EFFORT.—The plan must provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under the State medicaid plan as of the date of the enactment of this Act, the State will continue to make available (either under this plan, under the State medicaid plan, or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

(2) SERVICES.—

(A) SPECIFICATION.—Consistent with section 2104, the plan shall specify—

(i) the services made available under the State plan,

(ii) the extent and manner in which such services are allocated and made available to individuals with disabilities, and

(iii) the manner in which services under the State plan are coordinated with each other and with health and long-term care services available outside the plan for individuals with disabilities.

Subject to section 2104(e)(1)(B), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

(B) ALLOCATION.—The State plan—

(i) shall specify how it will allocate services under the plan, during and after the 7-fiscal-year phase-in period beginning with fiscal year 1996, among covered individuals with disabilities, and

(ii) may not allocate such services based on the income or other financial resources of such individuals.

(C) LIMITATION ON LICENSURE OR CERTIFICATION.—The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements which the Secretary finds not to be necessary for the health and safety of individuals with disabilities.

(D) CONSUMER CHOICE.—To the extent possible, the choice of an individual with disabilities (and that individual's family) regarding which covered services to receive and the providers who will provide such services shall be followed.

(E) REQUIREMENT TO SERVE LOW-INCOME INDIVIDUALS.—The State plan shall assure that—

(i) the proportion of the population of low-income individuals with disabilities in the State that represents individuals with disabilities who are provided home and community-based services either under the plan, under the State medicaid plan, or under both, is not less than

(ii) the proportion of the population of the State that represents individuals who are low-income individuals.

(3) COST SHARING.—The plan shall impose cost sharing with respect to covered services only in accordance with section 2105.

(4) TYPES OF PROVIDERS AND REQUIREMENTS FOR PARTICIPATION.—The plan shall specify—

(A) the types of service providers eligible to participate in the program under the plan, which shall include consumer-directed providers, and

(B) any requirements for participation applicable to each type of service provider.

(5) BUDGET.—The plan shall specify how the State will manage Federal and State funds available under the plan during each 5-fiscal-year period (with the first such period beginning with fiscal year 1996) to serve all categories of individuals with disabilities

and meet the requirements of this subsection.

(6) PROVIDER REIMBURSEMENT.—

(A) PAYMENT METHODS.—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. Such methods may include retrospective reimbursement on a fee-for-service basis, prepayment on a capitation basis, payment by cash or vouchers to individuals with disabilities, or any combination of these methods. In the case of the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax provisions.

(B) PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set payment rates for services furnished under the plan (including rates for cash payments or vouchers to individuals with disabilities).

(C) PLAN PAYMENT AS PAYMENT IN FULL.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted or provided for under section 2105 as payment in full for services furnished under the plan.

(7) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 2106.

(8) ADVISORY GROUP.—The State plan shall—

(A) assure the establishment and maintenance of an advisory group under section 2107(b), and

(B) include the documentation prepared by the group under section 2107(b)(4)..

(9) ADMINISTRATION.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to administer (or to supervise the administration of) the plan.

(B) ADMINISTRATIVE EXPENDITURES.—Effective beginning with fiscal year 2003, the plan shall contain assurances that not more than 10 percent of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

(C) COORDINATION.—The plan shall specify how the plan—

(i) will be integrated with the State medicaid plan, titles V and XX of the Social Security Act, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and any other Federal or State programs that provide services or assistance targeted to individuals with disabilities, and

(ii) will be coordinated with health plans.

(10) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this subpart, including the processing of claims under the plan, and

(B) such data and information as the Secretary may require in order to carry out the Secretary's responsibilities.

(11) USE OF STATE FUNDS FOR MATCHING.—

(A) IN GENERAL.—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this subpart.

(B) INCORPORATION OF DISQUALIFICATION FOR CERTAIN PROVIDER-RELATED DONATIONS AND HEALTH RELATED TAXES.—The Secretary shall apply the provisions of section 1903(w) of the Social Security Act to plans and payment under this title in a manner similar to the manner in which such section applies to plans and payment under title XIX of such Act.

(b) APPROVAL OF PLANS.—The Secretary shall approve a plan submitted by a State if the Secretary determines that the plan—

(1) was developed by the State after consultation with individuals with disabilities and representatives of groups of such individuals, and

(2) meets the requirements of subsection (a).

(c) MONITORING.—The Secretary shall monitor the compliance of State plans with the eligibility requirements of section 2103 and may monitor the compliance of such plans with other requirements of this subpart.

(d) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this subpart on a timely basis.

SEC. 2103. INDIVIDUALS WITH DISABILITIES DEFINED.

(a) IN GENERAL.—In this subpart, the term "individual with disabilities" means any individual within one or more of the following 4 categories of individuals:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living (as defined in subsection (c)), and

(B) is expected to require such assistance, supervision, or cueing over a period of at least 100 days.

(2) INDIVIDUALS WITH SEVERE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

(A) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, indicates either severe cognitive impairment or severe mental impairment, or both;

(B) who—

(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living,

(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies, or

(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others, and

(C) who is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 100 days.

(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) SEVERELY DISABLED CHILDREN.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition,

(B) but for receiving personal assistance services or any of the services described in section 2104(d)(1), would require institutionalization in a hospital, nursing facility, or intermediate care facility for the mentally retarded, and

(C) is expected to have such disability or condition and require such services over a period of at least 100 days.

(b) DETERMINATION.—

(1) IN GENERAL.—The determination of whether an individual is an individual with disabilities shall be made, by persons or entities specified under the State plan, using a uniform protocol consisting of an initial screening and assessment specified by the Secretary. A State may collect additional information, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 2104(b) or for other purposes. The State shall establish a fair hearing process for appeals of such determinations.

(2) PERIODIC REASSESSMENT.—The determination that an individual is an individual with disabilities shall be considered to be effective under the State plan for a period of not more than 12 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(c) ACTIVITY OF DAILY LIVING DEFINED.—In this subpart, the term "activity of daily living" means any of the following: eating, toileting, dressing, bathing, and transferring in and out of bed.

SEC. 2104. HOME AND COMMUNITY-BASED SERVICES COVERED UNDER STATE PLAN.

(a) SPECIFICATION.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the State plan under this subpart shall specify—

(A) the home and community-based services available under the plan to individuals with disabilities (or to such categories of such individuals), and

(B) any limits with respect to such services.

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—The services shall be specified in a manner that permits sufficient flexibility for providers to meet the needs of individuals with disabilities in a cost effective manner. Subject to subsection (e)(1)(B), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

(b) REQUIREMENT FOR NEEDS ASSESSMENT AND PLAN OF CARE.—

(1) IN GENERAL.—The State plan shall provide for home and community-based services to an individual with disabilities only if—

(A) a comprehensive assessment of the individual's need for home and community-based services (regardless of whether all needed services are available under the plan) has been made,

(B) an individualized plan of care based on such assessment is developed, and

(C) such services are provided consistent with such plan of care.

(2) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under paragraph (1)(B) for an individual with disabilities shall—

(A) be developed by qualified individuals (specified under the State plan),

(B) be developed and implemented in close consultation with the individual and the individual's family,

(C) be approved by the individual (or the individual's representative), and

(D) be reviewed and updated not less often than every 6 months.

(3) PLAN OF CARE.—The plan of care under paragraph (1)(B) shall—

(A) specify which services specified under the individual plan will be provided under the State plan under this subpart,

(B) identify (to the extent possible) how the individual will be provided any services

specified under the plan of care and not provided under the State plan, and

(C) specify how the provision of services to the individual under the plan will be coordinated with the provision of other health care services to the individual.

The State shall make reasonable efforts to identify and arrange for services described in subparagraph (B). Nothing in this subsection shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(c) MANDATORY COVERAGE OF PERSONAL ASSISTANCE SERVICES.—The State plan shall include, in the array of services made available to each category of individuals with disabilities, both agency-administered and consumer-directed personal assistance services (as defined in subsection (g)).

(d) ADDITIONAL SERVICES.—

(1) TYPES OF SERVICES.—Subject to subsection (e), services available under a State plan under this subpart shall include any (or all) of the following:

(A) Case management.

(B) Homemaker and chore assistance.

(C) Home modifications.

(D) Respite services.

(E) Assistive devices.

(F) Adult day services.

(G) Habilitation and rehabilitation.

(H) Supported employment.

(I) Home health services.

(J) Any other care or assistive services (approved by the Secretary) that the State determines will help individuals with disabilities to remain in their homes and communities.

(2) CRITERIA FOR SELECTION OF SERVICES.—The State plan shall specify—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of services to be covered under the plan and to be available to each category of individuals with disabilities, and

(B) how the types, and the amount, duration, and scope, of services specified meet the needs of individuals within each of the 4 categories of individuals with disabilities.

(e) EXCLUSIONS AND LIMITATIONS.—

(1) IN GENERAL.—A State plan may not provide for coverage of—

(A) room and board,

(B) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary,

(C) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(2) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in determining the amount and array of services made available to covered individuals with disability, the availability of informal care.

(f) PAYMENT FOR SERVICES.—A State plan may provide for the use of—

(1) vouchers,

(2) cash payments directly to individuals with disabilities,

(3) capitation payments to health plans, and

(4) payment to providers,

to pay for covered services.

(g) PERSONAL ASSISTANCE SERVICES.—

(1) IN GENERAL.—In this section, the term "personal assistance services" means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living, whether agency-administered or consumer-directed (as defined in paragraph (2)).

(2) CONSUMER-DIRECTED; AGENCY-ADMINISTERED.—In this part:

(A) The term "consumer-directed" means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the individual's option, trained) by the individual receiving the services.

(B) The term "agency-administered" means, with respect to such services, services that are not consumer-directed.

SEC. 2105. COST SHARING.

(a) NO OR NOMINAL COST SHARING FOR POOREST.—The State plan may not impose any cost sharing (other than nominal cost sharing) for individuals with income (as determined under subsection (c)) less than 150 percent of the poverty level (as defined in section 1902(25)) applicable to a family of the size involved.

(b) SLIDING SCALE FOR REMAINDER.—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

(1) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 250 percent, of the poverty level applicable to a family of the size involved;

(2) at a rate of 25 percent for such individuals with income not less than 250 percent, and less than 400 percent, of the poverty level applicable to a family of the size involved; and

(3) at a rate of 40 percent for such individuals with income equal to at least 400 percent of the poverty level applicable to a family of the size involved.

(c) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such process shall be consistent with standards specified by the Secretary.

SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.

(a) QUALITY ASSURANCE.—The State plan shall specify how the State will ensure and monitor the quality of services, including—

(1) safeguarding the health and safety of individuals with disabilities,

(2) the minimum standards for agency providers and how such standards will be enforced,

(3) the minimum competency requirements for agency provider employees who provide direct services under this subpart and how the competency of such employees will be enforced,

(4) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services,

(5) participation in quality assurance activities, and

(6) specifying the role of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) in assuring quality of services and protecting the rights of individuals with disabilities.

(b) SAFEGUARDS.—

(1) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan (including performance reviews under section 2602).

(2) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emotional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with disabilities).

SEC. 2107. ADVISORY GROUPS.

(a) FEDERAL ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group, to advise the Secretary and States on all aspects of the program under this subpart.

(2) COMPOSITION.—The group shall be composed of individuals with disabilities and their representatives, providers, Federal and State officials, and local community implementing agencies and a majority of its members shall be individuals with disabilities and their representatives.

(b) STATE ADVISORY GROUPS.—

(1) IN GENERAL.—Each State plan shall provide for the establishment and maintenance of an advisory group to advise the State on all aspects of the State plan under this subpart.

(2) COMPOSITION.—Members of each advisory group shall be appointed by the Governor (or other chief executive officer of the State) and shall include individuals with disabilities and their representatives, providers, State officials, and local community implementing agencies and a majority of its members shall be individuals with disabilities and their representatives.

(3) SELECTION OF MEMBERS.—Each State shall establish a process whereby all residents of the State, including individuals with disabilities and their representatives, shall be given the opportunity to nominate members to the advisory group.

(4) PARTICULAR CONCERNS.—Each advisory group shall—

(A) before the State plan is developed, advise the State on guiding principles and values, policy directions, and specific components of the plan,

(B) meet regularly with State officials involved in developing the plan, during the development phase, to review and comment on all aspects of the plan,

(C) participate in the public hearings to help assure that public comments are addressed to the extent practicable,

(D) document any differences between the group's recommendations and the plan,

(E) document specifically the degree to which the plan is consumer-directed, and

(F) meet regularly with officials of the designated State agency (or agencies) to provide advice on all aspects of implementation and evaluation of the plan.

SEC. 2108. PAYMENTS TO STATES.

(a) IN GENERAL.—Subject to section 2102(a)(9)(B) (relating to limitation on payment for administrative costs), the Secretary shall pay to each State with a plan approved under this subpart, for each quarter, from its allotment under section 2109(b), an amount equal to—

(1) the Federal matching percentage (as defined in subsection (b)) of amount demonstrated by State claims to have been expended during the quarter for home and community-based services under the plan for individuals with disabilities; plus

(2) an amount equal to 90 percent of amount expended during the quarter under the plan for activities (including preliminary screening) relating to determination of eligibility and performance of needs assessment; plus

(3) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2003, 75 percent) of the amount expended during the

quarter for the design, development, and installation of mechanical claims processing systems and for information retrieval; plus

(4) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) FEDERAL MATCHING PERCENTAGE.—

(1) IN GENERAL.—In subsection (a), the term "Federal matching percentage" means, with respect to a State, the reference percentage specified in paragraph (2) increased by 28 percentage points, except that the Federal matching percentage shall in no case be less than 75 percent or more than 95 percent.

(2) REFERENCE PERCENTAGE.—

(A) IN GENERAL.—The reference percentage specified in this paragraph is 100 percent less the State percentage specified in subparagraph (B), except that—

(i) the percentage under this paragraph shall in no case be less than 50 percent or more than 83 percent, and

(ii) the percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 percent.

(B) STATE PERCENTAGE.—The State percentage specified in this subparagraph is that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii.

(c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of the total sum to be expended in such quarter, and such other information as the Secretary may find necessary.

(2) From the allotment available therefore, the Secretary shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

(d) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act .

SEC. 2109. TOTAL FEDERAL BUDGET; ALLOTMENTS TO STATES.

(a) TOTAL FEDERAL BUDGET.—

(1) FISCAL YEARS 1996 through 2003.—For purposes of this subpart, the total Federal budget for State plans under this subpart for each of fiscal years 1996 through 2003 is the following:

(A) For fiscal year 1996, 4.5 billion.

(B) For fiscal year 1997, 7.8 billion.

(C) For fiscal year 1998, 11.0 billion.

(D) For fiscal year 1999, 14.7 billion.

(E) For fiscal year 2000, 18.7 billion. [$56 to 2000]

(F) For fiscal year 2001, 26.7 billion. [48-56 for out years]

(G) For fiscal year 2002, 35.5 billion.

(H) For fiscal year 2003, 38.3 billion.

(2) SUBSEQUENT FISCAL YEARS.—For purposes of this subpart, the total Federal budget for State plans under this subpart for each fiscal year after fiscal year 2003 is the total Federal budget under this subsection for the preceding fiscal year multiplied by—

(A) a factor (described in paragraph (3)) reflecting the change in the CPI for the fiscal year, and

(B) a factor (described in paragraph (4)) reflecting the change in the number of individuals with disabilities for the fiscal year.

(3) CPI INCREASE FACTOR.—For purposes of paragraph (2)(A), the factor described in this paragraph for a fiscal year is the ratio of—

(A) the annual average index of the consumer price index for the preceding fiscal year, to—

(B) such index, as so measured, for the second preceding fiscal year.

(4) DISABLED POPULATION FACTOR.—For purposes of paragraph (2)(B), the factor described in this paragraph for a fiscal year is 100 percent plus (or minus) the percentage increase (or decrease) change in the disabled population of the United States (as determined for purposes of the most recent update under subsection (b)(3)(D).

[review:] (5) ADDITIONAL FUNDS DUE TO MEDICAID OFFSETS.—

(A) IN GENERAL.—Each participating State must provide the Secretary with information concerning offsets and reductions in the medicaid program resulting from home and community-based services provided under this title, that would have been paid for under the State medicaid plan but for the provision of similar services under the program under this title.

(B) REPORTS.—Each State with a program under this title shall submit such reports to the Secretary as the Secretary may require in order to monitor compliance with subparagraph (A).

(C) COMPLIANCE.—The Secretary shall review such reports. The Secretary shall increase the total Federal budget for State plans under subsection (a)(1) by the amount of any reduction in Federal expenditures for medical assistance under the State medicaid plan for home and community based services.

(D) NO DUPLICATE PAYMENT.—No paymet may be made to a State under this section for any services to the extent that the State received payment for such services under section 1903(a) of the Social Security Act.

(b) ALLOTMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall allot to each State for each fiscal year an amount that bears the same ratio to the total Federal budget for the fiscal year (specified under paragraph (1) or (2) of subsection (a)) as the State allotment factor (under paragraph (2) for the State for the fiscal year) bears to the sum of such factors for all States for that fiscal year.

(2) STATE ALLOTMENT FACTOR.—

(A) IN GENERAL.—For each State for each fiscal year, the Secretary shall compute a State allotment factor equal to the sum of—

(i) the base allotment factor (specified in subparagraph (B)), and

(ii) the low income allotment factor (specified in subparagraph (C)),

for the State for the fiscal year.

(B) BASE ALLOTMENT FACTOR.—The base allotment factor, specified in this subparagraph, for a State for a fiscal year is equal to the product of the following:

(i) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in the State (determined under paragraph (3)) for the fiscal year.

(ii) 80 PERCENT OF THE NATIONAL PER CAPITA BUDGET.—80 percent of the national average per capita budget amount (determined under paragraph (4)) for the fiscal year.

(iii) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor (determined under paragraph (5)) for the State for the fiscal year.

(iv) FEDERAL MATCHING RATE.—The Federal matching rate (determined under section 2108(b)) for the fiscal year.

(C) LOW INCOME ALLOTMENT FACTOR.—The low income allotment factor, specified in this subparagraph, for a State for a fiscal year is equal to the product of the following:

(i) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in the State (determined under paragraph (3)) for the fiscal year.

(ii) 10 PERCENT OF THE NATIONAL PER CAPITA BUDGET.—10 percent of the national average per capita budget amount (determined under paragraph (4)) for the fiscal year.

(iii) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor (determined under paragraph (5)) for the State for the fiscal year.

(iv) FEDERAL MATCHING RATE.—The Federal matching rate (determined under section 2108(b)) for the fiscal year.

(v) LOW INCOME INDEX.—The low income index (determined under paragraph (6)) for the State for the preceding fiscal year.

(3) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in a State for a fiscal year shall be determined as follows:

(A) BASE.—The Secretary shall determine the number of individuals in the State by age, sex, and income category, based on the 1990 decennial census, adjusted (as appropriate) by the March 1994 current population survey.

(B) DISABILITY PREVALENCE LEVEL BY POPULATION CATEGORY.—The Secretary shall determine, for each such age, sex, and income category, the national average proportion of the population of such category that represents individuals with disabilities. The Secretary may conduct periodic surveys in order to determine such proportions.

(C) BASE DISABLED POPULATION IN A STATE.—The number of individuals with disabilities in a State in 1994 is equal to the sum of the products, for such each age, sex, and income category, of—

(i) the population of individuals in the State in the category (determined under subparagraph (A)), and

(ii) the national average proportion for such category (determined under subparagraph (B)).

(D) UPDATE.—The Secretary shall determine the number of individuals with disabilities in a State in a fiscal year equal to the number determined under subparagraph (C) for the State increased (or decreased) by the percentage increase (or decrease) in the disabled population of the State as determined under the current population survey from 1994 to the year before the fiscal year involved.

(4) NATIONAL PER CAPITA BUDGET AMOUNT.—The national average per capita budget amount, for a fiscal year, is—

(A) the total Federal budget specified under subsection (a) for the fiscal year; divided by

(B) the sum, for the fiscal year, of the numbers of individuals with disabilities (determined under paragraph (3)) for all the States for the fiscal year.

(5) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor, for a State for a fiscal year, is equal to the ratio of—

(A) the average hourly wages for service workers (other than household or protective services) in the State, to

(B) the national average hourly wages for service workers (other than household or protective services).

The hourly wages shall be determined under this paragraph based on data from the most recent decennial census for which such data are available.

(6) LOW INCOME INDEX.—The low income index for each State for a fiscal year is the ratio, determined for the preceding fiscal year, of—

(A) the percentage of the State's population that has income below 150 percent of the poverty level, to

(B) the percentage of the population of the United States that has income below 150 percent of the poverty level.

Such percentages shall be based on data from the most recent decennial census for which such data are available, adjusted by data from the most recent current population survey as determined appropriate by the Secretary.

(c) STATE ENTITLEMENT.—This subpart constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in section 2109(a).

PART 2—MEDICAID NURSING HOME IMPROVEMENTS

SEC. 2201. REFERENCE TO AMENDMENTS.

For amendments to the medicaid program under title XIX of the Social Security Act to improvement nursing home benefits under such program, see part 2 of subtitle C of title IV.

PART 3—PRIVATE LONG-TERM CARE INSURANCE

Subpart A—General Provisions

SEC. 2301. FEDERAL REGULATIONS; PRIOR APPLICATION OR CERTAIN REQUIREMENTS.

(a) IN GENERAL.—The Secretary, with the advice and assistance of the Advisory Council, as appropriate, shall promulgate regulations as necessary to implement the provisions of this part, in accordance with the timetable specified in subsection (b).

(b) TIMETABLE FOR PUBLICATION OF REGULATIONS.—

(1) FEDERAL REGISTER NOTICE.—Within 120 days after the date a majority of the members are first appointed to the Advisory Council pursuant to section 2302, the Secretary shall publish in the Federal Register a notice setting forth the projected timetable for promulgation of regulations required under this part. Such timetable shall indicate which regulations are proposed to be published by the end of the first, second, and third years after appointment of the Advisory Council.

(2) FINAL DEADLINE.—All regulations required under this part shall be published by the end of the third year after appointment of the Advisory Council.

(c) PROVISIONS EFFECTIVE WITHOUT REGARD TO PROMULGATION OF REGULATIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this part, insurers shall be required, not later than 6 months after the enactment of this Act, regardless of whether final implementing regulations have been promulgated by the Secretary, to comply with the following provisions of this part:

(A) Section 2321(c) (standard outline of coverage);

(B) Section 2321(d) (reporting to State insurance commissioners);

(C) Section 2322(b) (preexisting condition exclusions);

(D) Section 2322(c) (limiting conditions on benefits);

(E) Section 2322(d) (inflation protection);

(F) Section 2324 (sales practices);

(G) Section 2325 (continuation, renewal, replacement, conversion, and cancellation of policies); and

(H) Section 2326 (payment of benefits).

(2) INTERIM REQUIREMENTS.—Before the effective date of applicable regulations promulgated by the Secretary implementing requirements of this part as specified below, such requirements will be considered to be met—

(A) in the case of section 2321(c) (requiring a standard outline of coverage), if the long-term care insurance policy meets the requirements of section 6.G.(2) of the NAIC Model Act and of section 24 of the NAIC Model Regulation;

(B) in the case of section 2321(d) (requiring reporting to the State insurance commissioner), if the insurer meets the requirements of section 14 of the NAIC Model Regulation;

(C) in the case of section 2322(c)(1) (general requirements concerning limiting conditions on benefits), if such policy meets the requirements of section 6.D. of the NAIC Model Act;

(D) in the case of section 2322(c)(2) (limiting conditions on home health care or community-based services) if such policy meets the requirements of section 11 of the NAIC Model Regulations;

(E) in the case of section 2322(d) (concerning inflation protection), if the insurer meets the requirements of section 12 of the NAIC Model Regulation;

(F) in the case of section 2324(b) (concerning applications for the purchase of insurance), if the insurer meets the requirements of section 10 of the NAIC Model Regulation;

(G) in the case of section 2324(d) (concerning compensation for the sale of policies), if the insurer meets the requirements of the optional regulation entitled "Permitted Compensation Arrangements" included in the NAIC Model Regulation;

(H) in the case of section 2324(g) (concerning sales through employers or membership organizations), if the insurer and the membership organization meet the requirements of section 21.C. of the NAIC Model Regulation;

(I) in the case of section 2324(h) (concerning interstate sales of group policies), if the insurer and the policy meet the requirements of section 5 of the NAIC Model Act; and

(J) in the case of section 2325(f) (concerning continuation, renewal, replacement, and conversion of policies), if the insurer and the policy meet the requirements of section 7 of the NAIC Model Regulation.

SEC. 2302. NATIONAL LONG-TERM CARE INSURANCE ADVISORY COUNCIL.

(a) APPOINTMENT.—The Secretary shall appoint an advisory board to be known as the National Long-Term Care Insurance Advisory Council.

(b) COMPOSITION.—

(1) NUMBER AND QUALIFICATIONS OF MEMBERS.—The Advisory Council shall consist of 5 members, each of whom has substantial expertise in matters relating to the provision and regulation of long-term care insurance. At least one member shall have experience as a State insurance commissioner or legislator with expertise in policy development with respect to, and regulation of, long-term care insurance.

(2) TERMS OF OFFICE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, members shall be appointed for terms of office of 5 years.

(B) INITIAL MEMBERS.—Of the initial members of the Council, one shall be appointed for a term of 5 years, one for 4 years, one for 3 years, one for 2 years, and one for 1 year.

(C) TWO-TERM LIMIT.—No member shall be eligible to serve in excess of two consecutive terms, but may continue to serve until such member's successor is appointed.

(3) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term of such member's predecessor shall be appointed for the remainder of such term.

(4) REMOVAL.—No member may be removed during the member's term of office except for just and sufficient cause.

(c) CHAIRPERSON.—The Secretary shall appoint a Chairperson from among the members.

(d) COMPENSATION.—

(1) IN GENERAL.—Except as provided in paragraph (3), members of the Advisory Council, while serving on business of the Advisory Council, shall be entitled to receive compensation at a rate not to exceed the daily equivalent of the rate specified for level V of the Executive Schedule under section 5316 of title 5, United States Code.

(2) TRAVEL.—Except as provided in paragraph (3), members of the Advisory Council, while serving on business of the Advisory Council away from their homes or regular places of business, may be allowed travel expenses (including per diem in lieu of subsistence) as authorized by section 5703(b) of title 5, United States Code, for persons in the Government service employed intermittently.

(3) RESTRICTION.—A member of the Advisory Council may not be compensated under this section if the member is receiving compensation or travel expenses from another source while serving on business of the Advisory Council.

(e) MEETINGS.—The Advisory Council shall meet not less often than 2 times a year at the direction of the Chairperson.

(f) STAFF AND SUPPORT.—

(1) IN GENERAL.—The Advisory Council shall have a salaried executive director appointed by the Chairperson, and staff appointed by the executive director with the approval of the Chairperson.

(2) FEDERAL ENTITIES.—The head of each Federal department and agency shall make available to the Advisory Council such information and other assistance as it may require to carry out its responsibilities.

(g) GENERAL RESPONSIBILITIES.—The Advisory Council shall—

(1) provide advice, recommendations, and assistance to the Secretary on matters relating to long-term care insurance as specified in this part and as otherwise required by the Secretary;

(2) collect, analyze, and disseminate information relating to long-term care insurance in order to increase the understanding of insurers, providers, consumers, and regulatory bodies of the issues relating to, and to facilitate improvements in, such insurance;

(3) develop for the Secretary's consideration proposed models, standards, requirements, and procedures relating to long-term care insurance, as appropriate, with respect to the content and format of insurance policies, agent and insurer practices concerning the sale and servicing of such policies, and regulatory activities; and

(4) monitor the development of the long-term care insurance market (including policies, marketing practices, pricing, eligibility and benefit preconditions, and claims payment procedures) and advise the Secretary concerning the need for regulatory changes.

(h) SPECIFIC MATTERS FOR CONSIDERATION.—The Advisory Council shall consider, and provide views and recommendations to the Secretary concerning, the following matters relating to long-term care insurance:

(1) UNIFORM TERMS, DEFINITIONS, AND FORMATS.—The Advisory Council shall develop and propose to the Secretary uniform terminology, definitions, and formats for use in long-term care insurance policies.

(2) STANDARD OUTLINE OF COVERAGE.—The Advisory Council shall develop and propose to the Secretary a standard format for use by all insurers offering long-term care policies for the outline of coverage required pursuant to section 2321(c).

(3) PREMIUMS.—

(A) CONSIDERATION OF FEDERAL REQUIREMENTS.—The Advisory Council shall consider, and make recommendations to the Secretary concerning—

(i) whether Federal standards should be established governing the amounts of and rates of increase in premiums in long-term care policies, and

(ii) if so, what factors should be taken into account (and whether such factors should include the age of the insured, actuarial information, cost of care, lapse rates, financial reserve requirements, insurer solvency, and tax treatment of premiums, and benefits.

(4) UPGRADES OF COVERAGE.—The Advisory Council shall consider, and make recommendations to the Secretary concerning, whether Federal standards are needed governing the terms and conditions insurers may place on insured individuals' eligibility to obtain improved coverage (including any restrictions considered advisable with respect to premium increases, agent commissions, medical underwriting, and age rating).

(5) THRESHOLD CONDITIONS FOR PAYMENT OF BENEFITS.—The Advisory Council shall—

(A) consider, and make recommendations to the Secretary concerning, the advisability of establishing standardized sets of threshold conditions (based on degrees of functional or cognitive impairment or on other conditions) for payment of covered benefits;

(B) to the extent found appropriate, recommend to the Secretary specific sets of threshold conditions to be used for such purpose;

(C) develop and propose to the Secretary, with respect to assessments of insured individuals' levels of need for purposes of receipt of covered benefits—

(i) professional qualification standards applicable to individuals making such determinations; and

(ii) uniform procedures and formats for use in performing and documenting such assessments.

(6) DISPUTE RESOLUTION.—The Advisory Council shall consider, and make recommendations to the Secretary concerning, procedures that insurers and States should be required to implement to afford insured individuals a reasonable opportunity to dispute denial of benefits under a long-term care insurance policy.

(7) SALES AND SERVICING OF POLICIES.—The Advisory Council shall consider, and make recommendations to the Secretary concerning—

(A) training and certification to be required of agents involved in selling or servicing long-term care insurance policies;

(B) appropriate limits on commissions or other compensation paid to agents for the sale or servicing of such policies;

(C) sales practices that should be prohibited or limited with respect to such policies (including any financial limits that should be applied concerning the individuals to whom such policies may be sold); and

(D) appropriate standards and requirements with respect to sales of such policies by or through employers and other entities, to employees, members, or affiliates of such entities.

(8) CONTINUING CARE RETIREMENT COMMUNITIES.—The Advisory Council shall consider, and make recommendations to the Secretary concerning, the extent to which the long-term care insurance aspects of continuing care retirement community arrangements should be subject to regulation under this part (and the Secretary, in consultation with the Secretary of the Treasury, shall consider such recommendations and promulgate appropriate regulations).

(i) ACTIVITIES.—In order to carry out its responsibilities under this part, the Advisory Council is authorized to—

(1) consult individuals and public and private entities with experience and expertise in matters relating to long-term care insurance (and shall consult the National Association of Insurance Commissioners);

(2) conduct meetings and hold hearings;

(3) conduct research (either directly or under grant or contract);

(4) collect, analyze, publish, and disseminate data and information (either directly or under grant or contract); and

(5) develop model formats and procedures for insurance policies and marketing materials; and develop proposed standards, rules, and procedures for regulatory programs.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, for activities of the Advisory Council, $1,500,000 for fiscal year 1995, and $2,000,000 for each succeeding fiscal year.

SEC. 2303. RELATION TO STATE LAW.

Nothing in this part shall be construed as preventing a State from applying standards that provide greater protection to insured individuals under long-term care insurance policies than the standards promulgated under this part, except that such State standards may not be inconsistent with any of the requirements of this part or of regulations hereunder.

SEC. 2304. DEFINITIONS.

For purposes of this part:

(1) ACTIVITY OF DAILY LIVING.—The term "activity of daily living" means any of the following: eating, toileting, dressing, bathing, and transferring in and out of bed.

(2) ADULT DAY CARE.—The term "adult day care" means a program providing social and health-related services during the day to six or more adults with disabilities (or such smaller number as the Secretary may specify in regulations) in a community group setting outside the home.

(3) ADVISORY COUNCIL.—The term "Advisory Council" means the National Long-Term Care Insurance Advisory Council established pursuant to section 2302.

(4) CERTIFICATE.—The term "certificate" means a document issued to an individual as evidence of such individual's coverage under a group insurance policy.

(5) CONTINUING CARE RETIREMENT COMMUNITY.—The term "continuing care retirement community" means a residential community operated by a private entity that enters into contractual agreements with residents under which such entity guarantees, in consideration for residents' purchase of or periodic payment for membership in the community, to provide for such residents' future long-term care needs.

(6) DESIGNATED REPRESENTATIVE.—The term "designated representative" means the person designated by an insured individual (or, if such individual is incapacitated, pursuant to an appropriate administrative or judicial procedure) to communicate with the insurer on behalf of such individual in the event of such individual's incapacitation.

(7) HOME HEALTH CARE.—The term "home health care" means medical and nonmedical services including such services as homemaker services, assistance with activities of daily living, and respite care provided to individuals in their residences.

(8) INSURED INDIVIDUAL.—The term "insured individual" means, with respect to a long-term care insurance policy, any individual who has coverage of benefits under such policy.

(9) INSURER.—The term "insurer" means any person that offers or sells an individual or group long-term care insurance policy under which such person is at risk for all or part of the cost of benefits under the policy, and includes any agent of such person.

(10) LONG-TERM CARE INSURANCE POLICY.—The term "long-term care insurance policy" has the meaning given that term in section 4 of the NAIC Model Act, except that the last sentence of such section shall not apply.

(11) NAIC MODEL ACT.—The term "NAIC Model Act" means the Long-Term Care Insurance Model Act published by the NAIC, as amended through January 1993.

(12) NAIC model regulation.—The term "NAIC Model Regulation" means the Long-Term Care Insurance Model Regulation published by the NAIC, as amended through January 1993.

(13) NURSING FACILITY.—The term "nursing facility" means a facility licensed by the State to provide to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care;

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick individuals, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

(14) POLICYHOLDER.—The term "policyholder" means the entity which is the holder of record of a group long-term care insurance policy.

(15) RESIDENTIAL CARE FACILITY.—The term "residential care facility" means a facility (including a nursing facility) that—

(A) provides to residents medical or personal care services (including at a minimum assistance with activities of daily living) in a setting other than an individual or single-family home, and

(B) does not provide services of a higher level than can be provided by a nursing facility.

(16) RESPITE CARE.—The term "respite care" means the temporary provision of care (including assistance with activities of daily living) to an individual, in the individual's home or another setting in the community, for the purpose of affording such individual's unpaid caregiver a respite from the responsibilities of such care.

(17) STATE INSURANCE COMMISSIONER.—The term "State insurance commissioner" means the State official bearing such title, or, in the case of a jurisdiction where such title is not used, the State official with primary responsibility for the regulation of insurance.

Subpart B—Federal Standards and Requirements

SEC. 2321. REQUIREMENTS TO FACILITATE UNDERSTANDING AND COMPARISON OF BENEFITS.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the Advisory Council, shall promulgate regulations designed to standardize formats and terminology used in long-term care insurance policies, to require insurers to provide to customers and beneficiaries information on the range of public and private long-term care coverage available, and to establish such other requirements as may be appropriate to promote consumer understanding and facilitate comparison of benefits, which shall include at a minimum the requirements specified in this section.

(b) UNIFORM TERMS, DEFINITIONS, AND FORMATS.—Insurers shall be required to use, in long-term care insurance policies, uniform terminology, definitions of terms, and formats, in accordance with regulations promulgated by the Secretary, after considering recommendations of the Advisory Council.

(c) STANDARD OUTLINE OF COVERAGE.—

(1) IN GENERAL.—Insurers shall be required to develop for each long-term care insurance policy offered or sold, to include as a part of each such policy, and to make available to each potential purchaser and furnish to each insured individual and policyholder, an outline of coverage under such policy that—

(A) includes the elements specified in paragraph (2),

(B) is in a uniform format (as prescribed by Secretary on the basis of recommendations by the Advisory Council),

(C) accurately and clearly reflects the contents of the policy, and

(D) is updated periodically on such timetable as may be required by the Secretary (or more frequently as necessary to reflect significant changes in outlined information).

(2) CONTENTS OF OUTLINE.—The outline of coverage for each long-term care insurance policy shall include at least the following:

(A) BENEFITS.—A description of—

(i) the principal benefits covered, including the extent of—

(I) benefits for services furnished in residential care facilities, and

(II) other benefits,

(ii) the principal exclusions from and limitations on coverage,

(iii) the terms and conditions, if any, upon which the insured individual may obtain upgraded benefits, and

(iv) the threshold conditions for entitlement to receive benefits.

(B) CONTINUATION, RENEWAL, AND CONVERSION.—A statement of the terms under which a policy may be—

(i) returned (and premium refunded) during an initial examination period,

(ii) continued in force or renewed,

(iii) converted to an individual policy (in the case of coverage under a group policy),

(C) CANCELLATION.—A statement of the circumstances in which a policy may be terminated, and the refund or nonforfeitures benefits (if any) applicable in each such circumstance, including—

(i) death of the insured individual,

(ii) nonpayment of premiums,

(iii) election by the insured individual not to renew,

(iv) any other circumstance.

(D) PREMIUM.—A statement of—

(i) the total annual premium, and the portion of such premium attributable to each covered benefit,

(ii) any reservation by the insurer of a right to change premiums,

(iii) any limit on annual premium increases,

(iv) any expected premium increases associated with automatic or optional benefit increases (including inflation protection), and

(v) any circumstances under which payment of premium is waived.

(E) DECLARATION CONCERNING SUMMARY.—A statement, in bold face type on the face of the document in language understandable to the average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy contains the contractual provisions that govern.

(F) COST/VALUE COMPARISON.—

(i) Information on average costs (and variation in such costs) for nursing facility care (and such other care as the Secretary may specify) and information on the value of benefits relative to such costs.

(ii) A comparison of benefits, over a period of at least 20 years, for policies with and without inflation protection.

(iii) A declaration as to whether the amount of benefits will increase over time, and, if so, a statement of the type and amount of, any limitations on, and any premium increases for, such benefit increases.

(G) TAX TREATMENT.—A statement of the Federal income tax treatment of premiums and benefits under the policy, as determined by the Secretary of the Treasury.

(H) OTHER.—Such other information as the Secretary may require.

(d) REPORTING TO STATE INSURANCE COMMISSIONER.—Each insurer shall be required to report at least annually, to the State insurance commissioner of each State in which any long-term care insurance policy of the insurer is sold, such information, in such format, as the Secretary may specify with respect to each such policy, including—

(1) the standard outline of coverage required pursuant to subsection (c);

(2) lapse rates and replacement rates for such policies;

(3) the ratio of premiums collected to benefits paid;

(4) reserves;

(5) written materials used in sale or promotion of such policy; and

(6) any other information the Secretary may require.

(e) COMPARISON OF LONG-TERM CARE COVERAGE ALTERNATIVES.—Each insurer shall be required to furnish to each individual before a long-term care insurance policy of the insurer is sold to the individual information on the conditions of eligibility for, and benefits under, each of the following:

(1) POLICIES OFFERED BY THE INSURER.—The standard outline of coverage, and such other information as the Secretary may specify, with respect to each long-term care insurance policy offered by the insurer.

(2) COMPARISON TO OTHER AVAILABLE PRIVATE INSURANCE.—Information, in such format as may be required under this part, on—

(A) benefits offered under long-term care insurance policies of the insurer (and the threshold conditions for receipt by an insured individual of each such benefit); and

(B) additional benefits available under policies offered by other private insurers (to the extent such information is made available by the State insurance commissioner).

(3) PUBLIC PROGRAMS; REGIONAL ALLIANCES.—Information furnished to the insurer, pursuant to section 2342(b)(2), by the State in which such individual resides, on conditions of eligibility for, and long-term care benefits (or the lack of such benefits) under—

(A) each public long-term care program administered by the State,

(B) the Medicare programs under title XVIII of the Social Security Act; and

(C) each regional alliance operating in the State.

SEC. 2322. REQUIREMENTS RELATING TO COVERAGE.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the Advisory Council, shall promulgate regulations establishing requirements with respect to the terms of and benefits under long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS.—

(1) INITIAL POLICIES.—A long-term care insurance policy may not exclude or limit coverage for any service or benefit, the need for which is the result of a medical condition or disability because an insured individual received medical treatment for, or was diagnosed as having, such condition before the issuance of the policy, unless—

(A) the insurer, prior to issuance of the policy, determines and documents (with evidence including written evidence that such condition has been treated or diagnosed by a qualified health care professional) that the insured individual had such condition during the 6-month period (or such longer period as the Secretary may specify) ending on the effective date of the policy; and

(B) the need or such service or benefit begins within 6 months (or such longer period as the Secretary may specify) following the effective date of the policy.

(2) REPLACEMENT POLICIES.—Solely for purposes of the requirements of paragraph (1), with respect to an insured individual, the effective date of a long-term care insurance policy issued to replace a previous policy, with respect to benefits which are the same as or substantially equivalent to benefits under such previous policy, shall be considered to be the effective date of such previous policy with respect to such individual.

(c) LIMITING CONDITIONS ON BENEFITS.—

(1) IN GENERAL.—A long-term care insurance policy may not—

(A) condition eligibility for benefits for a type of service on the need for or receipt of any other type of service (such as prior hospitalization or institutionalization, or a higher level of care than the care for which benefits are covered);

(B) condition eligibility for any benefit (where the need for such benefit has been established by an independent assessment of impairment) on any particular medical diagnosis (including any acute condition) or on one of a group of diagnoses;

(C) condition eligibility for benefits furnished by licensed or certified providers on compliance by such providers with conditions not required under Federal or State law; or

(D) condition coverage of any service on provision of such service by a provider, or in a setting, providing a higher level of care than that required by an insured individual.

(2) HOME CARE OR COMMUNITY-BASED SERVICES.—A long-term care insurance policy that provides benefits for any home care or community-based services provided in a setting other than a residential care facility—

(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

(B) may not limit such benefits to services furnished by persons or entities participating in programs under titles XVIII and XIX of the Social Security Act and in part 1 of this subtitle; and

(C) must provide, at a minimum, benefits for personal assistance with activities of daily living, home health care, adult day care, and respite care.

(3) NURSING FACILITY SERVICES.—A long-term care insurance policy that provides benefits for any nursing facility services—

(A) must provide benefits for such services provided by all types of nursing facilities licensed by the State, and

(B) may provide benefits for care in other residential facilities.

(4) PROHIBITION ON DISCRIMINATION BY DIAGNOSIS.—A long-term care insurance policy may not provide for treatment of—

(A) Alzheimer's disease or any other progressive degenerative dementia of an organic origin,

(B) any organic or inorganic mental illness,

(C) mental retardation or any other cognitive or mental impairment, or

(D) HIV infection or AIDS,

different from the treatment of any other medical condition for purposes of determining whether threshold conditions for the receipt of benefits have been met, or the amount of benefits under the policy.

(d) INFLATION PROTECTION.—

(1) REQUIREMENT TO OFFER.—An insurer offering for sale any long-term care insurance policy shall be required to afford the purchaser the option to obtain coverage under such policy (upon payment of increased premiums) of annual increases in benefits at rates in accordance with paragraph (2).

(2) RATE INCREASE IN BENEFITS.—For purposes of paragraph (1), the benefits under a policy for each year shall be increased by a percentage of the full value of benefits under the policy for the previous year, which shall be not less than 5 percent of such value (or such other rate of increase as may be determined by the Secretary to be adequate to offset increases in the costs of long-term care services for which coverage is provided under the policy).

(3) REQUIREMENT OF WRITTEN REJECTION.—Inflation protection in accordance with paragraph (1) may be excluded from the coverage under a policy only if the insured individual (or, if different, the person responsible for payment of premiums has rejected in writing the option to obtain such coverage.

SEC. 2323. REQUIREMENTS RELATING TO PREMIUMS.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the Advisory Council, shall promulgate regulations establishing requirements applicable to premiums for long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) LIMITATIONS ON RATES AND INCREASES.—The Secretary, after considering recommendations of the Advisory Council, may establish by regulation such standards and requirements as may be determined appropriate with respect to—

(1) mandatory or optional State procedures for review and approval of premium rates and rate increases or decreases;

(2) limitations on the amount of initial premiums, or on the rate or amount of premium increases;

(3) the factors to be taken into consideration by an insurer in proposing, and by a State in approving or disapproving, premium rates and increases; and

(4) the extent to which consumers should be entitled to participate or be represented in the rate-setting process and to have access to actuarial and other information relied on in setting rates.

SEC. 2324. REQUIREMENTS RELATING TO SALES PRACTICES.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the Advisory Council, shall promulgate regulations establishing requirements applicable to the sale or offering for sale of long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) APPLICATIONS.—Any insurer that offers any long-term care insurance policy (including any group policy) shall be required to meet such requirements with respect to the content, format, and use of application forms for long-term care insurance as the Secretary may require by regulation.

(c) AGENT TRAINING AND CERTIFICATION.—An insurer may not sell or offer for sale a long-term care insurance policy through an agent who does not comply with minimum standards with respect to training and certification established by the Secretary after consideration of recommendations by the Advisory Council.

(d) COMPENSATION FOR SALE OF POLICIES.—Compensation by an insurer to an agent or agents for the sale of an original long-term care insurance policy, or for servicing or renewing such a policy, may not exceed amounts (or percentage shares of premiums or other reference amounts) specified by the Secretary in regulations, after considering recommendations of the Advisory Council.

(e) PROHIBITED SALES PRACTICES.—The following practices by insurers shall be prohibited with respect to the sale or offer for sale of long-term care insurance policies:

(1) FALSE AND MISLEADING REPRESENTATIONS.—Making any statement or representation—

(A) which the insurer knows or should know is false or misleading (including the inaccurate, incomplete, or misleading comparison of long-term care insurance policies or insurers), and

(B) which is intended, or would be likely, to induce any person to purchase, retain, terminate, forfeit, permit to lapse, pledge, assign, borrow against, convert, or effect a change with respect to, any long-term care insurance policy.

(2) INACCURATE COMPLETION OF MEDICAL HISTORY.—Making or causing to be made (by any means including failure to inquire about or to record information relating to preexisting conditions) statements or omissions, in records detailing the medical history of an applicant for insurance, which the insurer knows or should know render such records false, incomplete, or misleading in any way material to such applicant's eligibility for or coverage under a long-term care insurance policy.

(3) UNDUE PRESSURE.—Employing force, fright, threat, or other undue pressure, whether explicit or implicit, which is intended, or would be likely, to induce the purchase of a long-term care insurance policy.

(4) COLD LEAD ADVERTISING.—Using, directly or indirectly, any method of contacting consumers (including any method designed to induce consumers to contact the insurer or agent) for the purpose of inducing the purchase of long-term care insurance (regardless of whether such purpose is the sole or primary purpose of the contact) without conspicuously disclosing such purpose.

(f) PROHIBITION ON SALE OF DUPLICATE BENEFITS.—An insurer or agent may not sell or issue to an individual a long-term care insurance policy that the insurer or agent knows or should know provides for coverage that duplicates coverage already provided in another long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy).

(g) SALES THROUGH EMPLOYERS OR MEMBERSHIP ORGANIZATIONS.—

(1) REQUIREMENTS CONCERNING SUCH ARRANGEMENTS.—In any case where an employer, organization, association, or other entity (referred to as a "membership entity") endorses a long-term care insurance policy to, or such policy is marketed or sold through such membership entity to, employees, members, or other individuals affiliated with such membership entity—

(A) the insurer offering such policy shall not permit its marketing or sale through such entity unless the requirements of this subsection are met; and

(B) a membership entity that receives any compensation for such sale, marketing, or endorsement of such policy shall be considered the agent of the insurer for purposes of this part.

(2) DISCLOSURE AND INFORMATION REQUIREMENTS.—A membership entity that endorses a long-term care insurance policy, or through which such policy is sold, to individuals affiliated with such entity, shall—

(A) disclose prominently, in a form and manner designed to ensure that each such individual who receives information concerning any such policy through such entity is aware of and understands such disclosure—

(i) the manner in which the insurer and policy were selected;

(ii) the extent (if any) to which a person independent of the insurer with expertise in long-term care insurance analyzed the advantages and disadvantages of such policy from the standpoint of such individuals (including such matters as the merits of the policy compared to other available benefit packages, and the financial stability of the insurer), and the results of any such analysis;

(iii) any organizational or financial ties between the entity (or a related entity) and the insurer (or a related entity);

(iv) the nature of compensation arrangements (if any) and the amount of compensation (including all fees, commissions, and other forms of financial support) for the endorsement or sale of such policy; and

(B) make available to such individuals, either directly or through referrals, appropriate counseling to assist such individuals to make educated and informed decisions concerning the purchase of such policies.

SEC. 2325. CONTINUATION, RENEWAL, REPLACEMENT, CONVERSION, AND CANCELLATION OF POLICIES.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the Advisory Council, shall promulgate regulations establishing requirements applicable to the renewal, replacement, conversion, and cancellation of long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) INSURED'S RIGHT TO CANCEL DURING EXAMINATION PERIOD.—Each individual insured (or, if different, each individual liable for payment of premiums) under a long-term care insurance policy shall have the unconditional right to return the policy within 30 days after the date of its issuance and delivery, and to obtain a full refund of any premium paid.

(c) INSURER'S RIGHT TO CANCEL (OR DENY BENEFITS) BASED ON FRAUD OR NONDISCLOSURE.—An insurer shall have the right to cancel a long-term care insurance policy, or to refuse to pay a claim for benefits, based on evidence that the insured falsely represented or failed to disclose information

material to the determination of eligibility to purchase such insurance, but only if—

(1) the insurer presents written documentation, developed at the time the insured applied for such insurance, of the insurer's request for the information thus withheld or misrepresented, and the insured individual's response to such request;

(2) the insurer presents medical records or other evidence showing that the insured individual knew or should have known that such response was false, incomplete, or misleading;

(3) notice of cancellation is furnished to the insured individual before the date 3 years after the effective date of the policy (or such earlier date as the Secretary may specify in regulations); and

(4) the insured individual is afforded the opportunity to review and refute the evidence presented by the insurer pursuant to paragraphs (1) and (2).

(d) INSURER'S RIGHT TO CANCEL FOR NONPAYMENT OF PREMIUMS.—

(1) IN GENERAL.—Insurers shall have the right to cancel long-term care insurance policies for nonpayment of premiums, subject to the provisions of this subsection and subsection (e) (relating to nonforfeiture).

(2) NOTICE AND ACKNOWLEDGEMENT.—

(A) IN GENERAL.—The insurer may not cancel coverage of an insured individual until—

(i) the insurer, not earlier than the date when such payment is 30 days past due, has given written notice to the insured individual (by registered letter or the equivalent) of such intent, and

(ii) 30 days have elapsed since the insurer obtained written acknowledgment of receipt of such notice from the insured individual (or the designated representative, at the insured individual's option or in the case of an insured individual determined to be incapacitated in accordance with paragraph (4)).

(B) ADDITIONAL REQUIREMENT FOR GROUP POLICIES.—In the case of a group long-term care insurance policy, the notice and acknowledgement requirements of subparagraph (A) apply with respect to the policyholder and to each insured individual.

(3) REINSTATEMENT OF COVERAGE OF INCAPACITATED INDIVIDUALS.—In any case where the coverage of an individual under a long-term care insurance policy has been canceled pursuant to paragraph (2), the insurer shall be required to reinstate full coverage of such individual under such policy, retroactive to the effective date of cancellation, if the insurer receives from such individual (or the designated representative of such individual), within 5 months after such date—

(A) evidence of a determination of such individual's incapacitation in accordance with paragraph (4) (whether made before or after such date), and

(B) payment of all premiums due and past due, and all charges for late payment.

(4) DETERMINATION OF INCAPACITATION.—For purposes of this subsection, the term "determination of incapacitation" means a determination by a qualified health professional (in accordance with such requirements as the Secretary may specify), that an insured individual has suffered a cognitive impairment or loss of functional capacity which could reasonably be expected to render the individual permanently or temporarily unable to deal with business or financial matters. The standard used to make such determination shall not be more stringent than the threshold conditions for the receipt of covered benefits.

(5) DESIGNATION OF REPRESENTATIVE.—The insurer shall be required—

(A) to require the insured individual, at the time of sale or issuance of a long-term care insurance policy—

(i) to designate a representative for purposes of communication with the insurer concerning premium payments in the event the insured individual cannot be located or is incapacitated, or

(ii) to complete a signed and dated statement declining to designate a representative, and

(B) to obtain from the insured individual, at the time of each premium payment (but in no event less often than once in each 12-month period) reconfirmation or revision of such designation or declination.

(e) NONFORFEITURE.—

(1) IN GENERAL.—The Secretary, after consideration of recommendations by the Advisory Council, shall by regulation require appropriate nonforfeiture benefits with respect to each long-term care insurance policy that lapses for any reason (including nonpayment of premiums, cancellation, or failure to renew, but excluding lapses due to death) after remaining in effect beyond a specified minimum period.

(2) NONFORFEITURE BENEFITS.—The standards established under this subsection shall require that the amount or percentage of nonforfeiture benefits shall increase proportionally with the amount of premiums paid by a policyholder.

(f) CONTINUATION, RENEWAL, REPLACEMENT, AND CONVERSION OF POLICIES.—

(1) IN GENERAL.—Insurers shall not be permitted to cancel, or refuse to renew (or replace with a substantial equivalent), any long-term care insurance policy for any reason other than for fraud or material misrepresentation (as provided in subsection (c)) or for nonpayment of premium (as provided in subsection (d)).

(2) DURATION AND RENEWAL OF POLICIES.—Each long-term care insurance policy shall contain a provision that clearly states—

(A) the duration of the policy,

(B) the right of the insured individual (or policyholder) to renewal (or to replacement with a substantial equivalent),

(C) the date by which, and the manner in which, the option to renew must be exercised, and

(D) any applicable restrictions or limitations (which may not be inconsistent with the requirements of this part).

(3) REPLACEMENT OF POLICIES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an insurer shall not be permitted to sell any long-term care insurance policy as a replacement for another such policy unless coverage under such replacement policy is available to an individual insured for benefits covered under the previous policy to the same extent as under such previous policy (including every individual insured under a group policy) on the date of termination of such previous policy, without exclusions or limitations that did not apply under such previous policy.

(B) INSURED'S OPTION TO REDUCE COVERAGE.—In any case where an insured individual covered under a long-term care insurance policy knowingly and voluntarily elects to substitute for such policy a policy that provides less coverage, substitute policy shall be considered a replacement policy for purposes of this part.

(3) CONTINUATION AND CONVERSION RIGHTS WITH RESPECT TO GROUP POLICIES.—

(A) IN GENERAL.—Insurers shall be required to include in each group long-term care insurance policy, a provision affording to each insured individual, when such policy would otherwise terminate, the opportunity (at the insurer's option, subject to approval of the State insurance commissioner) either to continue or to convert coverage under such policy in accordance with this paragraph.

(B) RIGHTS OF RELATED INDIVIDUALS.—In the case of any insured individual whose eligibility for coverage under a group policy is based on relationship to another individual, the insurer shall be required to continue such coverage upon termination of the relationship due to divorce or death.

(C) CONTINUATION OF COVERAGE.—A group policy shall be considered to meet the requirements of this paragraph with respect to rights of an insured individual to continuation of coverage if coverage of the same (or substantially equivalent) benefits for such individual under such policy is maintained, subject only to timely payment of premiums.

(D) CONVERSION OF COVERAGE.—A group policy shall be considered to meet the requirements of this paragraph with respect to conversion if it entitles each individual who has been continuously covered under the policy for at least 6 months before the date of the termination to issuance of a replacement policy providing benefits identical to, substantially equivalent to, or in excess of, the benefits under such terminated group policy—

(i) without requiring evidence of insurability with respect to benefits covered under such previous policy, and

(ii) at premium rates no higher than would apply if the insured individual had initially obtained coverage under such replacement policy on the date such insured individual initially obtained coverage under such group policy.

(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—

(A) UNDER SECRETARY'S GUIDELINES.—The Secretary, after considering recommendations by the Advisory Council, shall develop guidelines for comparing long-term care insurance policies for the purpose of determining whether benefits under such policies are substantially equivalent.

(B) BEFORE EFFECTIVE DATE OF SECRETARY'S GUIDELINES.—During the period prior to the effective date of guidelines published by the Secretary under this paragraph, insurers shall comply with standards for determinations of substantial equivalence established by State insurance commissioners.

(5) ADDITIONAL REQUIREMENTS.—Insurers shall comply with such other requirements relating to continuation, renewal, replacement, and conversion of long-term care insurance policies as the Secretary may establish.

SEC. 2326. REQUIREMENTS RELATING TO PAYMENT OF BENEFITS.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the Advisory Council, shall promulgate regulations establishing requirements with respect to claims for and payment of benefits under long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) STANDARDS RELATING TO THRESHOLD CONDITIONS FOR RECEIPT OF COVERED BENEFITS.—Each long-term care insurance policy shall meet the following requirements with respect to identification of, and determination of whether an insured individual meets, the threshold conditions for receipt of benefits covered under such policy:

(1) DECLARATION OF THRESHOLD CONDITIONS.—

(A) IN GENERAL.—The policy shall specify the level (or levels) of functional or cognitive mental impairment (or combination of

impairments) required as a threshold condition of entitlement to receive benefits under the policy (which threshold condition or conditions shall be consistent with any regulations promulgated by the Secretary pursuant to subsection (B)).

(B) SECRETARIAL RESPONSIBILITY.—The Secretary (after considering the views of the Advisory Council on current practices of insurers concerning, and the appropriateness of standardizing, threshold conditions) may promulgate such regulations as the Secretary finds appropriate establishing standardized thresholds to be used under such policies as preconditions for varying levels of benefits.

(2) INDEPENDENT PROFESSIONAL ASSESSMENT.—The policy shall provide for a procedure for determining whether the threshold conditions specified under paragraph (1) have been met with respect to an insured individual which—

(A) applies such uniform assessment standards, procedures, and formats as the Secretary may specify, after consideration of recommendations by the Advisory Council;

(B) permits an initial evaluation (or, if the initial evaluation was performed by a qualified independent assessor selected by the insurer, a reevaluation) to be made by a qualified independent assessor selected by the insured individual (or designated representative) as to whether the threshold conditions for receipt of benefits have been met;

(C) permits the insurer the option to obtain a reevaluation by a qualified independent assessor selected and reimbursed by the insurer;

(D) provides that the insurer will consider that the threshold conditions have been met in any case where—

(i) the assessment under subparagraph (B) concluded that such conditions had been met, and the insurer declined the option under subparagraph (C), or

(ii) assessments under both subparagraphs (B) and (C) concluded that such conditions had been met; and

(E) provides for final resolution of the question by a State agency or other impartial third party in any case where assessments under subparagraphs (B) and (C) reach inconsistent conclusions.

(3) QUALIFIED INDEPENDENT ASSESSOR.—For purposes of paragraph (2), the term "qualified independent assessor" means a licensed or certified professional, as appropriate, who—

(A) meets such standards with respect to professional qualifications as may be established by the Secretary, after consulting with the Secretary of the Treasury, and

(B) has no significant or controlling financial interest in, is not an employee of, and does not derive more than 5 percent of gross income from, the insurer (or any provider of services for which benefits are available under the policy and in which the insurer has a significant or controlling financial interest).

(c) REQUIREMENTS RELATING TO CLAIMS FOR BENEFITS.—Insurers shall be required—

(1) to promptly pay or deny claims for benefits submitted by (or on behalf of) insured individuals who have been determined pursuant to subsection (b) to meet the threshold conditions for payment of benefits;

(2) to provide an explanation in writing of the reasons for payment, partial payment, or denial of each such claim; and

(3) to provide an administrative procedure under which an insured individual may appeal the denial of any claim.

Subpart C—Enforcement

SEC. 2342. STATE PROGRAMS FOR ENFORCEMENT OF STANDARDS.

(a) REQUIREMENT FOR STATE PROGRAMS IMPLEMENTING FEDERAL STANDARDS.—In order for a State to be eligible for grants under this subpart, the State must have in effect a program (including such laws and procedures as may be necessary) for the regulation of long-term care insurance which the Secretary has determined—

(1) includes the elements required under this subpart, and

(2) is designed to ensure the compliance of long-term care insurance policies sold in the State, and insurers offering such policies and their agents, with the requirements established pursuant to subpart B.

(b) ACTIVITIES UNDER STATE PROGRAM.—A State program approved under this subpart shall provide for the following procedures and activities:

(1) MONITORING OF INSURERS AND POLICIES.—Procedures for ongoing monitoring of the compliance of insurers doing business in the State, and of long-term care insurance policies sold in the State, with requirements under this part, including at least the following:

(A) POLICY REVIEW AND CERTIFICATION.—A program for review and certification (and annual recertification) of each such policy sold in the State.

(B) REPORTING BY INSURERS.—Requirements of annual reporting by insurers selling or servicing long-term care insurance policies in the State, in such form and containing such information as the State may require to determine whether the insurer (and policies) are in compliance with requirements under this part.

(C) DATA COLLECTION.—Procedures for collection, from insurers, service providers, insured individuals, and others, of information required by the State for purposes of carrying out its responsibilities under this part (including authority to compel compliance of insurers with requests for such information).

(D) MARKETING OVERSIGHT.—Procedures for monitoring (through sampling or other appropriate procedures) the sales practices of insurers and agents, including review of marketing literature.

(E) OVERSIGHT OF ADMINISTRATION OF BENEFITS.—Procedures for monitoring (through sampling or other appropriate procedures) insurers' administration of benefits, including monitoring of—

(i) determinations of insured individuals' eligibility to receive benefits, and

(ii) disposition of claims for payment.

(2) INFORMATION TO INSURERS.—Procedures for furnishing, to insurers selling or servicing any long-term care insurance policies in the State, information on conditions of eligibility for, and benefits under, each public long-term care program administered by the State, in order to enable them to comply with the requirement under section 2321(e)(3).

(3) CONSUMER COMPLAINTS AND DISPUTE RESOLUTION.—Administrative procedures for the investigation and resolution of complaints by consumers, and disputes between consumers and insurers, with respect to long-term care insurance, including—

(A) procedures for the filing, investigation, and adjudication of consumer complaints with respect to the compliance of insurers and policies with requirements under this part, or other requirements under State law; and

(B) procedures for resolution of disputes between insured individuals and insurers concerning eligibility for, or the amount of, benefits payable under such policies, and other issues with respect to the rights and responsibilities of insurers and insured individuals under such policies.

(4) TECHNICAL ASSISTANCE TO INSURERS.—Provision of technical assistance to insurers to help them to understand and comply with the requirements of this part, and other State laws, concerning long-term care insurance policies and business practices.

(c) STATE ENFORCEMENT AUTHORITIES.—A State program meeting the requirements of this subpart shall ensure that the State insurance commissioner (or other appropriate official or agency) has the following authority with respect to long-term care insurers and policies:

(1) PROHIBITION OF SALE.—Authority to prohibit the sale, or offering for sale, of any long-term care insurance policy that fails to comply with all applicable requirements under this part.

(2) PLANS OF CORRECTION.—Authority, in cases where the business practices of an insurer are determined not to comply with requirements under this part, to require the insurer to develop, submit for State approval, and implement a plan of correction which must be fulfilled within the shortest period possible (not to exceed a year) as a condition of continuing to do business in the State.

(3) CORRECTIVE ACTION ORDERS.—Authority, in cases where an insurer is determined to have failed to comply with requirements of this part, or with the terms of a policy, with respect to a consumer or insured individual, to direct the insurer (subject to appropriate due process) to eliminate such noncompliance within 30 days.

(4) CIVIL MONEY PENALTIES.—Authority to assess civil money penalties, in amounts for each violative act up to the greater of $10,000 or three times the amount of any commission involved—

(A) for violations of subsections (d) (concerning compensation or sale of policies), (e) (concerning prohibited sales practices), and (f) (prohibition on sale of duplicate benefits) of section 2324,

(B) for such other violative acts as the Secretary may specify in regulations, and

(C) in such other cases as the State finds appropriate.

(5) OTHER AUTHORITIES.—Such other authorities as the State finds necessary or appropriate to enforce requirements under this part.

(d) RECORDS, REPORTS, AND AUDITS.—As a condition of approval of its program under this part, a State must agree to maintain such records, make such reports (including expenditure reports), and cooperate with such audits, as the Secretary finds necessary to determine the compliance of such State program (and insurers and policies regulated under such program) with the requirements of this part.

(e) SECRETARIAL RESPONSIBILITIES.—

(1) APPROVAL OF STATE PROGRAMS.—The Secretary shall approve a State program meeting the requirements of this part.

(2) INFORMATION ON MEDICARE BENEFITS.—The Secretary shall furnish, to the official in each State with chief responsibility for the regulation of long-term care insurance, a description of the Medicare programs under title XVIII of the Social Security Act which makes clear the unavailability of long-term benefits under such programs, for distribution by such State official to insurers selling long-term care insurance in the State, in accordance with subsection (b)(2).

SEC. 2342. AUTHORIZATION OF APPROPRIATIONS FOR STATE PROGRAMS.

There are authorized to be appropriated $10,000,000 for fiscal year 1996, $10,000,000 for fiscal year 1997, $7,500,000 for fiscal year 1998, and $5,000,000 for fiscal year 1999 and each succeeding fiscal year, for grants to States with programs meeting the requirements of this part, to remain available until expended.

SEC. 2343. ALLOTMENTS TO STATES.

The allotment for any fiscal year to a State with a program approved under this part shall be an amount determined by the Secretary, taking into account the numbers of long-term care insurance policies sold, and of elderly individuals residing, in the State, and such other factors as the Secretary finds appropriate.

SEC. 2344. PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with a program approved under this part shall be entitled to payment under this title for each fiscal year in an amount equal to its allotment for such fiscal year, for expenditure by such State for up to 50 percent of the cost of activities under such program.

(b) STATE SHARE OF PROGRAM EXPENDITURES.—No Federal funds from any source may be used as any part of the non-Federal share of expenditures under the State program under this subpart.

(c) TRANSFER AND DEPOSIT REQUIREMENTS.—The Secretary shall make payments under this section in accordance with section 6503 of title 31, United States Code.

SEC. 2345. FEDERAL OVERSIGHT OF STATE ENFORCEMENT.

(a) IN GENERAL.—The Secretary shall periodically review State regulatory programs approved under section 2341 to determine whether they continue to comply with the requirements of this part.

(b) NOTICE OF DETERMINATION OF NONCOMPLIANCE.—The Secretary shall promptly notify the State of a determination that a State program fails to comply with this part, specifying the requirement or requirements not met and the elements of the State program requiring correction.

(c) OPPORTUNITY FOR CORRECTION.—

(1) IN GENERAL.—The Secretary shall afford a State notified of noncompliance pursuant to subsection (b) a reasonable opportunity to eliminate such noncompliance.

(2) CORRECTION PLANS.—In a case where substantial corrections are needed to eliminate noncompliance of a State program, the Secretary may—

(A) permit the State a reasonable time after the date of the notice pursuant to subsection (b) to develop and obtain the Secretary's approval of a correction plan, and

(B) permit the State a reasonable time after the date of approval of such plan to eliminate the noncompliance.

(d) WITHDRAWAL OF PROGRAM APPROVAL.—In the case of a State that fails to eliminate noncompliance with requirements under this part by the date specified by the Secretary pursuant to subsection (c), the Secretary shall withdraw the approval of the State program pursuant to section 2341(e).

SEC. 2346. EFFECT OF FAILURE TO HAVE APPROVED STATE PROGRAM.

(a) RESTRICTION ON SALE OF LONG-TERM CARE INSURANCE.—

(1) IN GENERAL.—No insurer may sell or offer for sale any long-term care insurance policy, on or after the date specified in subsection (c), in a State that does not have in effect a regulatory program approved under section 2341(e).

(2) APPLICATION OF PROHIBITION.—For purposes of paragraph (1), an insurance policy shall not be considered to be sold or offered for sale in a State solely because it is sold or offered to a resident of such State.

(b) CIVIL MONEY PENALTY.—

(1) IN GENERAL.—An insurer shall be subject to a civil money penalty, in an amount up to the greater of $10,000 or three times any commission involved, for each incident in which the insurer sells, or offers to sell, an insurance policy to an individual in violation of subsection (a).

(2) ENFORCEMENT PROCEDURE.—The Secretary shall enforce the provisions of this subsection in accordance with the procedures provided under section 5412 of this Act.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The date specified in this subsection, for purposes of subsection (a), with respect to any requirement under this part, is the date one year after the date the Secretary first promulgates regulations with respect to such requirement.

(2) EXCEPTION.—To the extent that a State demonstrates to the Secretary that State legislation is required to meet any such requirement, the State shall not be regarded as failing to have in effect a program in compliance with this part solely on the basis of its failure to comply with such requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the promulgation of the regulation imposing such requirement. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subpart D—Consumer Education Grants

SEC. 2361. GRANTS FOR CONSUMER EDUCATION.

(a) GRANT PROGRAM AUTHORIZED.—The Secretary is authorized to make grants—

(1) to States,

(2) to regional alliances (at the option of States within which such Alliances are located), and

(3) to national organizations representing insurance consumers, long-term care providers, and insurers,

for the development and implementation of long-term care information, counseling, and other programs.

(b) APPLICATIONS.—

(1) IN GENERAL.—Each State or organization seeking a grant under this section shall submit to the Secretary an application, in such format and containing such information as the Secretary may require.

(2) GOALS.—Programs under this section shall be directed at the goals of increasing consumers' understanding and awareness of options available to them with respect to long-term care insurance (and alternatives, such as public long-term care programs), including—

(A) the risk of needing long-term care;

(B) the costs associated with long-term care services;

(C) the lack of long-term care coverage under the Medicare program, Medicare supplemental (Medigap) policies, and standard private health insurance;

(D) the limitations on (and conditions of eligibility for) long-term care coverage under State programs;

(E) the availability, and variations in coverage and cost, of private long-term care insurance;

(F) features common to many private long-term care insurance policies; and

(G) pitfalls to avoid when purchasing a long-term care insurance policy.

(3) ACTIVITIES.—An application for a grant under this section shall indicate the activities the State or organization would carry out under such grant, which activities may include—

(A) coordination of the activities of State agencies and private entities as necessary to carry out the State's program under this section;

(B) collection, analysis, publication, and dissemination of information,

(C) conducting or sponsoring of consumer education, outreach, and information programs,

(D) providing (directly or through referral) counseling and consultation services to consumers to assist them in choosing long-term care insurance coverage appropriate to their circumstances, and

(E) other appropriate activities.

(4) PRIORITY FOR INNOVATION.—In awarding grants under this section, the Secretary shall give priority to applications proposing to use innovative approaches to providing information, counseling, and other assistance to individuals who might benefit from, or are considering the purchase of, long-term care insurance.

(c) PERIOD OF GRANTS.—Grants under this section shall be for not longer than 3 years.

(d) EVALUATIONS AND REPORTS.—

(1) BY GRANTEES TO THE SECRETARY.—Each recipient of a grant under this section shall annually evaluate the effectiveness of its program under such grant, and report its conclusions to the Secretary.

(2) BY THE SECRETARY TO THE CONGRESS.—The Secretary shall annually evaluate, and report to the Congress on, the effectiveness of programs under this section, on the basis of reports received under paragraph (1) and such independent evaluation as the Secretary finds necessary.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, for grants under this section—

(1) $10,000,000 for each of fiscal years 1995 through 1997 for grants to States, and

(2) $1,000,000 for each of fiscal years 1995 through 1997,

for grants to eligible organizations.

PART 4—TAX TREATMENT OF LONG-TERM CARE INSURANCE AND SERVICES

SEC. 2401. REFERENCE TO TAX PROVISIONS.

For amendments to the Internal Revenue Code of 1986 relating to the treatment of long-term care insurance and services, see subtitle G of title VII.

PART 5—TAX INCENTIVES FOR INDIVIDUALS WITH DISABILITIES WHO WORK

SEC. 2501. REFERENCE TO TAX PROVISION.

For amendment to the Internal Revenue Code of 1986 providing for a tax credit for cost of personal assistance services required by employed individuals, see section 7901.

PART 6—DEMONSTRATION AND EVALUATION

SEC. 2601. DEMONSTRATION ON ACUTE AND LONG-TERM CARE INTEGRATION.

(a) PROGRAM AUTHORIZED.—The Secretary of Health and Human Services shall conduct a demonstration program to test the effectiveness of various approaches to financing and providing integrated acute and long-term care services described in subsection (b) for the chronically ill and disabled who meet eligibility criteria under subsection (c).

(b) SERVICES AND BENEFITS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the following services and benefits shall be provided under each demonstration approved under this section:

(A) COMPREHENSIVE BENEFIT PACKAGE.—All benefits included in the comprehensive benefit package under title I of this Act.

(B) TRANSITIONAL BENEFITS.—Specialized benefits relating to the transition from acute to long-term care, including—

(i) assessment and consultation,

(ii) inpatient transitional care,

(iii) medical rehabilitation,

(iv) home health care and home care,

(v) caregiver support, and

(vi) self-help technology.

(C) LONG-TERM CARE BENEFITS.—Long-term care benefits, including—

(i) adult day care,

(ii) personal assistance services,

(iii) homemaker services and chore services;

(iv) home-delivered meals;

(v) respite services;

(vi) nursing facility services in specialized care units;

(vii) services in other residential settings including community supported living arrangements and assisted living facilities; and

(viii) assistive devices and environmental modifications.

(D) HABILITATION SERVICES.—Specialized habilitation services for participants with developmental disabilities.

(2) VARIATIONS IN MINIMUM BENEFITS.—

(A) IN GENERAL.—Subject to the requirement of subparagraph (B), demonstrations may omit specified services listed under subparagraphs (C) and (D) of paragraph (1), or provide additional services, as found appropriate by the Secretary in the case of a particular demonstration, taking into consideration factors such as—

(i) the needs of a specialized group of eligible beneficiaries;

(ii) the availability of the omitted benefits under other programs in the service area; and

(iii) the geographic availability of service providers.

(B) BREADTH REQUIREMENT.—In approving variant demonstrations pursuant to subparagraph (A), the Secretary shall ensure that demonstrations under this section, taken as a group, adequately test financing and delivery models covering the entire array of services and benefits described in paragraph (1).

(c) ELIGIBILITY CRITERIA.—The Secretary shall establish eligibility criteria for individuals who may receive services under demonstrations under this section. Under such criteria, any of the following may be found to be eligible populations for such demonstrations:

(1) Individuals with disabilities who are entitled to services and benefits under a State program under part 1 of this subtitle.

(2) Individuals who are entitled to benefits under parts A and B of title XVIII of the Social Security Act.

(3) Individuals who are entitled to medical assistance under a State plan under title XIX of the Social Security Act, and are also—

(A) individuals described in paragraph (2), or

(B) individuals eligible for supplemental security income under title XVI of that Act.

(d) APPLICATION.—

(1) IN GENERAL.—Each entity seeking to participate in a demonstration under this section shall submit an application, in such format and containing such information as the Secretary may require, including the information specified in this subsection.

(2) SERVICE DELIVERY.—The application shall state the services to be provided under the demonstration (either directly by the applicant or under other arrangements approved by the Secretary), which shall include services specified pursuant to subsection (b) and—

(A) enrollment services;

(B) client assessment and care planning;

(C) simplified access to needed services;

(D) integrated management of acute and chronic care, including measures to ensure continuity of care across settings and services;

(E) quality assurance, grievance, and appeals mechanisms; and

(F) such other services as the Secretary may require.

(3) CONSUMER PROTECTION AND PARTICIPATION.—The applicant shall provide evidence of consumer participation—

(A) in the planning of the demonstration (including a showing of support from community agencies or consumer interest groups); and

(B) in the conduct of the demonstration, including descriptions of methods and procedures to be used—

(i) to make available to individuals enrolled in the demonstration information on self-help, health promotion and disability prevention practices, and enrollees' contributions to the costs of care;

(ii) to ensure participation by such enrollees (or their designated representatives, where appropriate) in care planning and in decisions concerning treatment;

(iii) to handle and resolve client grievances and appeals;

(iv) to take enrollee views into account in quality assurance and provider contracting procedures; and

(v) to evaluate enrollee satisfaction with the program.

(4) APPLICANT QUALIFICATIONS.—Applicants for grants under this section shall meet eligibility criteria established by the Secretary, including requirements relating to—

(A) adequate financial controls to monitor administrative and service costs,

(B) demonstrated commitment of the Board of Directors or comparable governing body to the goals of demonstration,

(C) information systems adequate to pay service providers, to collect required utilization and cost data, and to provide data adequate to permit evaluation of program performance, and

(D) compliance with applicable State laws.

(e) PAYMENTS TO PARTICIPANTS.—An entity conducting a demonstration under this section shall be entitled to receive, with respect to each enrollee, for the period during which it is providing to such enrollee services under a demonstration under this section, such amounts as the Secretary shall provide, which amounts—

(1) may include risk-based payments and non-risk based payments by governmental programs, by third parties, or by project enrollees, or any combination of such payments, and

(2) may vary by project and by enrollee. .

(f) NUMBER AND DURATION OF DEMONSTRATION PROJECTS.—

(1) REQUEST FOR APPLICATIONS.—The Secretary shall publish a request for applications under this section not later than one year after enactment of this Act.

(2) NUMBER AND DURATION.—The Secretary shall authorize not more than 25 demonstrations under this section, each of which shall run for 7 years from the date of the award.

(g) EVALUATION AND REPORTS.—The Secretary shall evaluate the demonstration projects under this section, and shall submit to the Congress—

(1) an interim report, by three years after enactment, describing the status of the demonstration and characteristics of the approved projects; and

(2) a final report, by one year after completion of such demonstration projects, evaluating their effectiveness (including cost-effectiveness), and discussing the advisability of including some or all of the integrated models tested in the demonstration as a benefit under the comprehensive benefit package under title I of this Act, or under the programs under title XVIII of the Social Security Act.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) FOR SECRETARIAL RESPONSIBILITIES.—

(A) IN GENERAL.—There are authorized to be appropriated $7,000,000 for fiscal year 1996, and $4,500,000 for each of the 6 succeeding fiscal years, for payment of costs of the Secretary in carrying out this section (including costs for technical assistance to potential service providers, and research and evaluation), which amounts shall remain available until expended.

(B) SET-ASIDE FOR FEASIBILITY STUDIES.—Of the total amount authorized to be appropriated under subparagraph (A), not less than $1,000,000 shall be available for studies of the feasibility of systems to provide integrated care for nonaged populations (including physically disabled children and adults, the chronically mentally ill, and individuals with disabilities, and combinations of these groups).

(2) FOR COVERED BENEFITS.—There are authorized to be appropriated $50,000,000 for the first fiscal year for which grants are awarded under this section, and for each of the four succeeding fiscal years, for payment of costs of benefits for which no public or private program or entity is legally obligated to pay.

SEC. 2602. PERFORMANCE REVIEW OF THE LONG-TERM CARE PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall prepare and submit to the Congress—

(1) an interim report, not later than the end of the seventh full calendar year beginning after the date of the enactment of this Act, and

(2) a final report, not later than two years after the date of the interim report,

evaluating the effectiveness of the programs established and amendments made by this subtitle (and including at a minimum the elements specified in subsection (b)).

(b) ELEMENTS OF ASSESSMENT.—The evaluations to be made, and included in the reports required pursuant to subsection (a), include at least the following:

(1) STATE SERVICE DELIVERY PROGRAMS.—An evaluation of States' effectiveness in meeting the needs for home and community-based services (including personal assistance services) of individuals with disabilities (including individuals who do, and who do not, meet the eligibility criteria for the service program under part 1, individuals of different ages, type and degree of disability, and income levels, members of minority groups, and individuals residing in rural areas).

(2) SERVICE ACCESS.—An evaluation of the degree of (and obstacles to) access of individuals with disabilities to needed home and community-based services and to inpatient services.

(3) QUALITY.—An evaluation of the quality of long-term care services available.

(4) PRIVATE INSURANCE.—An evaluation of the performance of the private sector in offering affordable long-term care insurance that provides adequate protection against the costs of long-term care, and of the effectiveness of Federal standards and State enforcement, pursuant to part 3, in adequately protecting long-term care insurance consumers.

(5) COST ISSUES.—An evaluation of the effectiveness of amendments made by this subtitle in containing the costs of long-term care, and in limiting the share of such costs borne by individuals with lower incomes.

(6) SERVICE COORDINATION AND INTEGRATION.—An evaluation of the effectiveness of the programs established or amended under this subtitle in achieving coordination and integration of long-term care services, and of such services with acute care services and social services, and in ensuring provision of services in the least restrictive setting possible.

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SEC. 3001. NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—There is established within the Department of Health and Human Services a council to be known as the National Council on Graduate Medical Education.

(b) DUTIES.—The Secretary shall carry out subpart B acting through the National Council.

(c) COMPOSITION.—

(1) IN GENERAL.—The membership of the National Council shall include individuals who are appointed to the Council from among individuals who are not officers or employees of the United States. Such individuals shall be appointed by the Secretary, and shall include individuals from each of the following categories:

(A) Consumers of health care services.

(B) Physicians who are faculty members of medical schools.

(C) Physicians in private practice who are not physicians described in subparagraph (B).

(D) Officers or employees of regional and corporate health alliances.

(E) Officers or employees of health care plans that participate in such alliances.

(F) Such other individuals as the Secretary determines to be appropriate.

(2) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the National Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary or other Federal officers who are appointed by the President with the advice and consent of the Senate.

(d) CHAIR.—The Secretary shall, from among members of the National Council appointed under subsection (a)(1), designate an individual to serve as the Chair of the Council.

(e) DEFINITIONS.—For purposes of this subtitle:

(1) The term "medical school" means a school of medicine (as defined in section 799 of the Public Health Service Act) or a school of osteopathic medicine (as defined in such section).

(2) The term "National Council" means the council established in subsection (a).

Subpart B—Authorized Positions in Specialty Training

SEC. 3011. COOPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) IN GENERAL.—With respect to an approved physician training program in a medical specialty, a funding agreement for payments under section 3031 for a calendar year is that the program will ensure that the number of individuals enrolled in the program in the subsequent academic year is in accordance with this subpart.

(b) DEFINITIONS.—

(1) APPROVED PROGRAM.—

(A) For purposes of this subtitle, the term "approved physician training program", with respect to the medical speciality involved, means a residency or other postgraduate program that trains physicians and meets the following conditions:

(i) Participation in the program may be counted toward certification in the medical specialty.

(ii) The program is accredited by the Accreditation Council on Graduate Medical Education, or approved by the Council on Postgraduate Training of the American Osteopathic Association.

(B) For purposes of this subtitle, the term "approved physician training program" includes any postgraduate program described in subparagraph (A) that provides health services in an ambulatory setting, without regard to whether the program provides inpatient hospital services.

(2) ELIGIBLE PROGRAM; SUBPART DEFINITION.—For purposes of this subpart, the term "eligible program", with respect to an academic year, means an approved physician training program that receives payments under subpart C for the calendar year in which the academic year begins.

(3) OTHER DEFINITIONS.—For purposes of this subtitle:

(A)(i) The term "academic year" means the 1-year period beginning on July 1. The academic year beginning July 1, 1993, is academic year 1993-94.

(ii) With respect to the funding agreement described in subsection (a), the term "subsequent academic year" means the academic year beginning July 1 of the calendar year for which payments are to be made under the agreement.

(B) The term "funding agreement", with respect to payments under section 3031 to an approved physician training program, means that the Secretary may make the payments only if the program makes the agreement involved.

(C) The term "medical specialty" includes subspecialties.

SEC. 3012. ANNUAL AUTHORIZATION OF NUMBER OF SPECIALTY POSITIONS; REQUIREMENTS REGARDING PRIMARY HEALTH CARE.

(a) ANNUAL AUTHORIZATION OF NUMBER OF POSITIONS.—In the case of each medical specialty, the National Council shall designate for each academic year the number of individuals nationwide who under section 3011 are authorized to be enrolled in eligible programs. The preceding sentence is subject to subsection (c)(2).

(b) PRIMARY HEALTH CARE.—

(1) IN GENERAL.—Subject to paragraph (2), in carrying out subsection (a) for an academic year, the National Council shall ensure that, of the class of training participants entering eligible programs for academic year 2002-03 or any subsequent academic year, the percentage of such class that completes eligible programs in primary health care is not less than 55 percent (without regard to the academic year in which the members of the class complete the programs).

(2) RULE OF CONSTRUCTION.—The requirement of paragraph (1) regarding a percentage applies in the aggregate to training participants entering eligible programs for the academic year involved, and not individually to any eligible program.

(c) DESIGNATIONS REGARDING 3-YEAR PERIODS.—

(1) DESIGNATION PERIODS.—For each medical specialty, the National Council shall make the annual designations under subsection (a) for periods of 3 academic years.

(2) INITIAL PERIOD.—The first designation period established by the National Council after the date of the enactment of this Act shall be the academic years 1998-99 through 2000-01.

(d) CERTAIN CONSIDERATIONS IN DESIGNATING ANNUAL NUMBERS.—

(1) IN GENERAL.—Factors considered by the National Council in designating the annual number of specialty positions for an academic year for a medical specialty shall include the extent to which there is a need for additional practitioners in the speciality, as indicated by the following:

(A) The incidence and prevalence (in the general population and in various other populations) of the diseases, disorders, or other health conditions with which the specialty is concerned.

(B) The number of physicians who will be practicing in the specialty in the academic year.

(C) The number of physicians who will be practicing in the specialty at the end of the 5-year period beginning on the first day of the academic year.

(2) RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.—In designating the annual number of specialty positions for an academic year for a medical specialty, the National Council shall consider the recommendations of organizations representing physicians in the specialty and the recommendations of organizations representing consumers of the services of such physicians.

(3) MINIMUM TOTAL OF RESPECTIVE ANNUAL NUMBERS.—

(A) Subject to subparagraph (B), for academic year 2003-04 and subsequent academic years, the National Council shall ensure that the total of the respective annual numbers designated under subsection (a) for an academic year is a total that—

(i) bears a relationship to the number of individuals who graduated from medical schools in the United States in the preceding academic year; and

(ii) is consistent with the purposes of this subpart.

(B) For each of the academic years 2003-04 through 2007-08, the total determined under subparagraph (A) shall be reduced by a percentage determined by the National Council.

(e) DEFINITIONS.—For purposes of this subtitle:

(1) The term "annual number of specialty positions", with respect to a medical specialty, means the number designated by the National Council under subsection (a) for eligible programs for the academic year involved.

(2) The term "designation period" means a 3-year period under subsection (c)(1) for which designations under subsection (a) are made by the National Council.

(3) The term "primary health care" means the following medical specialties: Family medicine, general internal medicine, general pediatrics, and obstetrics and gynecology.

(4) The term "specialty position", with respect to a medical specialty, means a position (designated under subsection (a)) as one of the individuals who may be a training participant in an eligible program.

(5) The term "training participant" means an individual who is enrolled in an approved physician training program.

SEC. 3013. ALLOCATIONS AMONG SPECIALITIES AND PROGRAMS.

(a) IN GENERAL.—For each academic year, the National Council shall for each medical specialty make allocations among eligible programs of the annual number of specialty positions that the Council has designated for such year. The preceding sentence is subject to subsection (b)(3).

(b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

(1) IN GENERAL.—For each medical specialty, the National Council shall make the annual allocations under subsection (a) for periods of 3 academic years.

(2) ADVANCE NOTICE TO PROGRAMS.—With respect to the first academic year of an allocation period established by the National Council, the National Council shall, not later than July 1 of the preceding academic year, notify each eligible program of the allocations made for the program for each of the academic years of the period.

(3) INITIAL PERIOD.—The first allocation period established by the National Council after the date of the enactment of this Act shall be the academic years 1998-99 through 2000-01.

(c) CERTAIN CONSIDERATIONS.—

(1) GEOGRAPHIC AREAS; QUALITY OF RESIDENCY PROGRAMS.—In making allocations under subsection (a) for eligible programs of the various geographic areas, the National Council shall include among the factors considered the historical distribution among the areas of approved physician training programs, and the quality of each of the programs.

(2) UNDERREPRESENTATION OF MINORITY GROUPS.—In making an allocation under subsection (a) for an eligible program, the National Council shall include among the factors considered the following:

(A) The extent to which the population of training participants in the program includes training participants who are members of racial or ethnic minority groups.

(B) With respect to a racial or ethnic group represented among the training participants, the extent to which the group is underrepresented in the field of medicine generally and in the various medical specialities.

(3) RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.—In making allocations under subsection (a) for eligible programs, the National Council shall consider the recommendations of organizations representing physicians in the medical specialties and the recommendations of organizations representing consumers of the services of such physicians.

(d) DEFINITIONS.—For purposes of this subtitle, the term "allocation period" means a 3-year period under subsection (b)(1) for which allocations under subsection (a) are made by the National Council.

Subpart C—Institutional Costs of Graduate Medical Education

SEC. 3031. FEDERAL FORMULA PAYMENTS TO APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) IN GENERAL.—

(1) FORMULA PAYMENTS.—Subject to paragraph (2), in the case of any approved physician training program that submits to the Secretary an application for a calendar year in accordance with section 3032, the Secretary shall make payments for such year to the program for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3033, and may administer the payments as a contract, grant, or cooperative agreement.

(2) APPLICABLE YEARS.—Payments under paragraph (1) may not be made before calendar year 1998, except that the Secretary may make such payments before such year to eligible programs in any State that has become a participating State under title I.

(b) PAYMENTS FOR OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.—The purpose of payments under subsection (a) is to assist an eligible program with the costs of operation. A funding agreement for such payments is that the program will expend the payments only for such purpose.

(c) ELIGIBLE PROGRAM; SUBPART DEFINITION.—For purposes of this subpart, the term "eligible program", with respect to the calendar year involved, means an approved physician training program that submits to the Secretary an application for such year in accordance with section 3032.

SEC. 3032. APPLICATION FOR PAYMENTS.

(a) IN GENERAL.—For purposes of section 3031, an application for payments under such section is in accordance with this section if—

(1) the approved physician training program involved submits the application not later than the date specified by the Secretary;

(2) the condition described in subsection (b) is met with respect to the program;

(3) the application contains each funding agreement described in this part and the application provides assurances of compliance with such agreements that are satisfactory to the Secretary; and

(4) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(b) CERTAIN CONDITIONS.—An approved physician training program meets the condition described in this subsection for receiving payments under section 3031 for a calendar year if the institution within which the program operates agrees that such payments will be made by the Secretary directly to the program (and such agreement is included in the application under subsection (a)), and the Secretary shall ensure that such institution is permitted to participate as a provider in a regional or corporate alliance health plan during such year only if each of the approved physician training programs of the institution meets the requirements for receiving payments under such section for such year.

SEC. 3033. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) DETERMINATION BY SECRETARY OF FUNDS AVAILABLE FOR PAYMENTS.—

(1) ANNUAL HEALTH PROFESSIONS WORKFORCE ACCOUNT.—Subject to paragraph (2) and section 3034, the Secretary shall determine for each calendar year the amount to be made available for the purpose of making payments under section 3031 (and under section 3051, as applicable) for the year. In determining such amount, the Secretary shall consider the amount necessary for making payments in the amounts determined under subsection (b) (and the amounts necessary for making payments in the amounts determined under section 3051(e) for institutions, in the case of calendar years 1998 through 2001).

(2) LIMITATION.—The amount determined by the Secretary for a calendar year under paragraph (1) may not exceed the following amount, as applicable to the calendar year:

(A) In the case of calendar year 1996, $3,200,000,000.

(B) In the case of calendar year 1997, $3,500,000,000.

(C) In the case of calendar year 1998, $4,800,000,000.

(D) In the case of each of the calendar years 1999 and 2000, $5,800,000,000.

(E) In the case of each subsequent calendar year, the amount specified in subparagraph (D) increased by the product of such amount and the general health care inflation factor for such year (as defined in subsection (c)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE PROGRAMS.—

(1) IN GENERAL.—Subject to the annual health professions workforce account determined by the Secretary under subsection (a) for the calendar year involved, the amount of payments required in section 3031 to be made to an eligible program for the calendar year is an amount equal to the product of—

(A) the number of full-time equivalent training participants in the program; and

(B) the national average of the costs of such programs in training an individual, as determined by consideration of the following factors (and as adjusted under paragraph (2)(B)):

(i) The national average salary of training participants.

(ii) The national average costs of such programs in providing for faculty supervision of training participants and for related activities.

(2) ADDITIONAL PROVISIONS REGARDING NATIONAL AVERAGE COST.—

(A) The Secretary shall in accordance with paragraph (1)(B) determine, for academic year 1992-93, an amount equal to the national average described in such paragraph with respect to training an individual. The national average applicable under such paragraph for a calendar year is, subject to subparagraph (B), the amount determined under the preceding sentence increased by an amount necessary to offset the effects of health care inflation occurring since academic year 1992-93, as determined through use of the general health care inflation factors for such years (or if there is no such factor for a calendar year, the consumer price index for the year).

(B) The national average determined under subparagraph (A) and applicable to a calendar year shall, in the case of the eligible program involved, be adjusted by a factor to reflect regional differences in the applicable wage and wage-related costs.

(c) DEFINITIONS.—For purposes of this subtitle:

(1) The term "annual health professions workforce account", with respect to a calendar year, means the amount determined under subsection (a) for such year.

(2) The term "consumer price index" has the meaning given such term in section 1902.

(3) The term "general health care inflation factor", with respect to a year, has the meaning given such term in section 6001(a)(3) for such year.

SEC. 3034. ADDITIONAL FUNDING PROVISIONS.

(a) SOURCES OF FUNDS FOR ANNUAL HEALTH PROFESSIONS WORKFORCE ACCOUNT.—The annual health professions workforce account under section 3033(a) for a calendar year shall be derived from the sources specified in subsection (b).

(b) CONTRIBUTIONS FROM MEDICARE TRUST FUNDS, REGIONAL ALLIANCES, AND CORPORATE ALLIANCES.—For purposes of subsection (a),

the sources specified in this subsection for a calendar year are the following:

(1) Transfers made by the Secretary under section 4051.

(2) Payments made by regional alliances under section 1353 and transferred in an amount equal to the aggregate regional alliance portion determined under subsection (c)(2)(A).

(3) The transfer made under section (d)(1).

(c) CONTRIBUTIONS FROM REGIONAL AND CORPORATE ALLIANCES.—

(1) DETERMINATION OF AGGREGATE REGIONAL AND CORPORATE ALLIANCE AMOUNT.—For purposes regarding the provision of funds for the annual health professions workforce account for a calendar year, the Secretary shall determine an aggregate regional and corporate alliance amount, which amount is to be paid by such alliances pursuant to paragraphs (2) and (3) of subsection (b), respectively, and which amount shall be equal to the difference between—

(A) the annual health professions workforce account for such year; and

(B) the amount transferred under section 4051 for the year.

(2) ALLOCATION OF AMOUNT AMONG REGIONAL AND CORPORATE ALLIANCES.—With respect to the aggregate regional and corporate alliance amount determined under paragraph (1) for a calendar year—

(A) the aggregate regional alliance portion of such amount is the product of such amount and the percentage constituted by the ratio of the total plan payments of regional alliances to the combined total plan payments of regional alliances and corporate alliances; and

(B) the aggregate corporate alliance portion of such amount is the product of such amount and the percentage constituted by the ratio of the total plan payments of corporate alliances to such combined total plan payments.

(d) COMPLIANCE REGARDING CORPORATE ALLIANCES.—

(1) IN GENERAL.—Effective January 15 of each calendar year, there is hereby transferred to the Secretary, out of any money in the Treasury not otherwise appropriated, an amount equal to the aggregate corporate alliance portion determined under subsection (c)(2)(B) for such year.

(2) MANNER OF COMPLIANCE.—The payment by corporate alliances of the tax imposed under section 3461 of the Internal Revenue Code of 1986 (as added by section 7121 of this Act), together with the transfer made in paragraph (1) for the calendar year involved, is deemed to be the payment required pursuant to subsection (c)(1) for corporate alliances for such year.

(e) DEFINITIONS.—For purposes of this subtitle, the term "plan payments" with respect to a regional or corporate alliance, means the amount paid to health plans by the alliance.

Subpart D—General Provisions

SEC. 3041. DEFINITIONS.

For purposes of this subtitle:

(1) The term "academic year" has the meaning given such term in section 3011(b).

(2) The term "allocation period" has the meaning given such term in section 3013(d).

(3) The term "annual health professions workforce account" has the meaning given such term in section 3033(c).

(4) The term "annual number of specialty positions" has the meaning given such term in section 3012(e).

(5) The term "approved physician training program" has the meaning given such term in section 3011(b).

(6) The term "consumer price index" has the meaning given such term in section 3033(c).

(7) The term "designation period" has the meaning given such term in section 3012(e).

(8) The term "eligible program" has the meaning given such term in section 3011(b), in the case of subpart B; and has the meaning given such term in section 3031(c), in the case of subpart C.

(9) The term "funding agreement" has the meaning given such term in section 3011(b).

(10) The term "general health care inflation factor" has the meaning given such term in section 3033(c).

(11) The term "medical school" has the meaning given such term in section 3001(e).

(12) The term "medical specialty" has the meaning given such term in section 3011(b).

(13) The term "National Council" has the meaning given such term in section 3001(e).

(14) The term "plan payments" has the meaning given such term in section 3034(e).

(15) The term "primary health care" has the meaning given such term in section 3012(e).

(16) The term "specialty position" has the meaning given such term in section 3012(e).

(17) The term "training participant" has the meaning given such term in section 3012(e).

Subpart E—Transitional Provisions

SEC. 3051. TRANSITIONAL PAYMENTS TO INSTITUTIONS.

(a) PAYMENTS REGARDING EFFECTS OF SUBPART B ALLOCATIONS.—

(1) IN GENERAL.—For each of the calendar years 1998 through 2001, in the case of any eligible institution that submits to the Secretary an application for the year involved in accordance with subsection (d), the Secretary shall make payments for such year to the institution for the purpose specified in subsection (c). The Secretary shall make the payments in an amount determined in accordance with subsection (e), and may administer the payments as a contract, grant, or cooperative agreement.

(2) APPLICABLE YEARS.—Payments under paragraph (1) may not be made before calendar year 1998, except that the Secretary may make such payments before such year to eligible institutions in any State that has become a participating State under title I.

(b) ELIGIBLE INSTITUTION.—For purposes of this section, the term "eligible institution", with respect to a calendar year, means an institution—

(1) in which there are one or more programs that—

(A) are approved physician training programs; and

(B) are receiving payments under section 3031 for such year; and

(2) whose number of speciality positions (in the medical specialities with respect to which such payments are made) is below the number of such positions at the institution for academic year 1993-94 as a result of allocations under subpart B.

(c) PURPOSE OF PAYMENTS.—The purpose of payments under subsection (a) is to assist an eligible institution with the costs of operation. A funding agreement for such payments is that the institution will expend the payments only for such purpose.

(d) APPLICATION FOR PAYMENTS.—For purposes of subsection (a), an application for payments under such subsection is in accordance with this subsection if the institution involved submits the application not later than the date specified by the Secretary; the institution has cooperated with the approved physician training programs of the institution in meeting the condition described in section 3032(b); the application contains each funding agreement described in this section and provides assurances of compliance with such agreements satisfactory to the Secretary; and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(e) AMOUNT OF PAYMENTS.—

(1) IN GENERAL.—Subject to the annual health professions workforce account determined by the Secretary under section 3033(a) for the calendar year involved, the amount of payments required in subsection (a) to be made to an eligible institution for the calendar year is the product of the amount determined under paragraph (2) and the applicable percentage specified in paragraph (3).

(2) NUMBER OF SPECIALTY POSITIONS LOST; NATIONAL AVERAGE SALARY.—For purposes of paragraph (1), the amount determined under this paragraph for an eligible institution for the calendar year involved is the product of—

(A) an amount equal to the number of full-time equivalent specialty positions lost; and

(B) the national average salary of training participants.

(3) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage for a calendar year is the following, as applicable to such year:

(A) For calendar year 1998, 100 percent.

(B) For calendar year 1999, 75 percent.

(C) For calendar year 2000, 50 percent.

(D) For calendar year 2001, 25 percent.

(4) DETERMINATION OF SPECIALTY POSITIONS LOST.—

(A) For purposes of this section, the number of specialty positions lost, with respect to a calendar year, is the difference between—

(i) the number of specialty positions described in subparagraph (B) that are estimated for the institution involved for the academic year beginning in such calendar year; and

(ii) the number of such specialty positions at the institution for academic year 1993-94.

(B) For purposes of subparagraph (A), the specialty positions described in this subparagraph are specialty positions in the medical specialities with respect to which payments under section 3031 are made to programs of the institution involved.

(5) ADDITIONAL PROVISION REGARDING NATIONAL AVERAGE SALARY.—

(A) The Secretary shall determine, for academic year 1992-93, an amount equal to the national average described in paragraph (2)(B). The national average applicable under such paragraph for a calendar year is, subject to subparagraph (B), the amount determined under the preceding sentence increased by an amount necessary to offset the effects of health care inflation occurring since academic year 1992-93, as determined through use of the general health care inflation factors for such years (or if there is no such factor for a year, the consumer price index for the year).

(B) The national average determined under subparagraph (A) and applicable to a calendar year shall, in the case of the eligible institution involved, be adjusted by a factor to reflect regional differences in the applicable wage and wage-related costs.

PART 2—RELATED PROGRAMS

SEC. 3061. ADDITIONAL FUNDING FOR CERTAIN WORKFORCE PROGRAMS.

(a) IN GENERAL.—For purpose of carrying out the programs described in sections 3062

and 3063, there is authorized to be appropriated $200,000,000 for fiscal year 1994 and each subsequent fiscal year (in addition to amounts that may otherwise be authorized to be appropriated for carrying out the programs).

(b) ALLOCATIONS.—With respect to the amount appropriated under subsection (a) for a fiscal year, the Secretary of Health and Human Services and the Secretary of Labor shall enter into an agreement specifying the aggregate portion of such amount to be made available for the programs described in section 3062 and the aggregate portion to be made available for the programs described in section 3063.

SEC. 3062. PROGRAMS OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—The programs described in this section and carried out with amounts made available under section 3061 shall be carried out by the Secretary of Health and Human Services.

(b) PRIMARY CARE PHYSICIAN AND PHYSICIAN ASSISTANT TRAINING.—For purposes of section 3061, the programs described in this section include programs to support projects to train additional numbers of primary care physicians and physician assistants, including projects to enhance community-based generalist training for medical students, residents, and practicing physicians; to retrain mid-career physicians previously certified in a nonprimary care medical specialty; to expand the supply of physicians with special training to serve in rural and inner-city medically underserved areas; to support expansion of service-linked educational networks that train a range of primary care providers in community settings; to provide for training in managed care, cost-effective practice management, and continuous quality improvement; and to develop additional information on primary care workforce issues as required to meet future needs in health care.

(b) TRAINING OF UNDERREPRESENTED MINORITIES AND DISADVANTAGED PERSONS.—For purposes of section 3061, the programs described in this section include a program to support projects to increase the number of underrepresented minority and disadvantaged persons in medicine, osteopathy, dentistry, nursing, public health, and other health professions, including projects to provide continuing financial assistance for such persons entering health professions training programs; to increase support for recruitment and retention of such persons in the health professions; to maintain efforts to foster interest in health careers among such persons at the preprofessional level; and to increase the number of minority health professions faculty.

(c) NURSE TRAINING.—For purposes of section 3061, the programs described in this section include the following:

(1) A program to support projects to support midlevel provider training and address priority nursing workforce needs, including projects to train additional nurse practitioners and nurse midwives; to support baccalaureate-level nurse training programs providing preparation for careers in teaching, community health service, and specialized clinical care; to train additional nurse clinicians and nurse anesthetists; to support interdisciplinary school-based community nursing programs; and to promote research on nursing workforce issues.

(2) A program to develop and encourage the adoption of model professional practice statutes for advanced practice nurses and physician assistants, and to otherwise support efforts to remove inappropriate barriers to practice by such nurses and such physician assistants.

(d) OTHER PROGRAMS.—For purposes of section 3061, the programs described in this section include a program to train health professionals and administrators in managed care, cost-effective practice management, continuous quality improvement practices, and provision of culturally sensitive care.

(e) RELATIONSHIP TO EXISTING PROGRAMS.—This section may be carried out through programs established in title VII or VIII of the Public Health Service Act, as appropriate and as consistent with the purposes of such programs.

SEC. 3063. PROGRAMS OF THE SECRETARY OF LABOR.

(a) IN GENERAL.—The programs described in this section and carried out with amounts made available under section 3061 shall be carried out by the Secretary of Labor (in this section referred to as the "Secretary").

(b) RETRAINING PROGRAMS; ADVANCED CAREER POSITIONS; JOB BANKS.—

(1) IN GENERAL.—For purposes of section 3061, the programs described in this section are the following:

(A) A program to retrain administrative and clerical workers for positions as technicians, nurses, and physician assistants.

(B) A demonstration program to assist workers in health care institutions in obtaining advanced career positions.

(C) A program to support development of health-worker job banks in local employment services agencies.

(D) A program for skills upgrading, occupational retraining, and quality improvement.

(E) A program to facilitate the comprehensive workforce adjustment initiative.

(2) USE OF FUNDS.—Amounts made available under section 3061 for carrying out this section may be expended for program support, faculty development, trainee support, workforce analysis, and dissemination of information, as necessary to produce required performance outcomes, and for establishing and operating the Institute authorized in section 3064.

(c) CERTAIN REQUIREMENTS FOR PROGRAMS.—In carrying out the programs described in subsection (b), the Secretary shall, with respect to the organizations and employment positions involved, provide for the following:

(1) Explicit, clearly defined skill requirements developed for all the positions and projections of the number of openings for each position.

(2) Opportunities for internal career movement.

(3) Opportunities to work while training or completing and educational program.

(4) Evaluation and dissemination.

(5) Training opportunities in several forms, as appropriate.

(d) ADMINISTRATIVE REQUIREMENTS.—In carrying out the programs described in subsection (b), the Secretary shall, with respect to the organizations and employment positions involved, provide for the following:

(1) Implementation and administration jointly by management and employees and their representatives.

(2) Discussion with employees as to training needs for career advancement.

(3) Commitment to a policy of internal hirings and promotion.

(4) Provision of support services.

(5) Consultations with employers and with organized labor.

SEC. 3064. NATIONAL INSTITUTE FOR HEALTH CARE WORKFORCE DEVELOPMENT.

(a) ESTABLISHMENT OF INSTITUTE.—The Secretary of Health and Human Services and the Secretary of Labor may jointly establish an office to be known as the National Institute for Health Care Workforce Development. The subsequent provisions of this section apply to any such Institute.

(b) DIRECTOR.—The Institute shall be headed by a director, who shall be appointed jointly by the Secretaries.

(c) DUTIES.—

(1) IN GENERAL.—The Director of the Institute shall make recommendations to the Secretaries regarding—

(A) the supply of health care workers needed for the system of regional and corporate alliance health plans established under title I; and

(B) the impact of such system on health care workers and the needs of such workers with respect to the system, including needs regarding education, training, and other matters relating to career development.

(2) ADMINISTRATION OF PROGRAMS REGARDING RETRAINING, ADVANCED CAREER POSITIONS, AND JOB BANKS.—The Secretary of Labor may carry out section 3063 acting through the Director of the Institute.

(d) ADVISORY BOARD.—

(1) IN GENERAL.—The Secretaries shall establish an advisory board to assist in the develop of recommendations under subsection (c).

(2) COMPOSITION.—The Advisory Board shall be composed of—

(A) the Secretary of Labor;

(B) the Secretary of Health and Human Services;

(C) representatives of health care workers in organized labor;

(D) representatives of health care institutions;

(E) representatives of health care education organizations;

(F) representatives of consumer organizations; and

(G) such other individuals as the Secretaries determine to be appropriate.

(e) STAFF, QUARTERS, AND OTHER ASSISTANCE.—The Secretaries shall provide the Institute and the Advisory Board with such staff, quarters, and other administrative assistance as may be necessary for the Institute and the Advisory Board to carry out this section.

(f) DEFINITIONS.—For purposes of this section:

(1) The term "Advisory Board" means the advisory board established under subsection (c).

(2) The term "Institute" means an Institute established under subsection (a).

(3) The term "Secretaries" means the Secretary of Health and Human Services and the Secretary of Labor.

(g) SUNSET.—Effective upon the end of calendar year 2000, this section is repealed.

Subtitle B—Academic Health Centers

PART 1—FORMULA PAYMENTS

SEC. 3101. FEDERAL FORMULA PAYMENTS TO ACADEMIC HEALTH CENTERS.

(a) IN GENERAL.—

(1) FORMULA PAYMENTS.—In the case of any academic health center that submits to the Secretary a written request for a calendar year in accordance with section 3102, the Secretary shall make payments for such year to the center for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 3103, and shall administer the payments as a contract, grant, or cooperative agreement.

(2) APPLICABLE YEARS.—Payments under paragraph (1) may not be made before calendar year 1998, except that the Secretary may make such payments before such year to eligible programs in any State that has become a participating State under title I.

(b) PAYMENTS FOR COSTS ATTRIBUTABLE TO ACADEMIC NATURE OF CENTERS.—The purpose of payments under subsection (a) is to assist academic health centers with costs that are not routinely incurred by other entities in providing health services, but are incurred by such centers in providing health services by virtue of the academic nature of such centers.

(c) ACADEMIC HEALTH CENTERS.—For purposes of this subtitle, the term "academic health center" means an entity that operates a teaching hospital that carries out an approved physician training program (as defined in section 3011(b)).

SEC. 3102. REQUEST FOR PAYMENTS.

(a) IN GENERAL.—For purposes of section 3101, a written request for payments under such section is in accordance with this section if the academic health center involved submits the request not later than the date specified by the Secretary; the request is accompanied by each funding agreement described in this part; and the request is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(b) CONTINUED STATUS AS ACADEMIC HEALTH CENTER.—A funding agreement for payments under section 3101 is that the entity involved will maintain status as an academic health center. For purposes of this subtitle, the term "funding agreement", with respect to payments under section 3101 to an entity, means that the Secretary may make the payments only if the entity makes the agreement involved.

SEC. 3103. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.

(a) DETERMINATION BY SECRETARY OF FUNDS AVAILABLE FOR PAYMENTS.—

(1) ANNUAL ACADEMIC HEALTH CENTER ACCOUNT.—Subject to paragraph (2) and section 3104, the Secretary shall determine for each calendar year the amount to be made available for the purpose of making payments under section 3101 for the year to eligible centers. In determining such amount, the Secretary shall consider the need of eligible centers for assistance with the costs described in section 3101(b).

(2) LIMITATION.—The amount determined by the Secretary for a calendar year under paragraph (1) may not exceed the following amount, as applicable to the calendar year:

(A) In the case of calendar year 1996, $3,100,000,000.

(B) In the case of each of the calendar years 1997 and 1998, $3,200,000,000.

(C) In the case of calendar year 1999, $3,700,000,000.

(D) In the case of calendar year 2000, $3,800,000,000.

(E) In the case of each subsequent calendar year, the amount specified in subparagraph (C) increased by the product of such amount and the general health care inflation factor (as defined in subsection (c)).

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE CENTERS.—The amount of payments required in section 3101 to be made to an eligible center for a calendar year is an amount equal to the product of—

(1) the annual academic health center account determined by the Secretary under subsection (a) for the calendar year; and

(2) the percentage constituted by the ratio of—

(A) an amount equal to product of—

(i) the portion of the gross receipts of the center for the preceding calendar year that was derived from providing services to patients (both inpatients and outpatients); and

(ii) the indirect teaching adjustment factor determined under section 1886(d)(5)(B)(ii) of the Social Security Act (as in effect before January 1, 1998) and applicable to patients discharged from the center in such preceding year (or, in the case of patients discharged from the center on or after January 1, 1998, applicable to patients discharged in calendar year 1997); to

(B) the sum of the respective amounts determined under subparagraph (A) for eligible centers.

(c) REPORT REGARDING MODIFICATIONS IN FORMULA.—Not later than July 1, 1996, the Secretary shall submit to the Congress a report containing any recommendations of the Secretary regarding policies for allocating amounts under subsection (a) among eligible centers.

(d) DEFINITION.—For purposes of this subtitle:

(1) The term "eligible center", with respect to the calendar year involved, means an academic health center that submits to the Secretary a written request for such year in accordance with section 3102.

(2) The term "annual academic health center account", with respect to a calendar year, means the amount determined under subsection (a) for such year.

(2) The term "general health care inflation factor", with respect to a year, has the meaning given such term in section 6001(a)(3) for such year.

SEC. 3104. ADDITIONAL FUNDING PROVISIONS.

(a) SOURCES OF FUNDS FOR ANNUAL ACADEMIC HEALTH CENTER.—The annual academic health center account under section 3103(a) for a calendar year shall be derived from the sources specified in subsection (b).

(b) CONTRIBUTIONS FROM MEDICARE TRUST FUNDS, REGIONAL ALLIANCES, AND CORPORATE ALLIANCES.—For purposes of subsection (a), the sources specified in this subsection for a calendar year are the following:

(1) Transfers made by the Secretary under section 4052.

(2) Payments made by regional alliances under section 1353 and transferred in an amount equal to the aggregate regional alliance portion determined under subsection (c)(2)(A).

(3) The transfer made under section (d)(1).

(c) CONTRIBUTIONS FROM REGIONAL AND CORPORATE ALLIANCES.—

(1) DETERMINATION OF AGGREGATE REGIONAL AND CORPORATE ALLIANCE AMOUNT.—For purposes regarding the provision of funds for the annual academic health center account for a calendar year, the Secretary shall determine an aggregate regional and corporate alliance amount, which amount is to be paid by such alliances pursuant to paragraphs (2) and (3) of subsection (b), respectively, and which amount shall be equal to the difference between—

(A) the annual academic health center account for such year; and

(B) the amount transferred under section 4052 for the year.

(2) ALLOCATION OF AMOUNT AMONG REGIONAL AND CORPORATE ALLIANCES.—With respect to the aggregate regional and corporate alliance amount determined under paragraph (1) for a calendar year—

(A) the aggregate regional alliance portion of such amount is the product of such amount and the percentage constituted by the ratio of the total plan payments of regional alliances to the combined total plan payments of regional alliances and corporate alliances; and

(B) the aggregate corporate alliance portion of such amount is the product of such amount and the percentage constituted by the ratio of the total plan payments of corporate alliances to such combined total plan payments.

(d) COMPLIANCE REGARDING CORPORATE ALLIANCES.—

(1) IN GENERAL.—Effective January 15 of each calendar year, there is hereby transferred to the Secretary, out of any money in the Treasury not otherwise appropriated, an amount equal to the aggregate corporate alliance portion determined under subsection (c)(2)(B) for such year.

(2) MANNER OF COMPLIANCE.—The payment by corporate alliances of the tax imposed under section 3461 of the Internal Revenue Code of 1986 (as added by section 7121 of this Act), together with the transfer made in paragraph (1) for the calendar year involved, is deemed to be the payment required pursuant to subsection (c)(1) for corporate alliances for such year..

(e) DEFINITIONS.—For purposes of this subtitle, the term "plan payments" with respect to a regional or corporate alliance, means the amount paid to health plans by the alliance.

PART 2—ACCESS OF PATIENTS TO ACADEMIC HEALTH CENTERS

SEC. 3131. CONTRACTS FOR ENSURING ACCESS TO CENTERS.

(a) CONTRACTS WITH HEALTH PLANS.—Regional and corporate health alliances under this Act shall ensure that, in accordance with subsection (b), the health plans of the alliances enter into sufficient contracts with eligible centers to ensure that enrollees in regional or corporate alliance health plans, as appropriate, receive the specialized treatment expertise of such centers, subject to such exceptions as the Secretary may provide.

(b) UTILIZATION OF SPECIALIZED TREATMENT EXPERTISE OF CENTERS.—Contracts under subsection (a) between eligible centers and health plans are in accordance with this subsection if the contracts provide that, with respect to health conditions within the specialized treatment expertise of the centers, health plans will refer medical cases involving such conditions to the centers.

(c) SPECIALIZED TREATMENT EXPERTISE.—For purposes of this subtitle, the term "specialized treatment expertise", with respect to treatment of a health condition by an academic health center, means expertise in treating rare diseases, treating unusually severe conditions, and providing other specialized health care.

SEC. 3132. DISCRETIONARY GRANTS REGARDING ACCESS TO CENTERS.

(a) RURAL INFORMATION AND REFERRAL SYSTEMS.—The Secretary may make grants to eligible centers for the establishment and operation of information and referral systems to provide the services of such centers to rural regional and corporate health alliance health plans.

(b) OTHER PURPOSES REGARDING URBAN AND RURAL AREAS.—The Secretary may make grants to eligible centers to carry out activities (other than activities carried out under subsection (a)) for the purpose of providing the services of eligible centers to residents of rural or urban communities who otherwise would not have adequate access to such services.

Subtitle C—Health Research Initiatives

PART 1—PROGRAMS FOR CERTAIN AGENCIES

SEC. 3201. BIOMEDICAL AND BEHAVIORAL RESEARCH ON HEALTH PROMOTION AND DISEASE PREVENTION.

Section 402(f) of the Public Health Service Act (42 U.S.C. 282(f)), as amended by section 201 of Public Law 103-43 (107 Stat. 144), is amended—

(1) in paragraph (3), by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(2) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C);

(3) by inserting "(1)" after "(f)"; and

(4) by adding at the end the following paragraph:

"(2)(A) The Director of NIH, in collaboration with the Associate Director for Prevention and with the heads of the agencies of the National Institutes of Health, shall ensure that such Institutes conduct and support biomedical and behavioral research on promoting health and preventing diseases, disorders, and other health conditions (including Alzheimer's disease, breast cancer, heart disease, and stroke).

"(B) In carrying out subparagraph (A), the Director of NIH shall give priority to conducting and supporting research on child and adolescent health (including birth defects), chronic and recurrent health conditions, reproductive health, mental health, elderly health, substance abuse, infectious diseases, health and wellness promotion, and environmental health, and to resource development related to such research.".

SEC. 3202. HEALTH SERVICES RESEARCH.

Section 902 of the Public Health Service Act (42 U.S.C. 299a), as amended by section 2(b) of Public Law 102-410 (106 Stat. 2094), is amended by adding at the end the following subsection:

"(f) RESEARCH ON HEALTH CARE REFORM.—

"(1) IN GENERAL.—In carrying out section 901(b), the Administrator shall conduct and support research on the reform of the health care system of the United States, as directed by the National Board.

"(2) PRIORITIES.—In carrying out paragraph (1), the Administrator shall give priority to the following:

"(A) Conducting and supporting research on the appropriateness and effectiveness of alternative clinical strategies; the quality and outcomes of care; and administrative simplification.

"(B) Conducting and supporting research on consumer choice and information resources; the effects of health care reform on health delivery systems; workplace injury and illness prevention; methods for risk adjustment; factors influencing access to health care for underserved populations; and primary care.

"(C) The development of clinical practice guidelines consistent with section 913, the dissemination of such guidelines consistent with section 903, and the assessment of the effectiveness of such guidelines.".

PART 2—FUNDING FOR PROGRAMS

SEC. 3211. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) BIOMEDICAL AND BEHAVIORAL RESEARCH ON HEALTH PROMOTION AND DISEASE PREVENTION.—For the purpose of carrying out activities pursuant to the amendments made by section 3201, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $400,000,000 for fiscal year 1995, and $500,000,000 for each of the fiscal years 1996 through 2000.

(b) HEALTH SERVICES RESEARCH.—For the purpose of carrying out activities pursuant to the amendments made by section 3202, there are authorized to be appropriated from the Public Health Service Initiatives Fund $150,000,000 for fiscal year 1995, $400,000,000 for fiscal year 1996, $500,000,000 for fiscal year 1997, and $600,000,000 for each of the fiscal years 1998 through 2000.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsections (a) and (b) are in addition to any other authorizations of appropriations that are available for the purposes described in such subsections.

Subtitle D—Core Functions of Public Health Programs; National Initiatives Regarding Preventive Health

PART 1—FUNDING

SEC. 3301. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—For the purpose of carrying out part 2, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $12,000,000 for fiscal year 1995, $325,000,000 for fiscal year 1996, $450,000,000 for fiscal year 1997, $550,000,000 for fiscal year 1998, $650,000,000 for fiscal year 1999, and $750,000,000 for fiscal year 2000.

(b) NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION.—For the purpose of carrying out part 3, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $175,000,000 for fiscal year 1996, and $200,000,000 for each of the fiscal years 1997 through 2000.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsections (a) and (b) are in addition to any other authorizations of appropriations that are available for the purposes described in such subsections.

PART 2—CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS

SEC. 3311. PURPOSES.

Subject to the subsequent provisions of this subtitle, the purposes of this part are to strengthen the capacity of State and local public health agencies to carry out the following functions:

(1) To monitor and protect the health of communities against communicable diseases and exposure to toxic environmental pollutants, occupational hazards, harmful products, and poor quality health care.

(2) To identify and control outbreaks of infectious disease and patterns of chronic disease and injury.

(3) To inform and educate health care consumers and providers about their roles in preventing and controlling disease and the appropriate use of medical services.

(4) To develop and test new prevention and public health control interventions.

SEC. 3312. GRANTS TO STATES FOR CORE HEALTH FUNCTIONS.

(a) IN GENERAL.—The Secretary may make grants to States for the purpose of carrying out one or more of the functions described in subsection (b).

(b) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—For purposes of subsection (a), the functions described in this subsection are, subject to subsection (c), as follows:

(1) Data collection, activities related to population health measurement and outcomes monitoring, including the regular collection and analysis of public health data, vital statistics, and personal health services data and analysis for planning and needs assessment purposes of data collected from health plans through the information system under title V of this Act.

(2) Activities to protect the environment and to assure the safety of housing, workplaces, food and water, including the following activities:

(A) Monitoring the overall public health quality and safety of communities.

(B) Assessing exposure to high lead levels and water contamination.

(C) Monitoring sewage and solid waste disposal, radiation exposure, radon exposure, and noise levels.

(D) Abatement of lead-related hazards.

(E) Assuring recreation and worker safety.

(F) Enforcing public health safety and sanitary codes.

(G) Other activities relating to promoting the public health of communities.

(3) Investigation and control of adverse health conditions, including improvements in emergency treatment preparedness, cooperative activities to reduce violence levels in communities, activities to control the outbreak of disease, exposure related conditions and other threats to the health status of individuals.

(4) Public information and education programs to reduce risks to health such as use of tobacco, alcohol and other drugs, sexual activities that increase the risk to HIV transmission and sexually transmitted diseases, poor diet, physical inactivity, and low childhood immunization levels.

(5) Accountability and quality assurance activities, including monitoring the quality of personal health services furnished by health plans and providers of medical and health services in a manner consistent with the overall quality of care monitoring activities undertaken under title V, and monitoring communities' overall access to health services.

(6) Provision of public health laboratory services to complement private clinical laboratory services and that screen for diseases and conditions such as metabolic diseases in newborns, provide toxicology assessments of blood lead levels and other environmental toxins, diagnose sexually transmitted diseases, tuberculosis and other diseases requiring partner notification, test for infectious and food-borne diseases, and monitor the safety of water and food supplies.

(7) Training and education to assure provision of care by all health professionals, with special emphasis placed on the training of public health professions including epidemiologists, biostatisticians, health educators, public health administrators, sanitarians and laboratory technicians.

(8) Leadership, policy development and administration activities, including needs assessment, the setting of public health standards, the development of community public health policies, and the development of community public health coalitions.

(c) RESTRICTIONS ON USE OF GRANT.—

(1) IN GENERAL.—A funding agreement for a grant under subsection (a) for a State is that the grant will not be expended—

(A) to provide inpatient services;

(B) to make cash payments to intended recipients of health services;

(C) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(D) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

(E) to provide financial assistance to any entity other than a public or nonprofit private entity.

(2) LIMITATION ON ADMINISTRATIVE EXPENSES.—A funding agreement for a grant under subsection (a) is that the State involved will not expend more than 10 percent of the grant for administrative expenses with respect to the grant.

(d) MAINTENANCE OF EFFORT.—A funding agreement for a grant under subsection (a) is that the State involved will maintain expenditures of non-Federal amounts for core health functions at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant.

SEC. 3313. SUBMISSION OF INFORMATION.

The Secretary may make a grant under section 3312 only if the State involved submits to the Secretary the following information:

(1) A description of existing deficiencies in the State's public health system (at the State level and the local level), using standards of sufficiency developed by the Secretary.

(2) A description of health status measures to be improved within the State (at the State level and the local level) through expanded public health functions.

(3) Measurable outcomes and process objectives for improving health status and core health functions for which the grant is to be expended.

(4) Information regarding each such function, which—

(A) identifies the amount of State and local funding expended on each such function for the fiscal year preceding the fiscal year for which the grant is sought; and

(B) provides a detailed description of how additional Federal funding will improve each such function by both the State and local public health agencies.

(5) A description of the core health functions to be carried out at the local level, and a specification for each such function of—

(A) the communities in which the function will be carried out; and

(B) the amount of the grant to be expended for the function in each community so specified.

SEC. 3314. REPORTS.

A funding agreement for a grant under section 3312 is that the States involved will, not later than the date specified by the Secretary, submit to the Secretary a report describing—

(1) the purposes for which the grant was expended; and

(2) describing the extent of progress made by the State in achieving measurable outcomes and process objectives described in section 3313(3).

SEC. 3315. APPLICATION FOR GRANT.

The Secretary may make a grant under section 3312 only if an application for the grant is submitted to the Secretary, the application contains each agreement described in this part, the application contains the information required in section 3314, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

SEC. 3316. GENERAL PROVISIONS.

(a) UNIFORM DATA SETS.—The Secretary, in consultation with the States, shall develop uniform sets of data for the purpose of monitoring the core health functions carried out with grants under section 3312.

(b) DURATION OF GRANT.—The period during which payments are made to a State from a grant under section 3312 may not exceed 5 years. The provision of such payments shall be subject to annual approval by the Secretary of the payments. This subsection may not be construed as establishing a limitation on the number of grants under such section that may be made to the State.

SEC. 3317. ALLOCATIONS FOR CERTAIN ACTIVITIES.

Of the amounts made available under section 3301 for a fiscal year for carrying out this part, the Secretary may reserve not more than 5 percent for carrying out the following activities:

(1) Technical assistance with respect to planning, development, and operation of core health functions carried out under section 3312, including provision of biostatistical and epidemiological expertise and provision of laboratory expertise.

(2) Development and operation of a national information network among State and local health agencies.

(3) Program monitoring and evaluation of core health functions carried out under section 3312.

(4) Development of a unified electronic reporting mechanism to improve the efficiency of administrative management requirements regarding the provision of Federal grants to State public health agencies.

SEC. 3318. DEFINITIONS.

For purposes of this part:

(1) The term "funding agreement", with respect to a grant under section 3312 to a State, means that the Secretary may make the grant only if the State makes the agreement involved.

(2) The term "core health functions", with respect to a State, means the functions described in section 3312(b).

PART 3—NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 3331. GRANTS FOR NATIONAL PREVENTION INITIATIVES.

(a) IN GENERAL.—The Secretary may make grants to entities described in subsection (b) for the purpose of carrying out projects to develop and implement innovative community-based strategies to provide for health promotion and disease prevention activities for which there is a significant need, as identified under section 1701 of the Public Health Service Act.

(b) ELIGIBLE ENTITIES.—The entities referred to in subsection (a) are agencies of State or local government, private nonprofit organizations (including research institutions), and coalitions that link two or more of these groups.

(c) CERTAIN ACTIVITIES.—The Secretary shall ensure that projects carried out under subsection (a)—

(1) reflect approaches that take into account the special needs and concerns of the affected populations;

(2) are targeted to the most needy and vulnerable population groups and geographic areas of the Nation;

(3) examine links between various high priority preventable health problems and the potential community-based remedial actions; and

(4) establish or strengthen the links between the activities of agencies engaged in public health activities with those of health alliances, health care providers, and other entities involved in the personal health care delivery system described in title I.

SEC. 3332. PRIORITIES.

(a) ESTABLISHMENT.—

(1) ANNUAL STATEMENT.—After consultation with the advisory board established in section 3335, the Secretary shall for each fiscal year develop a statement of proposed priorities for grants under section 3331 for the fiscal year.

(2) ALLOCATIONS AMONG PRIORITIES.—With respect to the amounts available under section 3301 for the fiscal year for carrying out this part, each statement under paragraph (1) for a fiscal year shall include a specification of the percentage of the amount to be devoted to projects addressing each of the proposed priorities established in the statement.

(3) PROCESS FOR ESTABLISHING PRIORITIES.—Not later than January 1 of each fiscal year, the Secretary shall publish a statement under paragraph (1) in the Federal Register. A period of 60 days shall be allowed for the submission of public comments and suggestions concerning the proposed priorities. After analyzing and considering comments on the proposed priorities, the Secretary shall publish in the Federal Register final priorities (and associated reservations of funds) for approval of projects for the following fiscal year.

(b) APPLICABILITY TO MAKING OF GRANTS.—

(1) IN GENERAL.—Subject to paragraph (3), the Secretary may make grants under section 3331 for projects that the Secretary determines—

(A) are consistent with the applicable final statement of priorities and otherwise meets the objectives described in subsection (a); and

(B) will assist in meeting a health need or concern of a population served by a health plan or health alliance established under title I.

(2) SPECIAL CONSIDERATION FOR CERTAIN PROJECTS.—In making grants under section 3331, the Secretary shall, subject to paragraph (3), give special consideration to applicants that will carry out projects that, in addition to being consistent with the applicable published priorities under subsection (a) and otherwise meeting the requirements of this part, have the potential for replication in other communities.

SEC. 3333. SUBMISSION OF INFORMATION.

The Secretary may make a grant under section 3331 only if the applicant involved submits to the Secretary the following information:

(1) A description of the activities to be conducted, and the manner in which the activities are expected to contribute to meeting one or more of the priority health needs specified under section 3332 for the fiscal year for which the grant is initially sought.

(2) A description of the total amount of Federal funding requested, the geographic area and populations to be served, and the evaluation procedures to be followed.

(3) Such other information as the Secretary determines to be appropriate.

SEC. 3334. APPLICATION FOR GRANT.

The Secretary may make a grant under section 3331 only if an application for the grant is submitted to the Secretary, the application contains each agreement described in this part, the application contains the information required in section 3333, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

Subtitle E—Health Services for Medically Underserved Populations

PART 1—COMMUNITY AND MIGRANT HEALTH CENTERS

SEC. 3401. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) GRANTS TO COMMUNITY AND MIGRANT HEALTH CENTERS.—The Secretary shall make grants in accordance with this part to migrant health centers and community health centers.

(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out subsection (a), there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $100,000,000 for each of the fiscal years 1995 through 2000.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (b) for the purpose described in such subsection are in addition to any other authorizations of appropriations that are available for such purpose.

(d) DEFINITIONS.—For purposes of this subtitle, the terms "migrant health center" and "community health center" have the meanings given such terms in sections 329(a)(1) and 330(a) of the Public Health Service Act, respectively.

SEC. 3402. USE OF FUNDS.

(a) DEVELOPMENT, OPERATION, AND OTHER PURPOSES REGARDING CENTERS.—Subject to subsection (b), grants under section 3401 to migrant health centers and community health centers may be made only in accordance with the conditions upon which grants are made under sections 329 and 330 of the Public Health Service Act, respectively.

(b) REQUIRED FINANCIAL RESERVES.—The Secretary may authorize migrant health centers and community health centers to expend a grant under section 3401 to establish and maintain the financial reserves required under title I for providers of health services.

PART 2—INITIATIVES FOR ACCESS TO HEALTH CARE

Subpart A—Purposes; Funding

SEC. 3411. PURPOSES.

Subject to the provisions of subparts B through D, the purposes of this part are as follows:

(1) To improve access to health services for urban and rural medically-underserved populations through a program of flexible grants, contracts, and loans.

(2) To facilitate transition to a system in which medically-underserved populations have an adequate choice of community-oriented providers and health plans.

(3) To promote the development of community practice networks and community health plans that integrate health professionals and health care organizations supported through public funding with other providers in medically underserved areas.

(4) To support linkages between providers of health care for medically-underserved populations and regional and corporate alliance health plans.

(5) To expand the capacity of community practice networks and community health plans in underserved areas by increasing the number of practice sites and by renovating and converting substandard inpatient and outpatient facilities.

(6) To link providers in underserved areas with each other and with regional health care institutions and academic health centers through information systems and telecommunications.

(7) To support activities that enable medically underserved populations to gain access to the health care system and use it effectively.

SEC. 3412. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) DEVELOPMENT OF QUALIFIED COMMUNITY HEALTH PLANS AND PRACTICE GROUPS.—For the purpose of carrying out subparts B and C, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $200,000,000 for fiscal year 1995, $500,000,000 for fiscal year 1996, $600,000,000 for fiscal year 1997, $700,000,000 for fiscal year 1998, $500,000,000 for fiscal year 1999, and $200,000,000 for fiscal year 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

(c) RELATIONSHIP TO PROGRAM REGARDING SCHOOL-RELATED HEALTH SERVICES.—This section is subject to section 3692.

Subpart B—Development of Qualified Community Health Plans and Practice Networks

SEC. 3421. GRANTS AND CONTRACTS FOR DEVELOPMENT OF PLANS AND NETWORKS.

(a) IN GENERAL.—The Secretary may make grants to and enter into contracts with consortia of public or private health care providers for the development of qualified community health plans and qualified community practice networks. For purposes of this subtitle, the term "qualified community health group" means such a health plan or such a practice network.

(b) QUALIFIED COMMUNITY HEALTH PLANS.—For purposes of this subtitle, the term "qualified community health plan" means a health plan that meets the following conditions:

(1) The health plan is a public or nonprofit private entity whose principal purpose is, with respect to the items and services included in the comprehensive benefit package under title I, to provide each of such items and services in one or more health professional shortage areas or to provide such items and services to a significant number of individuals who are members of a medically underserved population.

(2) The health plan is a participant in one or more health alliances.

(3) Two or more of the categories specified in subsection (d) are represented among the entities providing health services through the health plan.

(c) QUALIFIED COMMUNITY PRACTICE NETWORKS.—For purposes of this subtitle, the term "qualified community practice network" means a consortium of health care providers meeting the following conditions:

(1) The consortium is a public or nonprofit private entity whose principal purpose is the purpose described in subsection (b)(1).

(2) The consortium has an agreement with one or more health plans that are participating in one or more health alliances.

(3) The participation of health care providers in the consortium is governed by a written agreement to which each of the participating providers is a party.

(4) Two or more of the categories described in subsection (d) are represented among the entities participating in the consortium.

(d) RELEVANT CATEGORIES OF ENTITIES.—For purposes of subsections (b)(3) and (c)(4), the categories described in this subsection are the following categories of entities:

(1) Physicians, other health professionals, or health care institutions that provide health services in one or more health professional shortage areas or provide such services to a significant number of individuals who are members of a medically underserved population, and that do not provide health services under any of the programs specified in paragraphs (2) through (7) or as employees of public entities.

(2) Entities providing health services under grants under sections 329 and 330 of the Public Health Service Act.

(3) Entities providing health services under grants under sections 340 and 340A of such Act.

(4) Entities providing health services under grants under section 1001 or title XXIII of such Act.

(5) Entities providing health services under title V of the Social Security Act.

(6) Entities providing health services through rural health clinics and other federally qualified health centers.

(7) Entities providing health services in urban areas through programs under title V of the Indian Health Care Improvement Act, and entities providing outpatient health services through programs under the Indian Self-Determination Act.

(8) Programs providing personal health services and operating through State or local public health agencies.

(e) RULE OF CONSTRUCTION.—The consortia to which the Secretary may make an award of financial assistance under subsection (a) for the development of qualified community practice networks include any health plan that participates in one or more health alliances, without regard to whether the health plan is a qualified community health plan.

(f) SERVICE AREA.—In making an award of financial assistance under subsection (a), the Secretary shall designate the geographic area with respect to which the qualified community health group involved is to provide health services. A funding agreement for such an award is that the qualified community health group involved will provide such services in the area so designated.

(g) DEFINITIONS.—For purposes of this subtitle:

(1) The term "health professional shortage areas" means health professional shortage areas designated under section 332 of the Public Health Service Act.

(2) The term "medically underserved population" means a medically underserved population designated under section 330 of the Public Health Service Act.

(3) The term "rural health clinic" has the meaning given such term in section 1861(aa)(2) of the Social Security Act.

(4) The term "federally qualified health centers" has the meaning given such term in section 1861(aa)(4) of the Social Security Act.

(5) The term "service area", with respect to a qualified community health group, means the geographic area designated under subsection (g).

(6) The term "funding agreement", with respect to an award of financial assistance under this section, means that the Secretary may make the award only if the applicant for the award makes the agreement involved.

(7) The term "financial assistance", with respect to awards under subsection (a), means a grant or contract.

SEC. 3422. PREFERENCES IN MAKING AWARDS OF ASSISTANCE.

In making awards of financial assistance under section 3421, the Secretary shall give preference to applicants in accordance with the following:

(1) The Secretary shall give preference if 3 or more of the categories described in subsection (d) of such section will be represented in the qualified community health group involved (pursuant to subsection (b)(3) or (c)(4), as the case may be).

(2) Of applicants receiving preference under paragraph (1), the Secretary shall give a greater degree of preference according to the extent to which a greater number of categories are represented.

(3) Of applicants receiving preference under paragraph (1), the Secretary shall give a greater degree of preference if one of the categories represented is the category described in subsection (d)(1) of such section.

SEC. 3423. CERTAIN USES OF AWARDS.

(a) IN GENERAL.—Subject to subsection (b), the purposes for which an award of financial assistance under section 3421 may be expended in developing a qualified community health group include the following:

(1) Planning such group, including entering into contracts between the recipient of the award and health care providers who are to participate in the group.

(2) Recruitment, compensation, and training of health professionals and administrative staff.

(3) Acquisition, expansion, modernization, and conversion of facilities, including for purposes of providing for sites at which health services are to be provided through such group.

(4) Acquisition and development of information systems (exclusive of systems that the Secretary determines are information highways).

(5) Such other expenditures as the Secretary determines to be appropriate.

(b) TWENTY-YEAR OBLIGATION REGARDING SIGNIFICANT CAPITAL EXPENDITURES; RIGHT OF RECOVERY.—

(1) IN GENERAL.—With respect to a facility for which substantial capital costs are to be paid from an award of financial assistance under section 3421, the Secretary may make the award only if the applicant involved agrees that the applicant will be liable to the United States for the amount of the award expended for such costs, together with an amount representing interest, if at any time during the 20-year period beginning on the date of completion of the activities involved, the facility—

(A) ceases to be a facility utilized by a qualified community health group, or by another public or nonprofit private entity that provides health services in one or more health professional shortage areas or that provides such services to a significant number of individuals who are members of a medically underserved population; or

(B) is sold or transferred to any entity other than an entity that is—

(i) a qualified community health group or other entity described in subparagraph (A); and

(ii) approved by the Secretary as a purchaser or transferee regarding the facility.

(2) SUBORDINATION; WAIVERS.—The Secretary may subordinate or waive the right of recovery under paragraph (1), and any other Federal interest that may be derived by virtue of an award of financial assistance under section 3421 from which substantial capital costs are to paid from an award, if the Secretary determines that subordination or waiver will further the objectives of this part.

SEC. 3424. ACCESSIBILITY OF SERVICES.

(a) SERVICES FOR CERTAIN INDIVIDUALS.—A funding agreement for an award of financial assistance under section 3421 is that the qualified community health group involved will ensure that the services of the group will be accessible directly or through formal contractual arrangements with its participating providers regardless of whether individuals who seek care from the applicant are eligible persons under title I.

(b) USE OF THIRD-PARTY PAYORS.—A funding agreement for an award of financial assistance under section 3421 is that the qualified community health group involved will ensure that the health care providers of the group are all approved by the Secretary as providers under title XVIII of the Social Security Act and by the appropriate State agency as providers under title XIX of the Social Security Act, and the applicant has made or will make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to individuals who are entitled to health benefits under title I of this Act, insurance benefits under title XVIII of the Social Security Act, medical assistance under a State plan approved under title XIX of the Social Security Act, or to assistance for medical expenses under any other public assistance program or private health insurance program.

(c) SCHEDULE OF FEES.—A funding agreement for an award of financial assistance under section 3421 is that the qualified community health group involved will—

(1) prepare a schedule of fees or payments for the provision of health services not covered by title I that is consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments (or payments of cost sharing amounts owed in the case of covered benefits) which discounts are applied on the basis of the patient's ability to pay; and

(2) make every reasonable effort to secure from patients payment in accordance with such schedules, and to collect reimbursement for services to persons entitled to public or private insurance benefits or other medical assistance on the basis of full fees without application of discounts, except that the applicant will ensure that no person is denied service based on the person's inability to pay therefor.

(d) BARRIERS WITHIN SERVICE AREA.—A funding agreement for an award of financial assistance under section 3421 is that the qualified community health group involved will ensure that the following conditions are met:

(1) In the service area of the group, the group will ensure that—

(A) the services of the group are accessible to all residents; and

(B) to the maximum extent possible, barriers to access to the services of the group are eliminated, including barriers resulting from the area's physical characteristics, its residential patterns, its economic, social and cultural groupings, and available transportation.

(2) The group will periodically conduct reviews within the service area of the group to determine whether the conditions described in paragraph (1) are being met.

(e) LIMITED ABILITY TO SPEAK ENGLISH LANGUAGE.—A funding agreement for an award of financial assistance under section 3421 is that, if the service area of the qualified community health group involved serves a substantial number of individuals who have a limited ability to speak the English language, the applicant will—

(1) maintain arrangements responsive to the needs of such individuals for providing services to the extent practicable in the language and cultural context most appropriate to such individuals; and

(2) maintain a sufficient number of staff members who are fluent in both English and the languages spoken by such individuals, and will ensure that the responsibilities of the employees include providing guidance and assistance to such individuals and to other staff members of the group.

SEC. 3425. ADDITIONAL AGREEMENTS.

(a) REQUIRED SERVICES.—A funding agreement for an award of financial assistance under section 3421 is that the qualified community health group involved will provide enabling services (as defined in section 3461(g)) and all of the items and services identified by the Secretary in rules regarding qualified community health plans and practice networks.

(b) QUALITY CONTROL SYSTEM.—A funding agreement for an award of financial assistance under section 3421 is that the qualified community health group involved will maintain a community-oriented, patient responsive, quality control system under which the group, in accordance with regulations prescribed by the Secretary—

(1) conducts an ongoing quality assurance program for the health services delivered by participating provider entities;

(2) maintains a continuous community health status improvement process; and

(3) maintains a system for development, compilation, evaluation and reporting of information to the public regarding the costs of operation, service utilization patterns, availability, accessibility and acceptability of services, developments in the health status of the populations served, uniform health and clinical performance measures and financial performance of the network or plan.

(c) USE OF EXISTING RESOURCES.—A funding agreement for an award of financial assistance under section 3421 is that the applicant will, in developing the qualified community health group involved, utilize existing resources to the maximum extent practicable.

SEC. 3426. SUBMISSION OF CERTAIN INFORMATION.

(a) ASSESSMENT OF NEED.—The Secretary may make an award of financial assistance under section 3421 only if the applicant involved submits to the Secretary an assessment of the need that the medically underserved population or populations proposed to be served by the applicant have for health services and for enabling services (as defined in section 3461(g)).

(b) DESCRIPTION OF INTENDED EXPENDITURES; RELATED INFORMATION.—The Secretary may make an award of financial assistance under section 3421 only if the applicant involved submits to the Secretary the following information:

(1) A description of how the applicant will design the proposed quality community health plan or practice network (including the service sites involved) for such populations based on the assessment of need.

(2) A description of efforts to secure, within the proposed service area of such health plan or practice network (including the service sites involved), financial and professional assistance and support for the project.

(3) Evidence of significant community involvement in the initiation, development and ongoing operation of the project.

SEC. 3427. REPORTS; AUDITS.

A funding agreement for an award of financial assistance under section 3421 is that the applicant involved will—

(1) provide such reports and information on activities carried out under this section in a

manner and form required by the Secretary; and

(2) provide an annual organization-wide audit that meets applicable standards of the Secretary.

SEC. 3428. APPLICATION FOR ASSISTANCE.

The Secretary may make an award of financial assistance under section 3421 only if an application for the award is submitted to the Secretary, the application contains each funding agreement described in this subpart, the application contains the information required in section 3426, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

SEC. 3429. GENERAL PROVISIONS.

(a) LIMITATION ON NUMBER OF AWARDS.—The Secretary may not make more than two awards of financial assistance under section 3421 for the same project.

(b) AMOUNT.—The amount of any award of financial assistance under section 3421 for any project shall be determined by the Secretary.

Subpart C—Capital Cost of Development of Qualified Community Health Plans and Practice Networks

SEC. 3441. LOANS AND LOAN GUARANTEES REGARDING PLANS AND NETWORKS.

(a) IN GENERAL.—The Secretary may make loans to, and guarantee the payment of principal and interest to Federal and non-Federal lenders on behalf of, public and private entities for the capital costs of developing qualified community health groups (as defined in section 3421(a)).

(b) PREFERENCES; ACCESSIBILITY OF SERVICES; CERTAIN OTHER PROVISIONS.—The provisions of subpart B apply to loans and loan guarantees under subsection (a) to the same extent and in the same manner as such provisions apply to awards of grants and contracts under section 3421.

(c) USE OF ASSISTANCE.—

(1) IN GENERAL.—With respect to the development of qualified community health groups, the capital costs for which loans made pursuant to subsection (a) may be expended are, subject to paragraphs (2) and (3), the following:

(A) The acquisition, modernization, expansion or construction of facilities, or the conversion of unneeded hospital facilities to facilities that will assure or enhance the provision and accessibility of health care and enabling services to medically underserved populations.

(B) The purchase of major equipment, including equipment necessary for the support of external and internal information systems.

(C) The establishment of reserves required for furnishing services on a prepaid basis.

(D) Such other capital costs as the Secretary may determine are necessary to achieve the objectives of this section.

(2) PRIORITIES REGARDING USE OF FUNDS.—In providing loans or loan guarantees under subsection (a) for an entity, the Secretary shall give priority to authorizing the use of amounts for projects for the renovation and modernization of medical facilities necessary to prevent or eliminate safety hazards, avoid noncompliance with licensure or accreditation standards, or projects to replace obsolete facilities.

(3) LIMITATION.—The Secretary may authorize the use of amounts under subsection (a) for the construction of new buildings only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, expanding or converting existing buildings, or that construction of new buildings will cost less.

(d) AMOUNT OF ASSISTANCE.—The principal amount of loans or loan guarantees under subsection (a) may, when added to any other assistance under this section, cover up to 100 percent of the costs involved.

SEC. 3442. CERTAIN REQUIREMENTS.

(a) LOANS.—

(1) IN GENERAL.—The Secretary may approve a loan under section 3441 only if—

(A) the Secretary is reasonably satisfied that the applicant for the project for which the loan would be made will be able to make payments of principal and interest thereon when due; and

(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(2) TERMS AND CONDITIONS.—Any loan made under section 3441 shall meet such terms and conditions (including provisions for recovery in case of default) as the Secretary determines to be necessary to carry out the purposes of such section while adequately protecting the financial interests of the United States. Terms and conditions for such loans shall include provisions regarding the following:

(A) Security.

(B) Maturity date.

(C) Amount and frequency of installments.

(D) Rate of interest, which shall be at a rate comparable to the rate of interest prevailing on the date the loan is made.

(b) LOAN GUARANTEES.—The Secretary may not approve a loan guarantee under section 3441 unless the Secretary determines that the terms, conditions, security (if any), schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable. Such loan guarantees shall be subject to such further terms and conditions as the Secretary determines to be necessary to ensure that the purposes of this section will be achieved.

(c) USE OF EXISTING RESOURCES.—The Secretary may provide a loan or loan guarantee under section 3441 only if the applicant involved agrees that, in developing the qualified community health group involved, the applicant will utilize existing resources to the maximum extent practicable.

SEC. 3443. DEFAULTS; RIGHT OF RECOVERY.

(a) DEFAULTS.—

(1) IN GENERAL.—The Secretary may take such action as may be necessary to prevent a default on loans or loan guarantees under section 3441, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes.

(2) FORECLOSURE.—The Secretary may take such action, consistent with State law respecting foreclosure procedures, as the Secretary deems appropriate to protect the interest of the United States in the event of a default on a loan made pursuant to section 3441, including selling real property pledged as security for such a loan or loan guarantee and for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.

(3) WAIVERS.—The Secretary may, for good cause, but with due regard to the financial interests of the United States, waive any right of recovery which the Secretary has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made pursuant to section 3441, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(b) TWENTY-YEAR OBLIGATION; RIGHT OF RECOVERY.—

(1) IN GENERAL.—With respect to a facility for which a loan is to be made pursuant to section 3441, the Secretary may provide the loan or loan guarantee only if the applicant involved agrees that the applicant will be liable to the United States for the amount of the loan or loan guarantee, together with an amount representing interest, if at any time during the 20-period beginning on the date of completion of the activities involved, the facility—

(A) ceases to be a facility utilized by a qualified community health group, or by another public or nonprofit private entity that provides health services in one or more health professional shortage areas or that provides such services to a significant number of individuals who are members of a medically underserved population; or

(B) is sold or transferred to any entity other than an entity that is—

(i) a qualified community health group or other entity described in subparagraph (A); and

(ii) approved by the Secretary as a purchaser or transferee regarding the facility.

(2) SUBORDINATION; WAIVERS.—The Secretary may subordinate or waive the right of recovery under paragraph (1), and any other Federal interest that may be derived by virtue of a loan or loan guarantee under subsection (a), if the Secretary determines that subordination or waiver will further the objectives of this part.

SEC. 3444. PROVISIONS REGARDING CONSTRUCTION OR EXPANSION OF FACILITIES.

(a) SUBMISSION OF INFORMATION.—In the case of a project for construction, conversion, expansion or modernization of a facility, the Secretary may provide loans or loan guarantees under section 3441 only if the applicant submits to the Secretary the following:

(1) A description of the site.

(2) Plans and specifications which meet requirements prescribed by the Secretary.

(3) Information reasonably demonstrating that title to such site is vested in one or more of the entities filing the application (unless the agreement described in subsection (b)(1) is made).

(4) A specification of the type of assistance being requested under section 3441.

(b) AGREEMENTS.—In the case of a project for construction, conversion, expansion or modernization of a facility, the Secretary may provide loans or loan guarantees under section 3441 only if the applicant makes the following agreements:

(1) Title to such site will be vested in one or more of the entities filing the application (unless the assurance described in subsection (a)(3) has been submitted under such subsection).

(2) Adequate financial support will be available for completion of the project and for its maintenance and operation when completed.

(3) All laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing

on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a et seq; commonly known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 FR 3176; 5 U.S.C. Appendix) and section 276c of title 40.

(4) The facility will be made available to all persons seeking service regardless of their ability to pay.

SEC. 3445. APPLICATION FOR ASSISTANCE.

The Secretary may provide loans or loan guarantees under section 3441 only if an application for such assistance is submitted to the Secretary, the application contains each agreement described in this subpart, the application contains the information required in section 3444(a), and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

SEC. 3446. ADMINISTRATION OF PROGRAMS.

This subpart, and any other program of the Secretary that provides loans or loan guarantees, shall be carried out by a centralized loan unit established within the Department of Health and Human Services.

Subpart D—Enabling Services

SEC. 3461. GRANTS AND CONTRACTS FOR ENABLING SERVICES.

(a) IN GENERAL.—

(1) GRANTS AND CONTRACTS.—The Secretary may make grants to and enter into contracts with entities described in paragraph (2) to assist such entities in providing the services described in subsection (b) for the purpose of increasing the capacity of individuals to utilize the items and services included in the comprehensive benefits package under title I.

(2) RELEVANT ENTITIES.—For purposes of paragraph (1), the entities described in this paragraph are qualified community health groups (as defined in section 3421(a)), and other public or nonprofit private entities, that—

(A) provide health services in one or more health professional shortage areas or that provide such services to a significant number of individuals who are members of a medically underserved population; and

(B) are experienced in providing services to increase the capacity of individuals to utilize health services.

(b) ENABLING SERVICES.—The services referred to in subsection (a)(1) are transportation, community and patient outreach, patient education, translation services, and such other services as the Secretary determines to be appropriate in carrying out the purpose described in such subsection.

(c) CERTAIN REQUIREMENTS REGARDING PROJECT AREA.—The Secretary may make an award of a grant or contract under subsection (a) only if the applicant involved—

(1) submits to the Secretary—

(A) information demonstrating that the medically underserved populations in the community to be served under the award have a need for enabling services; and

(B) a proposed budget for providing such services; and

(2) the applicant for the award agrees that the residents of the community will be significantly involved in the project carried out with the award.

(d) IMPOSITION OF FEES.—The Secretary may make an award of a grant or contract under subsection (a) only if the applicant involved agrees that, in the project carried out under such subsection, enabling services will be provided without charge to the recipients of the services.

(e) USE OF EXISTING RESOURCES.—The Secretary may make an award of a grant or contract under subsection (a) only if the applicant involved agrees that, in carrying out the project under such subsection, the applicant will utilize existing resources to the maximum extent practicable.

(f) APPLICATION FOR AWARDS OF ASSISTANCE.—The Secretary may make an award of a grant or contract under subsection (a) only if an application for the award is submitted to the Secretary, the application contains each agreement described in this subpart, the application contains the information required in subsection (d)(1), and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.

(g) DEFINITION.—For purposes of this section, the term "enabling services" means services described in subsection (b) that are provided for the purpose described in subsection (a)(1).

SEC. 3462. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) ENABLING SERVICES.—For the purpose of carrying out section 3461, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $200,000,000 for fiscal year 1996, $300,000,000 for each of the fiscal years 1997 through 1999, and $100,000,000 for fiscal year 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

PART 3—NATIONAL HEALTH SERVICE CORPS

SEC. 3471. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) ADDITIONAL FUNDING; GENERAL CORPS PROGRAM; ALLOCATIONS REGARDING NURSES.—For the purpose of carrying out subpart II of part D of title III of the Public Health Service Act, and for the purpose of carrying out section 3472, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $50,000,000 for fiscal year 1995, $100,000,000 for fiscal year 1996, and $200,000,000 for each of the fiscal years 1997 through 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

(c) AVAILABILITY OF FUNDS.—An appropriation under this section for any fiscal year may be made at any time before that fiscal year and may be included in an Act making an appropriation under an authorization under subsection (a) for another fiscal year; but no funds may be made available from any appropriation under this section for obligation under sections 331 through 335, section 336A, and section 337 before the fiscal year involved.

SEC. 3472. ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Of the amounts appropriated under section 3471, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program under section 338A of the Public Health Service Act, or in the Loan Repayment Program under section 338B of such Act, the total number who are being educated as nurses or are serving as nurses, respectively, is increased to 20 percent.

PART 4—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

SEC. 3481. PAYMENTS TO HOSPITALS.

(a) ENTITLEMENT STATUS.—The Secretary shall make payments in accordance with this part to eligible hospitals described in section 3482. The preceding sentence—

(1) is an entitlement in the Secretary on behalf of such eligible hospitals (but is not an entitlement in the State in which any such hospital is located or in any individual receiving services from any such hospital); and

(2) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the fiscal years, specified in subsection (b).

(b) AMOUNT OF ENTITLEMENT.—

(1) IN GENERAL.—For purposes of subsection (a)(2), the amounts and fiscal years specified in this subsection are (in the aggregate for all eligible hospitals) $800,000,000 for the fiscal year in which the general effective date occurs and for each subsequent fiscal year.

(2) SPECIAL RULE FOR YEARS BEFORE GENERAL EFFECTIVE DATE.—

(A) IN GENERAL.—For any fiscal year that begins prior to the general effective date, the amount specified in this subsection for purposes of subsection (a)(2) shall be equal to the aggregate DSH percentage of the amount otherwise determined under paragraph (1).

(B) AGGREGATE DSH PERCENTAGE DEFINED.—In subparagraph (A), the "aggregate DSH percentage" for a year is the amount (expressed as a percentage) equal to—

(i) the total amount of payment made by the Secretary under section 1903(a) of the Social Security Act during the base year with respect to payment adjustments made under section 1923(c) of such Act for hospitals in the States in which eligible hospitals for the year are located; divided by

(ii) the total amount of payment made by the Secretary under section 1903(a) of such Act during the base year with respect to payment adjustments made under section 1923(c) of such Act for hospitals in all States.

(c) PERIOD OF PAYMENT.—An eligible hospital shall receive a payment under this section for a period of 5 years, without regard to the year for which the hospital first receives a payment.

(d) PAYMENTS MADE ON QUARTERLY BASIS.—Payments to an eligible hospital under this section for a year shall be made on a quarterly basis during the year.

SEC. 3482. IDENTIFICATION OF ELIGIBLE HOSPITALS.

(a) HOSPITALS IN PARTICIPATING STATES.—In order to be an eligible hospital under this part, a hospital must be located in a State that is a participating State under this Act, except that an eligible hospital remains eligible to receive a payment under this part notwithstanding that, during the 5-year period for which the payment is to be made, the State in which it is located no longer meets the requirements for participating States under this Act.

(b) STATE IDENTIFICATION.—In accordance with the criteria described in subsection (c) and such procedures as the Secretary may

require, each State shall identify the hospitals in the State that meet such criteria and provide the Secretary with a list of such hospitals.

(c) CRITERIA FOR ELIGIBILITY.—A hospital meets the criteria described in this subsection if the hospital's low-income utilization rate for the base year under section 1923(b)(3) of the Social Security Act (as such section is in effect on the day before the date of the enactment of this Act) is not less than 25 percent.

SEC. 3483. AMOUNT OF PAYMENTS.

(a) DISTRIBUTION OF ALLOCATION FOR LOW-INCOME ASSISTANCE.—

(1) ALLOCATION FROM TOTAL AMOUNT.—Of the total amount available for payments under this section in a year, 75 percent shall be allocated to hospitals for low-income assistance in accordance with this subsection.

(2) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital from the allocation made under paragraph (1) during a year shall be the equal to the hospital's low-income percentage of the allocation for the year.

(b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE FOR UNCOVERED SERVICES.—

(1) ALLOCATION FROM TOTAL AMOUNT; DETERMINATION OF STATE-SPECIFIC PORTION OF ALLOCATION.—Of the total amount available for payments under this section in a year, 25 percent shall be allocated to hospitals for assistance in furnishing inpatient hospital services that are not covered services under title I (in accordance with regulations of the Secretary) in accordance with this subsection. The amount available for payments to eligible hospitals in a State shall be equal to an amount determined in accordance with a methodology specified by the Secretary.

(2) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital in a State from the amount available for payments to eligible hospitals in the State under paragraph (1) during a year shall be the equal to the hospital's low-income percentage of such amount for the year.

(c) LOW-INCOME PERCENTAGE DEFINED.—

(1) IN GENERAL.—In this subsection, an eligible hospital's "low-income percentage" for a year is equal to the amount (expressed as a percentage) of the total low-income days for all eligible hospitals for the year that are attributable to the hospital.

(2) LOW-INCOME DAYS DESCRIBED.—For purposes of paragraph (1), an eligible hospital's low-income days for a year shall be equal to the product of—

(A) the total number of inpatient days for the hospital for the year (as reported to the Secretary by the State in which the hospital is located, in accordance with a reporting schedule and procedures established by the Secretary); and

(B) the hospital's low-income utilization rate for the base year under section 1923(b)(3) of the Social Security Act (as such section is in effect on the day before the date of the enactment of this Act).

SEC. 3484. BASE YEAR.

In this part, the "base year" is, with respect to a State and hospitals in a State, the year immediately prior to the year in which the general effective date occurs.

Subtitle F—Mental Health; Substance Abuse

PART 1—FINANCIAL ASSISTANCE

SEC. 3501. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) IN GENERAL.—For the purpose of carrying out this part, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $100,000,000 for fiscal year 1995, $150,000,000 for fiscal year 1996, and $250,000,000 for each of the fiscal years 1997 through 2000.

(b) ALLOCATION AMONG PROGRAMS.—Of the amounts made available under subsection (a) for a fiscal year—

(1) the Secretary may reserve for carrying out section 3503 such amounts as the Secretary determines to be appropriate; and

(2) the Secretary shall, of the remaining amounts, reserve 50 percent for carrying out subsection (a) of section 3502 and 50 percent for carrying out subsection (b) of such section.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 3502. SUPPLEMENTAL FORMULA GRANTS FOR STATES REGARDING ACTIVITIES UNDER PART B OF TITLE XIX OF PUBLIC HEALTH SERVICE ACT.

(a) MENTAL HEALTH.—

(1) IN GENERAL.—In the case of any State that submits to the Secretary an application in accordance with subsection (e) for a fiscal year with respect to mental health, the Secretary shall make a grant to the State for the purposes authorized in subsection (c) with respect to mental health. The grant shall consist of the allotment determined under paragraph (2) for the State for such year.

(2) DETERMINATION OF ALLOTMENT.—For purposes of paragraph (1), the allotment under this paragraph for a State for a fiscal year shall be determined as follows: With respect to the amount reserved under section 3501(c)(2) for carrying out this subsection, section 1918 of the Public Health Service Act shall be applied to such amount to the same extent and in the same manner as such section 1918 is applied to the amount determined under section 1918(a)(2) of such Act.

(b) SUBSTANCE ABUSE.—

(1) IN GENERAL.—In the case of any State that submits to the Secretary an application in accordance with subsection (e) for a fiscal year with respect to substance abuse, the Secretary shall make a grant to the State for the purposes authorized in subsection (c) with respect to substance abuse. The grant shall consist of the allotment determined under paragraph (2) for the State for such year.

(2) DETERMINATION OF ALLOTMENT.—For purposes of paragraph (1), the allotment under this paragraph for a State for a fiscal year shall be determined as follows: With respect to the amount reserved under section 3501(c)(2) for carrying out this subsection, section 1933 of the Public Health Service Act shall be applied to such amount to the same extent and in the same manner as such section 1933 is applied to the amount determined pursuant to sections 1933(a)(1)(B)(i) and 1918(a)(2)(A) of such Act.

(c) USE OF GRANTS.—

(1) IN GENERAL.—With respect to the expenditure of a grant to a State under subsection (a) or (b), the Secretary—

(A) shall designate as authorized expenditures such of the activities described in paragraph (2) with respect to mental health and substance abuse, respectively, as the Secretary determines to be appropriate; and

(B) may make the grant only if the State agrees to expend the grant in accordance with the activities so designated.

(2) DESCRIPTION OF ACTIVITIES.—The activities referred to in paragraph (1) are (as applicable to the grant involved) the following:

(A) For the purpose of increasing the access of individuals to services relating to mental health and substance abuse, the following services: Transportation, community and patient outreach, patient education, translation services, and such other services as the Secretary determines to be appropriate regarding such purpose.

(B) Improving the capacity of State and local service systems to coordinate and monitor mental health and substance abuse services, including improvement of management information systems, and establishment of linkages between providers of mental health and substance abuse services and primary care providers and health plans.

(C) Providing incentives to integrate public and private systems for the treatment of mental health and substance abuse disorders.

(D) Any activity for which a grant under section 1911 or section 1921 of the Public Health Service Act is authorized to be expended.

(d) MAINTENANCE OF EFFORT.—

(1) IN GENERAL.—With respect to the activities for which a grant under subsection (a) or (b) is to be made, the Secretary may make the grant only if the State involved agrees to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant.

(2) WAIVER.—The Secretary may waive all or part of the requirement established for a State under paragraph (1) if—

(A) the State agrees that the amounts that otherwise would have been subject to such requirement will be expended for the purpose of developing community-based systems of care to promote the eventual integration of the public and private systems for treatment of mental health, or substance abuse, as applicable to the grant;

(B) the State submits to the Secretary a request for the waiver and a description of the manner in which the State will carry out such purpose; and

(C) the Secretary approves the waiver.

(e) APPLICATION FOR GRANT.—For purposes of subsection (a)(1) and (b)(1), an application for a grant under this section regarding mental health or substance abuse, respectively, is in accordance with this subsection if the State involved submits the application not later than the date specified by the Secretary, the application contains each applicable agreement described in this section, and the application otherwise is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out the purpose involved.

SEC. 3503. CAPITAL COSTS OF DEVELOPMENT OF CERTAIN CENTERS AND CLINICS.

(a) IN GENERAL.—The Secretary may make loans to, and guarantee the payment of principal and interest to Federal and non-Federal lenders on behalf of, public and private entities for the capital costs to be incurred by the entities in the development of non-acute, residential treatment centers and community-based ambulatory clinics.

(b) PRIORITIES REGARDING USE OF FUNDS.—In providing loans or loan guarantees under subsection (a), the Secretary shall give priority to authorizing the use of amounts for projects in health professional shortage areas or in geographic areas in which there resides a significant number of individuals

who are members of a medically underserved population.

(c) APPLICABILITY OF CERTAIN PROVISIONS.—The Secretary may provide loans or loan guarantees under subsection (a) only if the applicant involved agrees that, except to the extent inconsistent with the purpose described in subsection (a), subpart C of part 2 of subtitle E applies to such assistance to the same extent and in the same manner as such subpart applies to loans and loan guarantees under section 3441.

PART 2—AUTHORITIES REGARDING PARTICIPATING STATES

Subpart A—Report

SEC. 3511. REPORT ON INTEGRATION OF MENTAL HEALTH SYSTEMS.

(a) IN GENERAL.—As a condition of being a participating State under title I, each State shall, not later than October 1, 1998, submit to the Secretary a plan to achieve the integration of the mental health and substance abuse services of the State and its political subdivisions with the mental health and substance abuse services that are included in the comprehensive benefit package under title I.

(b) REQUIRED CONTENTS.—With respect to the provision of items and services relating to mental health and substance abuse, the report of a State under subsection (a) shall, at a minimum, contain the following information:

(1) Information on the number of individuals served by or through mental health and substance abuse programs administered by State and local agencies and the proportion who are eligible persons under title I.

(2) The following information on services furnished to eligible persons:

(A) Each type of benefit furnished.

(B) The mental health diagnoses for which each type of benefit is covered, the amount, duration and scope of coverage for each covered benefit, and any applicable limits on benefits.

(C) Cost sharing rules that apply.

(3) Information on the extent to which each health provider furnishing mental health and substance abuse services under a State program participates in one or more regional or corporate alliance health plans, and, in the case of providers that do not so participate, the reasons for the lack of participation.

(4) The amount of revenues from health plans received by mental health and substance abuse providers that are participating in such health plans and are funded under one or more State programs.

(5) With respect to the two years preceding the year in which the State becomes a participating State under title I—

(A) the amount of funds expended by the State and its political subdivisions for each of such years for items and services that are included in the comprehensive benefit package under such title;

(B) the amount of funds expended for medically necessary and appropriate items and services not included in such benefit package, including medical care, other health care, and supportive services related to the provision of health care.

(6) An estimate of the amount that the State will expend to furnish items and services not included in such package once the expansion of coverage for mental health and substance abuse services is implemented in the year 2001.

(7) A description of how the State will assure that all individuals served by mental health and substance abuse programs funded by the State will be enrolled in a health plan and how mental health and substance abuse services not covered under the benefit package will continue to be furnished to such enrollees.

(8) A description of the conditions under which the integration of mental health and substance abuse providers into regional and corporate alliances can be achieved, and an identification of changes in participation and certification requirements that are needed to achieve the integration of such programs and providers into health plans.

(9) If the integration of mental health and substance abuse programs operated by the State into one or more health plans is not medically appropriate or feasible for one or more groups of individuals treated under State programs, a description of the reasons that integration is not feasible or appropriate and a plan for assuring the coordination for such individuals of the care and services covered under the comprehensive benefit package with the additional items and services furnished by such programs.

(c) GENERAL PROVISIONS.—Reports under subsection (a) shall be provided at the time and in the manner prescribed by the Secretary.

Subpart B—Pilot Program

SEC. 3521. PILOT PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a pilot program to demonstrate model methods of achieving the integration of the mental health and substance abuse services of the States with the mental health and substance abuse services that are included in the comprehensive benefit package under title I.

(b) CERTAIN CONSIDERATIONS.—With respect to the provision of items and services relating to mental health and substance abuse, the Secretary, in carrying out subsection (a), shall consider the following:

(1) The types of items and services needed in addition to the items and services included in the comprehensive benefits package under title I.

(2) The optimal methods of treatment for individuals with long-term conditions.

(3) The capacity of alliance health plans to furnish such treatment.

(4) The modifications that should be made in the items and services furnished by such health plans.

(5) The role of publicly-funded health providers in the integration of acute and long-term treatment.

Subtitle G—Comprehensive School Health Education; School-Related Health Services

PART 1—GENERAL PROVISIONS

SEC. 3601. PURPOSES.

Subject to the subsequent provisions of this subtitle, the purposes of this subtitle are as follows:

(1) To support the provision in kindergarten through grade 12 of sequential, age-appropriate, comprehensive health education programs that address locally relevant priorities.

(2) To establish a national framework within which States can create comprehensive school health education programs that—

(A) target the health risk behaviors accounting for the majority of the morbidity and mortality among youth and adults, including the following: Tobacco use; alcohol and other drug abuse; sexual behaviors resulting in infection with the human immunodeficiency virus, in other sexually transmitted diseases or in unintended pregnancy; behaviors resulting in intentional and unintentional injuries; dietary patterns resulting in disease; and sedentary lifestyles; and

(B) are integrated with plans and programs in the State, if any, under title III of the Goals 2000: Educate America Act and those targeting health promotion and disease prevention goals related to the national health objectives set forth in Healthy People 2000.

(3) To pay the initial costs of planning and establishing Statewide comprehensive school health education programs that will be implemented and maintained with local, State, and other Federal resources.

(4) To support Federal activities such as research and demonstrations, evaluations, and training and technical assistance regarding comprehensive school health education.

(5) To motivate youth, especially low-achieving youth, to stay in school, avoid teen pregnancy, and strive for success by providing intensive, high-quality health education programs that include peer-teaching, family, and community involvement.

(6) To improve the knowledge and skills of children and youth by integrating academic and experiential learning in health education with other elements of a comprehensive school health program.

(7) To further the National Education Goals set forth in title I of the Goals 2000: Educate America Act and the national health objectives set forth in Healthy People 2000.

(8) With respect to health services, to make awards of financial assistance to eligible State health agencies and local community partnerships to provide for the development and operation of projects to coordinate and deliver comprehensive health services to children or youth in school-based, school-linked, or community-based locations.

SEC. 3602. DEFINITIONS.

(a) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—For purposes of this subtitle, the term "comprehensive school health education program" means a program that addresses locally relevant priorities and meets the following conditions:

(1) The program is sequential, and age and developmentally appropriate.

(2) The program is provided, in the area served by the program, every year for all students from kindergarten through grade 12.

(3) The program provides comprehensive health education, including the following components:

(A) Community health.

(B) Environmental health.

(C) Personal health.

(D) Family life.

(E) Growth and development.

(F) Nutritional health.

(G) Prevention and control of disease and disorders.

(I) Safety and prevention of injuries.

(J) Substance abuse, including tobacco and alcohol use.

(K) Consumer health, including education to ensure that students understand the benefits and appropriate use of medical services, including immunizations and other clinical preventive services.

(4) The program promotes personal responsibility for a healthy lifestyle and provides the knowledge and skills necessary to adopt a healthy lifestyle, including teaching the legal, social, and health consequences of behaviors that pose health risks.

(5) The program is sensitive to cultural and ethnic issues in the content of instructional materials and approaches.

(6) The program includes activities that support instruction.

(7) The program includes activities to promote involvement by parents, families, community organizations, and other appropriate entities.

(8) The program is coordinated with other Federal, State, and local health education and prevention programs and with other Federal, State and local education programs, including those carried out under title I of the Elementary and Secondary Education Act of 1965.

(9) The program focuses on the particular health concerns of the students in the State, school district, or school, as the case may be.

(b) OTHER DEFINITIONS.—For purposes of this subtitle:

(1) The term "local educational agency" has the meaning given such term in section 1471(12) of the Elementary and Secondary Education Act of 1965.

(2) The term "State educational agency" has the meaning given such term in section 1471(23) of the Elementary and Secondary Education Act of 1965.

PART 2—SCHOOL HEALTH EDUCATION; GENERAL PROVISIONS

SEC. 3611. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND..

(a) FUNDING FOR SCHOOL HEALTH EDUCATION.—For the purpose of carrying out parts 3 and 4, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $50,000,000 for each of the fiscal year 1995 through 2000.

(b) ALLOCATIONS.—Of the amounts appropriated under subsection (a) for a fiscal year—

(1) the Secretary may reserve not more than $13,000,000 for carrying out part 4;

(2) the Secretary may reserve not more than $5,000,000 to support national leadership activities, such as research and demonstration, evaluation, and training and technical assistance in comprehensive school health education; and

(3) the Secretary may reserve not more than 5 percent for administrative expenses regarding parts 3 and 4.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 3612. WAIVERS OF STATUTORY AND REGULATORY REQUIREMENTS.

(a) IN GENERAL.—

(1) WAIVERS.—Except as provided in subsection (c), upon the request of an entity receiving funds under part 3 or part 4 and under a program specified in paragraph (2), the Secretary of Health and Human Services or the Secretary of Education (as the case may be, according to which Secretary administers the program so specified) may grant to the entity a waiver of any requirement of such program regarding the use of funds, or of the regulations issued for the program by the Secretary involved, if the following conditions are met with respect to such program:

(A) The Secretary involved determines that the requirement of such program impedes the ability of the State educational agency or other recipient to achieve more effectively the purposes of part 3 or 4.

(B) The Secretary involved determines that, with respect to the use of funds under such program, the requested use of the funds by the entity would be consistent with the purposes of part 3 or 4.

(C) In the case of a request for a waiver submitted by a State educational agency, the State educational agency—

(i) provides all interested local educational agencies in the State with notice and an opportunity to comment on the proposal; and

(ii) submits the comments to the Secretary involved.

(D) In the case of a request for a waiver submitted by a local educational agency or other agency, institution, or organization that receives funds under part 3 from the State educational agency, such request has been reviewed by the State educational agency and is accompanied by the comments, if any, of such agency.

(2) RELEVANT PROGRAMS.—For purposes of paragraph (1), the programs specified in this paragraph are as follows:

(A) In the case of programs administered by the Secretary of Health and Human Services, the following:

(i) The program known as the Prevention, Treatment, and Rehabilitation Model Projects for High Risk Youth, carried out under section 517 of the Public Health Service Act.

(ii) The program known as the State and Local Comprehensive School Health Programs to Prevent Important Health Problems and Improve Educational Outcomes, carried out under such Act.

(B) In the case of programs administered by the Secretary of Education, any program carried out under part B of the Drug-Free Schools and Communities Act of 1986.

(b) WAIVER PERIOD.—

(1) IN GENERAL.—A waiver under this section shall be for a period not to exceed three years.

(2) EXTENSIONS.—The Secretary involved under subsection (a) may extend such period if the Secretary determines that—

(A) the waiver has been effective in enabling the State or affected recipients to carry out the activities for which it was requested and has contributed to improved performance; and

(B) such extension is in the public interest.

(c) WAIVERS NOT AUTHORIZED.—The Secretary involved under subsection (a) may not waive, under this section, any statutory or regulatory requirement relating to—

(1) comparability of services;

(2) maintenance of effort;

(3) the equitable participation of students attending private schools;

(4) parental participation and involvement;

(5) the distribution of funds to States or to local educational agencies or other recipients of funds under the programs specified in subsection (a)(2);

(6) maintenance of records;

(7) applicable civil rights requirements; or

(8) the requirements of sections 438 and 439 of the General Education Provisions Act.

(d) TERMINATION OF WAIVER.—The Secretary involved under subsection (a) shall terminate a waiver under this section if the Secretary determines that the performance of the State or other recipient affected by the waiver has been inadequate to justify a continuation of the waiver or if it is no longer necessary to achieve its original purposes.

PART 3—SCHOOL HEALTH EDUCATION; GRANTS TO STATES

Subpart A—Planning Grants for States

SEC. 3621. APPLICATION FOR GRANT.

(a) IN GENERAL.—Any State educational agency that wishes to receive a planning grant under this subpart shall submit an application to the Secretary of Health and Human Services, at such time and in such manner as the Secretary may require.

(b) APPLICATION; JOINT DEVELOPMENT; CONTENTS.—An application under subsection (a) shall be jointly developed by the State educational agency and the State health agencies of the State involved, and shall contain the following:

(1) An assessment of the State's need for comprehensive school health education, using goals established by the Department of Health and Human Services and the Department of Education and goals established under Goals 2000: Educate America Act.

(2) A description of how the State educational agency will collaborate with the State health agency in the planning and development of a comprehensive school health education program in the State, including coordination of existing health education programs and resources.

(3) A plan to build capacity at the State and local levels to provide staff development and technical assistance to local educational agency and local health agency personnel involved with comprehensive school health education.

(4) A preliminary plan for evaluating comprehensive school health education activities.

(5) Information demonstrating that the State has established a State-level advisory council whose membership includes representatives of the State agencies with principal responsibilities for programs regarding health, education, and mental health.

(6) A timetable and proposed budget for the planning process.

(7) Such other information and assurances as the Secretary may require.

(c) NUMBER OF GRANTS.—States may receive one planning grant annually and no more than two planning grants may be awarded to any one State.

SEC. 3622. APPROVAL OF SECRETARY.

The Secretary may approve the application of a State under section 3621 if the Secretary determines that—

(1) the application meets the requirements of this subpart; and

(2) there is a substantial likelihood that the State will be able to develop and implement a comprehensive school health education plan that complies with the requirements of subpart B.

SEC. 3623. AMOUNT OF GRANT.

For any fiscal year, the minimum grant to any State under this subpart is an amount determined by the Secretary to be necessary to enable the State to conduct the planning process, and the maximum such grant is $500,000.

SEC. 3624. AUTHORIZED ACTIVITIES.

A State may use funds received under this subpart only for the following:

(1) To establish and carry out the State planning process.

(2) To conduct Statewide or sub-State regional coordination and collaboration activities for local educational agencies, local health agencies, and other agencies and organizations, as appropriate.

(3) To conduct activities to build capacity to provide staff development and technical assistance services to local educational agency and local health agency personnel involved with comprehensive school health education.

(4) To develop student learning objectives and assessment instruments.

(5) To work with State and local health agencies and State and local educational agencies to reduce barriers to the implementation of comprehensive school health education programs in schools.

(6) To prepare the plan required to receive an implementation grant under subpart B.

(7) To adopt, validate, and disseminate curriculum models and program strategies, if the Secretary determines that such activities are necessary to achieving the objectives of the State's program.

Subpart B—Implementation Grants for States

SEC. 3631. APPLICATION FOR GRANT.

(a) IN GENERAL.—Any State that wishes to receive an implementation grant under this subpart shall submit an application to the Secretary of Health and Human Services, at such time, in such manner, and containing such information and assurances as the Secretary may require.

(b) APPLICATION AND STATE PLAN; JOINT DEVELOPMENT; CONTENTS.—An application under subsection (a) shall be jointly developed by the State educational agency and the State health agencies of the State involved, and shall include a State plan for comprehensive school health education programs (as defined in section 3602) that describes the following:

(1) The State's goals and objectives for those programs.

(2) How the State will allocate funds, if any, to local educational agencies in accordance with section 3634.

(3) How the State will coordinate programs under this subpart with other local, State and Federal health education programs.

(4) How comprehensive school health education programs will be coordinated with other local, State and Federal education programs, such as programs under title I of the Elementary and Secondary Education Act of 1965, with the State's school improvement plan, if any, under title III of the Goals 2000: Educate America Act, and with any similar programs.

(5) How the State has worked with State and local education agencies and with State and local health agencies to reduce barriers to implementing comprehensive school health education programs.

(6) How the State will monitor the implementation of such programs by local educational agencies.

(7) How the State will build capacity for professional development of health educators.

(8) How the State will provide staff development and technical assistance to local educational agencies.

(9) The respective roles of the State educational agency, local educational agencies, the State health agency, and the local health agencies in developing and implementing such school health education programs.

(10) How such school health education programs will be tailored to the extent practicable to be culturally and linguistically sensitive and responsive to the various needs of the students served, including individuals with disabilities, and individuals from disadvantaged backgrounds (including racial and ethnic minorities).

(11) How the State will evaluate and report on the State's progress toward attaining the goals and objectives described in paragraph (1).

SEC. 3632. SELECTION OF GRANTEES.

(a) SELECTION OF GRANTEES.—The Secretary shall establish criteria for the competitive selection of grantees under this subpart.

(b) OPPORTUNITY FOR PLANNING GRANT.—If the Secretary does not approve a State's application under this subpart and determines that the State could benefit from a planning grant under subpart A, the Secretary shall inform the State of any planning grant funds that may be available to it under subpart A, subject to section 3621(c).

SEC. 3633. AMOUNT OF GRANT.

(a) IN GENERAL.—For any fiscal year, the minimum grant to any State under this subpart is an amount determined by the Secretary to be necessary to enable the State to conduct the implementation process.

(b) CRITERIA.—In determining the amount of any such grant, the Secretary may consider such factors as the number of children enrolled in schools in the State, the number of school-aged children living in poverty in the State, and the scope and quality of the State's plan.

SEC. 3634. AUTHORIZED ACTIVITIES; LIMITATION ON ADMINISTRATIVE COSTS.

(a) SUBGRANTS TO LOCAL EDUCATIONAL AGENCIES.—Each State that receives funds under this subpart for any fiscal year shall retain not more than 75 percent of those funds in the first year, 50 percent of those funds in the second and third years, and 25 percent of those funds in each succeeding year. Those funds not retained by the State shall be used to make grants to local educational agencies in accordance with section 3635.

(b) STATE-LEVEL ACTIVITIES.—Each State shall use retained funds for any fiscal year for the following purposes:

(1) To conduct Statewide or sub-State regional coordination and collaboration activities.

(2) To adapt, validate, or disseminate program models or strategies for comprehensive school health education.

(3) To build capacity to deliver staff development and technical assistance services to local educational agencies, and State and local health agencies.

(4) To promote program activities involving families and coordinating program activities with community groups and agencies.

(5) To evaluate and report to the Secretary on the progress made toward attaining the goals and objectives described in section 3621(b)(1).

(6) To conduct such other activities to achieve the objectives of this subpart as the Secretary may by regulation authorize.

(c) STATE ADMINISTRATION.—Of the amounts received by a State for a fiscal year under this subpart and remaining after any grants to local educational agencies made from such amounts, the State may use up to 10 percent for the costs of administering such amounts, including the activities of the State advisory council and monitoring the performance of local educational agencies.

SEC. 3635. SUBGRANTS TO LOCAL EDUCATIONAL AGENCIES.

(a) APPLICATION FOR GRANT.—Any local educational agency that wishes to receive a grant under this subpart shall submit an application to the State, containing such information and assurances as the State may require, including a description of the following:

(1) The local educational agency's goals and objectives for comprehensive school health education programs.

(2) How the local educational agency will concentrate funds in high-need schools and provide sufficient funds to targeted schools to ensure the implementation of comprehensive programs.

(3) How the local educational agency will monitor the implementation of these programs.

(4) How the local educational agency will ensure that school health education programs are tailored to the extent practicable to be culturally and linguistically sensitive and responsive to the various needs of the students served, including individuals with disabilities, and individuals from disadvantaged backgrounds (including racial and ethnic minorities).

(5) How the local educational agency, in consultation with the local health agency, will evaluate and report on its progress toward attaining the goals and objectives described in paragraph (1).

(b) SELECTION OF SUBGRANTEES.—Each State shall give priority to applications from local educational agencies serving areas with high needs, as indicated by criteria developed by the State, which shall include, but need not be limited to, high rates of any of the following:

(1) Poverty among school-aged youth.

(2) Births to adolescents.

(3) Sexually transmitted diseases among school-aged youth.

(4) Drug and alcohol use among school-aged youth.

(5) Violence among school-aged youth.

(c) AUTHORIZED ACTIVITIES.—Each local educational agency that receives a grant under this subpart shall use the grant funds to implement comprehensive school health education programs, as defined in section 3602.

Subpart C—State and Local Reports

SEC. 3641. STATE AND LOCAL REPORTS.

(a) STATE REPORTS.—Each State that receives a grant under this part shall collect and submit to the Secretary such data and other information on State and local programs as the Secretary may require.

(b) IN GENERAL.— Each local educational agency that receives a grant under subpart B shall collect and report to the State such data and other information as the Secretary may require.

PART 4—SCHOOL HEALTH EDUCATION; GRANTS TO CERTAIN LOCAL EDUCATIONAL AGENCIES

Subpart A—Eligibility

SEC. 3651. SUBSTANTIAL NEED OF AREA SERVED BY AGENCY.

Any local educational agency is eligible for a grant under this part for any fiscal year if—

(1) the agency enrolls at least 25,000 students; and

(2) the geographic area served by the agency has a substantial need for such a grant, relative to other geographic areas in the United States.

Subpart B—Planning Grants for Local Education Agencies

SEC. 3661. APPLICATION FOR GRANT.

(a) IN GENERAL.—Any local educational agency that wishes to receive a planning grant under this subpart shall submit an application to the Secretary of Health and Human Services at such time and in such manner as the Secretary may require.

(b) STATE EDUCATIONAL AGENCY REVIEW.—Each such local educational agency, before submitting its application to the Secretary, shall submit the application to the State educational agency for comment by such agency and by the State health agencies of the State.

(c) CONTENTS OF APPLICATIONS.—Each such application shall contain the following:

(1) An assessment of the local educational agency's need for comprehensive school health education, using goals established by the Department of Health and Human Services and the Department of Education, as well as local health and education strategies,

such as State school improvement plans, if any, under title III of the Goals 2000: Educate America Act.

(2) Information demonstrating that the local educational agency has established or selected a community-level advisory council, which shall include representatives of relevant community agencies such as those that administer education, child nutrition, health, and mental health programs.

(3) A description of how the local educational agency will collaborate with the State educational agency, the State health agency, and the local health agency in the planning and development of a comprehensive school health education program in the local educational agency, including coordination of existing health education programs and resources.

(4) A plan to build capacity at the local educational agency to provide staff development and technical assistance to local educational agency and local health agency personnel involved with comprehensive school health education.

(5) A preliminary plan for evaluating comprehensive school health education activities.

(6) A timetable and proposed budget for the planning process.

(7) Such other information and assurances as the Secretary may require.

(d) NUMBER OF GRANTS.—Local educational agencies may receive at a maximum two annual planning grants.

SEC. 3662. SELECTION OF GRANTEES.

(a) SELECTION CRITERIA.—The Secretary shall establish criteria for the competitive selection of grantees under this part.

(b) LIMITATION.—The Secretary shall not approve an application from a local educational agency in a State that has an approved plan under subpart A or B of part 3 of this subtitle unless the Secretary determines, after consultation with the State that the local application is consistent with the State plan, if one exists.

SEC. 3663. AMOUNT OF GRANT.

For any fiscal year, the minimum grant to any local educational agency under this subpart is an amount determined by the Secretary to be necessary to enable the local educational agency to conduct the planning process, and the maximum such grant is $500,000.

SEC. 3664. AUTHORIZED ACTIVITIES.

A local educational agency may use funds received under this subpart only for the following:

(1) To establish and carry out the local educational agency planning process.

(2) To undertake joint training, staffing, administration, and other coordination and collaboration activities for local educational agencies, local health agencies, and other agencies and organizations, as appropriate.

(3) To conduct activities to build capacity to provide staff development and technical assistance services to local educational agency and local health agency personnel involved with comprehensive school health education.

(4) To develop student learning objectives and assessment instruments.

(5) To work with State and local health agencies and State educational agencies to reduce barriers to the implementation of comprehensive school health education programs in schools, by, for example, ensuring that adequate time is available during the school day for such programs.

(6) To prepare the plan required to receive an implementation grant under subpart C.

Subpart C—Implementation Grants for Local Educational Agencies

SEC. 3671. APPLICATION FOR GRANT.

(a) IN GENERAL.—Any local educational agency that wishes to receive an implementation grant under this subpart shall submit an application to the Secretary of Health and Human Services, at such time, in such manner, and containing such information and assurances as the Secretary may require.

(b) STATE EDUCATIONAL AGENCY REVIEW.—Each such local educational agency shall submit its application to the State educational agency for comment before submitting it to the Secretary.

(c) LOCAL EDUCATIONAL AGENCY PLAN.—Each such application shall include a local educational agency plan for comprehensive school health education programs (as defined in section 3602) that describes the following:

(1) The local educational agency's goals and objectives for those programs.

(2) How the local educational agency will coordinate programs under this subpart with other local, State and Federal health education programs.

(3) How comprehensive school health education programs will be coordinated with other local, State and Federal education programs, such as programs under title I of the Elementary and Secondary Education Act of 1965, and with State's school improvement plan, if any, under title III of the Goals 2000: Educate America Act.

(4) How the local educational agency has worked with State educational agencies and with State and local health agencies to reduce barriers to implementing comprehensive school health education programs.

(5) How local educational agencies will monitor the implementation of such programs.

(6) How the local educational agency, in consultation with the State educational agency and State and local health agencies and in conjunction with other local professional development activities, will build capacity for professional development of health educators.

(7) How the local educational agency, in consultation with the State educational agency and State and local health agencies, will provide staff development and technical assistance.

(8) The respective roles of the State educational agency, local educational agencies, the State health agency, and the local health agencies in developing and implementing such school health education programs.

(9) How such school health education programs will be tailored to the extent practicable to be culturally and linguistically sensitive and responsive to the various needs of the students served, including individuals with disabilities, and individuals from disadvantaged backgrounds (including racial and ethnic minorities).

(10) How the local educational agency, in consultation with the local health agency, will evaluate and report on the local educational agency's progress toward attaining the goals and objectives described in paragraph (1).

SEC. 3672. SELECTION OF GRANTEES.

(a) SELECTION OF GRANTEES.—The Secretary shall establish criteria for the competitive selection of grantees under this subpart.

(b) LIMITATION.—The Secretary shall not approve an application from a local educational agency in a State that has an approved plan under subpart A or B of part 3 unless the Secretary determines, after consultation with the State that the local application is consistent with such State plan.

(c) OPPORTUNITY FOR PLANNING GRANT.—If the Secretary does not approve a local educational agency's application under this subpart and determines that the local educational agency could benefit from a planning grant under subpart B, the Secretary shall inform the local educational agency of any planning grant funds that may be available to it under subpart B, subject to section 3661(d).

SEC. 3673. AMOUNT OF GRANT.

(a) IN GENERAL.—For any fiscal year, the minimum grant to any local educational agency under this subpart is an amount determined by the Secretary to be necessary to enable the local educational agency to conduct the implementation process.

(b) CRITERIA.—In determining the amount of any such grant, the Secretary may consider such factors as the number of children enrolled in schools in the local educational agency, the number of school-aged children living in poverty in the local educational agency, and the scope and quality of the local educational agency's plan.

SEC. 3674. AUTHORIZED ACTIVITIES.

Each local educational agency that receives a grant under this subpart shall use the grant funds as follows:

(1) To implement comprehensive school health education programs, as defined in section 3602.

(2) To conduct local or regional coordination and collaboration activities.

(3) To provide staff development and technical assistance to schools, local health agencies, and other community agencies involved in providing comprehensive school health education programs.

(4) To administer the program and monitor program implementation at the local level.

(5) To evaluate and report to the Secretary on the local educational agency's progress toward attaining the goals and objectives described in section 3671(c)(1).

(6) To conduct such other activities as the Secretary may by regulation authorize.

SEC. 3675. REPORTS.

Each local educational agency that receives a grant under this subpart shall collect and report to the Secretary and the State such data and other information as the Secretary may require.

PART 5—SCHOOL-RELATED HEALTH SERVICES

Subpart A—Development and Operation of Projects

SEC. 3681. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this subpart, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $100,000,000 for fiscal year 1996, $275,000,000 for fiscal year 1997, $350,000,000 for fiscal year 1998, and $400,000,000 for each of the fiscal years 1999 and 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 3682. ELIGIBILITY FOR DEVELOPMENT AND OPERATION GRANTS.

(a) IN GENERAL.—Entities eligible to apply for and receive grants under section 3484 or 3485 are:

(1) State health agencies that apply on behalf of local community partnerships and

other communities in need of adolescent health services within the State.

(2) Local community partnerships in States in which health agencies have not applied.

(b) LOCAL COMMUNITY PARTNERSHIPS.—

(1) IN GENERAL.—A local community partnership under subsection (a)(2) is an entity that, at a minimum, includes—

(A) a local health care provider with experience in delivering services to adolescents;

(B) one or more local public schools; and

(C) at least one community based organization located in the community to be served that has a history of providing services to at-risk youth in the community.

(2) PARTICIPATION.—A partnership described in paragraph (1) shall, to the maximum extent feasible, involve broad based community participation from parents and youth to be served, health and social service providers (including regional alliance health plans and corporate alliance health plans in which families in the community are enrolled), teachers and other public school and school board personnel, the regional health alliance in which the schools participating in the partnership are located, youth development and service organizations, and interested business leaders. Such participation may be evidenced through an expanded partnership, or an advisory board to such partnership.

SEC. 3683. PREFERENCES

(a) IN GENERAL.—In making grants under sections 3484 and 3485, the Secretary shall give preference to applicants whose communities to be served show the most substantial level of need for such services among individuals who are between the ages of 10 and 19 (inclusive), as measured by indicators of community health including the following:

(1) High levels of poverty.

(2) The presence of a medically underserved area or population (as defined under section 330(a) of the Public Health Service Act).

(3) A health professional shortage area, as designated under section 332 of the Public Health Service Act.

(4) High rates of indicators of health risk among children and youth, including a high proportion of children receiving services through the Individuals with Disabilities Education Act, adolescent pregnancy, sexually transmitted disease (including infection with the human immunodeficiency virus), preventable disease, communicable disease, intentional and unintentional injuries among children and youth, community and gang violence, youth unemployment, juvenile justice involvement, and high rates of drug and alcohol exposure.

(b) LINKAGE TO QUALIFIED COMMUNITY HEALTH GROUPS.—In making grants under sections 3484 and 3485, the Secretary shall give preference to applicants that demonstrate a linkage to qualified community health groups (as defined in section 3421(a)).

SEC. 3684. GRANTS FOR DEVELOPMENT OF PROJECTS.

(a) IN GENERAL.—The Secretary may make grants to State health agencies or to local community partnerships to develop school health service sites.

(b) USE OF FUNDS.—A project for which a grant may be made under subsection (a) may include but not be limited to the cost of the following:

(1) Planning for the provision of school health services.

(2) Recruitment, compensation, and training of health and administrative staff.

(3) The development of agreements with regional and corporate alliance health plans and the acquisition and development of equipment and information services necessary to support information exchange between school health service sites and health plans, health providers, and other entities authorized to collect information under this Act.

(4) In the case of communities described in subsection (d)(2)(B), funds to aid in the establishment of local community partnerships.

(5) Other activities necessary to assume operational status.

(c) AUTHORITY REGARDING QUALIFIED COMMUNITY HEALTH GROUPS.—A project under subsection (a) may require that, in order to receive services from the project, an individual be enrolled in a health plan of a qualified community health group (as defined in section 3421(a)).

(d) APPLICATION FOR GRANT.—

(1) IN GENERAL.—Applicants shall submit applications in a form and manner prescribed by the Secretary.

(2) APPLICATIONS BY STATE HEALTH AGENCIES.—

(A) In the case of applicants that are State health agencies, the application shall contain assurances that the State health agency is applying for funds—

(i) on behalf of at least one local community partnership; and

(ii) on behalf of at least one other community identified by the State as in need of the services funded under this part but without a local community partnership.

(B) In the case of communities identified in applications submitted by State health agencies that do not yet have local community partnerships, the State shall describe the steps that will be taken to aid the community in developing a local community partnership.

(C) A State applying on behalf of local community partnerships and other communities may retain not more than 10 percent of grants awarded under this part for administrative costs.

(e) CONTENTS OF APPLICATION.—In order to receive a grant under this section, an applicant must include in the application the following information:

(1) An assessment of the need for school health services in the communities to be served, using the latest available health data and health goals and objectives established by the Secretary.

(2) A description of how the applicant will design the proposed school health services to reach the maximum number of school-aged children and youth at risk for poor health outcome.

(3) An explanation of how the applicant will integrate its services with those of other health and social service programs within the community.

(4) An explanation of how the applicant will link its activities to the regional and corporate alliance health plans serving the communities in which the applicant's program is to be located.

(5) Evidence of linkages with regional and corporate health alliances in whose areas the applicant's program is to be located.

(6) A description of a quality assurance program which complies with standards that the Secretary may prescribe.

(f) NUMBER OF GRANTS.—Not more than two planning grants may be made to a single applicant.

SEC. 3685. GRANTS FOR OPERATION OF PROJECTS.

(a) IN GENERAL.—The Secretary may make grants to State health agencies or to local community partnerships for the cost of operating school health service sites

(b) USE OF GRANT.—The costs for which a grant may be made under this section include but are not limited to the following:

(1) The cost of furnishing health services that are not covered under title I of this Act or by any other public or private insurer.

(2) The cost of furnishing enabling services, as defined in section 3461(h).

(3) Training, recruitment and compensation of health professionals and other staff.

(4) Outreach services to at-risk youth and to parents.

(5) Linkage of individuals to health plans, community health services and social services.

(6) Other activities deemed necessary by the Secretary.

(c) APPLICATION FOR GRANT.—Applicants shall submit applications in a form and manner prescribed by the Secretary. In order to receive a grant under this section, an applicant must include in the application the following information:

(1) A description of the services to be furnished by the applicant.

(2) The amounts and sources of funding that the applicant will expend, including estimates of the amount of payments the applicant will received from alliance health plans and from other sources.

(3) Such other information as the Secretary determines to be appropriate.

(d) ADDITIONAL CONTENTS OF APPLICATION.—In order to receive a grant under this section, an applicant must meet the following conditions:

(1) The applicant furnishes the following services:

(A) Diagnosis and treatment of simple illnesses and minor injuries.

(B) Preventive health services, including health screenings.

(C) Enabling services, as defined in section 3461(h).

(D) Referrals and followups in situations involving illness or injury.

(E) Health and social services, counseling services, and necessary referrals, including referrals regarding mental health and substance abuse.

(F) Such other services as the Secretary determines to be appropriate.

(2) The applicant maintains agreements with all regional and corporate alliance health plans offering services in the applicant's service area.

(3) The applicant is a participating provider in the State's program for medical assistance under title XIX of the Social Security Act.

(4) The applicant does not impose charges on students or their families for services (including collection of any cost-sharing for services under the comprehensive benefit package that otherwise would be required).

(5) The applicant has reviewed and will periodically review the needs of the population served by the applicant in order to ensure that its services are accessible to the maximum number of school age children and youth in the area, and that, to the maximum extent possible, barriers to access to services of the applicant are removed (including barriers resulting from the area's physical characteristics, its economic, social and cultural grouping, the health care utilization patterns of children and youth, and available transportation).

(6) In the case of an applicant which serves a population that includes a substantial proportion of individuals of limited English speaking ability, the applicant has developed

a plan to meet the needs of such population to the extent practicable in the language and cultural context most appropriate to such individuals.

(7) The applicant will provide non-Federal contributions toward the cost of the project in an amount determined by the Secretary.

(8) The applicant will operate a quality assurance program consistent with section 3684(e)(6).

(e) DURATION OF GRANT.—A grant under this section shall be for a period determined by the Secretary.

(f) REPORTS.—A recipient of funding under this section shall provide such reports and information as are required in regulations of the Secretary.

SEC. 3686. FEDERAL ADMINISTRATIVE COSTS.

Of the amounts made available under section 3681, the Secretary may reserve not more than 5 percent for administrative expenses regarding this subpart.

Subpart B—Capital Costs of Developing Projects

SEC. 3691. LOANS AND LOAN GUARANTEES REGARDING PROJECTS.

(a) IN GENERAL.—The Secretary may make loans to, and guarantee the payment of principal and interest to Federal and non-Federal lenders on behalf of, State health agencies and local community partnerships for the capital costs of developing projects in accordance with subpart A.

(b) APPLICABILITY OF CERTAIN PROVISIONS.—The provisions of subpart A apply to loans and loan guarantees under subsection (a) to the same extent and in the same manner as such provisions apply to grants under subpart A. Except for any provision inconsistent with the purpose described in subsection (a), the provisions of subpart C of part 2 of subtitle E apply to loans and loan guarantees under subsection (a) to the same extent and in the same manner as such provisions apply to loans and loan guarantees under section 3441.

SEC. 3692. FUNDING.

Amounts available to the Secretary under section 3412 for the purpose of carrying out subparts B and C of part 2 of subtitle E are, in addition to such purpose, available to the Secretary for the purpose of carrying out this subpart.

Subtitle H—Public Health Service Initiative

SEC. 3701. PUBLIC HEALTH SERVICE INITIATIVE.

(a) IN GENERAL.—There is established pursuant to this title a Public Health Service Initiative consisting of the total amounts authorized and described in subsection (b). The Initiative includes all the programs authorized under the previous provisions of this title.

(b) TOTAL OF THE AMOUNTS AUTHORIZED TO BE APPROPRIATED.—The following is the total of the amounts authorized to be appropriated for the Initiative under the previous subtitles of this title:

(1) For fiscal year 1995, $1,125,000,000.
(2) For fiscal year 1996, $2,984,000,000.
(3) For fiscal year 1997, $3,830,000,000.
(4) For fiscal year 1998, $4,205,000,000.
(5) For fiscal year 1999, $4,055,000,000.
(6) For fiscal year 2000, $3,655,000,000.

(c) USE OF AMOUNTS; AVAILABILITY.—

(1) USE; ANNUAL APPROPRIATIONS.—Amounts appropriated to carry out the Initiative, including subtitles A through F of this title, are available to carry out the specific programs for which the amounts are appropriated.

(2) AVAILABILITY OF APPROPRIATED AMOUNTS.—Amounts appropriated for programs in the Initiative are available until expended.

Subtitle I—Coordination With Cobra Continuation Coverage

SEC. 3801. PUBLIC HEALTH SERVICE ACT; COORDINATION WITH COBRA CONTINUATION COVERAGE.

(a) PERIOD OF COVERAGE.—Subparagraph (D) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)) is amended—

(1) by striking "or" at the end of clause (i), by striking the period at the end of clause (ii) and inserting ", or", and by adding at the end the following new clause:

"(iii) eligible for comprehensive health coverage described in section 1101 of the Health Security Act.", and

(2) by striking "OR MEDICARE ENTITLEMENT" in the heading and inserting ", MEDICARE ENTITLEMENT, OR HEALTH SECURITY ACT ELIGIBILITY".

(b) QUALIFIED BENEFICIARY.—Section 2208(3) of such Act (42 U.S.C. 300bb-8(3)) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE FOR INDIVIDUALS COVERED BY HEALTH SECURITY ACT.—The term 'qualified beneficiary' shall not include any individual who, upon termination of coverage under a group health plan, is eligible for comprehensive health coverage described in section 1101 of the Health Security Act.".

(c) REPEAL UPON IMPLEMENTATION OF HEALTH SECURITY ACT.—

(1) IN GENERAL.—Title XXII of such Act (42 U.S.C. 300bb-1 et seq.) is hereby repealed.

(2) CONFORMING AMENDMENT.—The table of contents of such Act is amended by striking the item relating to title XXII.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the earlier of—

(A) January 1, 1998, or

(B) the first day of the first calendar year following the calendar year in which all States have in effect plans under which individuals are eligible for comprehensive health coverage described in section 1101 of this Act.

TITLE IV—MEDICARE AND MEDICAID

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TITLE IV—MEDICARE AND MEDICAID

SEC. 4000. REFERENCES IN TITLE.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO OBRA.—In this title, the terms "OBRA-1986", "OBRA-1987", "OBRA-1989", "OBRA-1990", and "OBRA-1993" refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66), respectively.

Subtitle A—Medicare and the Alliance System

PART 1—ENROLLMENT OF MEDICARE BENEFICIARIES IN REGIONAL ALLIANCE PLANS

SEC. 4001. OPTIONAL STATE INTEGRATION OF MEDICARE BENEFICIARIES INTO REGIONAL ALLIANCE PLANS.

Title XVIII is amended by adding at the end the following:

"INTEGRATION OF MEDICARE INTO STATE HEALTH SECURITY PROGRAMS

"SEC. 1893. (a) PAYMENT TO STATES.—The Secretary shall pay a participating State that has submitted an application, as specified by subsection (b) which the Secretary has approved under subsection (c), the amount specified by subsection (d) for the period specified by subsection (e) for covered medicare beneficiaries. This section shall apply without regard to whether or not a State is a single-payer State.

"(b) APPLICATION BY STATE.—An application submitted by a participating State shall contain the following assurances:

"(1) DESIGNATION OF CLASSES COVERED.—

"(A) DESIGNATION OF CLASSES OF MEDICARE BENEFICIARIES COVERED.—In the application the State shall designate which of the following classes of medicare beneficiaries are to be covered:

"(i) Individuals who are 65 years of age or older.

"(ii) Individuals who are eligible for benefits under part A by reason of section 226(b) or section 1818A (relating to disabled individuals).

"(iii) Individuals who are eligible for benefits under part A only by reason of section 226A (relating to individuals with end stage renal disease).

A State may not restrict the individuals within such a class who are to be covered under this section.

"(B) LIMITATION.—An individual may not be covered under the application unless the individual is entitled to benefits under part A and is enrolled under part B.

"(2) ENROLLMENT IN AND SELECTION OF HEALTH PLANS.—

"(A) ENROLLMENT.—Each medicare-eligible individual (within a class of medicare beneficiaries covered under the application) who is a resident of the State will be enrolled in a regional alliance health plan serving the area in which the individual resides (or, in the case of an individual who is a resident of a single-payer State, in the Statewide single-payer system operated under part 2 of subtitle C of title I of the Health Security Act).

"(B) SELECTION.—Each such individual will have the same choice among applicable health plans as other individuals in the State who are eligible individuals under the Health Security Act.

"(C) OFFER OF FEE-FOR-SERVICE PLAN.—Each such individual shall be offered enrollment in at least one health plan that is a fee-for-service plan (or, in the case of an indivdiual who is a resident of a single-payer State, the Statewide single-payer system under part 2 of subtitle B of title I of the Health Security Act) that meets the following requirements:

"(i) The plan's premium rate, and the actuarial value of the plan's deductibles, coinsurance, and copayments, charged to the individual do not exceed the actuarial value of the premium rate, coinsurance, and deductibles that would be applicable on the average to such individuals if this section did not apply to those individuals.

"(ii) The plan's payment rates for hospital services, post-hospital extended care services, home health services, home intravenous drug therapy services, comprehensive outpatient rehabilitation facility services, hospice care, dialysis services for individuals with end stage renal disease, and facility services furnished in connection with ambulatory surgical procedures are accepted as payment in full.

"(iii) The plan's payment rates for physicians' services are no less a percentage of the amounts accepted as payment in full than are the payment rates for physicians' services under part B.

"(3) COVERAGE OF FULL MEDICARE BENEFITS.—For each health plan providing coverage under this section—

"(A) the plan shall cover at least the items and services for which payment would otherwise be made under this title, and

"(B) coverage determinations under the plan are made under rules that are no more restrictive than otherwise applicable under this title.

"(4) PREMIUM.—During the period for which payments are made to a State under this section, the requirements of the Health Security Act relating to premiums that are otherwise applicable with respect to individuals enrolled in health plans in a State shall not apply with respect to medicare-eligible individuals in the State who are covered under the State's application under this section. Nothing in the previous sentence shall operate to permit a State or health plans in a State to charge different premiums among medicare-eligible individuals within the same premium class under the Health Security Act.

"(5) QUALITY ASSURANCE.—For each health plan providing coverage under this section there are quality assurance mechanisms for covered medicare individuals that equal, or exceed, such mechanisms otherwise applicable under this title.

"(6) REVIEW RIGHTS.—Covered medicare individuals have review, reconsideration, and appeal rights (including appeals to courts of the State) that equal or exceed such rights otherwise applicable under this title.

"(7) DATA REPORTING AND ACCESS TO DOCUMENTS.—The State will—

"(A) provide such utilization and statistical data as the Secretary determines are needed for purposes of the programs established under this title, and

"(B) the State will ensure access by the Secretary or the Comptroller General to relevant documents.

"(8) USE OF PAYMENTS.—Payments made to the State under subsection (a) will be used only to carry out the purposes of this section.

"(c) APPROVAL BY SECRETARY.—The Secretary shall approve an application under subsection (b) if the Secretary finds—

"(1) that the individuals covered under the State's application shall receive at least the benefits provided under this title (including cost sharing);

"(2) that the amount of expenditures that will be made under this title will not exceed

the amount of expenditures that will be made if the State's application is not accepted; and

"(3) that the State is able and willing to carry out the assurances provided in its application.

"(d) AMOUNT AND SOURCE OF PAYMENT.—

"(1) AMOUNT OF PAYMENT.—For purposes of subsection (a), the amount of payments to a State—

"(A) for the first year for which payments are made to the State under this section shall be determined by the applicable rate specified in section 1876(a)(1)(C) (but at 100 percent, rather than 95 percent, of the applicable amount) for each medicare-eligible individual who is a resident of the State (but without regard to any reduction based on payments to be made under section 1876(a)(1)(G)), and

"(B) for each succeeding year, shall be determined by the applicable rate determined under subparagraph (A) or this subparagraph for the preceding year for each such individual, adjusted by the regional alliance inflation factor applicable to regional alliances in the State (as determined in accordance with subtitle A of title VI of the Health Security Act) for the year.

"(2) SOURCE OF PAYMENT.—Payment shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as provided under paragraph (5) of section 1876(a) (other than as provided under subparagraph (B) of that paragraph).

"(e) PERIOD FOR WHICH PAYMENT MADE.—The period for which payment may be made under subsection (a) to a State—

"(1) begins with January 1 of the first calendar year for which the Secretary approves under subsection (c) the application of the State; and

"(2) ends—

"(A) on December 31 of the year in which the State notifies the Secretary (before April of that year) that the State no longer intends to receive payments under this section, or

"(B) if the Secretary finds that the State is no longer in substantial compliance with the requirements under paragraphs (2) or (3) of subsection (c), at the time specified by the Secretary.

No termination is effective under paragraph (2) unless notice has been provided to medicare covered individuals, health providers, and health plans affected by the termination.

"(f) PAYMENTS UNDER THIS SECTION AS SOLE MEDICARE BENEFITS.—Payments to a State under subsection (a) shall be instead of the amounts that would otherwise be payable, pursuant to sections 1814(b) and 1833(a), for services furnished to medicare-eligible residents of the State covered under the application.

"(g) EVALUATION.—The Secretary shall evaluate on an ongoing basis the compliance of a State with the requirements of this section.

"(h) DEFINITIONS.—In this section the terms 'applicable health plan', 'fee-for-service plan', 'health care budget', 'health plan', 'medicare-eligible individual', 'participating State', 'single-payer State', and 'Statewide single-payer system' have the meanings of those terms in the Health Security Act.".

SEC. 4002. INDIVIDUAL ELECTION TO REMAIN IN CERTAIN HEALTH PLANS.

(a) IN GENERAL.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

"(k)(1) Notwithstanding any other provision of this section, each eligible organization with a risk-sharing contract that is the sponsor of a health plan under subtitle E of title I of the Health Security Act shall provide each individual who meets the requirements of paragraph (2) with the opportunity to elect (by submitting an application at such time and in such manner as specified by the Secretary) to continue enrollment in such plan and to have payments made by the Secretary to the plan on the individual's behalf in accordance with paragraph (3).

"(2) An individual meets the requirements of this paragraph if the individual is—

"(A) enrolled in the health plan of an eligible organization in a month in which the individual is either not entitled to benefits under part A, or is an eligible employee (as defined in the Health Security Act) or the spouse of an eligible employee,

"(B) entitled to benefits under part A and enrolled under part B in the succeeding month,

"(C) an eligible individual under the Health Security Act in that succeeding month, and

"(D) not an eligible employee (as defined in the Health Security Act) or the spouse of an eligible employee in that succeeding month.

"(3) The Secretary shall make a payment to an eligible organization on behalf of each individual enrolled with the organization for whom an election is in effect under this subsection in an amount determined by the rate specified by subsection (a)(1)(C). Such payment shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as provided under subsection (a)(5) (other than as provided under subparagraph (B) of that paragraph).

"(4) The period for which payment may be made under paragraph (3)—

"(A) begins with the first month for which the individual meets the requirements of paragraph (2) (or a later month, in the case of a late application, as may be specified by the Secretary); and

"(B) ends with the earliest of—

"(i) the month following the month—

"(I) in which the individual notifies the Secretary that the individual no longer wishes to be enrolled in the health plan of the eligible organization and to have payment made on the individual's behalf under this subsection; and

"(II) which is a month specified by the Secretary as a uniform open enrollment period under subsection (c)(3)(A)(i), or

"(ii) the month in which the individual ceases to meet the requirements of paragraph (2).

"(5) Notwithstanding any other provision of this title, payments to a health plan under this subsection on behalf of an individual shall be the sole payments made with respect to items and services furnished to the individual during the period for which the indivdual's election under this subsection is in effect.".

(b) CONFORMING AMENDMENT.—Section 1838(b) (42 U.S.C. 1395q(b)) is amended by inserting after "section 1843(e)" the following: ", 1876(c)(3)(B), 1876(k)(4)(B), or 1890(j)(1)(B)(iv)".

SEC. 4003. TREATMENT OF CERTAIN MEDICARE BENEFICIARIES.

Title XVIII, as amended by section 4001, is further amended by adding at the end the following new section:

"TREATMENT OF CERTAIN MEDICARE-ELIGIBLE INDIVIDUALS UNDER HEALTH SECURITY ACT

"SEC. 1894. (a) NO MEDICARE COVERAGE FOR CERTAIN MEDICARE-ELIGIBLE INDIVIDUALS.—Notwithstanding any other provision of this title or title II, an individual is not entitled to receive payment or have payment made on the individual's behalf under this title for items and services furnished during a year if the individual is not treated as a medicare-eligible individual under the Health Security Act during the year through the application of section 1012(a) of such Act.

"(b) TRANSFERS TO REGIONAL ALLIANCES.—The Secretary shall provide for a transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in appropriate proportions, to each regional alliance in each year of the amount of the reductions in liability owed to the alliance in the year resulting from the application of section 6115 of the Health Security Act.".

SEC. 4004. PROHIBITING EMPLOYERS FROM TAKING INTO ACCOUNT STATUS AS MEDICARE BENEFICIARY ON ANY GROUNDS.

(a) EXTENSION OF PROTECTIONS FOR WORKING AGED TO GROUP HEALTH PLANS OF ALL EMPLOYERS.—Section 1862(b)(1)(A) (42 U.S.C. 1395y(b)(1)(A)) is amended by striking clauses (ii) and (iii).

(b) EXTENSION OF PROTECTIONS FOR DISABLED ACTIVE INDIVIDUALS TO ALL GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)), as amended by section 13561(e) of OBRA-1993, is amended—

(A) in clause (i)—

(i) by striking "large group health plan (as defined in clause (iv)(II))" and inserting "group health plan (as defined in subparagraph (A)(v))", and

(ii) by striking "clause (iv)(I)" and inserting "clause (iv)"; and

(B) by striking clause (iv).

(2) CONFORMING AMENDMENT.—Section 1862(b)(1)(A)(v) (42 U.S.C. 1395y(b)(1)(A)(v)) is amended by striking "this subparagraph, and subparagraph (C)" and inserting "this paragraph".

(c) REPEAL OF LIMITATION ON PERIOD OF PROTECTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—

(1) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)), as amended by section 13561(c) of OBRA-1993, is amended—

(A) in clause (i), by striking "during the 12-month period" and all that follows through "such benefits";

(B) in clause (ii), by striking the semicolon at the end and inserting a period; and

(C) by striking the matter following clause (ii).

(2) CONFORMING AMENDMENT.—Section 1862(b)(1) is amended—

(A) in subparagraph (A), by striking clause (iv); and

(B) in subparagraph (B), by striking clause (ii).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medicare-eligible individuals residing in a participating State as of January 1 of the first year for which the State is a participating State.

PART 2—ENCOURAGING MANAGED CARE UNDER MEDICARE PROGRAM; COORDINATION WITH MEDIGAP PLANS

SEC. 4011. ENROLLMENT AND TERMINATION OF ENROLLMENT.

(a) UNIFORM OPEN ENROLLMENT PERIODS.—

(1) FOR CAPITATED PLANS.—The first sentence of section 1876(c)(3)(A)(i) (42 U.S.C. 1395mm(c)(3)(A)(i)) is amended by inserting "(which may be specified by the Secretary)" after "open enrollment period".

(2) FOR MEDIGAP PLANS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (3), by striking "paragraphs (1) and (2)" and inserting "paragraph (1), (2), or (3)",

(B) by redesignating paragraph (3) as paragraph (4), and

(C) by inserting after paragraph (2) the following new paragraph:

"(3) Each issuer of a medicare supplemental policy shall have an open enrollment period (which may be specified by the Secretary), of at least 30 days duration every year, during which the issuer may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of age, health status, claims experience, receipt of health care, or medical condition. The policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods (except as provided by paragraph (2)(B)). The Secretary may require enrollment through a third party.".

(b) ENROLLMENTS FOR NEW MEDICARE BENEFICIARIES AND THOSE WHO MOVE.—Section 1876(c)(3)(A) (42 U.S.C. 1395mm(c)(3)(A)) is amended—

(1) in clause (i), by striking "clause (ii)" and inserting "clauses (ii) through (iv)", and

(2) by adding at the end the following:

"(iii) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) during any enrollment period specified by section 1837 that applies to that individual. Enrollment under this clause shall be effective as specified by section 1838.

"(iv) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) who has previously resided outside the geographic area which the organization serves. The enrollment period shall begin with the beginning of the month that precedes the month in which the individual becomes a resident of that geographic area and shall end at the end of the following month. Enrollment under this clause shall be effective as of the first of the month following the month in which the individual enrolls.".

(c) ENROLLMENT THROUGH THIRD PARTY; UNIFORM TERMINATION OF ENROLLMENT.—The first sentence of section 1876(c)(3)(B) (42 U.S.C. 1395mm(c)(3)(B)) is amended—

(1) by inserting "(including enrollment through a third party)" after "regulations", and

(2) by striking everything after "with the eligible organization" and inserting "during an annual period as prescribed by the Secretary, and as specified by the Secretary in the case of financial insolvency of the organization, if the individual moves from the geographic area served by the organization, or in other special circumstances that the Secretary may prescribe.".

(d) EFFECTIVE DATE.—The amendments made by the previous subsections apply to enrollments and terminations of enrollments occurring after 1995 (but only after the Secretary of Health and Human Services has prescribed the relevant annual period), except that the amendments made by subsection (a)(2) apply to enrollments for a medicare supplemental policy made after 1995.

SEC. 4012. UNIFORM INFORMATIONAL MATERIALS.

(a) FOR CAPITATION PLANS.—Section 1876(c)(3)(C) (42 U.S.C. 1395mm(c)(3)(C)) is amended by adding at the end the following: "In addition, the Secretary shall develop and distribute comparative materials about all eligible organizations. Each eligible organization shall reimburse the Secretary for its pro rata share (as determined by the Secretary) of the costs incurred by the Secretary in carrying out the requirements of the preceding sentence and other enrollment activities.".

(b) FOR MEDIGAP PLANS.—Paragraph (1) of section 1882(f) (42 U.S.C. 1395ss(f)) is amended to read as follows:

"(f)(1) The Secretary shall develop and distribute comparative materials about all medicare supplemental policies issued in a State. Each issuer of such a policy shall reimburse the Secretary for its pro rata share (as determined by the Secretary) of the costs incurred by the Secretary in carrying out the requirements of the preceding sentence and other enrollment activities, or the issuer shall no longer be considered as meeting the requirements of this section.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to materials for enrollment in years after 1995.

SEC. 4013. OUTLIER PAYMENTS.

(a) GENERAL RULE.—Section 1876(a)(1) (42 U.S.C. 1395mm(a)(1)) is amended by adding at the end the following:

"(G)(i) In the case of an eligible organization with a risk-sharing contract, the Secretary may make additional payments to the organization equal to not more than 50 percent of the imputed reasonable cost (or, if so requested by the organization, the reasonable cost) above the threshold amount of services covered under parts A and B and provided (or paid for) in a year by the organization to any individual enrolled with the organization under this section.

"(ii) For purposes of clause (i), the 'imputed reasonable cost' is an amount determined by the Secretary on a national, regional, or other basis that is related to the reasonable cost of services.

"(iii) For purposes of clause (i), the 'threshold amount' is an amount determined by the Secretary from time to time, adjusted by the geographic factor utilized in determining payments to the organization under subparagraph (C) and rounded to the nearest multiple of $100, such that the total amount to be paid under this subparagraph for a year is estimated to be 5 percent or less of the total amount to be paid under risk-sharing contracts for services furnished for that year.

"(iv) An eligible organization shall submit a claim for additional payments under subsection (i) within such time as the Secretary may specify.".

(b) CONFORMING AMENDMENT.—Section 1876(a)(1)(C) (42 U.S.C. 1395mm(a)(1)(C)), as amended by section 4122(a), is further amended by inserting ", and reduced (by a uniform percentage) determined by the Secretary so that the total reduction is estimated to equal the amount to be paid under subparagraph (G) for a particular year" before the period.

(c) EFFECTIVE DATE.—The amendments made by the preceding subsections apply to services furnished after 1994.

SEC. 4014. POINT OF SERVICE OPTION.

(a) POINT OF SERVICE CONTRACTS.—Part C of title XVIII is amended by inserting after section 1889 the following:

"POINT OF SERVICE OPTION

"SEC. 1890. (a) ESTABLISHMENT OF PROGRAM.—Not later than July 1, 1995, the Secretary shall promulgate regulations establishing a point-of-service program under which individuals entitled to benefits under this title may enroll in a point-of-service network that meets such criteria as the Secretary may establish and may obtain such benefits through providers and suppliers who are members of the network.

"(b) CRITERIA FOR NETWORKS.—In establishing criteria for point-of-service networks under the program under this section, the Secretary shall—

"(1) designate appropriate geographic service areas for such networks to ensure that each network has a sufficient number of participating members to provide items and services under this title to beneficiaries;

"(2) establish qualifications relating to the business structure and ownership of networks;

"(3) establish requirements for participating members;

"(4) establish a schedule of payments for services furnished by networks, including a schedule of bundled payment arrangements for selected medical and surgical procedures;

"(5) delineate permissible incentive arrangements to encourage physicians and other suppliers to join the network;

"(6) specify the rules under which carriers under section 1842 may administer the program;

"(7) identify certain illnesses and conditions for which the use of case management by the network will result in savings;

"(8) standards for the processing and payment of claims for payment for services furnished by the network, including standards for the apportionment of payments among the Trust Funds established under this title; and

"(9) such other criteria as the Secretary considers appropriate.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(A) by striking "and" at the end of paragraph (3),

(B) by substituting "; and" for the period at the end of paragraph (4), and

(C) by adding at the end the following:

"(5) such additional items and services furnished by a provider of services to an individual subject to case management as may be specified under a point-of-service network arrangement under section 1890.".

(2)(A) Section 1814(b) (42 U.S.C. 1395f(b)) is amended—

(i) in paragraph (1), by inserting "or (4)" after "paragraph (3)",

(ii) by striking "or" at the end of paragraph (2),

(iii) by substituting "; and" for the period at the end of paragraph (3), and

(iv) by inserting after paragraph (3) the following:

"(4) in the case of items and services furnished through a point of service network (as described in section 1890), the payment basis specified under the arrangement established for such network, plus any bonus payments as determined under subsection (i) of that section.".

(B) The matter in section 1886(d)(1)(A) (42 U.S.C. 1395ww(d)(1)(A)) preceding clause (i) is amended by inserting "(other than paragraph (4))" after "1814(b)".

(3) Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (I),

(B) by substituting "; and" for the period at the end of subparagraph (J), and

(C) by adding at the end the following:

"(K) such additional items and services (other than inpatient services furnished by providers of services) as may be specified in an arrangement for a point-of-service network under section 1890.".

(4) Section 1833 (42 U.S.C. 1395l), as amended by section 4032, is amended by adding at the end the following new subsection:

"(u) In the case of items and services furnished through a point of service network (as described in section 1890), there shall be paid (subject to subsection (b)) amounts equal to 80 percent of the payment basis specified in an agreement entered into pursuant to that section, plus any bonus payments as determined under subsection (i) of that section.".

(5) Section 1862(a)(1)(B) (42 U.S.C. 1395y(a)(1)(B)) is amended by inserting "or section 1890(h)" after "section 1861(s)(10)".

(6) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4034(b)(4), 4118(b), and 2001(c), is further amended—

(A) in paragraph (7), by striking "or under paragraph (1)(F)" and inserting ", under paragraph (1)(F), or under a contract under section 1890",

(B) by striking "or" at the end of paragraph (16),

(C) by striking the period at the end of paragraph (17) and inserting "; or", and

(D) by inserting after paragraph (17) the following new paragraph:

"(18) which are furnished to an individual and related to a health condition with respect to which he is subject to case management through a point-of-service network under section 1890 but which are not included in the plan of care developed for such individual and agreed to by him and the case manager.".

(c) EFFECTIVE DATE.—The amendments made by this subsection shall take effect January 1, 1996.

PART 3—MEDICARE COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS

SEC. 4021. REFERENCE TO COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS.

For provisions adding a new outpatient prescription drug benefit to the medicare program, see subtitle A of title II.

SEC. 4022. COVERAGE OF SERVICES OF ADVANCED PRACTICE NURSES.

(a) COVERAGE.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) by striking "and" at the end of clause (iii);

(2) in clause (iv), by striking "(i) or (ii)" and inserting "(i), (ii), or (iv)";

(3) by redesignating clause (iv) as clause (v); and

(4) by inserting after clause (iii) the following new clause:

"(iv) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by an advanced practice nurse (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with such a physician which the advanced practice nurse is legally authorized to perform by the State in which the services are performed, and".

(b) APPLICATION OF PAYMENT RULES AND METHODOLOGY USED FOR SERVICES OF NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS IN RURAL AREAS.—

(1) DIRECT PAYMENT.—Section 1832(a)(2)(B)(iii) (42 U.S.C. 1395k(a)(2)(B)(iii)) is amended by striking "1861(s)(2)(K)(i)," and inserting "1861(s)(2)(K)(i) or section 1861(s)(2)(K)(iv),".

(2) AMOUNT OF PAYMENT.—Section 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(M)), as amended by section 13544(b)(2)(B) of OBRA-1993, is amended by striking "rural area)," and inserting "rural area) or section 1861(s)(2)(K)(iv) (relating to services of advanced practice nurses),".

(3) MANDATORY ASSIGNMENT.—The section 1833(r) added by section 4155(b)(3) of OBRA-1990 is amended—

(1) in paragraph (1)—

(A) by striking "rural area)," and inserting "rural area) or section 1861(s)(2)(K)(iv) (relating to services of advanced practice nurses),", and

(B) by striking "nurse practitioner or clinical nurse specialist" each place it appears and inserting "nurse practitioner, clinical nurse specialist, or advanced practice nurse"; and

(2) by inserting "or section 1861(s)(2)(K)(iv)" after "section 1861(s)(2)(K)(iii)" each place it appears.

(c) SERVICES DEFINED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by striking "and the term 'clinical nurse specialist'" and inserting ", the term 'clinical nurse specialist', and the term 'advanced practice nurse'"; and

(2) by striking "or clinical nurse specialist" and inserting "clinical nurse specialist, or advanced practice nurse".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1995.

PART 4—COORDINATION WITH ADMINISTRATIVE SIMPLIFICATION AND QUALITY MANAGEMENT INITIATIVES

SEC. 4031. REPEAL OF SEPARATE MEDICARE PEER REVIEW PROGRAM.

Part B of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

"TERMINATION

"SEC. 1165. The provisions of this part shall terminate effective upon the adoption of the National Quality Management Program under subtitle A of title V of the Health Security Act. Any reference to this part or any section in this part shall not be effective after such date.".

SEC. 4032. MANDATORY ASSIGNMENT FOR ALL PART B SERVICES.

Section 1833 (42 U.S.C. 1395l) is amended—

(1) by redesignating the subsection (r) added by section 4206(b)(2) of OBRA-1990 as subsection (s); and

(2) by adding at the end the following new subsection:

"(t)(1) Notwithstanding any other provision of this part, payment under this part for any item or service furnished on or after January 1, 1996, may only be made on an assignment-related basis.

"(2) Except for deductible, coinsurance, or copayment amounts applicable under this part, no physician, supplier, or other person may bill or collect any amount from an individual enrolled under this part a bill for an item or service for which payment may be made under this part. No such individual is liable for payment of any amounts billed in violation of the previous sentence.

"(3) If a physician, supplier, or other person knowingly and willfully bills or collects an amount in violation of paragraph (2), the Secretary may apply sanctions against such physician, supplier, or other person in accordance with section 1842(j)(2). Paragraph (4) of section 1842(j) shall apply in this paragraph in the same manner as such paragraph applies to such section.".

SEC. 4033. ELIMINATION OF COMPLEXITIES CAUSED BY DUAL FUNDING SOURCES AND RULES FOR PAYMENT OF CLAIMS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act).

(b) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary shall contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate.

(c) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this section.

SEC. 4034. REPEAL OF PRO PRECERTIFICATION REQUIREMENT FOR CERTAIN SURGICAL PROCEDURES.

(a) IN GENERAL.—Section 1164 (42 U.S.C. 1320c-13) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 1154 (42 U.S.C. 1320c-3) is amended—

(A) in subsection (a), by striking paragraph (12), and

(B) in subsection (d), by striking "(and except as provided in section 1164)".

(2) Section 1833 (42 U.S.C. 1395l) is amended—

(A) in subsection (a)(1)(D)(i), by striking ", or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)";

(B) in subsection (a)(1), by striking clause (G);

(C) in subsection (a)(2)(A), by striking ", to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),";

(D) in subsection (a)(2)(D)(i)—

(i) by striking "basis," and inserting "basis or", and

(ii) by striking ", or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)";

(E) in subsection (a)(3), by striking "and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion)"; and

(F) in the first sentence of subsection (b), by striking "(4)" and all that follows through "and (5)" and inserting and "(4)".

(3) Section 1834(g)(1)(B) (42 U.S.C. 1395m(g)(1)(B)) is amended by striking "and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion)".

(4) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by adding "or" at the end of paragraph (14),

(B) by striking "; or" at the end of paragraph (15) and inserting a period, and

(C) by striking paragraph (16).

(5) The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395w(a)(2)(A)) is amended by striking ", with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after the date of the enactment of this Act.

SEC. 4035. REQUIREMENTS FOR CHANGES IN BILLING PROCEDURES.

(a) LIMITATION ON FREQUENCY OF SYSTEM CHANGES.—The Secretary of Health and Human Services may not implement any change in the system used for the billing and processing of claims for payment for items and services furnished under title XVIII of the Social Security Act within 6 months of implementing any previous change in such system.

(b) ADVANCE NOTIFICATION TO PROVIDERS AS REQUIREMENT FOR CARRIERS AND FISCAL INTERMEDIARIES.—

(1) FISCAL INTERMEDIARIES.—Section 1816(c) (42 U.S.C. 1395h(c)) is amended by adding at the end the following new paragraph:

"(4) Each agreement with an agency or organization under this section shall provide that the agency or organization shall notify providers of services of any major change in the procedures for billing for services furnished under this part at least 120 days before such change is to take effect.".

(2) CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (G) and the end of subparagraph (H); and

(B) by inserting after subparagraph (H) the following new subparagraph:

"(I) will notify individuals and entities furnishing items and services for which payment may be made under this part of any major change in the procedures for billing for such items and services at least 120 days before such change is to take effect; and".

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to agreements with fiscal intermediaries under section 1816 of the Social Security Act and to contracts with carriers under section 1842 of such Act for years beginning after the expiration of the 9-month period beginning on the date of the enactment of this Act.

PART 5—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS

SEC. 4041. ANTI-KICKBACK PROVISIONS.

(a) REVISION TO PENALTIES.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking "or" at the end of paragraphs (1) and (2);

(B) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

(C) by inserting after paragraph (3) the following new paragraph:

"(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b);".

(2) DESCRIPTION OF CIVIL MONETARY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking "given)." at the end of the first sentence and inserting the following: "given or, in cases under paragraph (4), $50,000 for each such violation).''; and

(B) by striking "claim." at the end of the second sentence and inserting the following: "claim (or, in cases under paragraph (4), an assessment of not more than three times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid solicited, or received for a lawful purpose).".

(3) INCREASE IN CRIMINAL PENALTY.—Paragraphs (1) and (2) of section 1128B(b) (42 U.S.C. 1320a-7b(b)) are each amended—

(A) by striking "$25,000" and inserting "$50,000"; and

(B) by striking the period at the end and inserting the following: ", and shall be subject to an assessment of not more than three times the total remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid solicited, or received for a lawful purpose.".

(4) CIVIL REMEDY.—Section 1128B(b) (42 U.S.C. 1320a-7b(b)) is amended by adding at the end the following new paragraph:

"(4) Any person who carries out any activity in violation of paragraph (1) or (2) shall be subject to a penalty of not more than $50,000 for each such violation, and shall be subject to an assessment of not more than three times the total remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose.".

(b) REVISIONS TO EXCEPTIONS.—

(1) EXCEPTION FOR DISCOUNTS.—Section 1128B(b)(3)(A) (42 U.S.C. 1320a-7b(b)(3)(A)) is amended by striking "program;" and inserting "program and is not—

"(i) for the furnishing of one item or service without charge or at a reduced charge in exchange for any agreement to buy a different item or service;

"(ii) applicable to one payor but not to providers of services or other entities under title XVIII or a State health care program; or

"(iii) in the form of a cash payment;".

(2) EXCEPTION FOR PAYMENTS TO EMPLOYEES.—Section 1128B(b)(3)(B) (42 U.S.C. 1320a-7b(b)(3)(B)) is amended by inserting at the end "if the amount of remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals, except that such employees can be paid remuneration in the form of a productivity bonus based on services personally performed by the employee.

(3) EXCEPTION FOR WAIVER OF COINSURANCE BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D) (42 U.S.C. 1320a-7b(b)(3)(D)) is amended to read as follows:

"(D) a waiver or reduction of any coinsurance or other copayment—

"(i) if the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals, or

"(ii) under part B of title XVIII by any person if the person does not routinely waive coinsurance or deductible amounts and the person—

"(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is indigent;

"(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

"(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary.".

(4) NEW EXCEPTION FOR CERTAIN PROVIDERS.—Section 1128B(b)(3) (42 U.S.C. 1320a-7b(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(F) any remuneration obtained by or given to an individual or entity who is obligated as a matter of law to waive or reduce coinsurance or other copayment for certain individuals pursuant to a public schedule of discounts, if the remuneration is pursuant to a written arrangement for the use or procurement of space, equipment, goods or services or for the referral of patients if—

"(i) the arrangement does not result in private inurement to any current employee, officer, member of the Board of Directors, or agent of the recipient or any other person involved in recommending or negotiating the arrangement; and

"(ii) the arrangement does not preclude the referral of patients to other providers of service of the patient's own choosing and does not interfere with the ability of health professionals to refer patients to providers of services they believe are the most appropriate, except to the extent such choices or referrals are limited by the terms of a health plan in which the patient has enrolled or the terms of the Federal grant or cooperative agreement.".

(5) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1128B(b)(3) (42 U.S.C. 1320a-7b(b)(3)), as amended by paragraph (4), is further amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by adding at the end the following new subparagraph—

"(G) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider of services for items or services furnished to an individual, or any discount or reduction in price given by the provider for such items or services, if the individual is enrolled with and such items and services are covered under any of the following:

"(i) A health plan which is furnishing items or services under title XVIII or a State health care program to individuals on an at-risk, prepaid, capitated basis pursuant to a written agreement with the Secretary or a State health care program.

"(ii) An organization receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972.

"(iii) Any other plan or insurer under which a participating provider is paid wholly on an at-risk, prepaid, capitated basis for such items or services pursuant to a written arrangement between the plan and the provider.".

(c) CLARIFICATION OF COVERAGE OF EMPLOYERS AND EMPLOYEES.—Section 1128B(b) (42 U.S.C. 1320a-7b(b)), as amended by subsection (a)(4), is further amended by adding at the end the following new paragraph:

"(5) In this subsection, the term 'referral' includes the referral by an employee to his or her employer of any item or service for which payment may be made in whole or in part under title XVIII or a State health care program."

(d) AUTHORIZATION FOR THE SECRETARY TO ISSUE REGULATIONS.—Section 1128B(b) (42 U.S.C. 1320a-7b(b)), as amended by subsections (a)(4) and (c), is further amended by adding at the end the following new paragraph—

"(6) The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions described in paragraph (3).".

(e) CLARIFICATION OF OTHER ELEMENTS OF OFFENSE.—Section 1128B(b) (42 U.S.C. 1320a-7b(b)) is amended—

(1) in paragraph (1) in the matter preceding subparagraph (A), by striking "kind—" and

inserting "kind with intent to be influenced—";

(2) in paragraph (1)(A), by striking "in return for referring" and inserting "to refer";

(3) in paragraph (1)(B), by striking "in return for purchasing, leasing, ordering, or arranging for or recommending" and inserting "to purchase, lease, order, or arrange for or recommend"; and

(4) in paragraph (2) in the matter preceding subparagraph (A), by striking "to induce such person" and inserting "with intent to influence such person".

SEC. 4042. REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

(a) CLARIFICATION OF PAYMENT BAN.—Section 1877(a)(1)(B) (42 U.S.C. 1395nn(a)(1)(B)) is amended to read as follows:

"(B) no physician or entity may present or cause to be presented a claim under this title or bill to any third party payor or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).".

(b) CLARIFICATION OF COVERAGE OF HOLDING COMPANY TYPE ARRANGEMENTS AND LOANS.—The last sentence of section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking "an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service" and inserting the following: "a loan from the entity, and an interest held indirectly through means such as (but not limited to) having a family member hold such investment interest or holding a legal or beneficial interest in another entity (such as a trust or holding company) that holds such investment interest".

(c) REVISIONS TO GENERAL EXCEPTIONS TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS.—

(1) REPEAL OF EXCEPTION FOR PHYSICIANS' SERVICES.—Section 1877(b) (42 U.S.C. 1395nn(b)) is amended—

(A) by striking paragraph (1); and

(B) by redesignating paragraphs (2) and (3) as paragraphs paragraphs (1) and (2).

(2) REVISION TO IN-OFFICE ANCILLARY SERVICES EXCEPTION.—Section 1877(b)(1) (42 U.S.C. 1395nn(b)(1)), as redesignated by paragraph (1), is amended—

(A) in the matter preceding subparagraph (A), by striking "services (other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)" and inserting "clinical laboratory services, x-ray and ultrasound services that are provided at low-cost (as determined in accordance with regulations of the Secretary)"; and

(B) in subparagraph (A)—

(i) in clause (ii)(I), by striking "(or another physician who is a member of the same group practice)",

(ii) in clause (ii)(II) by inserting "the same or" before "another building", and

(iii) in clause (ii)(II)(bb), by inserting "all of" after "centralized provision of".

(3) REVISION TO PREPAID PLAN EXCEPTION.—Section 1877(b)(2), (42 U.S.C. 1395nn(b)(2)), as redesignated by paragraph (1), is amended to read as follows:

"(2) PREPAID PLANS.—In the case of services furnished by an organization—

"(A) with a risk sharing contract under section 1876(g) to an individual enrolled with the organization,

"(B) receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization, or

"(C) that is a qualified health maintenance organization (within the meaning of section 1310(d) of the Public Health Service Act) to an individual enrolled with the organization.".

(4) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by paragraph (1), is amended by inserting after paragraph (2) the following new paragraph:

"(3) CAPITATED PAYMENTS.—In the case of a designated health service, if the designated health service is included in the services for which a physician or physician group is paid wholly on an at-risk, prepaid, capitated basis by a health plan or insurer pursuant to a written arrangement between the plan or insurer and the physician or physician group.".

(d) REVISION TO PUBLICLY TRADED SECURITIES EXCEPTION.—Section 1877(c)(1) (42 U.S.C. 1395nn(c)(1)) is amended by inserting "at the time acquired by the physician" after "which may be purchased on terms generally available to the public".

(e) REVISION TO RURAL PROVIDER EXCEPTION.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended by striking "substantially all" and inserting "not less than 85 percent (as determined in accordance with regulations of the Secretary)".

(f) REVISIONS TO EXCEPTIONS RELATING TO OTHER COMPENSATION ARRANGEMENTS.—

(1) EXCEPTION FOR PERSONAL SERVICES ARRANGEMENTS.—(A) Section 1877(e)(3)(B)(i)(II) (42 U.S.C. 1395nn(e)(3)(B)(i)(II)) is amended to read as follows:

"(II) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary pursuant to section 1876(i)(8)(A)(ii)), for services not provided by the physician, the entity complies with the provisions of subclauses (I) and (II) of section 1876(i)(8)(A)(ii).";

(B) Section 1877(e)(3)(B)(ii), 42 U.S.C. 1395nn(e)(3)(B)(ii) is amended by striking "may directly or indirectly have the effect of" and inserting "has the purpose of".

(2) REPEAL OF EXCEPTION FOR REMUNERATION UNRELATED TO THE PROVISION OF DESIGNATED HEALTH SERVICES.—Section 1877(e) (42 U.S.C. 1395nn(e)) is amended—

(A) by striking paragraph (4); and

(B) by redesignating paragraphs (5), (6), (7), and (8) as paragraphs (4), (5), (6), and (7).

(3) EXCEPTION FOR CERTAIN PHYSICIAN RECRUITMENT.—Section 1877(e)(4) (42 U.S.C. 1395nn(e)(4)), as redesignated by paragraph (2), is amended to read as follows:

"(4) PHYSICIAN RECRUITMENT.—In the case of remuneration which is provided by an entity located in a rural area (as defined in section 1886(d)(2)(D)) or a health professional shortage areas (designated under section 332 of the Public Health Service Act), or an entity that serves a significant number of individuals who are members of a medically underserved population (designated under section 330 of the Public Health Service Act), in order to induce a physician who has been practicing within the physician's current specialty for less than one year to establish staff privileges at the entity, or to induce any other physician to relocate his or her primary place of practice to the geographic area served by the entity, if the following standards are met:

"(A) The arrangement is set forth in a written agreement that specifies the benefits provided by the entity to the physician, the terms under which the benefits are to be provided, and the obligations of each party.

"(B) If a physician is leaving an established practice, the physical location of the new primary place of practice must be not less than 100 miles from the location of the established primary place of practice and at least 85 percent of the revenues of the physician's new practice must be generated from new patients for whom the physician did not previously provide services at the former practice.

"(C) The benefits are provided by the entity for a period not in excess of 3 years, and the terms of the agreement are not renegotiated during this 3-year period in any substantial aspect, unless the physician's new primary place of practice is designated as a health professional shortage area (pursuant to section 332 of the Public Health Service Act) for the physician's specialty category during the entire duration of the relationship between the physician and the entity.

"(D) There is no requirement that the physician make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the entity as a condition for receiving the benefits.

"(E) The physician is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of the physician's choosing.

"(F) The amount or value of the benefits provided by the entity may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any expected referrals to or business otherwise generated for the entity by the physician for which payment may be made in whole or in part under this title or a State health care program (as defined in section 1128(h)).

"(G) The physician agrees to treat patients entitled to benefits under this title or enrolled in a State plan for medical assistance under title XIX.".

(4) EXCEPTION FOR ISOLATED TRANSACTIONS.—Section 1877(e)(5) (42 U.S.C. 1395nn(e)(6)), as redesignated by paragraph (2), is amended—

(A) by redesignating subparagraph (B) as subparagraph (C);

(B) by striking "and" at the end of subparagraph (A); and

(C) by inserting after subparagraph (A) the following new subparagraph:

"(B) there is no financing of the sale between the parties, and".

(5) EXCEPTION FOR PAYMENTS BY A PHYSICIAN.—Section 1877(e)(7) (42 U.S.C. 1395nn(e)(7)), as redesignated by paragraph (2), is amended to read as follows:

"(7) PAYMENTS BY A PHYSICIAN FOR ITEMS AND SERVICES.—Payments made by a physician to a laboratory in exchange for the provision of clinical laboratory services furnished at a price that is consistent with fair market value.".

(6) ADDITIONAL EXCEPTION FOR DISCOUNTS OR OTHER REDUCTIONS IN PRICE.—Section 1877(e) (42 U.S.C. 1395nn(e)), as amended by paragraph (2), is amended by adding at the end the following new paragraph:

"(8) DISCOUNTS OR OTHER REDUCTIONS IN PRICE.—Discounts or other reductions in price between a physician and an entity for items or services for which payment may be made under this title so long as the discount or other reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the physician or entity under this title and is not—

"(A) for the furnishing of one item or service without charge or at a reduced charge in exchange for any agreement to buy a different item or service,

"(B) applicable to one or more payers but not to all individuals and entities providing services for which payment may be made under this title, or

"(C) in the form of a cash payment.".

(g) CLARIFICATION OF SANCTION AUTHORITY.—Section 1877(g)(4) (42 U.S.C. 1395nn(g)(4)) is amended by striking "Any physician" and all that follows through "to such entity," and inserting the following: "Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement or an arrangement with multiple leases overlapping in time for the same or similar rental space or equipment) which the physician or entity knows or should know has a principal purpose of inducing referrals to another entity, which referrals, if made directly by the physician or entity to such other entity,".

(h) CLARIFICATION OF DEFINITION OF REMUNERATION.—Section 1877(h)(1)(B) (42 U.S.C. 1395nn(h)(1)(B)) is amended to read as follows:

"(B) The term 'remuneration' includes any payment, discount or other reduction in price, forgiveness of debt or other benefit made directly or indirectly, overtly or covertly, in cash or in kind.".

(i) REVISION TO DEFINITION OF GROUP PRACTICE.—Section 1877(h)(4) (42 U.S.C. 1395nn(h)(4)) is amended—

(1) in subparagraph (A)(vi), by striking the period at the end and inserting the following: ", including a requirement for the physical grouping of physician practices as may be reasonably required to prevent the abuse of any exceptions provided to group practices under this section."; and

(2) in subparagraph (B)(i), by striking "or services incident to such personally performed services".

(j) REVISION OF DEFINITION OF REFERRAL; REFERRING PHYSICIAN.—

(1) IN GENERAL.—Section 1877(h)(5) (42 U.S.C. 1395nn(h)(5)) is amended by striking subparagraph (C).

(2) CONFORMING AMENDMENTS.—Section 1877(h)(5) (42 U.S.C. 1395nn(h)(5)) is amended—

(A) in subparagraph (A), by striking "Except as provided in subparagraph (C), in" and inserting "In"; and

(B) in subparagraph (B), by striking "Except as provided in subparagraph (C), the" and inserting "The".

(k) EXPANSION TO COVER ADDITIONAL ITEMS AND SERVICES.—Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)), as amended by section 2006(c)(3), is amended—

(1) in subparagraph (D), by striking "or other"; and

(2) by adding at the end the following new subparagraphs:

"(M) Diagnostic services.

"(N) Any other item or service not rendered by the physician personally or by a person under the physician's direct supervision.".

(l) AUTHORIZATION FOR THE SECRETARY TO ISSUE REGULATIONS.—Section 1877 (42 U.S.C. 1395nn) is amended by adding the following new subsection:

"(i) ADDITIONAL REQUIREMENTS.—The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions under this section.".

(m) INCORPORATION OF AMENDMENTS MADE UNDER OBRA-1993.—In this section, any reference to section 1877 of the Social Security Act shall be considered a reference to such section as amended by section 13562(a) of OBRA-1993.

SEC. 4043. CIVIL MONETARY PENALTIES.

(a) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) (as amended by section 4041(a)(1)) is amended—

(A) by striking "; or" at the end of paragraph (3) and inserting a semicolon;

(B) by striking the semicolon at the end of paragraph (4) and inserting "; or"; and

(C) by inserting after paragraph (4) the following new paragraph:

"(5) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;".

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a-7a(i)) is amended by adding at the end the following new paragraph:

"(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver of coinsurance or deductible amounts by a person or entity, if—

"(A) the waiver is not offered as part of any advertisement or solicitation;

"(B) the person does not routinely waive coinsurance or deductible amounts; and

"(C) the person—

"(i) waives the coinsurance and deductible amounts after determining in good faith that the individual is indigent;

"(ii) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

"(iii) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary.".

(b) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a-7a(a)(1)) is amended—

(1) in subparagraph (A), by striking "claimed," and inserting the following: "claimed, including any person who presents or causes to be presented a claim for an item or service which includes a procedure or diagnosis code that the person knows or should know will result in a greater payment to the person than the code applicable to the item or service actually provided or actual patient medical condition,";

(2) in subparagraph (C), by striking "or" at the end;

(3) in subparagraph (D), by striking "; or" and inserting ", or"; and

(4) by inserting after subparagraph (D) the following new subparagraph:

"(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or".

(c) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) of such Act, as amended by section 4041(a)(1) and subsection (a)(1), is further amended—

(1) by striking "or" at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting "; or"; and

(3) by inserting after paragraph (5) the following new paragraph:

"(6) in the case of a person who is not an organization, agency, or other entity, who is excluded from participating in a program under title XVIII or a State health care program in accordance with this section, section 1128, or section 1156 and who, during the period of exclusion, retains either a direct or indirect ownership or control interest of 5 percent or more in, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;".

(d) ADDITIONAL OFFENSES RELATING TO ALLIANCE SYSTEM.—Section 1128A(a) of such Act, as amended by section 4041(a)(1) and subsections (a)(1) and (c), is further amended—

(1) by striking "or" at the end of paragraph (5);

(2) by striking the semicolon at the end of paragraph (6) and inserting "; or"; and

(3) by inserting after paragraph (6) the following new paragraphs:

"(7) engages in a practice that circumvents a payment methodology intended to reimburse for two or more discreet medical items or services at a single or fixed amount, including but not limited to, multiple admissions or readmission to hospitals and other institutions reimbursed on a diagnosis reimbursement grouping basis;

"(8) engages in a practice which has the effect of limiting or discouraging (as compared to other plan enrollees) the utilization of health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

"(9) substantially fails to cooperate with a quality assurance program or a utilization review activity;

"(10) fails substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a health plan or public program for the delivery of or payment for health care items or services, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individual;

"(11) employs or contracts with any individual or entity who is excluded from participating in a program under title XVIII or a State health care program in accordance with this section, section 1128, or section 1156, for the provision of any services (including but not limited to health care, utilization review, medical social work, or administrative), or employs or contracts with any entity for the direct or indirect provision of such services, through such an excluded individual or entity; or

"(12) submits false or fraudulent statements, data or information or claims to the National Health Board established under part 1 of subtitle F of title I of the Health Security Act, any other federal agency, a state health care agency, a health alliance, or any other Federal, state or local agency charged with implementation or oversight of the plan that the person knows or should know is fraudulent;".

(e) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)), as amended by section 4041(a), subsection (a)(1), subsection (c), and subsection (d), is amended in the matter following paragraph (6)—

(1) by striking "$2,000" and inserting "$10,000";

(2) by inserting after "under paragraph (4), $50,000 for each such violation" the following: "; in cases under paragraph (5), $10,000

for each such offer of transfer; in cases under paragraph (6), $10,000 for each day the prohibited relationship occurs; in cases under paragraphs (7) through (12), an amount not to exceed $50,000 for each such determination by the Secretary"; and

(3) by striking "twice the amount" and inserting "three times the amount".

(f) INTEREST ON PENALTIES.—Section 1128A(f) (42 U.S.C. 1320a-7a(f)) is amended by adding after the first sentence the following: "Interest shall accrue on the penalties and assessments (as defined in subsection (g)) imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where the penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of penalties and assessments owed to cover the costs of collection.".

(g) AUTHORIZATION TO ACT.—

(1) IN GENERAL.—The first sentence of section 1128A(c)(1) (42 U.S.C. 1320a-7a(c)(1)) is amended by striking all that follows "(b)" and inserting the following: "unless, within one year after the date the Secretary presents a case to the Attorney General for consideration, the Attorney General brings an action in a district court of the United States.".

(2) EFFECTIVE DATE.—The amendment made by this paragraph (1) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

(h) DEPOSIT OF PENALTIES COLLECTED INTO ALL-PAYER TRUST FUND.—Section 1128A(f)(3) (42 U.S.C. 1320a-7a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the All-Payer Health Care Fraud and Abuse Control Trust Fund established under section 5402 of the Health Security Act".

(i) CLARIFICATION OF PENALTY IMPOSED ON EXCLUDED PROVIDER FURNISHING SERVICES.—Section 1128A(a)(1)(D) (42 U.S.C. 1320a-7a(a)(1)(D)) is amended by inserting "who furnished the service" after "in which the person was".

SEC. 4044. EXCLUSIONS FROM PROGRAM PARTICIPATION.

(a) MANDATORY EXCLUSION FOR INDIVIDUAL CONVICTED OF CRIMINAL OFFENSE RELATED TO HEALTH CARE FRAUD.—Section 1128 (42 U.S.C. 1320a-7) is amended—

(1) by amending paragraph (1) of subsection (a) to read as follows:

"(1) CONVICTIONS OF PROGRAM-RELATED CRIMES AND HEALTH CARE FRAUD.—

"(A) Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program; or

"(B) Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct."; and

(2) in subsection (b)(1), by striking "in connection with the delivery of a health care item or service or".

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.—Section 1128(c)(3) (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraphs (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that a longer period is appropriate because of aggravating circumstances.

"(E) In the case of an exclusion of an individual or entity under paragraph (4) or (5) of subsection (b), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

(c) REVISION TO EXCLUSION FOR DEFAULT ON HEALTH EDUCATION LOAN OR SCHOLARSHIP OBLIGATIONS.—Section 1128(b)(14) (42 U.S.C. 1320a-7(b)(14)) is amended by striking "all reasonable steps" and inserting "reasonable steps".

(d) PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.—Section 1128(b) (42 U.S.C. 1320a-7(b)), is amended by adding at the end the following new paragraph:

"(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity—

"(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

"(B) against which a civil monetary penalty has been assessed under section 1128A; or

"(C) that has been excluded from participation under a program under title XVIII or under a State health care program.".

(e) EXCLUSIONS BASED ON ACTIONS UNDER ALLIANCE SYSTEM.—Section 1128(b) (42 U.S.C. 1320a-7(b)), as amended by subsections (a) and (d), is amended—

(1) in paragraph (1), by striking "XVIII or under a State health care program" and inserting "XVIII, a State health care program, or under an applicable health plan (as defined in section 1902(6) of the Health Security Act)";

(2) in paragraph (7), by striking the period at the end and inserting ", or in section 5412 of the Health Security Act.";

(3) in paragraph (8)(B)—

(A) in clause (ii), by striking "1128A" and inserting "1128A or under section 5412 of the Health Security Act", and

(B) in clause (iii), by striking "XVIII or under a State health care program" and inserting "XVIII, a State health care program, or under an applicable health plan (as defined in section 1902(6) of the Health Security Act)";

(4) in paragraph (9), by striking the period at the end and inserting ", or any information requested by the Inspector General of the Department of Health and Human Services to carry out the All-Payer Health Care Fraud and Abuse Control Program established under section 5401 of the Health Security Act.";

(5) in paragraph (11)—

(A) by striking "title XVIII or a State health care program" and inserting "title XVIII, a State health care program, or an applicable health plan (as defined in section 1902(6) of the Health Security Act)",

(B) by striking "Secretary or the appropriate State agency" and inserting "Secretary, the appropriate State agency, or plan sponsor", and

(C) by striking "Secretary or that agency" and inserting "Secretary, that agency, or that sponsor";

(6) in paragraph (12), by adding at the end the following new subparagraph:

"(E) Any entity authorized by law to (i) conduct on-site health, safety or patient care reviews and surveys or (ii) to investigate whether any actions have occurred that would subject an individual or entity to the imposition of any sanctions under this section, section 1128A, section 1128B, or part 2 of subtitle E of title V of the Health Security Act."; and

(7) in paragraph (15)—

(A) in subparagraph (B), by striking "1128A" and inserting "1128A or section 54.. of the Health Security Act", and

(B) in subparagraph (C), by striking "title XVIII or under a State health care program" and inserting "title XVIII, a State health care program, or an applicable health plan (as defined in section 1902(6) of the Health Security Act".

(f) APPEAL OF EXCLUSIONS TO COURT OF APPEALS.—Section 1128(f)(1) (42 U.S.C. 1320a-7(f)(1)) is amended by striking the period at the end and inserting the following: ", except that any action brought to appeal such decision shall be brought in the United States Court of Appeals for the judicial circuit in which the individual or entity resides or has a principal place of business (or, if the individual or entity does not reside or have a principal place of business within any such judicial circuit, in the United States Court of Appeals for the District of Columbia Circuit).".

SEC. 4045. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS RELATING TO QUALITY OF CARE.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended by striking "may prescribe)" and inserting "may prescribe, except that such period may not be less than one year)".

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c-5(b)(2)) is amended by striking "shall remain" and inserting "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain".

(b) REPEAL OF "UNWILLING OR UNABLE" CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended—

(1) in the second sentence, by striking "and determines" and all that follows through "such obligations," and

(2) by striking the third sentence.

(c) AMOUNT OF CIVIL MONEY PENALTY.—Section 1156(b)(3) (42 U.S.C. 1320c-5(b)(3)) is amended by striking "the actual or estimated cost" and inserting the following: "$50,000 for each instance".

SEC. 4046. EFFECTIVE DATE.

The amendments made by this part shall take effect January 1, 1995.

PART 6—FUNDING OF GRADUATE MEDICAL EDUCATION AND ACADEMIC HEALTH CENTERS

SEC. 4051. TRANSFERS FROM MEDICARE TRUST FUNDS FOR GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—For purposes of complying with section 3034(a), there shall be transferred to the Secretary from the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act) the following amount (in the aggregate), as applicable to a calendar year:

(1) In the case of a calendar year prior to 1998, the proportion of the amounts expended from such Trust Funds during the most recent fiscal year ending before the first day of such calendar year for payments for the direct costs of graduate medical education under section 1886(h) of such Act that is attributable to payments to hospitals located in the States that are participating States for the calendar year.

(2) In the case of calendar year 1998, the amount expended from such Trust Funds during fiscal year 1997 for payments for such direct costs of graduate medical education.

(3) In the case of each subsequent calendar year, the amount specified in paragraph (2) increased by the product of such amount and the general health care inflation factor (as defined in section 6001(a)(3), except that for purposes of this subparagraph the increases provided for in subparagraphs (A) through (C) of such section shall not be made).

(b) ALLOCATION OF AMOUNT AMONG FUNDS.—With respect to the amount required under subsection (a) to be transferred for an academic year from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall determine an equitable allocation of such amount among the funds.

(c) TERMINATION OF GRADUATE MEDICAL EDUCATION PAYMENTS UNDER MEDICARE.—

(1) IN GENERAL.— Section 1886(h) (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

"(6) TERMINATION OF PAYMENTS ATTRIBUTABLE TO COSTS OF TRAINING PHYSICIANS.—Notwithstanding any other provision of this section or section 1861(v), no payment may be made under this title for direct graduate medical education costs attributable to an approved medical residency training program for any cost reporting period (or portion thereof) beginning on or after January 1, 1998 (or, in the case of costs of a program operating in a State that is a participating State under the Health Security Act for a year prior to 1998, on or after January 1 of the first year for which the State is such a participating State).".

(2) PROHIBITION AGAINST RECOGNITION OF COSTS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(T) Such regulations shall not include any provision for specific recognition of the costs of graduate medical education for hospitals for any cost reporting period (or portion thereof) beginning on or after January 1, 1998 (or, in the case of a hospital located in a State that is a participating State under the Health Security Act for a year prior to 1998, ending on or before December 31 of the year prior to the first year for which the State is such a participating State). Nothing in the previous sentence shall be construed to affect in any way payments to hospitals for the costs of any approved educational activities that are not described in such sentence.".

SEC. 4052. TRANSFERS FROM HOSPITAL INSURANCE TRUST FUND FOR ACADEMIC HEALTH CENTERS.

(a) IN GENERAL.—For purposes of complying with section 3104(a), there shall be transferred to the Secretary from the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act) the following amount (in the aggregate), as applicable to a calendar year:

(1) In the case of a calendar year prior to 1998, the proportion of the amounts expended from such Trust Fund during the most recent fiscal year ending before the first day of such calendar year for payments for the indirect costs of medical education under section 1886(d)(5)(B) of such Act that is attributable to discharges of hospitals located in the States that are participating States for the calendar year.

(2) In the case of calendar year 1998, the amount expended from such Trust Fund during fiscal year 1997 for payments for such indirect costs of medical education.

(3) In the case of each subsequent calendar year, the amount specified in paragraph (2) increased by the product of such amount and the general health care inflation factor (as defined in section 6001(a)(3), except that for purposes of this subparagraph the increases provided for in subparagraphs (A) through (C) of such section shall not be made).

(b) TERMINATION OF PAYMENTS UNDER MEDICARE.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended in the matter preceding clause (i) by striking "The Secretary" and inserting "For discharges occurring before January 1, 1998 (or, in the case of discharges of a hospital located in a State that is a participating State under the Health Security Act for a year prior to 1998, before January 1 of the first year for which the State is such a participating State), the Secretary".

(2) ADJUSTMENT TO STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking "excluding" and inserting "for discharges occurring before January 1, 1998, (or, in the case of discharges of a hospital located in a State that is a participating State under the Health Security Act for a year prior to 1998, before January 1 of the first year for which the State is such a participating State) excluding".

PART 7—COVERAGE OF SERVICES PROVIDED BY FACILITIES AND PLANS OF DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS

SEC. 4061. TREATMENT OF UNIFORMED SERVICES HEALTH PLAN AS ELIGIBLE ORGANIZATION UNDER MEDICARE.

(a) IN GENERAL.—Section 1876 (42 U.S.C. 1395mm), as amended by section 4002(a), is further amended by adding at the end the following new subsection:

"(l) Notwithstanding any other provision of this section, a Uniformed Services Health Plan of the Department of Defense under chapter 55 of title 10, United States Code, shall be considered an eligible organization under this section, and the Secretary shall make payments to such Plan during a year on behalf of any individuals entitled to benefits under this title who are enrolled with such a Plan during the year in such amounts and under such terms and conditions as may be imposed under an agreement between the Secretary and the Secretary of Defense.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished under title XVIII of the Social Security Act on or after January 1, 1998.

SEC. 4062. COVERAGE OF SERVICES PROVIDED TO MEDICARE BENEFICIARIES BY PLANS AND FACILITIES OF DEPARTMENT OF VETERANS AFFAIRS.

(a) IN GENERAL.—Title XVIII, as amended by sections 4001 and 4003, is further amended by adding at the end the following new section:

"TREATMENT OF PLANS AND FACILITIES OF DEPARTMENT OF VETERANS AFFAIRS AS PROVIDERS

"SEC. 1895. (a) IN GENERAL.—Notwithstanding any other provision of this title—

"(1) a VA health plan (as defined in section 1801(2) of title 38, United States Code) shall be considered an eligible organization for purposes of section 1876; and

"(2) a health care facility of the Department of Veterans Affairs shall be considered a provider of services under section 1861(u).

"(b) ELIGIBILITY FOR PAYMENTS.—

"(1) VA HEALTH PLANS.—The Secretary shall make payments to a VA health plan during a year on behalf of any individuals entitled to benefits under this title who are enrolled with such a plan during the year in the same amounts and under the same terms and conditions under which the Secretary makes payments to eligible organizations with a risk-sharing contract under section 1876.

"(2) HEALTH CARE FACILITIES.—The Secretary shall make payments to a health care facility of the Department of Veterans Affairs for services provided to an individual entitled to benefits under this title in the same amounts and under the same terms and conditions under which the Secretary makes payments to provider of services under this title.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished under title XVIII of the Social Security Act on or after January 1, 1998.

SEC. 4063. CONFORMING AMENDMENTS.

(a) PART A.—Section 1814 (42 U.S.C. 1395f) is amended by striking subsection (c).

(b) PART B.—Section 1835 (42 U.S.C. 1395n) is amended by striking subsection (d).

(c) ADDITIONAL CONFORMING AMENDMENT.—Section 1880(a) (42 U.S.C. 1395qq(a)) is amended by striking ", notwithstanding sections 1814(c) and 1835(d),".

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1998.

Subtitle B—Savings in Medicare Program

PART 1—SAVINGS RELATING TO PART A

SEC. 4101. REDUCTION IN UPDATE FOR INPATIENT HOSPITAL SERVICES.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)), as amended by section 13501(a)(1) of OBRA-1993, is amended—

(1) in subclause (XII)—

(A) by striking "fiscal year 1997" and inserting "for each of the fiscal years 1997 through 2000", and

(B) by striking "0.5 percentage point" and inserting "2.0 percentage points"; and

(2) in subclause (XIII), by striking "fiscal year 1998" and inserting "fiscal year 2001".

SEC. 4102. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

"(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c * (((1+r) to the nth power) - 1), where 'r' is

the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring on or after—

"(I) May 1, 1986, and before October 1, 1994, 'c' is equal to 1.89,

"(II) October 1, 1994, and before October 1, 1995, 'c' is equal to 1.395, and

"(III) October 1, 1995, 'c' is equal to 0.74.".

SEC. 4103. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—

(1) REDUCTION IN BASE PAYMENT RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)), as amended by section 13501(a)(3) of OBRA-1993, is amended by adding at the end the following new sentence: "In addition to the reduction described in the preceding sentence, the Secretary shall reduce by 7.31 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Health Security Act) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Health Security Act).".

(2) REDUCTION IN UPDATE.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

(A) in subparagraph (B)(i)—

(i) by striking "and (II)" and inserting "(II)", and

(ii) by striking the semicolon at the end and inserting the following: ", and (III) an annual update factor established for the prospective payment rates applicable to discharges in a fiscal year which (subject to reduction under subparagraph (C)) will be based upon such factor as the Secretary determines appropriate to take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality;";

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following new subparagraph:

"(C)(i) With respect to payments attributable to portions of cost reporting periods or discharges occurring during each of the fiscal years 1996 through 2000, the Secretary shall include a reduction in the annual update factor established under subparagraph (B)(i)(III) for discharges in the year equal to the applicable update reduction described in clause (ii) to adjust for excessive increases in capital costs per discharge for fiscal years prior to fiscal year 1992 (but in no event may such reduction result in an annual update factor less than zero).

"(ii) In clause (i), the term 'applicable update reduction' means, with respect to the update factor for a fiscal year—

"(I) 4.9 percentage points; or

"(II) if the annual update factor for the previous fiscal year was less than the applicable update reduction for the previous year, the sum of 4.9 percentage points and the difference between the annual update factor for the previous year and the applicable update reduction for the previous year.".

(b) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 4051(c)(2), is further amended by adding at the end the following new subparagraph:

"(U) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpatient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during each of the fiscal years 1996 through 2000.".

SEC. 4104. REVISIONS TO PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS IN PARTICIPATING STATES.

(a) APPLICATION OF ALTERNATIVE ADJUSTMENTS.—Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended—

(1) by redesignating subparagraphs (H) and (I) as subparagraphs (I) and (J); and

(2) by inserting after subparagraph (G) the following new subparagraph:

"(H)(i) In accordance with this subparagraph, the Secretary shall provide for an additional payment for each subsection (d) hospital that is located in a participating State under subtitle C of title I of the Health Security Act during a cost reporting period and that meets the eligibility requirements described in clause (iii).

"(ii) The amount of the additional payment made under clause (i) for each discharge shall be determined by multiplying—

"(I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A) for the discharge, by

"(II) the SSI adjustment percentage for the cost reporting period in which the discharge occurs (as defined in clause (iv)).

"(iii) A hospital meets the eligibility requirements described in this clause with respect to a cost reporting period if—

"(I) in the case of a hospital that is located in an urban area and that has more than 100 beds, the hospital's SSI patient percentage (as defined in clause (v)) for the cost reporting period is not less than 5 percent;

"(II) in the case of a hospital that is located in an urban area and that has less than 100 beds, the hospital's SSI patient percentage is not less than 17 percent;

"(III) in the case of a hospital that is classified as a rural referral center under subparagraph (C) or a sole community hospital under subparagraph (D), the hospital's SSI patient percentage for the cost reporting period is not less than 23 percent; and

"(IV) in the case of any other hospital, the hospital's SSI patient percentage is not less than 23 percent.

"(iv) For purposes of clause (ii), the 'SSI adjustment percentage' applicable to a hospital for a cost reporting period is equal to—

"(I) in the case of a hospital described in clause (iii)(I), the percentage determined in accordance with the following formula: e to the nth power, where 'e' is the natural antilog of 1 and where 'n' is equal to (.5642 * (the hospital's SSI patient percentage for the cost reporting period - .055)) - 1;

"(II) in the case of a hospital described in clause (iii)(II) or clause (iii)(IV), 2 percent; and

"(III) in the case of a hospital described in clause (iii)(III), the sum of 2 percent and .30 percent of the difference between the hospital's SSI patient percentage for the cost reporting period and 23 percent.

"(v) In this subparagraph, a hospital's 'SSI patient percentage' with respect to a cost reporting period is equal to the fraction (expressed as a percentage)—

"(I) the numerator of which is the number of the hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A and were entitled to supplementary security income benefits (excluding State supplementation) under title XVI; and

"(II) the denominator of which is the number of the hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A.".

(b) NO STANDARDIZATION RESULTING FROM REDUCTION.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended—

(1) by striking "exclude additional payments" and inserting "adjust such estimate for changes in payments";

(2) by striking "1989 or" and inserting "1989,"; and

(3) by striking the period at the end and inserting the following: ", or the enactment of section 4104 of the Health Security Act.".

(c) CONFORMING AMENDMENT.—Section 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) is amended in the matter preceding subclause (I) by inserting after "hospital" the following: "that is not located in a State that is a participating State under subtitle C of title I of the Health Security Act".

SEC. 4105. MORATORIUM ON DESIGNATION OF ADDITIONAL LONG-TERM CARE HOSPITALS.

Notwithstanding clause (iv) of section 1886(d)(1)(B) of the Social Security Act, a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services) of greater than 25 days shall not be treated as a hospital described in such clause for purposes of title XVIII of such Act unless the hospital was treated as a hospital described in such clause for purposes of such title as of the date of the enactment of this Act.

SEC. 4106. EXTENSION OF FREEZE ON UPDATES TO ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES.

(a) PAYMENTS BASED ON COST LIMITS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking "112 percent" each place it appears and inserting "100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(a)(1) of the Omnibus Budget Reconciliation Act of 1993)".

(b) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Section 1888(d)(2)(B) (42 U.S.C. 1395yy(d)(2)(B)) is amended by striking "105 percent" and inserting "100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(b) of the Omnibus Budget Reconciliation Act of 1993)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and(b) shall apply to cost reporting periods beginning on or after October 1, 1995.

PART 2—SAVINGS RELATING TO PART B

SEC. 4111. ESTABLISHMENT OF CUMULATIVE EXPENDITURE GOALS FOR PHYSICIAN SERVICES.

(a) USE OF CUMULATIVE PERFORMANCE STANDARD.—Section 1848(f)(2) (42 U.S.C. 1395w-4(f)(2)) is amended—

(1) in subparagraph (A)—

(A) in the heading, by striking "IN GENERAL" and inserting "FISCAL YEARS 1991 THROUGH 1993.—",

(B) in the matter preceding clause (i), by striking "a fiscal year (beginning with fiscal year 1991)" and inserting "fiscal years 1991, 1992, and 1993", and

(C) in the matter following clause (iv), by striking "subparagraph (B)" and inserting "subparagraph (C)";

(2) in subparagraph (B), by striking "subparagraph (A)" and inserting "subparagraphs (A) and (B)";

(3) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(4) by inserting after subparagraph (A) the following new subparagraph:

"(B) FISCAL YEARS BEGINNING WITH FISCAL YEAR 1994.—Unless Congress otherwise provides, the performance standard rate of increase, for all physicians' services and for each category of physicians's services, for a fiscal year beginning with fiscal year 1994 shall be equal to the performance standard rate of increase determined under this paragraph for the previous fiscal year, increased by the product of—

"(i) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services or for the category of physicians' services, respectively, under this part for portions of calendar years included in the fiscal year involved,

"(ii) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

"(iii) 1 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

"(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of physicians' services, respectively, in the fiscal year (compared with the previous fiscal year) which are estimated to result from changes in law or regulations affecting the percentage increase described in clause (i) and which is not taken into account in the percentage increase described in clause (i),

minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (C)).".

(b) TREATMENT OF DEFAULT UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3)(B) (42 U.S.C. 1395w–4(d)(3)(B)) is amended—

(A) in clause (i)—

(i) in the heading, by striking "IN GENERAL" and inserting "1992 THROUGH 1995", and

(ii) by striking "for a year" and inserting "for 1992, 1993, 1994, and 1995"; and

(B) by adding after clause (ii) the following new clause:

"(iii) YEARS BEGINNING WITH 1996.—

"(I) IN GENERAL.—The update for a category of physicians' services for a year beginning with 1996 provided under subparagraph (A) shall be increased or decreased by the same percentage by which the cumulative percentage increase in actual expenditures for such category of physicians' services for such year was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such category of services for such year.

"(II) CUMULATIVE PERCENTAGE INCREASE DEFINED.—In subclause (I), the 'cumulative percentage increase in actual expenditures' for a year shall be equal to the product of the adjusted increases for each year beginning with 1994 up to and including the year involved, minus 1 and multiplied by 100. In the previous sentence, the 'adjusted increase' for a year is equal to 1 plus the percentage increase in actual expenditures for the year.".

(2) CONFORMING AMENDMENT.—Section 1848(d)(3)(A)(i) (42 U.S.C. 1395w–4(d)(3)(A)(i)) is amended by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)".

SEC. 4112. USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY; REPEAL OF RESTRICTION ON MAXIMUM REDUCTION PERMITTED IN DEFAULT UPDATE.

(a) USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY.—Section 1848(f)(2)(B)(iii) (42 U.S.C. 1395w–4(f)(2)(B)(iii)), as added by section 4111(a), is amended to read as follows:

"(iii) 1 plus the average per capita growth in the real gross domestic product (divided by 100) for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for the category of services consisting of primary care services), and".

(b) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w–4(d)(3)(B)(ii)), as amended by section 13512(b) of OBRA–1993, is amended—

(1) in the heading, by inserting "IN CERTAIN YEARS" after "ADJUSTMENT";

(2) in the matter preceding subclause (I), by striking "for a year";

(3) in subclause (I), by adding "and" at the end;

(4) in subclause (II), by striking ", and" and inserting a period; and

(5) by striking subclause (III).

SEC. 4113. REDUCTION IN CONVERSION FACTOR FOR PHYSICIAN FEE SCHEDULE FOR 1995.

Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) in subparagraph (A), by inserting after "subparagraph (B)" the following: ", and, in the case of 1995, specified in subparagraph (C)";

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) SPECIAL PROVISION FOR 1995.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph for 1995 is—

"(i) in the case of physicians' services included in the category of primary care services (as defined in subsection (j)(1)), the conversion factor established under this subsection for 1994 adjusted by the update established under paragraph (3) for 1995; and

"(ii) in the case of any other physicians' services, the conversion factor established under this subsection for 1994 reduced by 3 percentage points.".

SEC. 4114. LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS.

(a) IN GENERAL.—

(1) LIMITATIONS DESCRIBED.—Part B of title XVIII, as amended by section 2003(a), is amended by inserting after section 1848 the following new section:

"LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS

"SEC. 1849. (a) SERVICES SUBJECT TO REDUCTION.—

"(1) DETERMINATION OF HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1997), the Secretary shall determine for each hospital—

"(A) the hospital-specific per admission relative value under subsection (b)(2) for the following year; and

"(B)(i) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (b)(1), and, if so, (ii) the hospital's projected excess relative value for the year under subsection (b)(3).

"(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (c)) the amount of payment otherwise determined under this part for each physicians' service furnished during the year to an inpatient of the hospital by an individual who is a member of the hospital's medical staff.

"(3) TIMING OF DETERMINATION; NOTICE TO HOSPITALS AND CARRIERS.—Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff under paragraph (1).

"(b) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

"(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—

"(A) URBAN HOSPITALS.—In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection—

"(i) for 1998 and 1999, is equal to 125 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs; and

"(ii) for 2000 and each succeeding year, is equal to 120 percent of the median of such relative values for all hospital medical staffs.

"(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

"(A) IN GENERAL.—The hospital-specific per admission relative value for a hospital (other than a teaching hospital), shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for each physician's service furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during 1996, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

"(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value for a teaching hospital shall be equal to the sum of—

"(i) the average per admission relative value (as determined under section 1848(c)(2)) for each physician's service furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during 1996, adjusted for variations in case-mix, disproportionate share status, and

teaching status among hospitals (as determined by the Secretary under subparagraph (C)); and

"(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for each physician's service furnished to inpatients of the hospital by interns and residents of the hospital during 1996, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall determine such equivalent relative value unit per admission for interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

"(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

"(3) PROJECTED EXCESS RELATIVE VALUE DEFINED.—The 'projected excess relative value' with respect to a hospital's medical staff for a year means the number of percentage points by which the Secretary determines (under subsection (a)(1)(B)) that the medical staff's hospital-specific per admission relative value (determined under paragraph (2)) will exceed the allowable average per admission relative value applicable to the hospital medical staff for the year (as determined under paragraph (1)).

"(c) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician's service that is subject to a reduction under subsection (a) during a year shall be reduced 15 percent, in the case of a service furnished by a member of the medical staff of a hospital for which the Secretary determines under subsection (a)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

"(d) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

"(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under subsection (b)(2)(C)).

"(2) RECONCILIATION WITH REDUCTIONS TAKEN.—In the case of a hospital for which the payment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the hospital were reduced under this section for a year—

"(A) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (c);

"(B) if the actual average per admission relative value for such hospital's medical staff during the year is less than 10 percentage points above the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a percent of the total allowed charges for physicians' services performed in such hospital (prior to the withhold), the difference between 10 percentage points and the actual number of percentage points that the staff exceeds the limit;

"(C) if the actual average per admission relative value for such hospital's medical staff during the year exceeded the allowable average per admission relative value applicable to the hospital's medical staff by 10 percentage points or more, none of the withhold is paid to the fiduciary agent for the medical staff.

"(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have one year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate withhold amount made by the carrier.

"(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(B) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff.

"(e) DEFINITIONS.—In this section, the following definitions apply:

"(1) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

"(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

"(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

"(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

"(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

"(B) if such physician provides at least one service to a Medicare beneficiary in such hospital.

"(2) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given such terms under section 1886(d)(2)(D).

"(3) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6).".

(2) CONFORMING AMENDMENTS.—(A) Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting "(subject to reduction under section 1849)" after "1848(a)(1)".

(B) Section 1848(a)(1)(B) (42 U.S.C. 1395w-4(a)(1)(B)) is amended by striking "this subsection," and inserting "this subsection and section 1849,".

(b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(4)(A)(i)) is amended by striking "beneficiary," and inserting "beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form),".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 4115. MEDICARE INCENTIVES FOR PHYSICIANS TO PROVIDE PRIMARY CARE.

(a) RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS.—

(1) INCREASE IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN SERVICES.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)), as amended by sections 13513 and 13514 of OBRA-93, is amended by adding at the end the following new subparagraph:

"(G) INCREASE IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN SERVICES.—The Secretary shall increase the practice expense relative value units applied in primary care services, as defined in section 1842(i)(4), by 10 percent, beginning with 1996.".

(2) ASSURING BUDGET NEUTRALITY.—Section 1842(c)(2)(F) (42 U.S.C. 1395u(c)(2)(F)), as added by section 13513 and amended by section 13514 of OBRA-93, is amended by adding at the end the following new clause:

"(iii) shall reduce the relative values for all services (other than anesthesia services and primary care services, as defined in section 1842(i)(4)) established under this paragraph (and, in the case of anesthesia services, the conversion factor established by the Secretary for such services) by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendment made by section 4115(a)(1) of the Health Security Act would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made.".

(3) STUDY.—The Secretary of Health and Human Services shall—

(A) develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative values unit for each physician's service, and

(B) transmit a report by June 30, 1996, on the methodology developed under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Fiance of the Senate. The report shall include a presentation of the data utilized in developing the methodology and an explanation of the methodology.

(b) OFFICE VISIT PRE- AND POST-TIME.—

(1) INCREASE IN WORK RELATIVE VALUE UNITS FOR OFFICE VISITS.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraph:

"(H) INCREASE IN WORK RELATIVE VALUE UNITS FOR CERTAIN SERVICES.—The Secretary shall increase the work relative value units applied to office visits by 10 percent, beginning with 1996.".

(2) ASSURING BUDGET NEUTRALITY.—Section 1842(c)(2)(F)(iii) is amended by striking "section 4115(a)" and substituting "sections 4115(a)(1) and (b)(1)".

(c) OFFICE CONSULTATIONS.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraph:

"(1) AMENDMENT IN RELATIVE VALUES FOR OFFICE CONSULTATIONS.—The Secretary shall reduce the work, practice expense and malpractice relative value components of office consultations to be equal to the work, practice expense and malpractice relative value components for comparable office visits beginning with 1996. In making such adjustment, the Secretary shall apply the savings from such reduction to increase each of the relative value components for office visits in a manner that would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made.".

(d) OUTLIER INTENSITY RELATIVE VALUE ADJUSTMENTS.—

(1) ADJUSTMENT OF OUTLIER INTENSITY OF RELATIVE VALUES.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraph:

"(J) ADJUSTMENT OF OUTLIER INTENSITY OF RELATIVE VALUES.—Beginning with 1996, the Secretary shall reduce the work relative value components of procedures, or classes of procedures, where the intensity exceeds thresholds established by the Secretary. In the previous sentence, intensity shall mean the work relative value units for the procedure divided by the time for the procedure. The Secretary shall apply the savings from such reductions to increase the work relative value components of primary care services, as defined in section 1842(i)(4), such that the changes made by this subsection would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made.".

(e) CHANGES IN UNDERSERVED AREA BONUS PAYMENTS.—

(1) Section 1833(m) (42 U.S.C. 1395l(m)) is amended by—

(A) striking "10 percent" and inserting "a percent",

(B) striking "service" the last time it appears and inserting "services", and

(C) adding the following new sentence: "The percent referred to in the previous sentence is 20 percent in the case of primary care services, as defined in section 1842(i)(4), and 10 percent for services other than primary care services furnished in health professional shortage areas located in rural areas as defined in section 1886(d).".

(2) The amendments made by subparagraph (A) are effective for services furnished on or after January 1, 1996.

SEC. 4116. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking "of 80 percent"; and

(2) by striking the period at the end and inserting the following: ", less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).".

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking "of 80 percent"; and

(2) by striking the period at the end and inserting the following: ", less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after July 1, 1994.

SEC. 4117. IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.

(a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

(1) by striking "(or 100 percent" and all that follows through "the first opinion))"; and

(2) by striking "100 percent of such negotiated rate" and inserting "80 percent of such negotiated rate".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 1995.

SEC. 4118. APPLICATION OF COMPETITIVE BIDDING PROCESS FOR PART B ITEMS AND SERVICES.

(a) GENERAL RULE.—Part B of title XVIII of the Social Security Act is amended by inserting after section 1846 the following:

"COMPETITION ACQUISITION FOR ITEMS AND SERVICES

"SEC. 1847. (a) ESTABLISHMENT OF BIDDING AREAS.—

"(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for the purpose of awarding a contract or contracts for the furnishing under this part of the items and services described in subsection (c) on or after January 1, 1995. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services under this part.

"(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall—

"(A) initially be, or be within, metropolitan statistical areas; and

"(B) be chosen based on the availability and accessibility of suppliers and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

"(b) AWARDING OF CONTRACTS IN AREAS.—

"(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services under this part for each competitive acquisition area established under subsection (a) for each class of items and services.

"(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any individual or entity under the competition conducted pursuant to paragraph (1) to furnish an item or service under this part unless the Secretary finds that the individual or entity—

"(A) meets quality standards specified by the Secretary for the furnishing of such item or service; and

"(B) offers to furnish a total quantity of such item or service that is sufficient to meet the expected need within the competitive acquisition area.

"(3) CONTENTS OF CONTRACT.—A contract entered into with an individual or entity under the competition conducted pursuant to paragraph (1) shall specify (for all of the items and services within a class)—

"(A) the quantity of items and services the entity shall provide; and

"(B) such other terms and conditions as the Secretary may require.

"(c) SERVICES DESCRIBED.—The items and services to which the provisions of this section shall apply are as follows:

"(1) Magnetic resonance imaging tests and computerized axial tomography scans, including a physician's interpretation of the results of such tests and scans.

"(2) Oxygen and oxygen equipment.

"(3) Enteral and parenteral nutrients, supplies, and equipment.

"(4) Such other items and services for which the Secretary determines that the use of competitive acquisition under this section will be appropriate and cost-effective.".

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 4034(b)(4), is amended—

(1) by striking "or" at the end of paragraph (14);

(2) by striking the period at the end of paragraph (15) and inserting "; or"; and

(3) by inserting after paragraph (15) the following new paragraph:

"(16) where such expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an individual or entity other than the supplier with whom the Secretary has entered into a contract under section 1847(b) for the furnishing of such item or service in that area, unless the Secretary finds that such expenses were incurred in a case of urgent need.".

(c) REDUCTION IN PAYMENT AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUCTION IN PAYMENTS.—Notwithstanding any other provision of title XVIII of the Social Security Act, if the establishment of competitive acquisition areas under section 1847 of such Act (as added by subsection (a)) and the limitation of coverage for items and services under part B of such title to items and services furnished by providers with competitive acquisition contracts under such section does not result in a reduction of at least 10 percent in the payment amount under part B during a year for any such item or service from the payment amount for the previous year, the Secretary shall reduce the payment amount by such percentage as the Secretary determines necessary to result in such a reduction.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished under part B of title XVIII of the Social Security Act on or after January 1, 1995.

SEC. 4119. APPLICATION OF COMPETITIVE ACQUISITION PROCEDURES FOR LABORATORY SERVICES.

(a) IN GENERAL.—Section 1847(c), as added by section 4117(a), is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

"(4) Clinical diagnostic laboratory tests.".

(b) REDUCTION IN FEE SCHEDULE AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE SAVINGS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

"(7) Notwithstanding any other provision of this subsection, if the Secretary applies the authority provided under section 1847 to establish competitive acquisition areas for the furnishing of clinical diagnostic laboratory tests in a year and the application of such authority does not result in a reduction of at least 10 percent in the fee schedules and negotiated rates established under this subsection for such tests under this part during the year from the fee schedules and rates for the previous year, the Secretary shall reduce each payment amount otherwise determined under the fee schedules and negotiated rates established under this subsection by such percentage as the Secretary determines necessary to result in such a reduction.".

PART 3—SAVINGS RELATING TO PARTS A AND B

SEC. 4131. MEDICARE SECONDARY PAYER CHANGES.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) REPEAL OF SUNSET ON APPLICATION TO DISABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN 20 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)), as amended by section 13561(b) of OBRA-1993, is amended—

(1) in the heading, by striking "SUNSET" and inserting "EFFECTIVE DATE"; and

(2) by striking ", and October 1, 1998".

(c) EXTENSION OF PERIOD FOR END STAGE RENAL DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)), as amended by section 13561(c) of OBRA-1993, is amended in the second sentence by striking "and on or before October 1, 1998,".

SEC. 4132. PAYMENT LIMITS FOR HMOS AND CMPS WITH RISK-SHARING CONTRACTS.

(a) IN GENERAL.—Section 1876(a)(1)(C) (42 U.S.C. 1395mm(a)(1)(C)) is amended—

(1) by inserting ", subject to adjustment to take into account the provisions of the succeeding clauses" before the period,

(2) by striking "(C)" and inserting "(C)(i)", and

(3) by adding at the end the following new clauses:

"(ii) The portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund may not exceed 95 percent of the following amount (unless the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Hospital Insurance Trust Fund is less than 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from the Federal Hospital Insurance Trust Fund):

"(I) For 1995, 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 80 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 150 percent of that weighted national average.

"(II) For 1996, 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 60 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 150 percent of that weighted national average.

"(III) For 1997, 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 40 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 150 percent of that weighted national average.

"(IV) For 1998, 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 20 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 150 percent of that weighted national average.

"(V) For 1999 and each succeeding year (subject to the establishment by the Secretary of alternative limits under clause (vi)), 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund.

"(iii) The portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Hospital Insurance Trust Fund may not exceed 95 percent of the following amount (unless the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund is less than 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund):

"(I) For 1995, 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 80 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 170 percent of that weighted national average.

"(II) For 1996, 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 60 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 170 percent of that weighted national average.

"(III) For 1997, 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 40 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 170 percent of that weighted national average.

"(IV) For 1998, 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 20 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 170 percent of that weighted national average.

"(V) For 1999 and each succeeding year (subject to the establishment by the Secretary of alternative limits under clause (vi)), 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund.

"(iv) The portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund may not be less than 80 percent of 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, unless the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Hospital Insurance Trust Fund is greater than 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from the Federal Hospital Insurance Trust Fund.

"(v) The portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Hospital Insurance Trust Fund may not be less than 80 percent of 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, unless the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund is greater than 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund.

"(vi) For 2000 and succeeding years, the Secretary may revise any of the percentages otherwise applicable during a year under the preceding clauses (other than clause (i)), but only if the aggregate payments made under this title to eligible organizations under risk-sharing contracts during the year is not greater than the aggregate payments that would have been made under this title to such organizations during the year if the Secretary had not revised the percentages.".

(b) CONFORMING AMENDMENT.—Section 1876(a)(5)(A) (42 U.S.C. 1395mm(a)(5)(A)) is amended by inserting ", adjusted to take into account the limitations imposed by clauses (ii) through (vi) of paragraph (1)(C)" before the period.

SEC. 4133. REDUCTION IN ROUTINE COST LIMITS FOR HOME HEALTH SERVICES.

(a) REDUCTION IN UPDATE TO MAINTAIN FREEZE IN 1996.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (II), by striking "or" at the end;

(2) in subclause (III), by striking "112 percent," and inserting "and before July 1, 1996, 112 percent, or"; and

(3) by inserting after subclause (III) the following new subclause:

"(IV) July 1, 1996, 100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993),".

(b) BASING LIMITS IN SUBSEQUENT YEARS ON MEDIAN OF COSTS.—

(1) IN GENERAL.—Section 1861(v)(1)(L)(i) (U.S.C. 1395x(v)(1)(L)(i)), as amended by subsection (a), is amended in the matter following subclause (IV) by striking "the mean" and inserting "the median".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 1997.

SEC. 4134. IMPOSITION OF COPAYMENT FOR CERTAIN HOME HEALTH VISITS.

(a) IN GENERAL.—

(1) PART A.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

"(5) The amount payable for home health services furnished to an individual under this part shall be reduced by a copayment amount equal to 10 percent of the average of all per visit costs for home health services furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year), unless such services were furnished to the individual during the 30-day period that begins on the date the individual is discharged as an inpatient from a hospital.".

(2) PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(A) in subparagraph (A), by striking "to home health services," and by striking the comma after "opinion)";

(B) in subparagraph (D), by striking "and" at the end;

(C) in subparagraph (E), by striking the semicolon at the end and inserting "; and"; and

(D) by adding at the end the following new subparagraph:

"(F) with respect to home health services—

"(i) the lesser of —

"(I) the reasonable cost of such services, as determined under section 1861(v), or

"(II) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A),

"(ii) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2), or

"(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section,

less a copayment amount equal to 10 percent of the average of all per visit costs for home health services furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year), unless such services were furnished to the individual during the 30-day period that begins on the date the individual is discharged as an inpatient from a hospital;".

(3) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(A) by striking "deduction or coinsurance" and inserting "deduction, coinsurance, or copayment"; and

(B) by striking "or (a)(4)" and inserting "(a)(4), or (a)(5)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to home health services furnished on or after July 1, 1995.

SEC. 4135. EXPANSION OF CENTERS OF EXCELLENCE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall use a competitive process to contract with centers of excellence for cataract surgery and such other services as the Secretary determines to be appropriate. Payment under title XVIII of the Social Security Act will be made for services subject to such contracts on the basis of negotiated or all-inclusive rates as follows:

(1) The center shall cover services provided in an urban area (as defined in section 1886(d)(2)(D) of the Social Security Act) for years beginning with fiscal year 1995.

(2) The amount of payment made by the Secretary to the center under title XVIII of the Social Security Act for services covered under the project shall be less than the aggregate amount of the payments that the Secretary would have made to the center for such services had the project not been in effect.

(3) The Secretary shall make payments to the center on such a basis for the following services furnished to individuals entitled to benefits under such title:

(A) Facility, professional, and related services relating to cataract surgery.

(B) Coronary artery bypass surgery and related services.

(C) Such other services as the Secretary and the center may agree to cover under the agreement.

(b) REBATE OF PORTION OF SAVINGS.—In the case of any services provided under a demonstration project conducted under subsection (a), the Secretary shall make a payment to each individual to whom such services are furnished (at such time and in such manner as the Secretary may provide) in an amount equal to 10 percent of the amount by which—

(1) the amount of payment that would have been made by the Secretary under title XVIII of the Social Security Act to the center for such services if the services had not been provided under the project, exceeds

(2) the amount of payment made by the Secretary under such title to the center for such services.

PART 4—PART B PREMIUM

SEC. 4141. GENERAL PART B PREMIUM.

Section 1839(e) (42 U.S.C. 1395r(e)), as amended by section 13571 of OBRA-1993, is amended—

(1) in paragraph (1)(A), by striking "and prior to January 1999"; and

(2) in paragraph (2), by striking "prior to January 1998".

Subtitle C—Medicaid

PART 1—COMPREHENSIVE BENEFIT PACKAGE

SEC. 4201. LIMITING COVERAGE UNDER MEDICAID OF ITEMS AND SERVICES COVERED UNDER COMPREHENSIVE BENEFIT PACKAGE.

(a) REMOVAL OF COMPREHENSIVE BENEFITS PACKAGE FROM STATE PLAN.—Title XIX is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

"TREATMENT OF COMPREHENSIVE BENEFIT PACKAGE UNDER HEALTH SECURITY ACT

"SEC. 1931. (a) ITEMS AND SERVICES COVERED UNDER COMPREHENSIVE BENEFIT PACKAGE.—If a State plan for medical assistance under this title provides for payment in accordance with section 1902(a)(63) for a year, notwithstanding any other provision of this title, the State plan under this title is not required to provide medical assistance consisting of payment for items and services in the comprehensive benefit package under subtitle B of title I of the Health Security Act for alliance eligible individuals (as defined in section 1902(5) of such Act).

"(b) CONSTRUCTION.—(1) Payment under section 1902(a)(63) shall not constitute medical assistance for purposes of section 1903(a).

"(2) This section shall not be construed as affecting the provision of medical assistance under this title for items and services included in the comprehensive benefit package for—

"(A) medicare-eligible individuals, or

"(B) certain emergency services to certain aliens under section 1903(v)(2).".

(b) SUBSTITUTE REQUIREMENT OF STATE PAYMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking "and" at the end of paragraph (61),

(2) by striking the period at the end of paragraph (62) and inserting "; and", and

(3) by inserting after paragraph (62) the following new paragraph:

"(63) provide for payment to regional alliances of the amounts required under part 1 of subtitle C of title VI of such Act.".

(c) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(1) by striking "or" at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting "; or", and

(3) by inserting after paragraph (15) the following new paragraph:

"(16) with respect to items and services covered under the comprehensive benefit package under subtitle B of title I of the Health Security Act for alliance eligible individuals (as defined in section 1902(5) of such Act).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to items or services furnished in a State on or after January 1 of the first year (as defined in section 1902(17)) for the State.

PART 2—EXPANDING ELIGIBILITY FOR NURSING FACILITY SERVICES; LONG-TERM CARE INTEGRATION OPTION

SEC. 4211. SPENDDOWN ELIGIBILITY FOR NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i) (42 U.S.C. 1396a(a)(10)(A)(i)) is amended—

(1) by striking "or" at the end of subclause (VI);

(2) by striking the semicolon at the end of subclause (VII) and inserting ", or"; and

(3) by inserting after subclause (VII) the following new subclause:

"(VIII) who are individuals who would meet the income and resource requirements of the appropriate State plan described in subclause (I) or the supplemental security income program (as the case may be), if incurred expenses for medical care as recognized under State law were deducted from income;".

(b) LIMITATION TO BENEFITS FOR NURSING FACILITY SERVICES.—Section 1902(a)(10)(A) of such Act (42 U.S.C. 1396a(a)(10)(A)), as amended by section 13603(c)(1) of OBRA-1993, is amended in the matter following subparagraph (F)—

(1) by striking "and (XIII)" and inserting "(XIII)"; and

(2) by inserting before the semicolon at the end the following: ", and (XIV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance for nursing facility services, except to the extent that assistance is provided in accordance with the option described in section 1932 in the case of a State exercising such option".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to a State as of January 1, 1996.

SEC. 4212. INCREASED INCOME AND RESOURCE DISREGARDS FOR NURSING FACILITY RESIDENTS.

(a) INCREASED DISREGARDS FOR PERSONAL NEEDS ALLOWANCE; RESOURCES.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(1)) is amended—

(1) by striking "and" at the end of paragraph (F); and

(2) by adding at the end the following new paragraph:

"(G) that, in determining the eligibility of any individual who is an inpatient in a nursing facility or intermediate care facility for the mentally retarded—

"(i) the first $70 of income for each month shall be disregarded; and

"(ii) in the case of an unmarried individual, the first $12,000 of resources may, at the option of the State, be disregarded;".

(b) CONFORMING SSI PERSONAL NEEDS ALLOWANCE.—For provision increasing SSI personal needs allowance, see section 4301.

(c) FEDERAL REIMBURSEMENT FOR REDUCTIONS IN STATE FUNDS ATTRIBUTABLE TO INCREASED DISREGARD.—Section 1903(a) (42 U.S.C. 1396b(a)) is amended—

(1) by striking "plus" at the end of paragraph (6);

(2) by striking the period at the end of paragraph (7) and inserting "; plus"; and

(3) by adding at the end the following new paragraph:

"(8) an amount equal to 100 percent of the difference between the amount of expenditures made by the State for nursing facility services and services in an intermediate care facility for the mentally retarded during the quarter and the amount of expenditures that would have been made by the State for such services during the quarter if the amendment made by subsection (a) had not taken effect (as estimated by the Secretary).".

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to months beginning with January 1996.

SEC. 4213. NEW STATE LONG-TERM CARE INTEGRATION OPTION.

Title XIX, as amended by section 4201(a), is amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

"STATE LONG-TERM CARE OPTION

"SEC. 1932. (a) IN GENERAL.—A State under this title may make an election under and subject to the succeeding provisions of this section. Under such an election instead of being entitled to receive payment under section 1903(a) for medical assistance for nursing facility services and intermediate care facilities for the mentally retarded, for one or more defined populations, the State is entitled to receive, subject to subsection (e), payment under section 1903(a) for long-term care services described in subsection (b)(2) for such populations under this section.

"(b) PLAN AMENDMENT REQUIRED.—A State making an election under subsection (a) shall submit a State plan amendment describing—

"(1) the category (or categories) of defined populations (otherwise eligible for medical assistance with respect to nursing facility services or home and community-based services or described in subsection (d)) with respect to whom this section shall apply;

"(2) the long-term care services (within the range of services described in subsection (c)(1)) for which medical assistance is available under the State plan for eligible individuals within each such category of individuals;

"(3) how the provision of such services, and expenditures under this section, will be coordinated with the provision of services and expenditures under part 1 of subtitle B of title II of the Health Security Act (relating to State programs for home and community-based services for individuals with disabilities); and

"(4) such other information as the Secretary determines as necessary to carry out this section.

"(c) CARE AND SERVICES.—

"(1) CONTINUUM OF CARE REQUIRED.—The services described in this paragraph shall represent a continuum of long-term care, and shall include (as appropriate based upon a plan of care described in paragraph (2))—

"(A) nursing facility services and other services described in section 1905(a),

"(B) home and community-based services described in section 1915(c) or 1915(d),

"(C) home and community care for functionally disabled elderly individuals described in section 1929, and

"(D) community supported living arrangements services (as defined in section 1930(a)).

"(2) PLAN OF CARE AND SERVICE EVALUATION.—A plan of care described in this paragraph shall—

"(A) be developed in consultation with the individual or, in the case of an individual incapable of participating in the development of the plan of care, the individual's family members or guardian;

"(C) be based on a comprehensive assessment of the individual's need for the continuum of services described in paragraph (1), and

"(D) be periodically updated based upon the individual's needs (but in no event less frequently than every 6 months).

"(3) INTAKE AND ASSESSMENT PROCESS.—A State shall use an intake and assessment process meeting standards established by the Secretary to develop the plan of care required under paragraph (2).

"(4) DISSEMINATION OF INFORMATION.—The State shall provide information about the availability of services under this section, and how to obtain them, in a manner that ensures that such information is widely disseminated to all eligible providers, agencies, and organizations providing services to the population of individuals receiving assistance under this section.

"(d) ADDITIONAL ELIGIBLE POPULATIONS.—

"(1) IN GENERAL.—A State may provide medical assistance under this section, in addition to individuals otherwise eligible for medical assistance, to individuals who would be so eligible but for—

"(A) failure to meet the disability criteria otherwise applicable, or

"(B) subject to paragraph (2), failure to meet income or resource requirements otherwise applicable.

"(2) LIMITATION ON INCOME.—A State may not provide under this subsection medical assistance to an individual whose income (as determined under section 1612 for purposes of the supplemental security income program) exceeds the greater of—

"(A) the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981), or

"(B) the maximum level of State supplementary payment under section 1616 (or under section 212 of Public Law 93-66).

"(e) RULES RELATING TO FEDERAL FINANCIAL PARTICIPATION.—

"(1) IN GENERAL.—With respect to medical assistance provided under this section for a category of individuals (specified under subsection (b)(1))—

"(A) the amount of medical assistance that may otherwise be taken into account in making payment under section 1903(a)(1) shall not exceed the amount specified in paragraph (2) for the category;

"(B) the amount of State expenditures (other than for medical assistance) that may otherwise be taken into account in making payment under section 1903(a) (other than paragraph (1)) shall not exceed the amount specified in paragraph (3) for the category; and

"(C) a State may include (as expenditures for medical assistance under the State plan) expenditures for room and board and other community-assisted residential services furnished in settings that meet standards established by the Secretary and that otherwise may not qualify as settings for which Federal financial participation is available under this title.

"(2) LIMIT ON MEDICAL ASSISTANCE.—The amount specified in this paragraph (for a calendar quarter or other period) is as follows:

"(A) BASE MEDICAL ASSISTANCE.—The total medical assistance provided under the State plan for the services described in subsection (c)(1) for the category of individuals in the base period (specified by the Secretary).

"(B) UPDATE.—The amount determined under subparagraph (A) shall be updated (to the calendar quarter or other period involved)—

"(i) for periods through fiscal year 2002, by the rate of growth (estimated by the Secretary) in the medical assistance described in subparagraph (A) under the State plan if the election in subsection (a) had not been made, and

"(ii) beginning in fiscal year 2003, by a factor (for each such fiscal year) equivalent to the product of the factors described in subparagraph (A) and (B) of section 2109(a)(2) of the Health Security Act for the fiscal year.

"(3) LIMIT ON ADMINISTRATION.—The amount specified in this paragraph is such amount as the State establishes, to the satisfaction of the Secretary, does not exceed the amount of expenditures that would have been made for administrative expenditures with respect to services covered under this section if the election in subsection (a) had not been made.

"(4) EFFECT ON ENTITLEMENT.—In the case of a State that has made an election under subsection (a), notwithstanding any other provision of this title, no individual is entitled to medical assistance under the State plan for nursing facility services and intermediate care facilities for the mentally retarded except as the State provides under this section.

"(f) OTHER REQUIREMENTS.—

"(1) SAFEGUARDS.—The State must establish necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under this section and to assure financial accountability of funds. Nothing in this section shall be construed as waiving requirements otherwise applicable under this title with respect to providers of covered services.

"(2) FINANCIAL COORDINATION.—The State must provide for the financial coordination of expenditures for medical assistance under this section with expenditures under any State program for home and community-based services for individuals with disabilities under part 1 of subtitle B of title II of the Health Security Act.".

SEC. 4214. INFORMING NURSING HOME RESIDENTS ABOUT AVAILABILITY OF ASSISTANCE FOR HOME AND COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking "and" at the end of paragraph (61),

(2) by striking the period at the end of paragraph (62) and inserting "; and", and

(3) by inserting after paragraph (62) the following new paragraph:

"(63) provide, in the case of an individual who is a resident (or who is applying to become a resident) of a nursing facility or intermediate care facility for the mentally retarded, at the time of application for medical assistance and periodically thereafter, the individual (or a designated representative) with information on the range of home and community-based services for which assistance is available in the State either under the plan under this title, under the program under part 1 of subtitle B of title II of the Health Security Act, or any other public program.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to quarters beginning on or after January 1, 1996.

PART 3—OTHER BENEFITS

SEC. 4221. TREATMENT OF ITEMS AND SERVICES NOT COVERED UNDER THE COMPREHENSIVE BENEFIT PACKAGE.

(a) CONTINUATION OF ELIGIBILITY FOR ASSISTANCE FOR AFDC AND SSI RECIPIENTS.—With respect to an individual who is described in section 1933(b) of the Social Security Act (as added by subsection (b)(1)), nothing in this Act shall be construed as—

(1) changing the eligibility of the individual for medical assistance under title XIX of the Social Security Act for items and services not covered under the comprehensive benefit package, or

(2) subject to the amendments made by this subtitle, changing the amount, duration, or scope of medical assistance required (or permitted) to be provided to the individual under such title.

(b) LIMITATION ON SCOPE OF ASSISTANCE FOR OTHER MEDICAID BENEFICIARIES.—

(1) IN GENERAL.—Title XIX, as amended by sections 4201 and 4213, is amended by redesignating section 1933 as section 1934 and by inserting after section 1932 the following new section:

"LIMITATION ON SCOPE OF ASSISTANCE FOR MOST NON-CASH BENEFICIARIES

"SEC 1933. (a) LIMITATION.—Notwithstanding any other provision of this title, the medical assistance made available under section 1902(a) to an individual not described in subsection (b) shall be limited to medical assistance for—

"(1) long-term care services (as defined in subsection (c)); and

"(2) medicare cost-sharing (as defined in section 1905(p)(3)), in accordance with the requirements of section 1902(a)(10)(E).

"(b) INDIVIDUALS EXEMPT FROM LIMITATION.—The individuals described in this subsection are the following:

"(1) AFDC recipients (as defined in section 1902(3) of the Health Security Act) 18 years of age or older.

"(2) SSI recipients (as defined in section 1902(33) of the Health Security Act) 18 years of age or older.

"(3) Individuals entitled to benefits under title XVIII.

"(c) LONG-TERM CARE SERVICES DEFINED.—In subsection (a), the term 'long-term care services' means the following items and services, but only to the extent they are not included as an item or service under the comprehensive benefit package under the Health Security Act:

"(1) Nursing facility services and intermediate care facility services for the mentally retarded (including items and services that may be included in such services pursuant to regulations in effect as of October 26, 1993).

"(2) Personal care services.

"(3) Home or community-based services provided under a waiver granted under subsection (c), (d), or (e) of section 1915.

"(4) Home and community care provided to functionally disabled elderly individuals under section 1929.

"(5) Community supported living arrangements services provided under section 1930.

"(6) Case-management services (as described in section 1915(g)(2)).

"(7) Home health care services, clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in paragraphs (1) through (6).

"(8) Hospice care.".

(2) CONFORMING AMENDMENT.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)), as amended by section 13603(c)(1) of OBRA-1993 and section 4211(b), is amended in the matter following subparagraph (G) (as inserted by section 4212(a))—

(A) by striking "and (XIV)" and inserting "(XIV)"; and

(B) by inserting before the semicolon at the end the following: ", and (XV) the medical assistance made available to an individual who is not described in section 1933(b) shall be limited in accordance with section 1933".

(c) CONFORMING AMENDMENTS RELATING TO SECONDARY PAYER.—(1) Section 1902(a)(25)(A) (42 U.S.C. 1396a(a)(25)(A)), as amended by section 13622(a) of OBRA-1993, is amended by inserting "health plans (as defined in section 1400 of the Health Security Act)," after "of 1974),".

(2) Section 1903(o) (42 U.S.C. 1396b(o)), as so amended, is amended by inserting "and a health plan (as defined in section 1400 of the Health Security Act)" after "of 1974)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished in a State on or after January 1 of the first year for which the State is a participating State under the Health Security Act.

SEC. 4222. ESTABLISHMENT OF PROGRAM FOR POVERTY-LEVEL CHILDREN WITH SPECIAL NEEDS.

(a) ESTABLISHMENT OF PROGRAM.—Title XIX, as amended by sections 4201 and 4213 and by subsection (b), is amended by redesignating section 1934 as section 1935 and by inserting after section 1933 the following new section:

"SERVICES FOR POVERTY-LEVEL CHILDREN WITH SPECIAL NEEDS

"SEC 1934. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established a program under which the Secretary shall make payments on behalf of each qualified child (as defined in subsection (b)) during a year for all medically necessary items and services described in section 1905(a) (including items and services described in section 1905(r) but excluding long-term care services described in section 1933(c)) that are not included in the comprehensive benefit package under subtitle B of title I of the Health Security Act.

"(b) QUALIFIED CHILD DEFINED.—

"(1) IN GENERAL.—In this section, a 'qualified child' is an eligible individual (as defined in section 1001(c)) who—

"(A) for years prior to 1998, is a resident of a participating State under the Health Security Act;

"(B) is under the age of 18; and

"(C) meets the requirements relating to financial eligibility described in paragraph (2).for kids over 6, is 100%: missing date; at 100% (vo. 133%); also excluded children eligible by virtue of medcailly needy;

"(2) REQUIREMENTS RELATING TO FINANCIAL ELIGIBILITY.—An individual meets the requirements of this paragraph if—

"(A) the individual is an AFDC recipient or an SSI recipient (as such terms are defined in section 1902 of the Health Security Act);

"(B) the individual is eligible to receive medical assistance under the State plan under section 1902(a)(10)(C); or

"(C) the individual is—

"(i) under one year of age and has adjusted family income at or below 133 percent of the applicable poverty level (as defined in section 1902(25)(A) of the Health Security Act) (or, in the case of a State that established an income level greater than 133 percent for individuals under 1 year of age for purposes of section 1902(l)(2)(A) as of October 1, 1993, an income level which is a percentage of such level not greater than 185 percent),

"(ii) the individual has attained 1 year of age but is under 6 years of age and has adjusted family income at or below 133 percent of the applicable poverty level (as defined in section 1902(25)(A) of the Health Security Act), or

"(iii) the individual was born after September 30, 1983, has attained 6 years of age, and has adjusted family income at or below 100 percent of the applicable poverty level (as defined in section 1902(25)(A) of the Health Security Act).

"(3) ENROLLMENT PROCEDURES.—

"(A) IN GENERAL.—Not later than July 1, 1995, the Secretary shall establish procedures for the enrollment of qualified children in the program under this section under which—

"(i) essential community providers certified by the Secretary under subpart B of part 2 of subtitle F of title I of the Health Security Act serve as enrollment sites for the program; and

"(ii) any forms used for enrollment purposes are designed to make the enrollment as simple as practicable.

"(B) INDIVIDUALS UNDER ALLIANCE PLANS AUTOMATICALLY ENROLLED.—The Secretary shall establish a process under which an individual who is a qualified child under paragraph (1) and is enrolled in an alliance health plan (as defined in section 1300 of the Health Security Act) shall automatically be deemed to have met any enrollment requirements established under paragraph (1).

"(c) ADDITIONAL RESPONSIBILITIES OF SECRETARY.—Not later than July 1, 1995, the Secretary shall promulgate such regulations as are necessary to establish and operate the program under this section, including regulations with respect to the following:

"(1) The benefits to be provided and the circumstances under which such benefits shall be considered medically necessary.

"(2) Procedures for the periodic redetermination of an individual's eligibility for benefits.

"(3) Qualification criteria for providers participating in the program.

"(4) Payment amounts for services provided under the program, the methodology used to determine such payment amounts, and the procedures for making payments to providers.

"(5) Standards to ensure the quality of services and the coordination of services under the program with services under the comprehensive benefit package, as well as services under parts B and H of the Individuals With Disabilities Education Act, title V, and any other program providing health care, remedial, educational, and social services to qualified children as the Secretary may identify.

"(6) Hearing and appeals for individuals adversely affected by any determination by the Secretary under the program.

"(7) Such other requirements as the Secretary determines to be necessary for the proper and efficient administration of the program.

"(d) FEDERAL PAYMENT FOR PROGRAM.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall pay 100 percent of the costs of providing benefits under this program in a year, including all administrative expenses.

"(2) ANNUAL LIMIT ON EXPENDITURES.—The total amount of Federal expenditures that may be made under this section in a year may not exceed—

"(A) for a year prior to 1998, an amount equal to the percentage of total expenditures

for medical assistance under State plans under this title during fiscal year 1993 for services described in subsection (a) furnished to qualified children that is attributable to States in which the program is in operation during the year (adjusted to take into account the operation of the program under this section on a calendar year basis)—

"(i) adjusted to take into account any increases or decreases in the number of qualified children under the most recent decennial census, as adjusted by the most recent current population survey for the year in question, and

"(ii) adjusted by the applicable percentage applied to the State non-cash baseline amount for the year under section 9003(a) of the Health Security Act; and

"(B) for 1998, the total expenditures for medical assistance under State plans under this title during 1993 for services described in subsection (a) furnished to qualified children (adjusted to take into account the operation of the program under this section on a calendar year basis)—

"(i) adjusted to take into account any increases or decreases in the number of qualified children under the most recent decennial census, as adjusted by the most recent current population survey for the year in question, and

"(ii) adjusted by the update applied to the State non-cash baseline amount for the year under section 9003(b) of the Health Security Act; and

"(C) for each succeeding year, the limit established under this paragraph for the previous year (adjusted to take into account the operation of the program under this section on a calendar year basis), adjusted by the update applied to the State non-cash baseline amount for the year under section 9003(b) of the Health Security Act.".

(b) REPEAL OF ALTERNATIVE ELIGIBILITY STANDARDS FOR CHILDREN IN PARTICIPATING STATES.—Section 1902(r)(2) (42 U.S.C. 1396a(r)(2)) is amended by adding at the end the following new subparagraph:

"(C) Subparagraph (A) shall not apply with respect to the determination of income and resources for children under age 18 under the State plan of a State (other than under the State plan of a State that utilized an alternative methodology pursuant to such subparagraph as of October 1, 1993)—

"(i) in the case of a State that is a participating State under the Health Security Act for a year prior to 1998, for quarters beginning on or after January 1 of the first year for which the State is such a participating State; and

"(ii) in the case of any State not described in clause (i), for quarters beginning on or after January 1, 1998.".

PART 4—DISCONTINUATION OF CERTAIN PAYMENT POLICIES

SEC. 4231. DISCONTINUATION OF MEDICAID DSH PAYMENTS.

(a) ELIMINATION OF SPECIFIC OBLIGATION.—Section 1923(a) (42 U.S.C. 1396r-4(a)) is amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, the requirement of this subsection shall not apply—

"(A) with respect to a State for any portion of a fiscal year during which the State is a participating State within the meaning of section 1200 of the Health Security Act; or

"(B) with respect to any State for any months beginning on or after January 1, 1997.".

(b) ELIMINATION OF STATE PLAN REQUIREMENT.—Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)) is amended by inserting after "special needs" the following: "(but only with respect to a quarters during which the State is not a participating State within the meaning of section 1200 of the Health Security Act or with respect to any quarters ending on or before December 31, 1996)".

(c) ELIMINATION OF STATE DSH ALLOTMENTS AND FEDERAL FINANCIAL PARTICIPATION.—Section 1923(f) (42 U.S.C. 1396r-4(f)) is amended—

(1) in paragraph (2), by inserting "and paragraph (5)" after "subparagraph (B)", and

(2) by adding at the end the following new paragraph:

"(5) ELIMINATION OF ALLOTMENTS FOR PARTICIPATING STATES AND SUNSET FOR ALL STATES.—

"(A) IN GENERAL.—Notwithstanding any other provision of this section, the State DSH allotment shall be zero with respect to—

"(i) any participating State within the meaning of section 1200 of the Health Security Act; and

"(ii) any State for any portion of a fiscal year that occurs on or after January 1, 1997.

"(B) NO REDISTRIBUTION OF REDUCTIONS.—In the computation of State supplemental amounts under paragraph (3), the State DSH allotments shall be determined under subparagraph (A)(ii) of such paragraph as if this paragraph did not apply.".

SEC. 4232. DISCONTINUATION OF REIMBURSEMENT STANDARDS FOR INPATIENT HOSPITAL SERVICES.

Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)), as amended by section 4231(b), is amended by inserting "(in the case of services other than hospital services in a State that is a participating State under the Health Security Act)" before "are reasonable and adequate".

PART 5—COORDINATION WITH ADMINISTRATIVE SIMPLIFICATION AND QUALITY MANAGEMENT INITIATIVES

SEC. 4241. REQUIREMENTS FOR CHANGES IN BILLING PROCEDURES.

(a) LIMITATION ON FREQUENCY OF SYSTEM CHANGES; ADVANCE NOTIFICATION TO PROVIDERS.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 4213, is amended—

(1) by striking "and" at the end of paragraph (62),

(2) by striking the period at the end of paragraph (63) and inserting "; and", and

(3) by inserting after paragraph (63) the following new paragraph:

"(64) provide that the State—

"(A) will not implement any change in the system used for the billing and processing of claims for payment for items and services furnished under the State plan within 6 months of implementing any previous change in such system; and

"(B) shall notify individuals and entities providing medical assistance under the State plan of any major change in the procedures for billing for services furnished under the plan at least 120 days before such change is to take effect.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to a State as of January 1 of the first year for which the State is a participating State.

PART 6—MEDICAID COMMISSION

SEC. 4251. MEDICAID COMMISSION.

(a) ESTABLISHMENT.—There is established a commission to be known as the "Medicaid Commission" (in this section referred to as the "Commission").

(b) MEMBERSHIP.—(1) The Commission shall be composed of 15 members appointed by the Secretary for the life of the Commission.

(2) Members shall include representatives of the Federal Government and State Governments.

(3) The Administrator of the Health Care Financing Administration shall be an ex officio member of the Commission.

(4) Individuals, while serving as members of the Commission, shall not be entitled to compensation, other than travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(c) STUDY.—The Commission shall study options with respect to each of the following in relation to the medicaid program under title XIX of the Social Security Act:

(1) USE OF BLOCK GRANT.—Whether, and (if so) how, to convert payments for services not covered in the comprehensive benefit package (for all recipients, including AFDC and SSI recipients defined in section 1902 of the Health Security Act) into new financing mechanisms that give the States greater flexibility in targeting and delivering needed services.

(2) INTEGRATION OF ACUTE AND LONG-TERM CARE SERVICES FOR HEALTH PLANS.—Whether, and (if so) how, to integrate long-term care services and the home and community-based services program under part 1 of subtitle B of title II with the services covered under the comprehensive benefit package offered by health plans.

(3) CONSOLIDATING INSTITUTIONAL AND HOME AND COMMUNITY-BASED LONG-TERM CARE.—Whether, and (if so) how, to offer States an option to combine together expenditures under the home and community-based services program (under part 1 of subtitle B of title II) with continuing home and community-based services and institutional care under the medicaid program into a global budget for long-term care services, and how such a combined program could be implemented.

(d) REPORT AND RECOMMENDATIONS.—The Commission shall submit to the Secretary and the National Health Board, not later than 1 year after the date of the enactment of this Act, a report on its study under subsection (c). The Commission shall include in such report such recommendations for changes in the medicaid program, and the programs under this Act, as it deems appropriate.

(e) OPERATIONS.—(1) The Commission shall appoint a chair from among its members.

(2) Upon request of the Chair of the Commission, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of that department or agency to the Commission to assist it in carrying out its duties under this section.

(3) The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chair of the Commission, the head of that department or agency shall furnish that information to the Commission.

(4) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(e) TERMINATION.—The Commission shall terminate 90 days after the date of submission of its report under subsection (d).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriate such sums as may be necessary to carry out this section.

Subtitle D—Increase in SSI Personal Needs Allowance

SEC. 4301. INCREASE IN SSI PERSONAL NEEDS ALLOWANCE.

(a) IN GENERAL.—Section 1611(e)(1)(B) (42 U.S.C. 1382(e)(1)(B)) is amended—

(1) in clauses (i) and (ii)(I), by striking "$360" and inserting "$840"; and

(2) in clause (iii), by striking "$720" and inserting "$1,680".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to months beginning with January 1996.

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Subtitle A—Quality Management and Improvement

SEC. 5001. NATIONAL QUALITY MANAGEMENT PROGRAM.

Not later than 1 year after the date of the enactment of this Act, the National Health Board shall establish and oversee a performance-based program of quality management and improvement designed to enhance the quality, appropriateness, and effectiveness of health care services and access to such services. The program shall be known as the National Quality Management Program and shall be administered by the National Quality Management Council established under section 5002.

SEC. 5002. NATIONAL QUALITY MANAGEMENT COUNCIL.

(a) ESTABLISHMENT.—There is established a council to be known as the National Quality Management Council.

(b) DUTIES.—The Council shall—

(1) administer the National Quality Management Program;

(2) perform any other duty specified as a duty of the Council in this subtitle; and

(3) advise the National Health Board with respect to its duties under this subtitle.

(c) NUMBER AND APPOINTMENT.—The Council shall be composed of 15 members appointed by the President. The Council shall consist of members who are broadly representative of the population of the United States and shall include—

(1) individuals representing the interests of governmental and corporate purchasers of health care;

(2) individuals representing the interests of health plans;

(3) individuals representing the interests of States;

(4) individuals representing the interests of health care providers and academic health centers (as defined in section 3101(c)); and

(5) individuals distinguished in the fields of public health, health care quality, and related fields of health services research.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council shall serve for a term of 3 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (c), the President shall appoint 5 members to serve for a term of 3 years, 5 members to serve for a term of 2 years, and 5 members to serve for a term of 1 year.

(3) SERVICE BEYOND TERM.—A member of the Council may continue to serve after the

expiration of the term of the member until a successor is appointed.

(e) VACANCIES.—If a member of the Council does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(f) CHAIR.—The President shall designate an individual to serve as the chair of the Council.

(g) MEETINGS.—The Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the President or the chair.

(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Council shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(i) STAFF.—The National Health Board shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(j) HEALTH CARE PROVIDER.—For purposes of this subtitle, the term "health care provider" means an individual who, or entity that, provides an item or service to an individual that is covered under the health plan (as defined in section 1400) in which the individual is enrolled.

SEC. 5003. NATIONAL MEASURES OF QUALITY PERFORMANCE.

(a) IN GENERAL.—The National Quality Management Council shall develop a set of national measures of quality performance, which shall be used to assess the provision of health care services and access to such services.

(b) SUBJECT OF MEASURES.—National measures of quality performance shall be selected in a manner that provides information on the following subjects:

(1) Access to health care services by consumers.

(2) Appropriateness of health care services provided to consumers.

(3) Outcomes of health care services and procedures.

(4) Health promotion.

(5) Prevention of diseases, disorders, and other health conditions.

(6) Consumer satisfaction with care.

(c) SELECTION OF MEASURES.—

(1) CONSULTATION.—In developing and selecting the national measures of quality performance, the National Quality Management Council shall consult with appropriate interested parties, including—

(A) States;

(B) health plans;

(C) employers and individuals purchasing health care through regional and corporate alliances;

(D) health care providers;

(E) the National Quality Consortium established under section 5009;

(F) individuals distinguished in the fields of law, medicine, economics, public health, and health services research;

(G) the Administrator for Health Care Policy and Research;

(H) the Director of the National Institutes of Health; and

(I) the Administrator of the Health Care Financing Administration.

(2) CRITERIA.—The following criteria shall be used in developing and selecting national measures of quality performance:

(A) SIGNIFICANCE.—When a measure relates to a specific disease, disorder, or other health condition, the disease, disorder, or condition shall be of significance in terms of prevalence, morbidity, mortality, or the costs associated with the prevention, diagnosis, treatment, or clinical management of the disease, disorder, or condition.

(B) RANGE OF SERVICES.—The set of measures, taken as a whole, shall be representative of the range of services provided to consumers of health care by the individuals and entities described in subsection (a).

(C) RELIABILITY AND VALIDITY.—The measures shall be reliable and valid.

(D) UNDUE BURDEN.—The data needed to calculate the measures shall be obtained without undue burden on the entity or individual providing the data.

(E) VARIATION.—Performance with respect to measures that are applicable to each category of individual or entity described in subsection (a) shall be expected to vary widely among individuals or entities in the category.

(F) LINKAGE TO HEALTH OUTCOME.—When a measure is a rate of a process of care, the process shall be linked to a health outcome based upon the best available scientific evidence.

(G) PROVIDER CONTROL AND RISK ADJUSTMENT.—When a measure is an outcome of the provision of care, the outcome shall be within the control of the provider and one with respect to which an adequate risk adjustment can be made.

(H) PUBLIC HEALTH.—The measures may incorporate standards identified by the Secretary of Health and Human Services for meeting public health objectives.

(d) UPDATING.—The National Quality Management Council shall review and update the set of national measures of quality performance annually to reflect changing goals for quality improvement. The Board shall establish and maintain a priority list of performance measures that within a 5-year period it intends to consider for inclusion within the set through the updating process.

SEC. 5004. CONSUMER SURVEYS.

(a) IN GENERAL.—The National Quality Management Council shall conduct periodic surveys of health care consumers to gather information concerning access to care, use of health services, health outcomes, and patient satisfaction. The surveys shall monitor consumer reaction to the implementation of this Act and be designed to assess the impact of this Act on the general population of the United States and potentially vulnerable populations.

(b) SURVEY ADMINISTRATION.—The National Quality Management Council shall develop and approve a standard design for the surveys, which shall be administered by the Administrator for Health Care Policy and Research on a plan-by-plan and State-by-State basis. A State may add survey questions on quality measures of local interest to surveys conducted in the State.

(c) SAMPLING STRATEGIES.—The National Quality Management Council shall develop sampling strategies that ensure that survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care and may be difficult to reach through consumer-sampling methods, including individuals who—

(1) fail to enroll in a health plan;

(2) resign from a plan; or

(3) are members of a vulnerable population.

SEC. 5005. EVALUATION AND REPORTING OF QUALITY PERFORMANCE.

(a) NATIONAL GOALS.—In subject matter areas with respect to which the National Quality Management Council determines that sufficient information and consensus exist, the Council will recommend to the Board that it establish goals for performance by health plans and health care providers on a subset of the set of national measures of quality performance.

(b) IMPACT OF REFORM.—The National Quality Management Council shall evaluate the impact of the implementation of this Act on the quality of health care services in the United States and the access of consumers to such services.

(c) PERFORMANCE REPORTS.—

(1) ALLIANCE AND HEALTH PLAN REPORTS.—Each health alliance annually shall publish and make available to the public a performance report outlining in a standard format the performance of each health plan offered in the alliance on the set of national measures of quality performance. The report shall include the results of a smaller number of such measures for health care providers who are members of provider networks of such plans (as defined in section 1402(f)), if the available information is statistically meaningful. The report also shall include the results of consumer surveys described in section 5004 that were conducted in the alliance during the year that is the subject of the report.

(2) NATIONAL QUALITY REPORTS.—The National Quality Management Council annually shall provide to the Congress and to each health alliance a report that—

(A) outlines in a standard format the performance of each regional alliance, corporate alliance, and health plan;

(B) discusses State-level and national trends relating to health care quality; and

(C) presents data for each health alliance from consumer surveys described in section 5004 that were conducted during the year that is the subject of the report.

SEC. 5006. DEVELOPMENT AND DISSEMINATION OF PRACTICE GUIDELINES.

(a) DEVELOPMENT OF GUIDELINES.—

(1) IN GENERAL.—The National Quality Management Council shall direct the Administrator for Health Care Policy and Research to develop and periodically review and update clinically relevant guidelines that may be used by health care providers to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

(2) CERTAIN REQUIREMENTS.—Guidelines under paragraph (1) shall—

(A) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures;

(B) be presented in formats appropriate for use by health care providers, medical educators, medical review organizations, and consumers of health care;

(C) include treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care;

(D) include information on risks and benefits of alternative strategies for prevention, diagnosis, treatment, and management of a given disease, disorder, or other health condition;

(E) include information on the costs of alternative strategies for the prevention, diagnosis, treatment, and management of a given disease, disorder, or other health condition, where cost information is available and reliable; and

(F) be developed in accordance with priorities that shall be established by the National Quality Management Council based on the research priorities that are established under section 5007(b) and the 5-year priority list of performance measures described in section 5003(d).

(3) HEALTH SERVICE UTILIZATION PROTOCOLS.—The National Quality Management Council shall establish standards and procedures for evaluating the clinical appropriateness of protocols used to manage health service utilization.

(4) USE IN MEDICAL MALPRACTICE LIABILITY PILOT PROGRAM.—Guidelines developed under this subsection may be used by the Secretary of Health and Human Services in the pilot program applying practice guidelines to medical malpractice liability under section 5312.

(b) EVALUATION AND CERTIFICATION OF OTHER GUIDELINES.—

(1) METHODOLOGY.—The National Quality Management Council shall direct the Administrator for Health Care Policy and Research to develop and publish standards relating to methodologies for developing the types of guidelines described in subsection (a)(1).

(2) EVALUATION AND CERTIFICATION.—The National Quality Management Council shall direct the Administrator for Health Care Policy and Research to establish a procedure by which individuals and entities may submit guidelines of the type described in subsection (a)(1) to the Council for evaluation and certification by the Council using the standards developed under paragraph (1).

(3) USE IN MEDICAL MALPRACTICE LIABILITY PILOT PROGRAM.—Guidelines certified under paragraph (2) may be used by the Secretary of Health and Human Services in the pilot program applying practice guidelines to medical malpractice liability under section 5312.

(c) GUIDELINE CLEARINGHOUSE.—The National Quality Management Council shall direct the Administrator for Health Care Policy and Research to establish and oversee a clearinghouse and dissemination program for practice guidelines that are developed or certified under this section.

(d) DISSEMINATION OF INFORMATION ON INEFFECTIVE TREATMENTS.—The National Quality Management Council shall disseminate information documenting clinically ineffective treatments and procedures.

SEC. 5007. RESEARCH ON HEALTH CARE QUALITY.

(a) RESEARCH SUPPORT.—The National Quality Management Council shall direct the Administrator for Health Care Policy and Research to support research directly related to the 5-year priority list of performance measures described in section 5003(d), including research with respect to—

(1) outcomes of health care services and procedures;

(2) effective and efficient dissemination of information, standards, and guidelines;

(3) methods of measuring quality and shared decisionmaking; and

(4) design and organization of quality of care components of automated health information systems.

(b) RESEARCH PRIORITIES.—The National Quality Management Council shall establish priorities for research with respect to the quality, appropriateness, and effectiveness of health care and make recommendations concerning research projects. In establishing the priorities, the National Quality Management Council shall emphasize research involving diseases, disorders, and health conditions as to which—

(1) there is the highest level of uncertainty concerning treatment;

(2) there is the widest variation in practice patterns;

(3) the costs associated with prevention, diagnosis, treatment, or clinical management are significant; and

(4) the rate of incidence or prevalence is high for the population as a whole or for particular subpopulations.

SEC. 5008. REGIONAL PROFESSIONAL FOUNDATIONS.

(a) ESTABLISHMENT.—The National Health Board shall establish and oversee regional professional foundations to perform the duties specified in subsection (c).

(b) STRUCTURE AND MEMBERSHIP.—

(1) IN GENERAL.—The National Quality Consortium established under section 5009 shall oversee the establishment of regional professional foundations, the membership requirements for each foundation, and any other requirement for the internal operation of each foundation.

(2) ENTITIES ELIGIBLE FOR MEMBERSHIP.—Each regional professional foundation shall include at least one academic health center (as defined in section 3101(c)). The following entities also shall be eligible to serve as members of the regional professional foundation for the region in which the entity is located:

(A) Schools of public health (as defined in section 799 of the Public Health Service Act).

(B) Other schools and programs defined in such section.

(C) Health plans.

(D) Regional alliances.

(E) Corporate alliances.

(F) Health care providers.

(c) DUTIES.—A regional professional foundation shall carry out the following duties for the region in which the foundation is located (such region to be demarcated by the National Health Board with the advice of the National Quality Consortium established under section 5009):

(1) Developing programs in lifetime learning for health professionals (as defined in section 1112(c)(1)) to ensure the delivery of quality health care.

(2) Fostering collaboration among health plans and health care providers to improve the quality of primary and specialized health care.

(3) Disseminating information about successful quality improvement programs, practice guidelines, and research findings.

(4) Disseminating information on innovative uses of health professionals.

(5) Developing innovative patient education systems that enhance patient involvement in decisions relating their health care.

(6) Applying for and conducting research described in section 5007.

(d) PROGRAMS IN LIFETIME LEARNING.—The programs described in subsection (c)(1) shall ensure that health professionals remain abreast of new knowledge, acquire new skills, and adopt new roles as technology and societal demands change.

SEC. 5009. NATIONAL QUALITY CONSORTIUM.

(a) ESTABLISHMENT.—The National Health Board shall establish a consortium to be known as the National Quality Consortium.

(b) DUTIES.—The Consortium shall—

(1) establish programs for continuing education for health professionals;

(2) advise the National Quality Management Council and the Administrator for Health Care Policy and Research on research priorities;

(3) oversee the development of the regional professional foundations established under section 5008;

(4) advise the National Quality Management Council with respect to the funding of proposals to establish such foundations;

(5) consult with the National Quality Management Council regarding the selection of national measures of quality performance under section 5003(c); and

(6) advise the National Health Board and the National Quality Management Council with respect to any other duty of the Board or the Council under this subtitle.

(c) MEMBERSHIP.—The Consortium shall be composed of 11 members appointed by the National Health Board. The members of the Consortium shall include—

(1) 5 individuals representing the interests of academic health centers; and

(2) 6 other individuals representing the interests of one of the following persons:

(A) Schools of public health.

(B) Other schools and programs defined in section 799 of the Public Health Service Act (including medical schools, nursing schools, and allied health professional schools).

(d) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Consortium shall serve for a term of 3 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Consortium under subsection (c), the National Health Board shall appoint 4 members to serve for a term of 3 years, 3 members to serve for a term of 2 years, and 4 members to serve for a term of 1 year.

(e) CHAIR.—The National Health Board shall designate an individual to serve as the chair of the Consortium.

SEC. 5010. ELIMINATING CLIA REQUIREMENT FOR CERTIFICATE OF WAIVER FOR SIMPLE LABORATORY EXAMINATIONS AND PROCEDURES.

(a) IN GENERAL.—Section 353 of the Public Health Service Act (42 U.S.C. 263a) is amended—

(1) in subsection (b), by inserting before the period at the end the following: "or unless the laboratory is exempt from the certificate requirement under subsection (d)(2)";

(2) by amending paragraph (2) of subsection (d) to read as follows:

"(2) EXEMPTION FROM CERTIFICATE REQUIREMENT FOR LABORATORIES PERFORMING ONLY SIMPLE EXAMINATIONS AND PROCEDURES.—A laboratory which performs only laboratory examinations and procedures described in paragraph (3) is not required to have in effect a certificate under this section."; and

(3) by striking paragraph (4) of subsection (d).

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first month beginning after the date of the enactment of this Act.

SEC. 5012. ROLE OF ALLIANCES IN QUALITY ASSURANCE.

Each regional alliance and each corporate alliance shall—

(1) disseminate to consumers information related to quality and access to aid in their selection of plans in accordance with section 1325;

(2) disseminate information on the quality of health plans and health care providers contained in reports of the National Quality Management Council section 5005(d);

(3) ensure through negotiations with health plans that performance and quality standards are continually improved; and

(4) conduct educational programs in cooperation with regional quality foundations to assist consumers in using quality and other information in choosing health plans.

SEC. 5013. ROLE OF HEALTH PLANS IN QUALITY MANAGEMENT.

Each health plan shall—

(1) measure and disclose performance on quality measures used by—

(A) participating States in which the plan does business;

(B) regional alliances and corporate alliances that offer the plan; and

(C) the National Quality Management Council;

(2) furnish information required under subtitle B of this title and provide such other reports and information on the quality of care delivered by health care providers who are members of a provider network of the plan (as defined in section 1402(f)) as may be required under this Act; and

(3) maintain quality management systems that—

(A) use the national measures of quality performance developed by the National Quality Management Council under section 5003; and

(B) measure the quality of health care furnished to enrollees under the plan by all health care providers who are members of a provider network of the plan.

Subtitle B—Information Systems, Privacy, and Administrative Simplification

PART 1—HEALTH INFORMATION SYSTEMS

SEC. 5101. ESTABLISHMENT OF HEALTH INFORMATION SYSTEM.

(a) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the National Health Board shall develop and implement a health information system by which the Board shall collect, report, and regulate the collection and dissemination of the health care information described in subsection (e) pursuant to standards promulgated by the Board and (if applicable) consistent with policies established as part of the National Information Infrastructure Act of 1993.

(b) PRIVACY.—The health information system shall be developed and implemented in a manner that is consistent with the privacy and security standards established under section 5120.

(c) REDUCTION IN ADMINISTRATIVE COSTS.—The health information system shall be developed and implemented in a manner that is consistent with the objectives of reducing wherever practicable and appropriate—

(1) the costs of providing and paying for health care;

(2) the time, effort, and financial resources expended by persons to provide information to States and the Federal Government.

(d) USES OF INFORMATION.—The health care information described in subsection (e) shall be collected and reported in a manner that facilitates its use for the following purposes:

(1) Health care planning, policy development, policy evaluation, and research by Federal, State, and local governments and regional and corporate alliances.

(2) Establishing and monitoring payments for health services by the Federal Government, States, regional alliances, and corporate alliances.

(3) Assessing and improving the quality of health care.

(4) Measuring and optimizing access to health care.

(5) Evaluating the cost of specific clinical or administrative functions.

(6) Supporting public health functions and objectives.

(7) Improving the ability of health plans, health care providers, and consumers to coordinate, improve, and make choices about health care.

(8) Managing and containing costs at the alliance and plan levels.

(e) HEALTH CARE INFORMATION.—The health care information referred to in subsection (a) shall include data on—

(1) enrollment and disenrollment in health plans;

(2) clinical encounters and other items and services provided by health care providers;

(3) administrative and financial transactions and activities of participating States, regional alliances, corporate alliances, health plans, health care providers, employers, and individuals that are necessary to determine compliance with this Act or an Act amended by this Act;

(4) the characteristics of regional alliances, including the number, and demographic characteristics of eligible individuals residing in each alliance area;

(5) the characteristics of corporate alliances, including the number, and demographic characteristics of individuals who are eligible to be enrolled in each corporate alliance health plan and individuals with respect to whom a large employer has exercised an option under section 1311 to make ineligible for such enrollment;

(6) terms of agreement between health plans and the health care providers who are members of provider networks of the plans (as defined in section 1402(f));

(7) payment of benefits in cases in which benefits may be payable under a health plan and any other insurance policy or health program;

(8) utilization management by health plans and health care providers;

(9) the information collected and reported by the Board or disseminated by other individuals or entities as part of the National Quality Management Program under subtitle A;

(10) grievances filed against regional alliances, corporate alliances, and health plans and the resolutions of such grievances; and

(11) any other fact that may be necessary to determine whether a health plan or a health care provider has complied with a Federal statute pertaining to fraud or misrepresentation in the provision or purchasing of health care or in the submission of a claim for benefits or payment under a health plan.

SEC. 5102. ADDITIONAL REQUIREMENTS FOR HEALTH INFORMATION SYSTEM.

(a) CONSULTATION.—The health information system shall be developed in consultation with—

(1) Federal agencies that—

(A) collect health care information;

(B) oversee the collection of information or records management by other Federal agencies;

(C) directly provide health care services;

(D) provide for payments for health care services; or

(E) enforce a provision of this Act or any Act amended by this Act;

(2) the National Quality Management Council established under section 5002;

(3) participating States;

(4) regional alliances and corporate alliances;

(5) health plans;

(6) representatives of health care providers;

(7) representatives of employers;

(8) representatives of consumers of health care;

(9) experts in public health and health care information and technology; and

(10) representatives of organizations furnishing health care supplies, services, and equipment.

(b) COLLECTION AND TRANSMISSION REQUIREMENTS.—In establishing standards under section 5101, the National Health Board shall specify the form and manner in which individuals and entities are required to collect or transmit health care information for or to the Board. The Board also shall specify the frequency with which individuals and entities are required to transmit such information to the Board. Such specifications shall include, to the extent practicable—

(1) requirements for use of uniform paper forms containing standard data elements, definitions, and instructions for completion in cases where the collection or transmission of data in electronic form is not specified by the Board;

(2) requirements for use of uniform health data sets with common definitions to standardize the collection and transmission of data in electronic form;

(3) uniform presentation requirements for data in electronic form; and

(4) electronic data interchange requirements for the exchange of data among automated health information systems.

(c) PREEMPTION OF STATE "PEN & QUILL" LAWS.—A standard established by the National Health Board relating to the form in which medical or health plan records are required to be maintained shall supercede any contrary provision of State law, except where the Board determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

SEC. 5103. ELECTRONIC DATA NETWORK.

(a) IN GENERAL.—As part of the health information system, the National Health Board shall oversee the establishment of an electronic data network consisting of regional centers that collect, compile, and transmit information.

(b) CONSULTATION.—The electronic data network shall be developed in consultation with—

(1) Federal agencies that—

(A) collect health care information;

(B) oversee the collection of information or records management by other Federal agencies;

(C) directly provide health care services;

(D) provide for payments for health care services; or

(E) enforce a provision of this Act or any Act amended by this Act;

(2) the National Quality Management Council established under section 5002;

(3) participating States;

(4) regional alliances and corporate alliances; and

(5) health plans.

(c) DEMONSTRATION PROJECTS.—The electronic data network shall be tested prior to full implementation through the establishment of demonstration projects.

(d) DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE INFORMATION.—The electronic data network may be used to disclose individually identifiable health information (as defined in section 5123(3)) to any individual or entity only in accordance with the health information system privacy standards promulgated by the National Health Board under section 5120.

SEC. 5104. UNIQUE IDENTIFIER NUMBERS.

(a) IN GENERAL.—As part of the health information system, the Board shall establish a system to provide for a unique identifier number for each—

(1) eligible individual;

(2) employer;

(3) health plan; and

(4) health care provider.

(b) IMPERMISSIBLE DATA LINKS.—In establishing the system under subsection (a), the National Health Board shall ensure that a unique identifier number may not be used to connect individually identifiable health information (as defined in section 5123(3)) that is collected as part of the health information system or that otherwise may be accessed through the number with individually identifiable information from any other source, except in cases where the National Health Board determines that such connection is necessary to carry out a duty imposed on any individual or entity under this Act.

(c) PERMISSIBLE USES OF IDENTIFIER.—The National Health Board shall by regulation establish the purposes for which a unique identifier number provided pursuant to this section may be used.

SEC. 5105. HEALTH SECURITY CARDS.

(a) PERMISSIBLE USES OF CARD.—A health security card that is issued to an eligible individual under section 1001(b) may be used by an individual or entity, in accordance with regulations promulgated by the Board, only for the purpose of providing or assisting the eligible individual in obtaining an item or service that is covered under—

(1) the applicable health plan in which the individual is enrolled (as defined in section 1902);

(2) a policy consisting of a supplemental health benefit policy (described in part 2 of subtitle E of title I), a cost sharing policy (described in such part), or both;

(3) a FEHBP supplemental plan (described in subtitle C of title VIII);

(4) a FEHBP medicare supplemental plan (described in such subtitle); or

(5) such other programs as the Board may specify.

(b) FORM OF CARD AND ENCODED INFORMATION.—The National Health Board shall establish standards respecting the form of health security cards and the information to be encoded in electronic form on the cards. Such information shall include—

(1) the identity of the individual to whom the card is issued;

(2) the applicable health plan in which the individual is enrolled;

(3) any policy described in paragraph (2), (3), or (4) of subsection (a) in which the individual is enrolled; and

(4) any other information that the National Health Board determines to be necessary in order for the card to serve the purpose described in subsection (a).

(c) UNIQUE IDENTIFIER NUMBERS.—The unique identifier number system developed by the National Health Board under section 5104 shall be used in encoding the information described in subsection (b).

(d) REGISTRATION OF CARD.—The Board shall take appropriate steps to register the card, the name of the card, and other indicia relating to the card as a trademark or service mark (as appropriate) under the Trademark Act of 1946. For purposes of this subsection, the "Trademark Act of 1946" refers to the Act entitled "An Act to provide for the registration and protection of trademarks used in commerce, to carry out the provisions of international conventions, and for other purposes", approved July 5, 1946 (15 U.S.C. et seq.).

(e) REFERENCE TO CRIME.—For a provision relating to criminal penalties for misuse of a health security card or a unique identifier number, see section 5438.

SEC. 5106. TECHNICAL ASSISTANCE IN THE ESTABLISHMENT OF HEALTH INFORMATION SYSTEMS.

The National Health Board shall provide information and technical assistance to participating States, regional alliances, corporate alliances, health plans, and health care providers with respect to the establishment and operation of automated health information systems. Such assistance shall focus on—

(1) the promotion of community-based health information systems; and

(2) the promotion of patient care information systems that collect data at the point of care or as a by-product of the delivery of care.

PART 2—PRIVACY OF INFORMATION

SEC. 5120. HEALTH INFORMATION SYSTEM PRIVACY STANDARDS.

(a) HEALTH INFORMATION SYSTEM STANDARDS.—Not later than 2 years after the date of the enactment of this Act, the National Health Board shall promulgate standards respecting the privacy of individually identifiable health information that is in the health information system described in part 1 of this subtitle. Such standards shall include standards concerning safeguards for the security of such information. The Board shall develop and periodically revise the standards in consultation with—

(1) Federal agencies that—

(A) collect health care information;

(B) oversee the collection of information or records management by other Federal agencies;

(C) directly provide health care services;

(D) provide for payments for health care services; or

(E) enforce a provision of this Act or any Act amended by this Act;

(2) the National Quality Management Council established under section 5002;

(3) participating States;

(4) regional alliances and corporate alliances;

(5) health plans; and

(6) representatives of consumers of health care.

(b) INFORMATION COVERED.—The standards established under subsection (a) shall apply to individually identifiable health information collected for or by, reported to or by, or the dissemination of which is regulated by, the National Health Board under section 5101.

(c) PRINCIPLES.—The standards established under subsection (a) shall incorporate the following principles:

(1) UNAUTHORIZED DISCLOSURE.—All disclosures of individually identifiable health information by an individual or entity shall be unauthorized unless—

(A) the disclosure is by the enrollee identified in the information or whose identity can be associated with the information;

(B) the disclosure is authorized by such enrollee in writing in a manner prescribed by the Board;

(C) the disclosure is to Federal, State, or local law enforcement agencies for the purpose of enforcing this Act or an Act amended by this Act; or

(D) the disclosure otherwise is consistent with this Act and specific criteria governing disclosure established by the Board.

(2) MINIMAL DISCLOSURE.—All disclosures of individually identifiable health information shall be restricted to the minimum amount of information necessary to accomplish the purpose for which the information is being disclosed.

(3) RISK ADJUSTMENT.—No individually identifiable health information may be provided by a health plan to a regional alliance or a corporate alliance for the purpose of setting premiums based on risk adjustment factors.

(4) REQUIRED SAFEGUARDS.—Any individual or entity who maintains, uses, or disseminates individually identifiable health information shall implement administrative, technical, and physical safeguards for the security of such information.

(5) RIGHT TO KNOW.—An enrollee (or an enrollee representative of the enrollee) has the right to know—

(A) whether any individual or entity uses or maintains individually identifiable health information concerning the enrollee; and

(B) for what purposes the information may be used or maintained.

(6) RIGHT TO ACCESS.—Subject to appropriate procedures, an enrollee (or an enrollee representative of the enrollee) has the right, with respect to individually identifiable health information concerning the enrollee that is recorded in any form or medium—

(A) to see such information;

(B) to copy such information; and

(C) to have a notation made with or in such information of any amendment or correction of such information requested by the enrollee or enrollee representative.

(7) RIGHT TO NOTICE.—An enrollee and an enrollee representative have the right to receive a written statement concerning—

(A) the purposes for which individually identifiable health information provided to a health care provider, a health plan, a regional alliance, a corporate alliance, or the National Health Board may be used or disclosed by, or disclosed to, any individual or entity; and

(B) the right of access described in paragraph (6).

(8) USE OF UNIQUE IDENTIFIER.—When individually identifiable health information concerning an enrollee is required to accomplish the purpose for which information is being transmitted between or among the National Health Board, regional and corporate alliances, health plans, and health care providers, the transmissions shall use the unique identifier number provided to the enrollee pursuant to section 5104 in lieu of the name of the enrollee.

(9) USE FOR EMPLOYMENT DECISIONS.—Individually identifiable health care information may not be used in making employment decisions.

SEC. 5121. OTHER DUTIES WITH RESPECT TO PRIVACY.

(a) RESEARCH AND TECHNICAL SUPPORT.—The National Health Board may sponsor—

(1) research relating to the privacy and security of individually identifiable health information;

(2) the development of consent forms governing disclosure of such information; and

(3) the development of technology to implement standards regarding such information.

(c) EDUCATION.—The National Health Board shall establish education and awareness programs—

(1) to foster adequate security practices by States, regional alliances, corporate alliances, health plans, and health care providers;

(2) to train personnel of public and private entities who have access to individually identifiable health information respecting the duties of such personnel with respect to such information; and

(3) to inform individuals and employers who purchase health care respecting their rights with respect to such information.

SEC. 5122. COMPREHENSIVE HEALTH INFORMATION PRIVACY PROTECTION ACT.

(a) IN GENERAL.—Not later than 3 years after the date of the enactment of this Act,

the National Health Board shall submit to the President and the Congress a detailed proposal for legislation to provide a comprehensive scheme of Federal privacy protection for individually identifiable health information.

(b) CODE OF FAIR INFORMATION PRACTICES.—The proposal shall include a Code of Fair Information Practices to be used to advise enrollees to whom individually identifiable health information pertains of their rights with respect to such information in an easily understood and useful form.

(c) ENFORCEMENT.—The proposal shall include provisions to enforce effectively the rights and duties that would be created by the legislation.

SEC. 5123. DEFINITIONS.

For purposes of this part:

(1) ENROLLEE.—The term "enrollee" means an individual who enrolls or has enrolled under a health plan. The term includes a deceased individual who was enrolled under a health plan.

(2) ENROLLEE REPRESENTATIVE.—The term "enrollee representative" means any individual legally empowered to make decisions concerning the provision of health care to an enrollee or the administrator or executor of the estate of a deceased enrollee.

(3) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term "individually identifiable health information" means any information, whether oral or recorded in any form or medium, that—

(A) identifies or can readily be associated with the identity of an enrollee; and

(B) relates to—

(i) the past, present, or future physical or mental health of the enrollee;

(ii) the provision of health care to the enrollee; or

(iii) payment for the provision of health care to the enrollee.

PART 3—INTERIM REQUIREMENTS FOR ADMINISTRATIVE SIMPLIFICATION

SEC. 5130. STANDARD BENEFIT FORMS.

(a) DEVELOPMENT.—Not later than 1 year after the date of the enactment of this Act, the National Health Board shall develop, promulgate, and publish in the Federal Register the following standard health care benefit forms:

(1) An enrollment and disenrollment form to be used to record enrollment and disenrollment in a health benefit plan.

(2) A clinical encounter record to be used by health benefit plans and health service providers.

(3) A claim form to be used in the submission of claims for benefits or payment under a health benefit plan.

(b) INSTRUCTIONS, DEFINITIONS, AND CODES.—Each standard form developed under subsection (a) shall include instructions for completing the form that—

(1) specifically define, to the extent practicable, the data elements contained in the form; and

(2) standardize any codes or data sets to be used in completing the form.

(c) REQUIREMENTS FOR ADOPTION OF FORMS.—

(1) HEALTH SERVICE PROVIDERS.—On or after the date that is 270 days after the publication of the standard forms developed under subsection (a), a health service provider that furnishes items or services in the United States for which payment may be made under a health benefit plan may not—

(A) maintain records of clinical encounters involving such items or services that are required to be maintained by the National Health Board in a paper form that is not the clinical encounter record promulgated by the Board; or

(B) submit any claim for benefits or payment for such services to such plan in a paper form that is not the claim form promulgated by the National Health Board.

(2) HEALTH BENEFIT PLANS.—On or after the date that is 270 days after the publication of the standard forms developed under subsection (a), a health benefit plan may not—

(A) record enrollment and disenrollment in a paper form that is not the enrollment and disenrollment form promulgated by the National Health Board;

(B) maintain records of clinical encounters that are required to be maintained by the National Health Board in a paper form that is not the clinical encounter record promulgated by the Board; or

(C) reject a claim for benefits or payment under the plan on the basis of the form or manner in which the claim is submitted if—

(i) the claim is submitted on the claim form promulgated by the National Health Board; and

(ii) the plan accepts claims submitted in paper form.

(d) DEFINITIONS.—For purposes of this subtitle:

(1) HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term "health benefit plan" means, except as provided in subparagraphs (B) through (D), any public or private entity or program that provides for payments for health care services, including—

(i) a group health plan (as defined in section 5000(b)(1) of the Internal Revenue Code of 1986); and

(ii) any other health insurance arrangement, including any arrangement consisting of a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract.

(B) PLANS EXCLUDED.—Such term does not include—

(i) accident-only, credit, or disability income insurance;

(ii) coverage issued as a supplement to liability insurance;

(iii) an individual making payment on the individual's own behalf (or on behalf of a relative or other individual) for deductibles, coinsurance, or services not covered under a health benefit plan; and

(iv) such other plans as the National Health Board may determine, because of the limitation of benefits to a single type or kind of health care, such as dental services or hospital indemnity plans, or other reasons should not be subject to the requirements of this section.

(C) PLANS INCLUDED.—Such term includes—

(i) workers compensation or similar insurance insofar as it relates to workers compensation medical benefits (as defined in section 10000(3)) provided by or through health plans; and

(ii) automobile medical insurance insofar as it relates to automobile insurance medical benefits (as defined in section 10100(2)) provided by or through health plans.

(D) TREATMENT OF DIRECT PROVISION OF SERVICES.—Such term does not include a Federal or State program that provides directly for the provision of health services to beneficiaries.

(2) HEALTH SERVICE PROVIDER.—The term "health service provider" includes a provider of services (as defined in section 1861(u) of the Social Security Act), physician, supplier, and other person furnishing health care services. Such term includes a Federal or State program that provides directly for the provision of health services to beneficiaries.

(e) INTERIM NATURE OF REQUIREMENTS.—The National Health Board may modify, update, or supercede any standard form or requirement developed, promulgated, or imposed under this section through the establishment of a standard under section 5101.

PART 4—GENERAL PROVISIONS

SEC. 5140. NATIONAL PRIVACY AND HEALTH DATA ADVISORY COUNCIL.

(a) ESTABLISHMENT.—There is established an advisory council to be known as the National Privacy and Health Data Advisory Council.

(b) DUTIES.—The Council shall advise the National Health Board with respect its duties under this subtitle.

(c) NUMBER AND APPOINTMENT.—The Council shall be composed of 15 members appointed by the National Health Board. The members of the Council shall include—

(1) individuals representing the interests of consumers, employers, and other purchasers of health care;

(2) individuals representing the interests of health plans, health care providers, corporate alliances, regional alliances, public health agencies, and participating States; and

(3) individuals distinguished in the fields of data collection, data protection and privacy, law, ethics, medical and health services research, public health, and civil liberties and patient advocacy.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council shall serve for a term of 3 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (c), the National Health Board shall appoint 5 members to serve for a term of 3 years, 5 members to serve for a term of 2 years, and 5 members to serve for a term of 1 year.

(3) SERVICE BEYOND TERM.—A member of the Council may continue to serve after the expiration of the term of the member until a successor is appointed.

(e) VACANCIES.—If a member of the Council does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(f) CHAIR.—The National Health Board shall designate an individual to serve as the chair of the Council.

(g) MEETINGS.—The Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the National Health Board or the chair.

(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Council shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(i) STAFF.—The National Health Board shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(j) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise provided by law.

SEC. 5141. CIVIL MONEY PENALTIES.

(a) VIOLATION OF HEALTH INFORMATION SYSTEM STANDARDS.—Any person who the Secretary of Health and Human Services determines—

(1) is required, but has substantially failed, to comply with a standard established by the National Health Board under section 5101 or 5120;

(2) has required the display of, has required the use of, or has used a health security card for any purpose other than a purpose described in section 5105(a); or

(3) has required the disclosure of, has required the use of, or has used a unique identifier number provided pursuant to section 5104 for any purpose that is not authorized by the National Health Board pursuant to such section

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such violation.

(b) STANDARD BENEFIT FORMS.—Any health service provider or health benefit plan that the Secretary of Health and Human Services determines is required, but has substantially failed, to comply with section 5130(c) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such violation.

(c) PROCESS.—The process for the imposition of a civil money penalty under the All-Payer Health Care Fraud and Abuse Control Program under part 1 of subtitle E of this title shall apply to a civil money penalty under this section in the same manner as such process applies to a penalty or proceeding under such program.

SEC. 5142. RELATIONSHIP TO OTHER LAWS.

(a) COURT ORDERS.—Nothing in this title shall be construed to invalidate or limit the power or authority of any court of competent jurisdiction with respect to health care information.

(b) PUBLIC HEALTH REPORTING.—Nothing in this title shall be construed to invalidate or limit the authorities, powers, or procedures established under any law that provides for the reporting of disease, child abuse, birth, or death.

Subtitle C—Remedies and Enforcement

PART 1—REVIEW OF BENEFIT DETERMINATIONS FOR ENROLLED INDIVIDUALS

Subpart A—General Rules

SEC. 5201. HEALTH PLAN CLAIMS PROCEDURE.

(a) DEFINITIONS.—For purposes of this section—

(1) CLAIM.—The term "claim" means a claim for payment or provision of benefits under a health plan or a request for preauthorization of items or services which is submitted to a health plan prior to receipt of the items or services.

(2) INDIVIDUAL CLAIMANT.—The term "individual claimant" with respect to a claim means any individual who submits the claim to a health plan in connection with the individual's enrollment under the plan, or on whose behalf the claim is submitted to the plan by a provider.

(3) PROVIDER CLAIMANT.—The term "provider claimant" with respect to a claim means any provider who submits the claim to a health plan with respect to items or services provided to an individual enrolled under the plan.

(b) GENERAL RULES GOVERNING TREATMENT OF CLAIMS.—

(1) ADEQUATE NOTICE OF DISPOSITION OF CLAIM.—In any case in which a claim is submitted in complete form to a health plan, the plan shall provide to the individual claimant and any provider claimant with respect to the claim a written notice of the plan's approval or denial of the claim within 30 days after the date of the submission of the claim. The notice to the individual claimant shall be written in language calculated to be understood by the typical individual enrolled under the plan and in a form which takes into account accessibility to the information by individuals whose primary language is not English. In the case of a denial of the claim, the notice shall be provided within 5 days after the date of the determination to deny the claim, and shall set forth the specific reasons for the denial. The notice of a denial shall include notice of the right to appeal the denial under paragraph (2). Failure by any plan to comply with the requirements of this paragraph with respect to any claim submitted to the plan shall be treated as approval by the plan of the claim.

(2) PLAN'S DUTY TO REVIEW DENIALS UPON TIMELY REQUEST.—The plan shall review its denial of the claim if an individual claimant or provider claimant with respect to the claim submits to the plan a written request for reconsideration of the claim after receipt of written notice from the plan of the denial. The plan shall allow any such claimant not less than 60 days, after receipt of written notice from the plan of the denial, to submit the claimant's request for reconsideration of the claim.

(3) TIME LIMIT FOR REVIEW.—The plan shall complete any review required under paragraph (2), and shall provide the individual claimant and any provider claimant with respect to the claim written notice of the plan's decision on the claim after reconsideration pursuant to the review, within 30 days after the date of the receipt of the request for reconsideration.

(4) DE NOVO REVIEWS.—Any review required under paragraph (2)—

(A) shall be de novo,

(B) shall be conducted by an individual who did not make the initial decision denying the claim and who is authorized to approve the claim, and

(C) shall include review by a qualified physician if the resolution of any issues involved requires medical expertise.

(c) TREATMENT OF URGENT REQUESTS TO PLANS FOR PREAUTHORIZATION.—

(1) IN GENERAL.—This subsection applies in the case of any claim submitted by an individual claimant or a provider claimant consisting of a request for preauthorization of items or services which is accompanied by an attestation that—

(A) failure to immediately provide the items or services could reasonably be expected to result in—

(i) placing the health of the individual claimant (or, with respect to an individual claimant who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part,

or

(B) immediate provision of the items or services is necessary because the individual claimant has made or is at serious risk of making an attempt to harm such individual claimant or another individual.

(2) SHORTENED TIME LIMIT FOR CONSIDERATION OF REQUESTS FOR PREAUTHORIZATION.—Notwithstanding subsection (b)(1), a health plan shall approve or deny any claim described in paragraph (1) within 24 hours after submission of the claim to the plan. Failure by the plan to comply with the requirements of this paragraph with respect to the claim shall be treated as approval by the plan of the claim.

(3) EXPEDITED EXHAUSTION OF PLAN REMEDIES.—Any claim described in paragraph (1) which is denied by the plan shall be treated as a claim with respect to which all remedies under the plan provided pursuant to this section are exhausted, irrespective of any review provided under subsection (b)(2).

(4) DENIAL OF PREVIOUSLY AUTHORIZED CLAIMS NOT PERMITTED.—In any case in which a health plan approves a claim described in paragraph (1)—

(A) the plan may not subsequently deny payment or provision of benefits pursuant to the claim, unless the plan makes a showing of an intentional misrepresentation of a material fact by the individual claimant, and

(B) in the case of a violation of subparagraph (A) in connection with the claim, all remedies under the plan provided pursuant to this section with respect to the claim shall be treated as exhausted.

(d) TIME LIMIT FOR DETERMINATION OF INCOMPLETENESS OF CLAIM.—For purposes of this section—

(1) any claim submitted by an individual claimant and accepted by a provider serving under contract with a health plan and any claim described in subsection (b)(1) shall be treated with respect to the individual claimant as submitted in complete form, and

(2) any other claim for benefits under the plan shall be treated as filed in complete form as of 10 days after the date of the submission of the claim, unless the plan provides to the individual claimant and any provider claimant, within such period, a written notice of any required matter remaining to be filed in order to complete the claim.

Any filing by the individual claimant or the provider claimant of additional matter requested by the plan pursuant to paragraph (2) shall be treated for purposes of this section as an initial filing of the claim.

(e) ADDITIONAL NOTICE AND DISCLOSURE REQUIREMENTS FOR HEALTH PLANS.—In the case of a denial of a claim for benefits under a health plan, the plan shall include, together with the specific reasons provided to the individual claimant and any provider claimant under subsection (b)(1)—

(1) if the denial is based in whole or in part on a determination that the claim is for an item or service which is not covered by the comprehensive benefit package or exceeds payment rates under the applicable alliance or State fee schedule, the factual basis for the determination,

(2) if the denial is based in whole or in part on exclusion of coverage with respect to services because the services are determined to comprise an experimental treatment or investigatory procedure, the medical basis for the determination and a description of the process used in making the determination, and

(3) if the denial is based in whole or in part on a determination that the treatment is not medically necessary or appropriate or is inconsistent with the plan's practice guidelines, the medical basis for the determination, the guidelines used in making the determination, and a description of the process used in making the determination.

(f) WAIVER OF RIGHTS PROHIBITED.—A health plan may not require any party to waive any right under the plan or this Act as a condition for approval of any claim under the plan, except to the extent otherwise specified in a formal settlement agreement.

SEC. 5202. REVIEW IN REGIONAL ALLIANCE COMPLAINT REVIEW OFFICES OF GRIEVANCES BASED ON ACTS OR PRACTICES BY HEALTH PLANS.

(a) COMPLAINT REVIEW OFFICES.—

(1) IN GENERAL.—In accordance with rules which shall be prescribed by the Secretary of Labor, each State shall establish and maintain a complaint review office for each regional alliance established by such State. According to designations which shall be made by each State under regulations of the Secretary of Labor, the complaint review office for a regional alliance established by such State shall also serve as the complaint review office for corporate alliances operating in the State with respect to individuals who are enrolled under corporate alliance health plans maintained by such corporate alliances and who reside within the area of the regional alliance.

(2) REGIONAL ALLIANCES NOT ESTABLISHED BY STATES.—In the case of any regional alliance established in any State by the Secretary of Health and Human Services, the Secretary of Health and Human Services shall assume all duties and obligations of such State under this part in accordance with the applicable regulations of the Secretary of Labor under this part.

(b) FILINGS OF COMPLAINTS BY AGGRIEVED PERSONS.—In the case of any person who is aggrieved by—

(1) any act or practice engaged in by any health plan which consists of or results in denial of payment or provision of benefits under the plan or delay in the payment or provision of benefits, or

(2) any act or practice engaged in by any other plan maintained by a regional alliance or a corporate alliance which consists of or results in denial of payment or provision of benefits under a cost sharing policy described in section 1421(b)(2) or delay in the payment or provision of the benefits,

if the denial or delay consists of a failure to comply with the terms of the plan (including the provision of benefits in full when due in accordance with the terms of the plan), or with the applicable requirements of this Act, such person may file a complaint with the appropriate complaint review office.

(c) EXHAUSTION OF PLAN REMEDIES.—Any complaint including a claim to which section 5201 applies may not be filed until the complainant has exhausted all remedies provided under the plan with respect to the claim in accordance with such section.

(d) EXCLUSIVE MEANS OF REVIEW FOR PLANS MAINTAINED BY CORPORATE ALLIANCES.—Proceedings under sections 5203 and 5204 pursuant to complaints filed under subsection (b), and review under section 5205 of determinations made under section 5204, shall be the exclusive means of review of acts or practices described in subsection (b) which are engaged in by a corporate alliance health plan or by any plan maintained by a corporate alliance with respect to benefits under a cost sharing policy described in section 1421(b)(2).

(e) FORM OF COMPLAINT.—The complaint shall be in writing under oath or affirmation, shall set forth the complaint in a manner calculated to give notice of the nature of the complaint, and shall contain such information as may be prescribed in regulations of the Secretary of Labor.

(f) NOTICE OF FILING.—The complaint review office shall serve by certified mail a notice of the complaint (including the date, place, and circumstances of the alleged violation) on the person or persons alleged in the complaint to have committed the violation within 10 days after the filing of the complaint.

(g) TIME LIMITATION.—Complaints may not be brought under this section with respect to any violation later than one year after the date on which the violation occurs. This subsection shall not prevent the subsequent amending of a complaint.

SEC. 5203. INITIAL PROCEEDINGS IN COMPLAINT REVIEW OFFICES.

(a) ELECTIONS.—Whenever a complaint is brought to the complaint review office under section 5202(b), the complaint review office shall provide the complainant with an opportunity, in such form and manner as shall be prescribed in regulations of the Secretary of Labor, to elect one of the following:

(1) to forego further proceedings in the complaint review office and rely on remedies available in a court of competent jurisdiction, except with respect to any matter in the complaint with respect to which proceedings under this section and section 5204, and review under section 5205, are not under section 5202(d) the exclusive means of review,

(2) to submit the complaint as a dispute under the Early Resolution Program established under subpart B and thereby suspend further review proceedings under this section pending termination of proceedings under the Program, or

(3) in any case in which an election under paragraph (2) is not made, or such an election was made but resolution of all matters in the complaint was not obtained upon termination of proceedings pursuant to the election by settlement agreement or otherwise, to proceed with the complaint to a hearing in the complaint review office under section 5204 regarding the unresolved matters.

(b) EFFECT OF PARTICIPATION IN EARLY RESOLUTION PROGRAM.—Any matter in a complaint brought to the complaint review office which is included in a dispute which is timely submitted to the Early Resolution Program established under subpart B shall not be assigned to a hearing under this section unless the proceedings under the Program with respect to the dispute are terminated without settlement or resolution of the dispute with respect to such matter. Upon termination of any proceedings regarding a dispute submitted to the Program, the applicability of this section to any matter in a complaint which was included in the dispute shall not be affected by participation in the proceedings, except to the extent otherwise required under the terms of any settlement agreement or other formal resolution obtained in the proceedings.

SEC. 5204. HEARINGS BEFORE HEARING OFFICERS IN COMPLAINT REVIEW OFFICES.

(a) HEARING PROCESS.—

(1) ASSIGNMENT OF COMPLAINTS TO HEARING OFFICERS AND NOTICE TO PARTIES.—

(A) IN GENERAL.—In the case of an election under section 5203(a)(3)—

(i) the complaint review office shall assign the complaint, and each motion in connection with the complaint, to a hearing officer employed by the State in the office; and

(ii) the hearing officer shall have the power to issue and cause to be served upon the plan named in the complaint a copy of the complaint and a notice of hearing before the hearing officer at a place fixed in the notice, not less than 5 days after the serving of the complaint.

(B) QUALIFICATIONS FOR HEARING OFFICERS.—No individual may serve in a complaint review office as a hearing officer unless the individual meets standards which shall be prescribed by the Secretary of Labor. Such standards shall include experience, training, affiliations, diligence, actual or potential conflicts of interest, and other qualifications deemed relevant by the Secretary of Labor. At no time shall a hearing officer have any official, financial, or personal conflict of interest with respect to issues in controversy before the hearing officer.

(2) AMENDMENT OF COMPLAINTS.—Any such complaint may be amended by the hearing officer conducting the hearing, upon the motion of the complainant, in the hearing officer's discretion at any time prior to the issuance of an order based thereon.

(3) ANSWERS.—The party against whom the complaint is filed shall have the right to file an answer to the original or amended complaint and to appear in person or otherwise and give testimony at the place and time fixed in the complaint.

(b) ADDITIONAL PARTIES.—In the discretion of the hearing officer conducting the hearing, any other person may be allowed to intervene in the proceeding and to present testimony.

(c) HEARINGS.—

(1) DE NOVO HEARING.—Each hearing officer shall hear complaints and motions de novo.

(2) TESTIMONY.—The testimony taken by the hearing officer shall be reduced to writing. Thereafter, the hearing officer, in his or her discretion, upon notice may provide for the taking of further testimony or hear argument.

(3) AUTHORITY OF HEARING OFFICERS.—The hearing officer may compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing. In case of contumacy or refusal to obey a subpoena lawfully issued under this paragraph and upon application of the hearing officer, an appropriate district court may issue an order requiring compliance with the subpoena and any failure to obey the order may be punished by the court as a contempt thereof. The hearing officer may also seek enforcement of the subpoena in a State court of competent jurisdiction.

(4) EXPEDITED HEARINGS.—Notwithstanding section 5203 and the preceding provisions of this section, upon receipt of a complaint containing a claim described in section 5201(c)(1), the complaint review office shall promptly provide the complainant with the opportunity to make an election under section 5203(a)(3) and assignment to a hearing on the complaint before a hearing officer. The complaint review office shall ensure that such a hearing commences not later than 24 hours after receipt of the complaint by the complaint hearing office.

(d) DECISION OF HEARING OFFICER.—

(1) IN GENERAL.—The hearing officer shall decide upon the preponderance of the evidence whether to decide in favor of the complainant with respect to each alleged act or practice. Each such decision—

(A) shall include the hearing officer's findings of fact, and

(B) shall constitute the hearing officer's final disposition of the proceedings.

(2) DECISIONS FINDING IN FAVOR OF COMPLAINANT.—

(A) IN GENERAL.—If the hearing officer's decision includes a determination that any party named in the complaint has engaged in or is engaged in an act or practice described in section 5202(b), the hearing officer shall issue and cause to be served on such party an order which requires such party—

(i) to cease and desist from such act or practice,

(ii) to provide the benefits due under the terms of the plan and to otherwise comply

with the terms of the plan and the applicable requirements of this Act,

(iii) to pay to the complainant prejudgment interest on the actual costs incurred in obtaining the items and services at issue in the complaint, and

(iv) to pay to the prevailing complainant a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the hearing on the charges on which the complainant prevails.

(3) DECISIONS NOT IN FAVOR OF COMPLAINANT.—If the hearing officer's decision includes a determination that the party named in the complaint has not engaged in or is not engaged in an act or practice referred to in section 5202(b), the hearing officer—

(A) shall include in the decision a dismissal of the charge in the complaint relating to the act or practice, and

(B) upon a finding that such charge is frivolous, shall issue and cause to be served on the complainant an order which requires the complainant to pay to such party a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the proceedings on such charge.

(4) SUBMISSION AND SERVICE OF DECISIONS.—The hearing officer shall submit each decision to the complaint review office at the conclusion of the proceedings and the office shall cause a copy of the decision to be served on the parties to the proceedings.

(e) REVIEW.—

(1) IN GENERAL.—The decision of the hearing officer shall be final and binding upon all parties. Except as provided in paragraph (2), any party to the complaint may, within 30 days after service of the decision by the complaint review office, file an appeal of the decision with the Federal Health Plan Review Board under section 5205 in such form and manner as may be prescribed by such Board.

(2) EXCEPTION.—The decision in the case of an expedited hearing under subsection (c)(4) shall not be subject to review.

(f) COURT ENFORCEMENT OF ORDERS.—

(1) IN GENERAL.—If a decision of the hearing officer in favor of the complainant is not appealed under section 5205, the complainant may petition any court of competent jurisdiction for enforcement of the order. In any such proceeding, the order of the hearing officer shall not be subject to review.

(2) AWARDING OF COSTS.—In any action for court enforcement under this subsection, a prevailing complainant shall be entitled to a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to such action.

SEC. 5205. REVIEW BY FEDERAL HEALTH PLAN REVIEW BOARD.

(a) ESTABLISHMENT AND MEMBERSHIP.—The Secretary of Labor shall establish by regulation a Federal Health Plan Review Board (hereinafter in this subtitle referred to as the "Review Board"). The Review Board shall be composed of 5 members appointed by the Secretary of Labor from among persons who by reason of training, education, or experience are qualified to carry out the functions of the Review Board under this subtitle. The Secretary of Labor shall prescribe such rules as are necessary for the orderly transaction of proceedings by the Review Board. Every official act of the Review Board shall be entered of record, and its hearings and records shall be open to the public.

(b) REVIEW PROCESS.—The Review Board shall ensure, in accordance with rules prescribed by the Secretary of Labor, that reasonable notice is provided for each appeal before the Review Board of a hearing officer's decision under section 5304, and shall provide for the orderly consideration of arguments by any party to the hearing upon which the hearing officer's decision is based. In the discretion of the Review Board, any other person may be allowed to intervene in the proceeding and to present written argument. The National Health Board may intervene in the proceeding as a matter of right.

(c) SCOPE OF REVIEW.—The Review Board shall review the decision of the hearing officer from which the appeal is made, except that the review shall be only for the purposes of determining—

(1) whether the determination is supported by substantial evidence on the record considered as a whole,

(2) in the case of any interpretation by the hearing officer of contractual terms (irrespective of the extent to which extrinsic evidence was considered), whether the determination is supported by a preponderance of the evidence,

(3) whether the determination is in excess of statutory jurisdiction, authority, or limitations, or in violation of a statutory right, or

(4) whether the determination is without observance of procedure required by law.

(d) DECISION OF REVIEW BOARD.—The decision of the hearing officer as affirmed or modified by the Review Board (or any reversal by the Review Board of the hearing officer's final disposition of the proceedings) shall become the final order of the Review Board and binding on all parties, subject to review under subsection (e). The Review Board shall cause a copy of its decision to be served on the parties to the proceedings not later than 5 days after the date of the proceeding.

(e) REVIEW OF FINAL ORDERS.—

(1) IN GENERAL.—Not later than 60 days after the entry of the final order, any person aggrieved by any such final order under which the amount or value in controversy exceeds $10,000 may seek a review of the order in the United States court of appeals for the circuit in which the violation is alleged to have occurred or in which the complainant resides.

(2) FURTHER REVIEW.—Upon the filing of the record with the court, the jurisdiction of the court shall be exclusive and its judgment shall be final, except that the judgment shall be subject to review by the Supreme Court of the United States upon writ of certiorari or certification as provided in section 1254 of title 28 of the United States Code.

(3) ENFORCEMENT DECREE IN ORIGINAL REVIEW.—If, upon appeal of an order under paragraph (1), the United States court of appeals does not reverse the order, the court shall have the jurisdiction to make and enter a decree enforcing the order of the Review Board.

(f) DETERMINATIONS.—Determinations made under this section shall be in accordance with the provisions of this Act, the comprehensive benefit package as provided by this Act, the rules and regulations of the National Health Board prescribed under this Act, and decisions of the National Health Board published under this Act.

(g) AWARDING OF ATTORNEYS' FEES AND OTHER COSTS AND EXPENSES.—In any proceeding before the Review Board under this section or any judicial proceeding under subsection (e), the Review Board or the court (as the case may be) shall award to a prevailing complainant reasonable costs and expenses (including a reasonable attorney's fee) on the causes on which the complainant prevails.

SEC. 5206. CIVIL MONEY PENALTIES.

(a) DENIAL OR DELAY IN PAYMENT OR PROVISION OF BENEFITS.—

(1) IN GENERAL.—The Secretary of Labor may assess a civil penalty against any health plan, or against any other plan in connection with benefits provided thereunder under a cost sharing policy described in section 1421(b)(2), for unreasonable denial or delay in the payment or provision of benefits thereunder, in an amount not to exceed—

(A) $25,000 per violation, or $75,000 per violation in the case of a finding of bad faith on the part of the plan, and

(B) in the case of a finding of a pattern or practice of such violations engaged in by the plan, $1,000,000 in addition to the total amount of penalties assessed under subparagraph (A) with respect to such violations.

For purposes of subparagraph (A), each violation with respect to any single individual shall be treated as a separate violation.

(2) CIVIL ACTION TO ENFORCE CIVIL PENALTY.—The Secretary of Labor may commence a civil action in any court of competent jurisdiction to enforce a civil penalty assessed under subsection (a).

(b) CIVIL PENALTIES FOR CERTAIN OTHER ACTIONS.—The Secretary of Labor may assess a civil penalty described in section 5412(b)(1) against any corporate alliance health plan, or against any other plan sponsored by a corporate alliance in connection with benefits provided thereunder under a cost sharing policy described in section 1421(b)(2), for any action described in section 5412(a). The Secretary of Labor may initiate proceedings to impose such penalty in the same manner as the Secretary of Health and Human Services may initiate proceedings under section 5412 with respect to actions described in section 5412(a).

Subpart B—Early Resolution Programs

SEC. 5211. ESTABLISHMENT OF EARLY RESOLUTION PROGRAMS IN COMPLAINT REVIEW OFFICES.

(a) ESTABLISHMENT OF PROGRAMS.—Each State shall establish and maintain an Early Resolution Program in each complaint review office in such State. The Program shall include—

(1) the establishment and maintenance of forums for mediation of disputes in accordance with this subpart, and

(2) the establishment and maintenance of such forums for other forms of alternative dispute resolution (including binding arbitration) as may be prescribed in regulations of the Secretary of Labor.

Each State shall ensure that the standards applied in Early Resolution Programs administered in such State which apply to any form of alternative dispute resolution described in paragraph (2) and which relate to time requirements, qualifications of facilitators, arbitrators, or other mediators, and confidentiality are at least equivalent to the standards which apply to mediation proceedings under this subpart.

(b) DUTIES OF COMPLAINT REVIEW OFFICES.—Each complaint review office in a State—

(1) shall administer its Early Resolution Program in accordance with regulations of the Secretary of Labor,

(2) shall, pursuant to subsection (a)(1)—

(A) recruit and train individuals to serve as facilitators for mediation proceedings under the Early Resolution Program from attorneys who have the requisite expertise for such service, which shall be specified in regulations of the Secretary of Labor,

(B) provide meeting sites, maintain records, and provide facilitators with administrative support staff, and

(C) establish and maintain attorney referral panels,

(3) shall ensure that, upon the filing of a complaint with the office, the complainant is adequately apprised of the complainant's options for review under this part, and

(4) shall monitor and evaluate the Program on an ongoing basis.

SEC. 5212. INITIATION OF PARTICIPATION IN MEDIATION PROCEEDINGS.

(a) ELIGIBILITY OF CASES FOR SUBMISSION TO EARLY RESOLUTION PROGRAM.—A dispute may be submitted to the Early Resolution Program only if the following requirements are met with respect to the dispute:

(1) NATURE OF DISPUTE.—The dispute consists of an assertion by an individual enrolled under a health plan of one or more claims against the health plan for payment or provision of benefits, or against any other plan maintained by the regional alliance or corporate alliance sponsoring the health plan with respect to benefits provided under a cost sharing policy described in section 1421(b)(2), based on alleged coverage under the plan, and a denial of the claims, or a denial of appropriate reimbursement based on the claims, by the plan.

(2) NATURE OF DISPUTED CLAIM.—Each claim consists of—

(A) a claim for payment or provision of benefits under the plan; or

(B) a request for information or documents the disclosure of which is required under this Act (including claims of entitlement to disclosure based on colorable claims to rights to benefits under the plan).

(b) FILING OF ELECTION.—A complainant with a dispute which is eligible for submission to the Early Resolution Program may make the election under section 5203(a)(2) to submit the dispute to mediation proceedings under the Program not later than 15 days after the date the complaint is filed with the complaint review office under subpart A.

(c) AGREEMENT TO PARTICIPATE.—

(1) ELECTION BY CLAIMANT.—A complainant may elect participation in the mediation proceedings only by entering into a written agreement (including an agreement to comply with the rules of the Program and consent for the complaint review office to contact the health plan regarding the agreement), and by releasing plan records to the Program for the exclusive use of the facilitator assigned to the dispute.

(2) PARTICIPATION BY PLANS OR HEALTH BENEFITS CONTRACTORS.—Each party whose participation in the mediation proceedings has been elected by a claimant pursuant to paragraph (1) shall participate in, and cooperate fully with, the proceedings. The claims review office shall provide such party with a copy of the participation agreement described in paragraph (1), together with a written description of the Program. Such party shall submit the copy of the agreement, together with its authorized signature signifying receipt of notice of the agreement, to the claims review office, and shall include in the submission to the claims review office a copy of the written record of the plan claims procedure completed pursuant to section 5201 with respect to the dispute and all relevant plan documents. The relevant documents shall include all documents under which the health plan is or was administered or operated, including copies of any insurance contracts under which benefits are or were provided and any fee or reimbursement schedules for health care providers.

SEC. 5213. MEDIATION PROCEEDINGS.

(a) ROLE OF FACILITATOR.—In the course of mediation proceedings under the Early Resolution Program, the facilitator assigned to the dispute shall prepare the parties for a conference regarding the dispute and serve as a neutral mediator at such conference, with the goal of achieving settlement of the dispute.

(b) PREPARATIONS FOR CONFERENCE.—In advance of convening the conference, after identifying the necessary parties and confirming that the case is eligible for the Program, the facilitator shall analyze the record of the claims procedure conducted pursuant to section 5201 and any position papers submitted by the parties to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents.

(c) CONFERENCE.—Upon convening the conference, the facilitator shall assist the parties in identifying undisputed issues and exploring settlement. If settlement is reached, the facilitator shall assist in the preparation of a written settlement agreement. If no settlement is reached, the facilitator shall present the facilitator's evaluation, including an assessment of the parties' positions, the likely outcome of further administrative action or litigation, and suggestions for narrowing the issues in dispute.

(d) TIME LIMIT.—The facilitator shall ensure that mediation proceedings with respect to any dispute under the Early Resolution Program shall be completed within 120 days after the election to participate. The parties may agree to one extension of the proceedings by not more than 30 days if the proceedings are suspended to obtain an agency ruling or to reconvene the conference in a subsequent session.

(e) INAPPLICABILITY OF FORMAL RULES.—Formal rules of evidence shall not apply to mediation proceedings under the Early Resolution Program. All statements made and evidence presented in the proceedings shall be admissible in the proceedings. The facilitator shall be the sole judge of the proper weight to be afforded to each submission. The parties to mediation proceedings under the Program shall not be required to make statements or present evidence under oath.

(f) REPRESENTATION.—Parties may participate pro se or be represented by attorneys throughout the proceedings of the Early Resolution Program.

(g) CONFIDENTIALITY.—

(1) IN GENERAL.—Under regulations of the Secretary of Labor, rules similar to the rules under section 574 of title 5, United States Code (relating to confidentiality in dispute resolution proceedings) shall apply to the mediation proceedings under the Early Resolution Program.

(2) CIVIL REMEDIES.—The Secretary of Labor may assess a civil penalty against any person who discloses information in violation of the regulations prescribed pursuant to subsection (a) in the amount of three times the amount of the claim involved. The Secretary of Labor may bring a civil action to enforce such civil penalty in any court of competent jurisdiction.

SEC. 5214. LEGAL EFFECT OF PARTICIPATION IN MEDIATION PROCEEDINGS.

(a) PROCESS NONBINDING.—Findings and conclusions made in the mediation proceedings of the Early Resolution Program shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties under subpart A shall not be affected by participation in the Program.

(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a case is settled through participation in mediation proceedings under the Program, the facilitator shall assist the parties in drawing up an agreement which shall constitute, upon signature of the parties, a binding contract between the parties, which shall be enforceable under section 5215.

(c) PRESERVATION OF RIGHTS OF NON-PARTIES.—The settlement agreement shall not have the effect of waiving or otherwise affecting any rights to review under subpart A, or any other right under this Act or the plan, with respect to any person who is not a party to the settlement agreement.

SEC. 5215. ENFORCEMENT OF SETTLEMENT AGREEMENTS.

(a) ENFORCEMENT.—Any party to a settlement agreement entered pursuant to mediation proceedings under this subpart may petition any court of competent jurisdiction for the enforcement of the agreement, by filing in the court a written petition praying that the agreement be enforced. In such a proceeding, the order of the hearing officer shall not be subject to review.

(b) COURT REVIEW.—It shall be the duty of the court to advance on the docket and to expedite to the greatest possible extent the disposition of any petition filed under this section, with due deference to the role of settlement agreements under this part in achieving prompt resolution of disputes involving health plans.

(d) AWARDING OF ATTORNEY'S FEES AND OTHER COSTS AND EXPENSES.—In any action by an individual enrolled under a health plan for court enforcement under this section, a prevailing plaintiff shall be entitled to reasonable costs and expenses (including a reasonable attorney's fee and reasonable expert witness fees) on the charges on which the plaintiff prevails.

PART 2—ADDITIONAL REMEDIES AND ENFORCEMENT PROVISIONS

SEC. 5231. JUDICIAL REVIEW OF FEDERAL ACTION ON STATE SYSTEMS.

(a) IN GENERAL.—Any State or an alliance that is aggrieved by a determination by the National Health Board under subpart B of part 1 of subtitle F of title I shall be entitled to judicial review of such determination in accordance with this section.

(b) JUDICIAL REVIEW.—

(1) JURISDICTION.—The courts of appeals of the United States (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction to review a determination described in subsection (a), to affirm the determination, or to set it aside, in whole or in part. A judgment of a court of appeals in such an action shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(2) PETITION FOR REVIEW.—A State or an alliance that desires judicial review of a determination described in subsection (a) shall, within 30 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which the State or alliance is located a petition for review of such determination. A copy of the petition shall be transmitted by the clerk of the court to the National Health Board, and the Board shall file in the court the record of the proceedings on which the determination or action was based, as provided in section 2112 of title 28, United States Code.

(3) SCOPE OF REVIEW.—The findings of fact of the National Health Board, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Board to take further evidence, and the Board may make new or

modified findings of fact and may modify its previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

SEC. 5232. ADMINISTRATIVE AND JUDICIAL REVIEW RELATING TO COST CONTAINMENT.

There shall be no administrative or judicial review of any determination by the National Health Board respecting any matter under subtitle A of title VI.

SEC. 5233. CIVIL ENFORCEMENT.

Unless otherwise provided in this Act, the district courts of the United States shall have jurisdiction of civil actions brought by—

(1) the Secretary of Labor to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this Act; and

(2) the Secretary of Health and Human Services to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this Act.

SEC. 5234. PRIORITY OF CERTAIN BANKRUPTCY CLAIMS.

Section 507(a)(8) of title 11, United States Code, is amended to read as follows:

"(8) Eighth, allowed unsecured claims—

"(A) based upon any commitment by the debtor to the Federal Deposit Insurance Corporation, the Resolution Trust Corporation, the Director of the Office of Thrift Supervision, the Comptroller of the Currency, or the Board of Governors of the Federal Reserve System, or their predecessors or successors, to maintain the capital of an insured depository institution;

"(B) for payments under subtitle B of title IV of the Health Security Act owed to a regional alliance (as defined in section 1301 of such Act);

"(C) for payments owed to a corporate alliance health plan under trusteeship of the Secretary of Labor under section 1395 of the Health Security Act; or

"(D) for assessments and related amounts owed to the Secretary of Labor under section 1397 of the Health Security Act.".

SEC. 5235. PRIVATE RIGHT TO ENFORCE STATE RESPONSIBILITIES.

The failure of a participating State to carry out a responsibility applicable to participating States under this Act constitutes a deprivation of rights secured by this Act for the purposes of section 1977 of the Revised Statutes of the United States (42 U.S.C. 1983). In an action brought under such section, the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

SEC. 5236. PRIVATE RIGHT TO ENFORCE FEDERAL RESPONSIBILITIES IN OPERATING A SYSTEM IN A STATE.

(a) IN GENERAL.—The failure of the Secretary of Health and Human Services to carry out a responsibility under section 1522 (relating to operation of an alliance system in a State) confers an enforceable right of action on any person who is aggrieved by such failure. Such a person may commence a civil action against the Secretary in an appropriate State court or district court of the United States.

(b) EXHAUSTION OF REMEDIES.—In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

(c) RELIEF.—In an action under subsection (a), if the court finds that a failure described in such subsection has occurred, the aggrieved person may recover compensatory and punitive damages and the court may order any other appropriate relief.

(d) ATTORNEY'S FEES.—In an action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

SEC. 5237. PRIVATE RIGHT TO ENFORCE RESPONSIBILITIES OF ALLIANCES.

(a) IN GENERAL.—The failure of a regional alliance or a corporate alliance to carry out a responsibility applicable to the alliance under this Act confers an enforceable right of action on any person who is aggrieved by such failure. Such a person may commence a civil action against the alliance in an appropriate State court or district court of the United States.

(b) EXHAUSTION OF REMEDIES.—

(1) IN GENERAL.—Except as provided in paragraph (2), in an action under subsection (a) the court may not exercise jurisdiction until the aggrieved person has exhausted any administrative remedies that may be provided by law.

(2) NO EXHAUSTION REQUIRED.—In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law if the action relates to—

(A) whether the person is an eligible individual within the meaning of section 1001(c);

(B) whether the person is eligible for a premium discount under subpart A of part 1 of subtitle B of title VI;

(C) whether the person is eligible for a reduction in cost sharing under subpart D of part 3 of subtitle D of title I; or

(D) enrollment or disenrollment in a health plan.

(c) RELIEF.—In an action under subsection (a), if the court finds that a failure described in such subsection has occurred, the aggrieved person may recover compensatory and punitive damages and the court may order any other appropriate relief.

(d) ATTORNEY'S FEES.—In any action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

SEC. 5238. DISCRIMINATION CLAIMS.

(a) CIVIL ACTION BY AGGRIEVED PERSON.—

(1) IN GENERAL.—Any person who is aggrieved by the failure of a health plan to comply with section 1402(c) may commence a civil action against the plan in an appropriate State court or district court of the United States.

(2) STANDARDS.—The standards used to determine whether a violation has occurred in a complaint alleging discrimination under section 1402(c) shall be the standards applied under the Age Discrimination Act of 1973 (42 U.S.C. 6102 et seq.) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

(3) RELIEF.—In an action under paragraph (1), if the court finds that the health plan has failed to comply with section 1402(c), the aggreived person may recover compensatory and punitive damages and the court may order any other appropriate relief.

(4) ATTORNEY'S FEES.—In any action under paragraph (1), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(c) ACTION BY SECRETARY.—Whenever the Secretary of Health and Human Services finds that the health plan has failed to comply with section 1402(c), or with an applicable regulation issued under such section, the Secretary shall notify the plan. If within a reasonable period of time the health plan fails or refuses to comply, the Secretary may—

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted;

(2) terminate the participation of the health plan in an alliance; or

(3) take such other action as may be provided by law.

(d) ACTION BY ATTORNEY GENERAL.—When a matter is referred to the Attorney General under subsection (c)(1), the Attorney General may bring a civil action in a district court of the United States for such relief as may be appropriate, including injunctive relief. In a civil action under this section, the court—

(1) may grant any equitable relief that the court considers to be appropriate;

(2) may award such other relief as the court considers to be appropriate, including compensatory and punitive damages; and

(3) may, to vindicate the public interest when requested by the Attorney General, assess a civil money penalty against the health plan in an amount—

(A) not exceeding $50,000 for a first violation; and

(B) not exceeding $100,000 for any subsequent violation.

SEC. 5239. NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS.

Federal payments to regional alliances under part 2 of subtitle C of title VI shall be treated as Federal financial assistance for purposes of section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 303 of the Age Discrimination Act of 1975 (42 U.S.C. 6102), and section 601 of the Civil Rights Act of 1964 (42 U.S.C. 2000d).

SEC. 5240. CIVIL ACTION BY ESSENTIAL COMMUNITY PROVIDER.

(a) IN GENERAL.—An electing essential community provider (as defined in section 1431(d)) who is aggrieved by the failure of a health plan to fulfill a duty imposed on the plan by section 1431 may commence a civil action against the plan in an appropriate State court or district court of the United States.

(b) RELIEF.—In an action under subsection (a), if the court finds that the health plan has failed to fulfill a duty imposed on the plan by section 1431, the electing essential community provider may recover compensatory damages and the court may order any other appropriate relief.

(c) ATTORNEY'S FEES.—In any action under subsection (a), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

SEC. 5241. FACIAL CONSTITUTIONAL CHALLENGES.

(a) JURISDICTION.—The United States District Court for the District of Columbia shall have original and exclusive jurisdiction of any civil action brought to invalidate this Act or a provision of this Act on the ground of its being repugnant to the Constitution of the United States on its face and for every

purpose. In any action described in this subsection, the district court may not grant any temporary order or preliminary injunction restraining the enforcement, operation, or execution of this Act or any provision of this Act.

(b) STATUTE OF LIMITATIONS.—An action described in subsection (a) shall be commenced not later than 1 year after the date of the enactment of this Act.

(c) CONVENING OF THREE-JUDGE COURT.—An action described in subsection (a) shall be heard and determined by a district court of three judges in accordance with section 2284 of title 28, United States Code.

(d) CONSOLIDATION.—When actions described in subsection (a) involving a common question of law or fact are pending before a district court, the court shall order all the actions consolidated.

(e) DIRECT APPEAL TO SUPREME COURT.—In any action described in subsection (a), an appeal may be taken directly to the Supreme Court of the United States from any final judgment, decree, or order in which the district court—

(1) holds this Act or any provision of this Act invalid; and

(2) makes a determination that its holding will materially undermine the application of the Act as whole.

(f) CONSTRUCTION.—This section does not limit—

(1) the right of any person—

(A) to a litigation concerning the Act or any portion of the Act; or

(B) to petition the Supreme Court for review of any holding of a district court by writ of certiorari at any time before the rendition of judgment in a court of appeals; or

(2) the authority of the Supreme Court to grant a writ of certiorari for the review described in paragraph (1)(B).

SEC. 5242. TREATMENT OF PLANS AS PARTIES IN CIVIL ACTIONS.

(a) IN GENERAL.—A health plan may sue or be sued under this Act as an entity. Service of summons, subpoena, or other legal process of a court or hearing officer upon a trustee or an administrator of any such plan in his capacity as such shall constitute service upon the plan. In a case where a plan has not designated in applicable plan documents an individual as agent for the service of legal process, service upon the Secretary of Health and Human Services (in the case of a regional alliance health plan) or the Secretary of Labor (in the case of a corporate alliance health plan) shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(b) OTHER PARTIES.—Any money judgment under this Act against a plan referred to in subsection (b) shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this Act.

SEC. 5243. GENERAL NONPREEMPTION OF EXISTING RIGHTS AND REMEDIES.

Nothing in this title shall be construed to deny, impair, or otherwise adversely affect a right or remedy available under law to any person on the date of the enactment of this Act or thereafter, except to the extent the right or remedy is inconsistent with this title.

Subtitle D—Medical Malpractice

PART 1—LIABILITY REFORM

SEC. 5301. FEDERAL TORT REFORM.

(a) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in section 5302, this part shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this part shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(2) PREEMPTION.—The provisions of this part shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this part shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this part.

(3) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in paragraph (2) shall be construed to—

(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(B) waive or affect any defense of sovereign immunity asserted by the United States;

(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(4) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this part shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

(b) DEFINITIONS.—In this subtitle, the following definitions apply:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term "alternative dispute resolution system" or "ADR" means a system that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term "claimant" means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) HEALTH CARE PROFESSIONAL.—The term "health care professional" means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(4) HEALTH CARE PROVIDER.—The term "health care provider" means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(5) INJURY.—The term "injury" means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice claim.

(6) MEDICAL MALPRACTICE LIABILITY ACTION.—The term "medical malpractice liability action" means a civil action brought in a State or Federal court against a health care provider or health care professional (regardless of the theory of liability on which the claim is based) in which the plaintiff alleges a medical malpractice claim.

(7) MEDICAL MALPRACTICE CLAIM.—The term "medical malpractice claim" means a claim in a civil action brought against a health care provider or health care professional in which a claimant alleges that injury was caused by the provision of (or the failure to provide) health care services, except that such term does not include—

(A) any claim based on an allegation of an intentional tort; or

(B) any claim based on an allegation that a product is defective that is brought against any individual or entity that is not a health care professional or health care provider.

SEC. 5302. PLAN-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.

(a) APPLICATION TO MALPRACTICE CLAIMS UNDER PLANS.—In the case of any medical malpractice claim arising from the provision of (or failure to provide) health care services to an individual enrolled in a regional alliance plan or a corporate alliance plan, no medical malpractice liability action may be brought with respect to such claim until the final resolution of the claim under the alternative dispute resolution system adopted by the plan under subsection (b).

(b) ADOPTION OF MECHANISM BY PLANS.—Each regional alliance plan and corporate alliance plan shall—

(1) adopt at least one of the alternative dispute resolution methods specified under subsection (c) for the resolution of medical malpractice claims arising from the provision of health care services to individuals enrolled in the plan; and

(2) disclose to enrollees (and potential enrollees), in a manner specified by the regional alliance or the corporate alliance, the availability and procedures for consumer grievances under the plan, including the alternative dispute resolution method or methods adopted under this subsection.

(c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE DISPUTE RESOLUTION METHODS.—

(1) IN GENERAL.—The National Health Board shall, by regulation, develop alternative dispute resolution methods for the use by regional alliance and corporate alliance plans in resolving medical malpractice claims under subsection (a). Such methods shall include at least the following:

(A) ARBITRATION.—The use of arbitration.

(B) MEDIATION.—The use of required mediation.

(C) EARLY OFFERS OF SETTLEMENT.—The use of a process under which parties are required to make early offers of settlement.

(2) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under paragraph (1), the National Health Board shall assure that the methods promote the resolution of medical malpractice claims in a manner that—

(A) is affordable for the parties involved;

(B) provides for timely resolution of claims;

(C) provides for the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution for individuals enrolled in plans.

(d) FURTHER REDRESS.—A plan enrollee dissatisfied with the determination reached as a result of an alternative dispute resolution method applied under this section may, after the final resolution of the enrollee's claim under the method, bring a cause of action to

seek damages or other redress with respect to the claim to the extent otherwise permitted under State law.

SEC. 5303. REQUIREMENT FOR CERTIFICATE OF MERIT.

(a) REQUIRING SUBMISSION WITH COMPLAINT.—No medical malpractice liability action may be brought by any individual unless, at the time the individual brings the action (except as provided in subsection (b)(2)), the individual submits an affidavit—

(1) declaring that the individual (or the individual's attorney) has consulted and reviewed the facts of the action with a qualified medical specialist (as defined in subsection (c));

(2) including a written report by a qualified medical specialist that clearly identifies the individual and that includes the medical specialist's determination that, after a review of the medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant; and

(3) on the basis of the qualified medical specialist's review and consultation, that the individual (or the individual's attorney) has concluded that there is a reasonable and meritorious cause for the filing of the action.

(b) EXTENSION IN CERTAIN INSTANCES.—

(1) IN GENERAL.—Subject to paragraph (2), subsection (a) shall not apply with respect to an individual who brings a medical malpractice liability action without submitting an affidavit described in such subsection if—

(A) the individual is unable to obtain the affidavit before the expiration of the applicable statute of limitations; or

(B) at the time the individual brings the action, the individual has been unable to obtain medical records or other information necessary to prepare the affidavit requested pursuant to any applicable law.

(2) DEADLINE FOR SUBMISSION WHERE EXTENSION APPLIES.—In the case of an individual who brings an action for which paragraph (1) applies, the action shall be dismissed unless the individual submits the affidavit described in subsection (a) not later than—

(A) in the case of an action for which subparagraph (A) of paragraph (1) applies, 90 days after bringing the action; or

(B) in the case of an action for which subparagraph (B) of paragraph (1) applies, 90 days after obtaining the information described in such subparagraph.

(c) QUALIFIED MEDICAL SPECIALIST DEFINED.—In subsection (a), a "qualified medical specialist" means, with respect to a defendant to a medical malpractice liability action, a health care professional who—

(1) is knowledgeable of, and has expertise in, the same specialty area of medical practice that is the subject of the action; and

(2) is reasonably believed by the individual bringing the action (or the individual's attorney)—

(A) to be knowledgeable in the relevant issues involved in the particular action,

(B) to practice (or to have practiced within the preceding 6 years) or to teach (or to have taught within the preceding 6 years) in the same area of health care or medicine that is at issue in the action, and

(C) to be qualified by experience or demonstrated competence in the subject of the case.

(d) SANCTIONS FOR SUBMITTING FALSE ALLEGATIONS.—Upon the motion of any party or its own initiative, the court in a medical malpractice liability action may impose a sanction on a party or the party's attorney (or both), including a requirement that the party reimburse the other party to the action for costs and reasonable attorney's fees, if any information contained in an affidavit described in subsection (a) is submitted without reasonable cause and is found to be untrue.

SEC. 5304. LIMITATION ON AMOUNT OF ATTORNEY'S CONTINGENCY FEES.

(a) IN GENERAL.—An attorney who represents, on a contingency fee basis, a plaintiff in a medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with such action (including the resolution of the claim that is the subject of the action under any alternative dispute resolution) in excess of 33⅓ of the total amount recovered by judgment or settlement in such action.

(b) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subsection (a) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term "contingency fee" means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 5305. REDUCTION OF AWARDS FOR RECOVERY FROM COLLATERAL SOURCES.

The total amount of damages recovered by a plaintiff in a medical malpractice liability action shall be reduced by the amount of any past or future payment which the claimant has received or for which the claimant is eligible on account of the same injury for which the damages are awarded, including payment under—

(1) Federal or State disability or sickness programs;

(2) Federal, State, or private health insurance programs;

(3) private disability insurance programs;

(4) employer wage continuation programs; and

(5) any other program, if the payment is intended to compensate the claimant for the same injury for which damages are awarded.

SEC. 5306. PERIODIC PAYMENT OF AWARDS.

At the request of any party to a medical malpractice liability action, the defendant shall not be required to pay damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on such schedule as the court considers appropriate, taking into account the periods for which the injured party will need medical and other services.

PART 2—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 5311. ENTERPRISE LIABILITY DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—Not later than January 1, 1996, the Secretary of Health and Human Services shall establish a demonstration project under which the Secretary shall provide funds (in such amount as the Secretary considers appropriate) to one or more eligible States to demonstrate whether substituting liability for medical malpractice on the part of the health plan in which a physician participates for the personal liability of the physician will result in improvements in the quality of care provided under the plan, reductions in defensive medical practices, and better risk management.

(b) ELIGIBILITY OF STATE.—A State is eligible to participate in the demonstration project established under subsection (a) if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing such information and assurances as the Secretary may require, including assurances that the State—

(1) has entered into an agreement with a health plan (other than a fee-for-service plan) operating in the State under which the plan assumes legal liability with respect to any medical malpractice claim arising from the provision of (or failure to provide) services under the plan by any physician participating in the plan;

(2) has provided that, under the law of the State, a physician participating in a plan that has entered into an agreement with the State under paragraph (1) may not be liable in damages or otherwise for such a claim and the plan may not require such physician to indemnify the plan for any such liability; and

(3) will provide the Secretary with such reports on the operation of the project as the Secretary may require.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out demonstration projects under this section.

SEC. 5312. PILOT PROGRAM APPLYING PRACTICE GUIDELINES TO MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) ESTABLISHMENT.—Not later than 1 year after the Secretary of Health and Human Services determines that appropriate practice guidelines are available, the Secretary shall establish a pilot program under which the Secretary shall provide funds (in such amount as the Secretary considers appropriate) to one or more eligible States to determine the effect of applying practice guidelines in the resolution of medical malpractice liability actions.

(b) ELIGIBILITY OF STATE.—A State is eligible to participate in the pilot program established under subsection (a) if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing—

(1) assurances that, under the law of the State, in the resolution of any medical malpractice liability action, it shall be a complete defense to any allegation that a party against whom the action is filed was negligent that, in the provision of (or the failure to provide) the services that are the subject of the action, the party followed the appropriate practice guideline established by the National Quality Management Program under subtitle A; and

(2) such other information and assurances as the Secretary may require.

(c) REPORTS TO CONGRESS.—Not later than 3 months after each year for which the pilot program established under subsection (a) is in effect, the Secretary shall submit a report to Congress describing the operation of the program during the previous year and containing such recommendations as the Secretary considers appropriate, including recommendations relating to revisions to the laws governing medical malpractice liability.

Subtitle E—Fraud and Abuse

PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

SEC. 5401. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1996, the Secretary of Health and Human

Services (acting through the Office of the Inspector General of the Department of Health and Human Services) and the Attorney General shall establish a program—

(1) to coordinate the functions of the Attorney General, the Secretary, and other organizations with respect to the prevention, detection, and control of health care fraud and abuse,

(2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(3) to facilitate the enforcement of this subtitle and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Secretary and Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH HEALTH ALLIANCES AND HEALTH PLANS.—In carrying out the program under subsection (a), the Secretary and Attorney General shall consult with, and arrange for the sharing of data with representatives of health alliances and health plans.

(d) AUTHORITIES OF ATTORNEY GENERAL, SECRETARY, AND INSPECTOR GENERAL.—In carrying out duties established under subsection (a), the Attorney General, the Secretary, and the Inspector General are authorized—

(1) to conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the program established under such subsection; and

(2) to have access (including on-line access as requested and available) to all records available to health alliances and health plans that relate to ongoing investigations or the imposition of sanctions under such program (subject to restrictions based on the confidentiality of certain information under subtitle B).

(e) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act.

(f) AUTHORIZATIONS OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Secretary and the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such additional amounts as may be necessary to enable the Secretary and the Attorney General to conduct investigations, audits, evaluations, and inspections of allegations of health care fraud and abuse and otherwise carry out the program established under subsection (a) in a fiscal year.

(g) USE OF POWERS UNDER INSPECTOR GENERAL ACT OF 1978.—In carrying out duties and responsibilities under the program established under subsection (a), the Inspector General is authorized to exercise all powers granted under the Inspector General Act of 1978 to the same manner and extent as provided in that Act.

(h) DEFINITIONS.—In this part and part 2—

(1) the term "Inspector General" means the Inspector General of the Department of Health and Human Services; and

(2) the term "Secretary" means Secretary of Health and Human Services.

SEC. 5402. ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States an account to be known as the "All-Payer Health Care Fraud and Abuse Control Account" (in this section referred to as the "Anti-Fraud Account "). The Anti-Fraud Account shall consist of such gifts and bequests as may be made as provided in paragraph (2) and such amounts as may be deposited in such Anti-Fraud Account as provided in subsection (b)(4) and title XI of the Social Security Act. It shall also include the following:

(A) All criminal fines imposed in cases involving a Federal health care offense (as defined in subsection (e)).

(B) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(C) Administrative penalties and assessments imposed under titles XI, XVIII and XIX of the Social Security Act and section 5412 (except as otherwise provided by law).

(D) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

Any such funds received on or after the date of the enactment of this Act shall be deposited in the Anti-Fraud Account.

(2) AUTHORIZATION TO ACCEPT GIFTS.—The Anti-Fraud Account is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Anti-Fraud Account, for the benefit of the Anti-Fraud Account, or any activity financed through the Anti-Fraud Account.

(b) USE OF FUNDS.—

(1) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available without appropriation and until expended to assist the Secretary and Attorney General in carrying out the All-Payer Health Care Fraud and Abuse Control Program established under section 5401 (including the administration of the Program), and may be used to cover costs incurred in operating the Program, including—

(A) costs of prosecuting health care matters (through criminal, civil and administrative proceedings);

(B) costs of investigations (including equipment, salaries, administratively uncontrollable work, travel and training of law enforcement personnel);

(C) costs of financial and performance audits of health care programs and operations;

(D) costs of inspections and other evaluations.

(2) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(c) ANNUAL REPORT.—The Secretary and the Attorney General shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

(d) FEDERAL HEALTH CARE OFFENSE DEFINED.—The term "Federal health care offense" means a violation of, or a criminal conspiracy to violate—

(1) sections 226, 668, 1033, or 1347 of title 18, United States Code;

(2) section 1128B of the Social Security Act;

(3) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud;

(4) sections 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud;

(5) sections 301, 303(a)(2), or 303(b) or (e) of the Federal Food Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.

SEC. 5403. USE OF FUNDS BY INSPECTOR GENERAL.

(a) REIMBURSEMENTS FOR INVESTIGATIONS.—

(1) IN GENERAL.—The Inspector General is authorized to receive and retain for current use reimbursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payor, or otherwise.

(2) CREDITING.—Funds received by such Office as reimbursement for costs of conducting investigations shall be deposited to the credit of such Office appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 365 days from the date of their deposit.

(3) EXCEPTION FOR FORFEITURES.—This subsection does not apply to investigative costs paid to such Office from the Health Care Asset Forfeiture Fund, which monies shall be deposited and expended in accordance with subsection (b).

(b) HHS OFFICE OF INSPECTOR GENERAL ASSET FORFEITURE PROCEEDS FUND.—

(1) IN GENERAL.—There is established in the Treasury of the United States the "HHS Office of Inspector General Asset Forfeiture Proceeds Fund," to be administered by the Inspector General, which shall be available to such Office without fiscal year limitation for expenses relating to the investigation of matters within the jurisdiction of such Office.

(2) DEPOSITS.—There shall be deposited in the Fund all proceeds from forfeitures that have been transferred to the Office of Inspector General from the Department of Justice Asset Forfeiture Fund under section 524(d)(1) of title 28, United States Code.

PART 2—APPLICATION OF FRAUD AND ABUSE AUTHORITIES UNDER THE SOCIAL SECURITY ACT TO ALL PAYERS

SEC. 5411. EXCLUSION FROM PARTICIPATION.

(a) MANDATORY EXCLUSION.—The Secretary shall exclude an individual or entity from participation in any applicable health plan if the individual or entity is described in section 1128(a) of the Social Security Act (relating to individuals and entities convicted of health care-related crimes or patient abuse).

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude an individual or entity from participation in any applicable health plan if the individual or entity is described in section 1128(b) of the Social Security Act (other than paragraphs (6)(A), (6)(C), (6)(D), (10), or (13) of such section).

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.— (1) An exclusion under this section or section 5412(b)(3) shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2) Such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 5412 of this Act, the minimum period (or, in the case of an exclusion of an individual described in section 1128(b)(12) of the Social Security Act, the period) of the exclusion.

(B) In the case of a mandatory exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years.

(C) In the case of an exclusion of an individual described in paragraph (1), (2), or (3) of section 1128(b) of the Social Security Act, the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that a longer period is necessary because of aggravating circumstances.

(D) In the case of an exclusion of an individual or entity described in paragraph (4) or (5) of sections 1128(b) of the Social Security Act, the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(E) In the case of an exclusion of an individual or entity described in paragraph (6)(B) of section 1128(b) of the Social Security Act, the period of the exclusion shall be not less than 1 year.

(F) In the case of an exclusion of an individual described in paragraph (12) of section 1128(b) of the Social Security Act, the period of the exclusion shall be equal to the sum of—

(i) the length of the period in which the individual failed to grant the immediate access described in that paragraph, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(d) NOTICE TO ENTITIES ADMINISTERING PUBLIC PROGRAMS FOR THE DELIVERY OF OR PAYMENT FOR HEALTH CARE ITEMS OR SERVICES.—(1) The Secretary shall exercise the authority under this section in a manner that results in an individual's or entity's exclusion from all applicable health plans for the delivery of or payment for health care items or services.

(2) The Secretary shall promptly notify each sponsor of an applicable health plan and each entity that administers a State health care program described in section 1128(h) of the Social Security Act of the fact and circumstances of each exclusion effected against an individual or entity under this section or under section 5412.

(e) NOTICE TO STATE LICENSING AGENCIES.—The provisions of section 1128(e) of the Social Security Act shall apply to this section in the same manner as such provisions apply to sections 1128 and 1128A of such Act.

(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b) of the Social Security Act, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g) of such Act, except that such action shall be brought in the Court of Appeals of the United States for the judicial circuit in which the individual or entity resides, or has a principal place of business, or, if the individual or entity does not reside or have a principal place of business within any such judicial circuit, in the United States Court of Appeals for the District of Columbia Circuit.

(2) Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination based on paragraphs (3), (4), (5), (6), (7), (8), (9), or (14) of section 1128(b) of the Social Security Act, shall be entitled to a hearing by an administrative law judge (as provided under section 205(b) of the Social Security Act) on the determination before any exclusion based upon the determination takes effect. If a hearing is requested, the exclusion shall be effective upon the issuance of an order by the administrative law judge upholding the determination of the Secretary to exclude.

(3) The provisions of section 205(h) of the Social Security Act shall apply with respect to this section to the same extent as such provisions apply with respect to title II of such Act.

(g) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual or entity excluded (or directed to be excluded) from participation under this section or section 5412(b)(3) may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion (or, in the case of an individual or entity described in section 1128(b)(8), the period of exclusion) provided under this section and a such other times as the Secretary may provide, for termination of the exclusion.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(A) there is no basis under this section or section 5412(b)(3) for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each sponsor of an applicable health plan entity that administers a State health care program described in section 1128(h) of the Social Security Act of each termination of exclusion made under this subsection.

(h) CONVICTED DEFINED.—In this section, the term "convicted" has the meaning given such term in section 1128(i) of the Social Security Act.

(i) REQUEST FOR EXCLUSION.—The sponsor of any applicable health plan (including a State in the case of a regional alliance health plan and the Secretary of Labor in the case of a corporate alliance health plan) may request that the Secretary of Health and Human Services exclude an individual or entity with respect to actions under such a plan in accordance with this section.

SEC. 5412. CIVIL MONETARY PENALTIES.

(a) ACTIONS SUBJECT TO PENALTY.—Any person who is determined by the Secretary to have committed any of the following actions with respect to an applicable health plan shall be subject to a penalty in accordance with subsection (b):

(1) ACTIONS SUBJECT TO PENALTY UNDER MEDICARE, MEDICAID, AND OTHER SOCIAL SECURITY HEALTH PROGRAMS.—Any action that would subject the person to a penalty under paragraphs (1) through (12) of section 1128A of the Social Security Act if the action was taken with respect to title V, XVIII, XIX or XX of such Act.

(2) TERMINATION OF ENROLLMENT.—The termination of an individual's enrollment (including the refusal to re-enroll an individual) in violation of subtitle E of title I or State law.

(3) DISCRIMINATING ON BASIS OF MEDICAL CONDITION.—The engagement in any practice that would reasonably be expected to have the effect of denying or discouraging the initial or continued enrollment in a health plan by individuals whose medical condition or history indicates a need for substantial future medical services.

(4) INDUCING ENROLLMENT ON FALSE PRETENSES.—The engagement in any practice to induce enrollment in an applicable health plan through representations to individuals which the person knows or should know are false or fraudulent.

(5) PROVIDING INCENTIVES TO ENROLL.—The offer or payment of remuneration to any individual eligible to enroll in an applicable health plan that such person knows or should know is likely to influence such individual to enroll in a particular plan.

(b) PENALTIES DESCRIBED.—

(1) GENERAL RULE.—Any person who the Secretary determines has committed an action described in paragraphs (2) through (6) of subsection (a) shall be subject to a civil monetary penalty in an amount not to exceed $50,000 for each such determination.

(2) ACTIONS SUBJECT TO PENALTIES UNDER SOCIAL SECURITY ACT.—In the case of a person who the Secretary determines has committed an action described in paragraph (1) of subsection (a), the person shall be subject to the civil monetary penalty (together with any additional assessment) to which the person would be subject under section 1128A of the Social Security Act if the action on which the determination is based had been committed with respect to title V, XVIII, XIX or XX of such Act.

(3) DETERMINATIONS TO EXCLUDE PERMITTED.—In addition to any civil monetary penalty imposed under this subsection, the Secretary may make a determination in the same proceeding to exclude the person from participation in all applicable health plans for the delivery of or payment for health care items or services (in accordance with section 5411(c)).

(c) PROCEDURES FOR IMPOSITION OF PENALTIES.—

(1) APPLICABILITY OF PROCEDURES UNDER SOCIAL SECURITY ACT.—Except as otherwise provided in paragraphs (2) and (3), the provisions of subsections (c), (d), (e), (g), (j), (k), and (l) of section 1128A of the Social Security Act shall apply with respect to the imposition of penalties under this section in the same manner as such provisions apply with respect to the imposition of civil monetary penalties under section 1128A of such Act.

(2) LIMITATION ON TIME FOR ATTORNEY GENERAL TO ACT.—The first sentence of section 1128A(c) of the Social Security Act shall be applied with respect to civil monetary penalties under this section as if the reference in such section to "one year" was a reference to "60 days".

(3) AUTHORITY OF STATES TO IMPOSE PENALTIES.—If no proceeding to impose a civil monetary penalty under this section with respect to actions relating to a regional alliance health plan has been initiated (by either the Attorney General or the Secretary) within 120 days after the Secretary presents a case to the Attorney General for consideration of the imposition of such a penalty, the State in which the alliance is located may initiate proceedings to impose a civil monetary penalty under this section with respect

to the action in the same manner as the Secretary may initiate such proceedings.

(d) TREATMENT OF AMOUNTS RECOVERED.—Any amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) Such portions of the amounts recovered as is determined to have been improperly paid from an applicable health plan for the delivery of or payment for health care items or services shall be repaid to such plan.

(2) The remainder of the amounts recovered shall be deposited in the All-Payer Health Care Fraud and Abuse Control Account established under section 5402.

(e) NOTIFICATION OF LICENSING AUTHORITIES.—Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under this section becomes final, the Secretary shall notify the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) of the Social Security Act) that such a penalty, assessment, or exclusion has become final and the reasons therefor.

SEC. 5413. LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

The provisions of section 1877 of the Social Security Act shall apply—

(1) to items and services (and payments and claims for payment for such items and services) furnished under any applicable health plan in the same manner as such provisions apply to designated health services (and payments and claims for payment for such services) under title XVIII of the Social Security Act; and

(2) to a State (with respect to an item or service furnished or payment made under a regional alliance health plan) and to the Secretary of Labor (with respect to a an item or service furnished or payment made under a corporate alliance health plan) in the same manner as such provisions apply to the Secretary.

SEC. 5414. CONSTRUCTION OF SOCIAL SECURITY ACT REFERENCES.

(a) INCORPORATION OF OTHER AMENDMENTS.—Any reference in this part to a provision of the Social Security Act shall be considered a reference to the provision as amended under title IV.

(b) EFFECT OF SUBSEQUENT AMENDMENTS.—Except as provided in subsection (a), any reference to a provision of the Social Security Act in this part shall be deemed to be a reference to such provision as in effect on the date of the enactment of this Act, and (except as Congress may otherwise provide) any amendments made to such provisions after such date shall not be taken into account in determining the applicability of such provisions to individuals and entities under this Act.

PART 3—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS UNDER THE SOCIAL SECURITY ACT

SEC. 5421. REFERENCE TO AMENDMENTS.

For provisions amending the anti-fraud and abuse provisions existing under the Social Security Act, see part 5 of subtitle A of title IV.

PART 4—AMENDMENTS TO CRIMINAL LAW

SEC. 5431. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

"(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

"(1) to defraud any health alliance, health plan, or other person, in connection with the delivery of or payment for health care benefits, items, or services;

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health alliance, health plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title) such person shall be imprisoned for life or any term of years.

"(b) As used in this section, the terms 'health alliance' and 'health plan' have the meanings given those terms in title I of the Health Security Act.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud.".

SEC. 5432. FORFEITURES FOR VIOLATIONS OF FRAUD STATUTES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:

"(6) If the court determines that a Federal health care offense (as defined in section 5402(e) of the Health Security Act) is of a type that poses a serious threat to the health of any person or has a significant detrimental impact on the health care system, the court, in imposing sentence on a person convicted of that offense, shall order that person to forfeit property, real or personal, that—

"(A)(i) is used in the commission of the offense; or

"(ii) constitutes or is derived from proceeds traceable to the commission of the offense; and

"(B) is of a value proportionate to the seriousness of the offense.".

(b) PROCEEDS OF HEALTH CARE FRAUD FORFEITURES.—Section 524(c)(4)(A) of title 28, United States Code, is amended by inserting "all proceeds of forfeitures relating to Federal health care offenses (as defined in section 5402(e) of the Health Security Act), and" after "except".

SEC. 5433. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"§ 1033. False statements relating to health care matters

"(a) Whoever, in any matter involving a health alliance or health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section the terms 'health alliance' and 'health plan' have the meanings given those terms in title I of the Health Security Act.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"1033. False statements relating to health care matters.".

SEC. 5434. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"§ 226. Bribery and graft in connection with health care

"(a) Whoever—

"(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises a health care official to give anything of value to any other person, with intent—

"(A) to influence, or for or because of, any of the health care official's actions, decisions, or duties relating to a health alliance or health plan;

"(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a health alliance or health plan, or for or because of any such conduct on the part of such an official; or

"(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official, or for or because of such conduct; or

"(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection.

"(b) As used in this section—

"(1) the term 'health care official' means—

"(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any health care alliance or health plan;

"(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any health alliance or health plan;

"(C) an official or employee of a State agency having regulatory authority over any health alliance or health plan;

"(D) an officer, counsel, agent, or employee of a health care sponsor; and

"(2) the term 'health care sponsor' means any individual or entity serving as the sponsor of a health alliance or health plan for purposes of the Health Security Act, and includes the joint board of trustees or other similar body used by two or more employers to administer a health alliance or health plan for purposes of such Act.".

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"226. Bribery and graft in connection with health care.".

SEC. 5435. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (A);

(2) by inserting "or" at the end of subparagraph (B); and

(3) by adding at the end the following:

"(C) committing or about to commit a Federal health care offense (as defined in section 5402(e) of the Health Security Act);".

SEC. 5436. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

"(c) A person who is privy to grand jury information concerning a health law violation—

"(1) received in the course of duty as an attorney for the Government; or

"(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil proceeding related to a Federal health care offense (as defined in section 5402(e) of the Health Security Act), or for use in connection with civil forfeiture under section 981(a)(1)(C) of this title.".

SEC. 5437. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"§ 668. Theft or embezzlement in connection with health care

"(a) Whoever embezzles, steals, willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, securities, premiums, credits, property, or other assets of a health alliance, health plan, or of any fund connected with such an alliance or plan, shall be fined under this title or imprisoned not more than 10 years, or both.

"(b) As used in this section, the terms 'health alliance' and 'health plan' have the meanings given those terms under title I of the Health Security Act.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"668. Theft or embezzlement in connection with health care.".

SEC. 5438. MISUSE OF HEALTH SECURITY CARD OR UNIQUE IDENTIFIER.

(a) IN GENERAL.—Chapter 33 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 716. Misuse of health security card or unique identifier

"Whoever—

"(1) requires the display of, requires the use of, or uses a health security card that is issued under section 1001(b) of the American Health Security Act for any purpose other than a purpose described in section 5105(a) of such Act; or

"(2) requires the disclosure of, requires the use of, or uses a unique identifier number provided pursuant to section 5104 of such Act for any purpose that is not authorized by the National Health Board pursuant to such section;

shall be fined under this title or imprisoned not more than 2 years, or both.".

(b) CLERICAL AMENDMENTS TO TABLE OF SECTIONS.—The table of sections at the beginning of chapter 33, United States Code, is amended—

(1) by amending the catchline to read as follows:

"CHAPTER 33—EMBLEMS, INSIGNIA, IDENTIFIERS, AND NAMES";

and

(2) by adding at the end the following new item:

"716. Misuse of health security card or unique identifier.".

(c) CLERICAL AMENDMENT TO TABLE OF CHAPTERS.—The item relating to chapter 33 in the table of chapters at the beginning of part 1 of title 18, United States Code, is amended to read as follows:

"33. Emblems, insignia, identifiers, and names ..... 701".

PART 5—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

SEC. 5441. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.

Section 3729 of title 31, United States Code, is amended—

(1) in subsection (a)(7), by inserting "or to a health plan," after "property to the Government,";

(2) in the matter following subsection (a)(7), by inserting "or health plan" before "sustains because of the act of that person,";

(3) at the end of the first sentence of subsection (a), by inserting "or health plan" before "sustains because of the act of the person.";

(4) in subsection (c)—

(A) by inserting "the term" after "section,"; and

(B) by adding at the end the following: "The term also includes any request or demand, whether under contract of otherwise, for money or property which is made or presented to a health plan." ; and

(5) by adding at the end the following:

"(f) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' has the meaning given such term under section 1400 of the Health Security Act.".

Subtitle F—McCarran-Ferguson Reform

SEC. 5501. REPEAL OF EXEMPTION FOR HEALTH INSURANCE.

(a) IN GENERAL.—Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson Act, is amended by adding at the end the following:

"(c) Notwithstanding that the business of insurance is regulated by State law, nothing in this Act shall limit the applicability of the following Acts to the business of insurance to the extent that such business relates to the provision of health benefits:

"(1) The Sherman Act (15 U.S.C. 1 et seq.).

"(2) The Clayton Act (15 U.S.C. 12 et seq.).

"(3) Federal Trade Commission Act (15 U.S.C. 41 et seq.).

"(4) The Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 21a et seq.), known as the Robinson-Patman Antidiscrimination Act.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the first day of the sixth month beginning after the date of the enactment of this Act.

TITLE VI—PREMIUM CAPS; PREMIUM-BASED FINANCING; AND PLAN PAYMENTS

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SEC. 6000. GENERAL DEFINITIONS.

(a) DEFINITIONS RELATING TO BIDS.—In this title:

(1) ACCEPTED BID.—The term "accepted bid" means the bid which is agreed to between a regional alliance health plan and a regional alliance for coverage of the comprehensive benefit package in the alliance area under part 1.

(2) FINAL ACCEPTED BID.—The term "final accepted bid" means the accepted bid, taking into account any voluntary reduction in such bid made under section 6004(e).

(3) WEIGHTED AVERAGE ACCEPTED BID.—The term "weighted average accepted bid" means, for a regional alliance for a year, the average of the accepted bids for all regional alliance health plans offered by such alliance, weighted to reflect the relative enrollment of regional alliance eligible individuals among such plans.

(4) REDUCED WEIGHTED AVERAGE ACCEPTED BID.—The term "reduced weighted average accepted bid", for a health plan offered by a regional alliance for a year, is the lesser of—

(A) the weighted average accepted bid for the regional alliance for the year (determined using the final accepted bids as the accepted bids), or

(B) the regional alliance per capita target for the year.

(b) WEIGHTED AVERAGE PREMIUM.—In this title, the term "weighted average premium" means, for a class of family enrollment and with respect to a regional alliance for a year, the product of—

(1) reduced weighted average accepted bid (as defined in subsection (a)(4));

(2) the uniform per capita conversion factor (established under section 1341(b)) for the alliance; and

(3) the premium class factor established by the Board for that class under section 1531.

(c) INCORPORATION OF OTHER DEFINITIONS.—Except as otherwise provided in this title, the definitions of terms in subtitle J of title I of this Act shall apply to this title.

Subtitle A—Premium Caps

PART 1—REGIONAL ALLIANCE HEALTH EXPENDITURES

Subpart A—Computation of Targets and Accepted Bids

SEC. 6001. COMPUTATION OF REGIONAL ALLIANCE INFLATION FACTORS.

(a) COMPUTATION.—

(1) IN GENERAL.—This section provides for the computation of a factors that limit the growth of premiums for the comprehensive benefit package in regional alliance health plans. The Board shall compute and publish, not later than March 1 of each year (beginning with 1995) the regional alliance inflation factor (as defined in paragraph (2)) for each regional alliance for the following year.

(2) REGIONAL ALLIANCE INFLATION FACTOR.—In this part, the term "regional alliance inflation factor" means, for a year for a regional alliance—

(A) the general health care inflation factor for the year (as defined in paragraph (2));

(B) adjusted under subsection (c) (to take into account material changes in the demographic and socio-economic characteristics of the population of alliance eligible individuals);

(C) decreased by the percentage adjustment (if any) provided with respect to the regional alliance under subsection (d) (relating to adjustment for previous excess expenditures); and

(D) in the case of the year 2001, increased by a factor that the Board determines to reflect the ratio of (i) the actuarial value of the increase in benefits provided in that year under the comprehensive benefit package to (ii) the actuarial value of the benefits that would have been in such package in the year without regard to the increase.

(3) GENERAL HEALTH CARE INFLATION FACTOR.—

(A) 1996 THROUGH 1999 of this part, the term "general health care inflation factor", for a year, means the percentage increase in the CPI (as specified under subsection (b)) for the year plus the following:

(i) For 1996, 1.5 percentage points.

(ii) For 1997, 1.0 percentage points.

(iii) For 1998, 0.5 percentage points.

(iv) For 1999, 0 percentage points.

(B) YEARS AFTER 1999.—

(i) RECOMMENDATION TO CONGRESS.—In 1998, the Board shall submit to Congress recommendations on what the general health care inflation factor should be for years beginning with 2000.

(ii) FAILURE OF CONGRESS TO ACT.—If the Congress fails to enact a law specifying the general health care inflation factor for a year after 1999, the Board, in January of the year before the year involved, shall compute such factor for the year involved. Such factor shall be the product of the factors described in subparagraph (C) for that fiscal year.

(C) FACTOR.—The factor described in this subparagraph for a year is 1 plus the following:

(i) CPI.—The percentage change in the CPI for the year, determined based upon the percentage change in the average of the CPI for the 12-month period ending with August 31 of the previous fiscal year over such average for the preceding 12-month period.

(ii) POPULATION.—The average annual percentage change in the population of the United States during the 3-year period ending in the calendar year, determined by the Board based on data supplied by the Bureau of the Census.

(iii) REAL GDP PER CAPITA.—The average annual percentage change in the real, per capita gross domestic product of the United States during the 3-year period ending in the preceding calendar year, determined by the Board based on data supplied by the Department of Commerce.

(b) PROJECTION OF INCREASE IN CPI.—

(1) IN GENERAL.—For purposes of this section, the Board shall specify, as of the time of publication, the annual percentage increase in the CPI (as defined in section 1902(9)) for the following year.

(2) DATA TO BE USED.—Such increase shall be the projection of the CPI contained in the budget of the United States transmitted by the President to the Congress in the year.

(c) SPECIAL ADJUSTMENT FOR MATERIAL CHANGES IN DEMOGRAPHIC CHARACTERISTICS OF POPULATION.—

(1) ADJUSTMENT FOR CORPORATE ALLIANCE OPT-IN.—

(A) IN GENERAL.—The Board shall develop a method for adjusting the regional alliance inflator factor for each regional alliance in order to reflect material changes in the demographic characteristics of regional alliance eligible individuals residing in the alliance area (in comparison with such characteristics for the previous year) as a result of one or more corporate alliances terminating an election under section 1313.

(B) BASIS FOR ADJUSTMENTS.—Adjustments under this paragraph (whether an increase or decrease) shall be based on the characteristics and factors used for making adjustments in payments under section 6124.

(2) ADJUSTMENT FOR REGIONAL TREND COMPARED TO NATIONAL TREND.—

(A) IN GENERAL.—The Board shall develop a method for adjusting the regional alliance inflator factor for each regional alliance in order to reflect material changes in the demographic characteristics (including at least age, gender, and socio-economic status) and health status of regional alliance eligible individuals residing in the alliance area in comparison with the average change in such characteristics for such individuals residing in the United States. The adjustment under this paragraph shall be for changes not taken into account in the adjustment under paragraph (1).

(B) NEUTRAL ADJUSTMENT.—Such method (and any annual adjustment under this paragraph) shall be designed to result in the adjustment effected under this paragraph for a year not changing the weighted average of the regional alliance inflation factors.

(3) APPLICATION.—The Board shall provide, on an annual basis, for an adjustment of regional alliance inflation factors under this subsection using such method.

(d) ADJUSTMENT FOR PREVIOUS EXCESS RATE OF INCREASE IN EXPENDITURES.—

(1) IN GENERAL.—If actual weighted average accepted bid for a regional alliance for a year (as determined by the Board based on actual enrollment in the first month of the year) exceeds the regional alliance per capita premium target (determined under section 6003(a)) for the year, then the regional alliance inflation factor—

(A) for the succeeding year shall be reduced by the product of—

(i) ½ of the excess percentage (described in paragraph (3)) for the previous year, and

(ii) the adjustment factor (described in paragraph (2)(A)) for such succeeding year; and

(B) in the second succeeding year shall be reduced by the product of—

(i) ½ of such excess percentage, and

(ii) the adjustment factor (described in paragraph (2)(B)) for such second succeeding year.

(2) ADJUSTMENT FACTORS.—

(A) SUCCEEDING YEAR.—With respect to a succeeding year, the adjustment factor described in this subparagraph is 1 plus the regional alliance inflation factor for such year.

(B) SECOND SUCCEEDING YEAR.—With respect to a second succeeding year, the adjustment factor described in this subparagraph is the product of—

(i) 1 plus the regional alliance inflation factor for such year, and

(ii) 1 plus the regional alliance inflation factor for the previous year.

(C) NO ADJUSTMENT IN FACTOR CONSIDERED.—For purposes of subparagraphs (A) and (B), the regional alliance inflation factor for a year shall not take into account any adjustment under this subsection.

(3) EXCESS PERCENTAGE.—The excess percentage described in this paragraph for a year is the percentage by which—

(A) actual weighted average accepted bid (referred to in paragraph (1)) for a regional alliance for the year, exceeds

(B) the regional alliance per capita premium target (determined under section 6003(a)) for the year.

(e) CONSULTATION PROCESS.—The Board shall have a process for consulting with representatives of States and regional alliances before establishing the regional alliance inflation factors for each year under this section.

SEC. 6002. BOARD DETERMINATION OF NATIONAL PER CAPITA BASELINE PREMIUM TARGET.

(a) IN GENERAL.—Not later than January 1, 1995, the Board shall determine a national per capita baseline premium target. Such target is equal to—

(1) the national average per capita current coverage health expenditures (determined under subsection (b)),

(2) updated under subsection (c).

(b) DETERMINATION OF NATIONAL AVERAGE PER CAPITA CURRENT COVERAGE HEALTH EXPENDITURES.—

(1) IN GENERAL.—The Board shall determine the national average per capita current coverage health expenditures equal to—

(A) total covered current health care expenditures (described in paragraph (2)), divided by

(B) the estimated population in the United States of regional alliance eligible individuals (as determined by the Board as of the 1993 under subsection (c)(3)) for whom such expenditures were determined.

The population under subparagraph (B) shall not include SSI recipients or AFDC recipients.

(2) CURRENT HEALTH CARE EXPENDITURES.—For purposes of paragraph (1)(A), the Board shall determine current health care expenditures as follows:

(A) DETERMINATION OF TOTAL EXPENDITURES.—The Board shall first determine the amount of total payments made for items and services included in the comprehensive benefit package (determined without regard to cost sharing) in the United States in 1993.

(B) REMOVAL OF CERTAIN EXPENDITURES NOT TO BE COVERED THROUGH REGIONAL ALLIANCES.—The amount so determined shall be decreased by the proportion of such amount that is attributable to any of the following:

(i) Medicare beneficiaries (other than such beneficiaries who are regional alliance eligible individuals).

(ii) AFDC recipients or SSI recipients.

(iii) Expenditures which are paid for through workers' compensation or automobile or other liability insurance.

(iv) Expenditures by parties (including the Federal Government) that the Board determines will not be payable by regional alliance health plans for coverage of the comprehensive benefit package under this Act.

(C) ADDITION OF PROJECTED EXPENDITURES FOR UNINSURED AND UNDERINSURED INDIVIDUALS.—The amount so determined and adjusted shall be increased to take into account increased utilization of, and expenditures for, items and services covered under the comprehensive benefit package likely to occur, as a result of coverage under a regional alliance health plan of individuals who, as of 1993 were uninsured or underinsured with respect to the comprehensive benefit package. In making such determination, such expenditures shall be based on the estimated average cost for such services in 1993 (and not on private payment rates established for such services). In making such determination, the estimated amount of uncompensated care in 1993 shall be removed.

(D) ADDITION OF HEALTH PLAN AND ALLIANCE COSTS OF ADMINISTRATION.—

(i) IN GENERAL.—The amount so determined and adjusted shall be increased by an estimated percentage (determined by the Board, but no more than 15 percent) that reflects the proportion of premiums that are required for health plan and regional alliance administration (including regional alliance costs for administration of income-related premium discounts and cost sharing reductions) and for State premium taxes (which taxes shall be limited to such amounts in 1993 as are attributable to the health benefits to be included in the comprehensive benefit package).

(E) DECREASE FOR COST SHARING.—The amount so determined and adjusted shall be decreased by a percentage that reflects (i) the estimated average percentage of total amounts payable for items and services covered under the comprehensive benefit package that will be payments in the form of cost sharing under a high cost sharing plan, and (ii) the percentage reduction in utilization estimated to result from the application of high cost sharing.

(3) SPECIAL RULES.—

(A) BENEFITS USED.—The determinations under this section shall be based on the comprehensive benefit package as in effect in 1996.

(B) ASSUMING NO CHANGE IN EXPENDITURE PATTERN.—The determination under paragraph (2) shall be made without regard to any change in the pattern of expenditures that may result from the enrollment of AFDC recipients and SSI recipients in regional alliance health plans.

(C) ELIGIBLE INDIVIDUALS.—In this subsection, the determination of who are regional alliance eligible individuals under this subsection shall be made as though this Act was fully in effect in each State as of 1993.

(c) UPDATING.—

(1) IN GENERAL.—Subject to paragraph (3), the Board shall update the amount determined under subsection (b)(1) for each of 1994, 1995, and 1996 by the appropriate update factor described in paragraph (2) for the year.

(2) APPROPRIATE UPDATE FACTOR.—In paragraph (1), the appropriate update factor for a year is 1 plus the annual percentage increase for the year (as determined by the Administrator of the Health Care Financing Administration, based on actual or projected information) in private sector health care spending for items and services included in the comprehensive benefit package (as of 1996).

(3) LIMIT.—The total, cumulative update under this subsection shall not exceed 15 percent.

SEC. 6003. DETERMINATION OF ALLIANCE PER CAPITA PREMIUM TARGETS.

(a) INITIAL DETERMINATION.—Not later than January 1, 1995, the Board shall determine, for each regional alliance for 1996, a regional alliance per capita premium target. Such target shall equal—

(1) the national per capita baseline premium target (determined by the Board under section 6002),

(2) updated by the regional alliance inflation factor (as determined under section 6001(a)(2)) for 1996, and

(3) adjusted by the adjustment factor for the regional alliance (determined under subsection (c)).

(b) SUBSEQUENT DETERMINATIONS.—

(1) DETERMINATION.—Not later than March 1 of each year (beginning with 1996) the Board shall determine, for each regional alliance for the succeeding year a regional alliance per capita premium target.

(2) GENERAL RULE.—Subject to paragraph (3), such target shall equal—

(A) the regional alliance per capita target determined under this section for the regional alliance for the previous year, and

(B) updated by the regional alliance inflation factor (as determined in section 6001(a)) for the year.

(c) ADJUSTMENT FACTORS FOR REGIONAL ALLIANCES FOR INITIAL DETERMINATION.—

(1) IN GENERAL.—The Board shall establish an adjustment factor for each regional alliance in a manner consistent with this subsection.

(2) CONSIDERATIONS.—In establishing the factor for each regional alliance, the Board shall consider, using information of the type described in paragraph (3), the difference between the national average of the factors taken into account in determining the national per capita baseline premium target and such factors for the regional alliance, including variations in health care expenditures and in rates of uninsurance and underinsurance in the different alliance areas and including variations in the proportion of expenditures for services provided by academic health centers in the different alliance areas.

(3) TYPES OF INFORMATION.—The type of information described in this paragraph is—

(A) information on variations in premiums across States and across alliance areas within a State (based on surveys and other data);

(B) information on variations in per capita health spending by State, as measured by the Health Care Financing Administration;

(C) information on variations across States in per capita spending under the medicare program and in such spending among alliance areas within a State under such program; and

(D) area rating factors commonly used by actuaries.

(4) APPLICATION OF FACTORS IN NEUTRAL MANNER.—The application of the adjustment factors under this subsection for 1996 shall be done in a manner so that the weighted average of the regional alliance per capita premium targets for 1996 is equal to the national per capita baseline premium target determined under section 6002. Such weighted average shall be based on the Board's estimate of the expected distribution of alliance eligible individuals (taken into account under section 6002) among the regional alliances.

(5) CONSULTATION PROCESS.—The Board shall have a process for consulting with representatives of States and regional alliances before establishing the adjustment for regional alliances under this subsection.

(d) TREATMENT OF CERTAIN STATES.—

(1) NON-ALLIANCE STATES.—In the case of a State that is not a participating State or otherwise has not established regional alliances, the entire State shall be treated under the provisions of this part as composing a single regional alliance.

(2) CHANGES IN ALLIANCE BOUNDARIES.—In the case of a State that changes the boundaries of its regional alliances (including the establishment of such alliances after 1996), the Board shall provide a method for computing a regional alliance per capita premium target for each regional alliance affected by such change in a manner that—

(A) reflects the factors taken into account in establishing the adjustment factors for regional alliances under subsection (c), and

(B) results in the weighted average of the newly computed regional targets for the regional alliances affected by the change equal to the weighted average of the regional targets for the regional alliances as previously established.

SEC. 6004. ALLIANCE INITIAL BIDDING AND NEGOTIATION PROCESS.

(a) BIDDING PROCESS.—

(1) OBTAINING BIDS.—

(A) IN GENERAL.—Not later than July 1 before the first year, and not later than August 1 of each succeeding year, the regional alliance shall have obtained premium bids from each plan seeking to participate as a regional alliance health plan with respect to the alliance in the following year.

(B) DISCLOSURE.—In obtaining such bids, a regional alliance may determine to disclose (or not to disclose) the regional alliance per capita premium target for the regional alliance (determined under section 6003) for the year involved.

(C) CONDITION.—Each bid submitted by a plan under this subsection shall be conditioned upon the plan's agreement to accept any premium payment reduction that may be imposed under section 6011.

(2) NEGOTIATION PROCESS.—Following the bidding process under paragraph (1), a State may provide for negotiations with health plans relating to the premiums to be charged by such plans. Such negotiations may result in the resubmission of bids, but in no case shall a health plan resubmit a bid that exceeds its prior bid.

(3) LEGALLY BINDING BIDS.—All bids submitted under this subsection must be legally binding with respect to the plans involved.

(4) ACCEPTANCE.—The final bid submitted by a plan under this subsection shall be considered to be the accepted bid, except as provided in subsection (e).

(5) ASSISTANCE.—The Board shall provide regional alliances with such information and technical assistance as may assist such alliances in the bidding process under this subsection.

(b) SUBMISSION OF INFORMATION TO BOARD.—By not later than September 1 of each year for which bids are obtained under subsection (a), each regional alliance shall submit to the Board a report that discloses—

(1) information regarding the final bids obtained under subsection (a) by the different plans;

(2)(A) for the first year, any information the Board may request concerning an estimation of the enrollment likely in each such plan of alliance eligible individuals who will be offered enrollment in a health plan by alliance in the first year, or

(B) for a succeeding year, the actual distribution of enrollment of alliance eligible individuals in regional alliance health plans in the year in which the report is transmitted; and

(3) limitations on capacity of regional alliance health plans.

(c) COMPUTATION OF WEIGHTED AVERAGE ACCEPTED BID.—

(1) IN GENERAL.—For each regional alliance the Board shall determine a weighted average accepted bid for each year for which bids are obtained under subsection (a). Such determination shall be based on information on accepted bids for the year, submitted under subsection (b)(1), and shall take into account, subject to paragraph (2), the information on enrollment distribution submitted under subsection (b)(2).

(2) ENROLLMENT DISTRIBUTION RULES.—In making the determination under paragraph (1) for a regional alliance, the Board shall establish rules respecting the treatment of enrollment in plans that are discontinued or are newly offered.

(d) NOTICE TO CERTAIN ALLIANCES.—

(1) IN GENERAL.—By not later than October 1 of each year for which bids are obtained, the Board shall notify a regional alliance—

(A) if the weighted average accepted bid (determined under subsection (c)) for the alliance is greater than the regional alliance per capita premium target for the alliance (determined under section 6002) for the year, and

(B) the reduced weighted average accepted bid for the alliance.

(2) NOTICE OF PREMIUM REDUCTIONS.—If notice is provided to a regional alliance under paragraph (1), the Board shall notify the regional alliance and each noncomplying plan of any plan payment reduction computed under section 6011 for such a plan and the opportunity to voluntarily reduce the accepted bid under subsection (e) in order to avoid such a reduction.

(e) VOLUNTARY REDUCTION OF ACCEPTED BID (FINAL ACCEPTED BID).—After the Board has determined under subsection (c) the weighted average accepted bid for a regional alliance and the Board has determined preliminary plan payment reductions, before such date as the Board may specify (in order to provide for an open enrollment period), a noncomplying plan has the opportunity to voluntarily reduce its accepted bid by the amount of the plan payment reduction that would otherwise apply to the plan. Such reduction shall not affect the amount of the plan payment reduction for any other plan for that year.

SEC. 6005. STATE FINANCIAL INCENTIVES.

(a) ELECTION.—Any participating State may elect to assume responsibility for containment of health care expenditures in the State consistent with this part. Such responsibility shall include submitting annual reports to the Board on any activities undertaken by the State to contain such expenditures.

(b) FINANCIAL INCENTIVE.—In the case of a State that has made an election under subsection (a), if Board determines for a particular year (beginning with the first year) that the statewide weighted average of the reduced weighted average accepted bids (based on actual average enrollment for the year), for regional alliances in the State, is less than the statewide weighted average of the regional alliance per capita premium targets (based upon such enrollment) for such alliances for the year, then the amount of the State maintenance-of-effort payment under section 9001(b), for the following year, shall be reduced by ½ of the product of—

(1)(A) the amount by which the amount of such target exceeds the amount of such premium, divided by (B) the amount of such target; and

(2) the total of the amount of the Federal payments made in that particular year to regional alliances in the State under subtitle B of title IX.

SEC. 6006. RECOMMENDATIONS TO ELIMINATE REGIONAL VARIATIONS IN ALLIANCE TARGETS DUE TO VARIATION IN PRACTICE PATTERNS; CONGRESSIONAL CONSIDERATION.

(a) ESTABLISHMENT OF ADVISORY COMMISSION ON REGIONAL VARIATIONS IN HEALTH EXPENDITURES.—The chair of the Board shall establish, by not later than 60 days after the date of appointment of the first chair, an advisory commission on regional variations in health expenditures.

(b) COMPOSITION.—The advisory commission shall be composed of consumers, employers, providers, representatives of health plans, States, regional alliances, individuals with expertise in the financing of health care, individuals with expertise in the economics of health care, and representatives of diverse geographic areas.

(c) REGIONAL VARIATIONS.—

(1) INFORMATION.—The advisory commission shall provide the Board, States, and regional alliances with information about regional differences in health care costs and practice patterns.

(2) METHODS FOR ELIMINATION OF REGIONAL VARIATION DUE TO PRACTICE PATTERN.—The advisory commission shall examine methods of eliminating variation in regional alliance per capita premium targets due to variation in practice patterns, not due to other factors (such as health care input prices and demographic factors), by 2002.

(3) METHODS FOR REDUCING REGIONAL VARIATION IN PREMIUM PAYMENTS FOR AFDC AND SSI RECIPIENTS DUE TO HISTORICAL VARIATION IN CHARACTERISTICS OF STATE MEDICAID PLANS.—The advisory commission shall examine methods of reducing the variation in Federal and State payments under sections 9011 and 9101. In addition to the factors considered in paragraph (2), the commission shall examine methods of reducing variation due to historical differences in the rates of reimbursement to providers and in the amount, duration, and scope of benefits covered under State medicaid plans.

(4) METHODS FOR REDUCTION OF REGIONAL VARIATION IN STATE MAINTENANCE-OF-EFFORT PAYMENTS FOR NON-CASH ASSISTANCE RECIPIENTS.—The advisory commission shall study the reasons for variation among States in the level of maintenance of effort payments for non-cash assistance recipients and shall examine methods of reducing variation across States in the level of maintenance of effort payments compared to the population of the State. The commission shall link consideration of the variation in premium targets under paragraph (2) with the variation in State and Federal payments described in this paragraph.

(5) OTHER FACTORS.—The advisory commission shall examine methods of reducing variations in spending among States for health care services that are attributable to historical differences.

(d) RECOMMENDATIONS TO BOARD.—The advisory commission shall submit to the Board a report that specifies—

(1) one or more methods for eliminating the variation described in subsection (c)(2), and

(2) one or more methods for reducing variations described in subsection (c)(4) across States.

(e) REPORT TO CONGRESS.—

(1) IN GENERAL.—The Board shall submit to Congress, by not later than July 1, 1995, detailed recommendations respecting the specific method to be used to achieve each of the following:

(A) The elimination of the variation in the regional alliance per capita premium (as described in subsection (b)(2)) by 2002.

(B) Reducing the variation in State payments under sections 9001 and 9011 (taking into account any interaction between these payments), in a manner that is budget neutral with respect to total government payments and payments by the Federal Government.

In making recommendations in subparagraph (B), the Board shall consider the fiscal capacity of the States.

(2) SUBSEQUENT REPORT.—If a joint resolution described in subsection (f) does not become law, the Board shall submit to Congress revised detailed recommendations respecting the specific method to be used to achieve the elimination of such variation by 2002. Such recommendations shall be submitted not later than 90 days after the date such resolution is disapproved by either House (or vetoed by the President) or, if earlier, 150 days after the date of submission of the recommendations under paragraph (1).

(f) CONGRESSIONAL CONSIDERATION.—

(1) IN GENERAL.—Detailed recommendations submitted under paragraph (1)(A) or (1)(B) or (2) of subsection (e) shall apply under this subtitle only if a joint resolution (described in paragraph (2)) approving such recommendations is enacted, in accordance with the provisions of paragraph (3), before the end of the 60-day period beginning on the date on which such recommendations were submitted. For purposes of applying the preceding sentence and paragraphs (2) and (3), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

(2) JOINT RESOLUTION OF APPROVAL.—A joint resolution described in this paragraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the Board submits recommendations under paragraph (1)(A), (1)(B), or (2) of subsection (e) and—

(A) which does not have a preamble;

(B) the matter after the resolving clause of which is either of the following 2 clauses:

(i) For recommendations under paragraph (1)(A): "That Congress approves the recommendations of the National Health Board concerning elimination of regional variation in regional alliance per capita premium targets under subtitle A of title VI of the Health Security Act, as submitted by the Board on _____.", the blank space being filled in with the appropriate date; or

(ii) For recommendations under paragraph (1)(B): "That Congress approves the recommendations of the National Health Board concerning reducing the variation in State payments under sections 9001 and 9011 of the Health Security Act, as submitted by the Board on _____.", the blank space being filled in with the appropriate date; and

(C) the title of which, respectively, is either of the following:

(i) For recommendations under paragraph (1)(A): "Joint resolution approving recommendations of the National Health Board concerning elimination of regional variation in regional alliance per capita premium targets under subtitle A of title VI of the Health Security Act, as submitted by the Board on _____.", the blank space being filled in with the appropriate date; or

(ii) For recommendations under paragraph (1)(B): "Joint resolution approving recommendations of the National Health Board concerning reducing the variation in State payments under sections 9001 and 9011 of the Health Security Act, as submitted by the Board on _____.", the blank space being filled in with the appropriate date.

(3) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to paragraph (4), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in paragraph (2) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(4) SPECIAL RULES.—For purposes of applying paragraph (3) with respect to such provisions—

(A) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of recommendations under subsection (e)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Majority Leader of the Senate at the time of submission of recommendations under subsection (e)); and

(B) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the Board submits a recommendation under paragraph (1)(A), (1)(B), or (2) of subsection (e).

SEC. 6007. REFERENCE TO LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN DETERMINATIONS.

For limitation on administrative and judicial review of certain determinations under this part, see section 5232.

Subpart B—Plan and Provider Payment Reductions to Maintain Expenditures within Targets

SEC. 6011. PLAN PAYMENT REDUCTION.

(a) PLAN PAYMENT REDUCTION.—In order to assure that payments to regional alliance health plans by a regional alliance are consistent with the applicable regional alliance per capita target for the alliance (computed under this subtitle), each noncomplying plan (as defined in subsection (b)(2)) for a year is subject to a reduction in plan payment (under section 1351) by the amount equal to plan payment reduction specified in subsection (c) for the year.

(b) NONCOMPLYING ALLIANCE AND NONCOMPLYING PLAN DEFINED.—In this part:

(1) NONCOMPLYING ALLIANCE.—The term "noncomplying alliance" means, for a year, a regional alliance for which the weighted average accepted bid (computed under section 6004(c)) exceeds the regional alliance per capita target for the year.

(2) NONCOMPLYING PLAN.—The term "noncomplying plan" means, for a year, a regional alliance health plan offered through a noncomplying alliance if the final accepted bid for the year exceeds the maximum complying bid (as defined in subsection (d)) for the year. No plan shall be a noncomplying plan for a year before the first year in which the plan is offered by a regional alliance.

(c) AMOUNT OF PLAN PAYMENT REDUCTION.—

(1) IN GENERAL.—The amount of the plan payment reduction, for a noncomplying plan offered by an alliance, is the alliance-wide reduction percentage (as defined in paragraph (2)) of the excess bid amount (as defined in paragraph (3)).

(2) ALLIANCE-WIDE REDUCTION PERCENTAGE.—

(A) IN GENERAL.—In paragraph (1), the term "alliance-wide reduction percentage" means, for a noncomplying plan offered by an alliance for a year—

(i) the amount by which (I) the weighted average accepted bid (computed under section 6004(c)(1)) for the alliance for the year, exceeds the regional alliance per capita target for the alliance for the year; divided by

(ii) the sum, for noncomplying plans offered by the alliance, of the plan proportions of alliance excess bid amount (described in subparagraph (B)(i)) for the year.

(B) PLAN PROPORTION OF ALLIANCE EXCESS BID AMOUNT DESCRIBED.—

(i) IN GENERAL.—The "plan proportion of alliance excess bid amount" described in this clause, for a noncomplying plan, is the product of—

(I) the excess bid amount (as defined in paragraph (4)) for the plan, and

(II) the plan enrollment proportion (as defined in clause (ii)) for the plan.

(ii) PLAN ENROLLMENT PROPORTION.—In clause (i)(II), the term "plan enrollment proportion" means, with respect to a health plan offered by a regional alliance, the total enrollment of alliance eligible individuals enrolled in such plan expressed as a percentage of the total enrollment of alliance eligible individuals in all regional alliance plans offered by the alliance. Such proportion shall be computed based on the information used in computing the weighted average accepted bid for the alliance under section 6004(c)(1).

(3) EXCESS BID AMOUNT.—In this subsection, the "excess bid amount", with respect to a noncomplying plan for a year, is the amount by which—

(i) the accepted bid for the year (not taking into account any voluntary reduction under section 6004(e)), exceeds

(ii) the maximum complying bid (as defined in subsection (d)) for the plan for the year.

(d) MAXIMUM COMPLYING BID.—

(1) FIRST YEAR.—In this part, subject to paragraph (3), for the first year, the "maximum complying bid" for each plan offered by a regional alliance, is the regional alliance per capita premium target for the alliance (determined under section 6002) for the year.

(2) SUBSEQUENT YEARS.—In this part, subject to paragraph (3), for a subsequent year, the "maximum complying bid", for a plan offered by an alliance for a year, is the sum of the following:

(A) NET PREVIOUS YEAR ACCEPTED BID FOR PLAN.—The accepted bid for the previous year (not taking into account any voluntary reduction under section 6004(e)), minus the amount of any plan payment reduction for the plan for that year.

(B) ALLIANCE-WIDE INFLATION ALLOWANCE.—The amount by which—

(i) regional alliance per capita premium target for the year, exceeds

(ii) such target for the previous year, or, if less, the weighted average accepted bid (computed under section 6004(c)(1)) for such year.

(3) SPECIAL RULES FOR NEW PLANS.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a plan that is first offered by a regional alliance in a year after the first year the maximum complying bid shall be the regional alliance per capita premium target for the year.

(B) AUTHORITY.—The Board or a State may establish rules to modify the application of subparagraph (A) for regional alliance health plans in the State in order—

(i) to prevent abusive premium practices by entities previously offering plans, or

(ii) to encourage the availability of all types of plans in the State and to permit establishment of new plans.

SEC. 6012. PROVIDER PAYMENT REDUCTION.

(a) PARTICIPATING PROVIDERS.—

(1) IN GENERAL.—Each regional alliance health plan, as part of its contract under section 1406(e) with any participating provider (as defined in section 1407(c), or group of participating providers) shall—

(A) include a provision that provides that if the plan is a noncomplying plan for a year, payments to the provider (or group) shall be reduced by the applicable network reduction percentage (described in paragraph (2)) for the year, and

(B) not include any provision which the State determines otherwise varies the payments to such providers (or group) because of, or in relation to, a plan payment reduction under section 6011 or otherwise is intended to nullify the effect of subparagraph (A).

The Board may issue regulations relating to the requirements of this paragraph.

(2) APPLICABLE NETWORK REDUCTION PERCENTAGE.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the "adjusted plan reduction percentage", with respect to network providers of a noncomplying plan for a year is—

(i) the plan payment reduction amount for the plan for the year (as determined under section 6011(c)), divided by

(ii) the final accepted bid for the plan for the year,

adjusted under subparagraph (B).

(B) INDUCED VOLUME OFFSET.—The Board shall provide for an appropriate increase of the percentage reduction computed under subparagraph (A) to take into account any estimated increase in volume of services provided that may reasonably be anticipated as a consequence of applying a reduction in payment under this subsection. The Board may compute and apply such increase differently for different classes of providers or services or different types of health plans (as the Board may define).

(b) OTHER PROVIDERS.—

(1) IN GENERAL.—Each regional alliance health plan that is a noncomplying plan in a

year shall provide for a reduction in the amount of payments to providers (or groups of providers) that are not participating providers under the applicable alliance fee schedule under section 1406(c)(3) by the applicable nonnetwork reduction percentage (described in paragraph (2)) for the year.

(2) APPLICABLE NONNETWORK REDUCTION PERCENTAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), the "adjusted plan reduction percentage", with respect to nonnetwork providers of a noncomplying plan for a year is—

(i) the plan payment reduction amount for the plan for the year (as determined under section 6011(c)), divided by

(ii) the final accepted bid for the plan for the year,

adjusted under subparagraph (B).

(B) INDUCED VOLUME OFFSET.—The Board shall provide for an appropriate adjustment of the percentage reduction computed under subparagraph (A) to take into account any estimated increase in volume of services provided that may reasonably be anticipated as a consequence of applying a reduction in payment under this subsection.

(c) APPLICATION TO COST SHARING AND TO BALANCE BILLING RESTRICTIONS.—For purposes of applying section 1406(d) (relating to balance billing limitations) and part 3 of subtitle B of title I (relating to computation of cost sharing), the payment basis otherwise used for computing any limitation on billing or cost sharing shall be such payment basis as adjusted by any reductions effected under this section.

PART 2—CORPORATE ALLIANCES HEALTH EXPENDITURES

SEC. 6021. CALCULATION OF PREMIUM EQUIVALENTS.

(a) IN GENERAL.—By January 1, 1997, the Board shall develop a methodology for calculating an annual per capita expenditure equivalent for amounts paid for coverage for the comprehensive benefit package within a corporate alliance.

(b) ADJUSTMENT PERMITTED.—Such methodology shall permit a corporate alliance to petition the Secretary of Labor for an adjustment of the inflation adjustment that would otherwise apply to compensate for material changes in the demographic characteristics of the eligible individuals receiving coverage through the alliance.

(c) REPORTING.—In 2000 and each subsequent year, each corporate alliance shall report to the Secretary of Labor, in a form and manner specified by the Secretary, the average of the annual per capita expenditure equivalent for the previous 3-year period.

SEC. 6022. TERMINATION OF CORPORATE ALLIANCE FOR EXCESS INCREASE IN EXPENDITURES.

(a) TERMINATION.—

(1) IN GENERAL.—If a corporate alliance has two excess years (as defined in subsection (b)) in a 3-year-period, then, effective beginning with the second year following the second excess year in such period—

(A) the Secretary of Labor shall terminate the corporate alliance, and

(B) employers that were corporate alliance employers with respect to such corporate alliance shall become regional alliance employers (unless, in the case of a corporate alliance with a plan sponsor described in subparagraph (B) or (C) of section 1311(b)(1), the employers become corporate alliance employers of another such corporate alliance).

(2) INITIAL 3-YEAR-PERIOD.—Paragraph (1) shall first apply to the 3-year-period beginning with 1997.

(3) SPECIAL SUBSEQUENT TREATMENT FOR LARGE EMPLOYERS.—In the case of corporate alliance employers described in paragraph (1)(B) that are large employers, the employer premium payments under section 6121 are subject to adjustment under section 6124.

(4) NO FURTHER ELECTION.—If a corporate alliance of a large employer is terminated under this subsection, no employer that is a corporate alliance employer for that alliance is eligible to be a sponsor of a corporate alliance.

(b) EXCESS YEAR.—

(1) IN GENERAL.—In subsection (a), the term "excess year" means, for a corporate alliance, a year (beginning on or after 2000) for which—

(A) the rate of increase for the corporate alliance (specified in paragraph (2)) for the year, exceeds

(B) the national corporate inflation factor (specified in paragraph (3)) for the year.

(2) RATE OF INCREASE FOR CORPORATE ALLIANCE.—The rate of increase for a corporate alliance for a year, specified in this paragraph, is the percentage by which—

(A) the average of the annual per capita expenditure equivalent for the corporate alliance (reported under section 6021(c)) for the 3-year period ending with such year, exceeds

(B) the average of the annual per capita expenditure equivalent for the corporate alliance (reported under such subsection) for the 3-year period ending with the previous year.

(3) NATIONAL CORPORATE INFLATION FACTOR.—The national corporate inflation factor for a year, specified in this paragraph, is the average of the general health care inflation factors (as defined in section 6001(a)(3)) for each of the 3 years ending with such year.

PART 3—TREATMENT OF SINGLE-PAYER STATES

SEC. 6031. SPECIAL RULES FOR SINGLE-PAYER STATES.

In the case of a Statewide single-payer State, for purposes of section 1222(6), the Board shall compute a Statewide per capita premium target for each year in the same manner as a regional alliance per capita premium target is determined under section 6003.

PART 4—TRANSITION PROVISIONS

SEC. 6041. MONITORING PRICES AND EXPENDITURES.

(a) IN GENERAL.—The Secretary shall establish a program to monitor prices and expenditures in the health care system in the Unites States.

(b) REPORTS.—The Secretary shall periodically report to the President on—

(1) the rate of increase in expenditures in each sector of the health care system, and

(2) how such rates compare with rate of overall increase in health care spending and rate of increase in the consumer price index.

(c) ACCESS TO INFORMATION.—

(1) IN GENERAL.—The Secretary may obtain, through surveys or otherwise, information on prices and expenditures for health care services. The Secretary may compel health care providers and third party payers to disclose such information as is necessary to carry out the program under this section.

(2) CONFIDENTIALITY.—Non-public information obtained under this subsection with respect to individual patients is confidential.

(d) PERIODIC REPORTS.—The Secretary shall periodically issue public reports on the matters described in subsection (b).

Subtitle B—Premium-Related Financings

PART 1—FAMILY PREMIUM PAYMENTS

Subpart A—Family Share

SEC. 6101. FAMILY SHARE OF PREMIUM.

(a) REQUIREMENT.—Each family enrolled in a regional alliance health plan or in a corporate alliance health plan in a class of family enrollment is responsible for payment of the family share of premium payable respecting such enrollment. Such premium may be paid by an employer or other person on behalf of such a family.

(b) FAMILY SHARE OF PREMIUM DEFINED.—

(1) IN GENERAL.—In this subtitle, the term "family share of premium" means, with respect to enrollment of a family—

(A) in a regional alliance health plan, the amount specified in paragraph (2) for the class, or

(B) in a corporate alliance health plan, the amount specified in paragraph (3) for the class.

(2) REGIONAL ALLIANCE.—

(A) IN GENERAL.—The amount specified in this paragraph for a health plan based on a class of family enrollment is the sum of the base amounts described in subparagraph (B) reduced (but not below zero) by the sum of the amounts described in subparagraph (C).

(B) BASE.—The base amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) REGIONAL ALLIANCE PREMIUM.—The premium specified in section 6102(a) with respect to such class of enrollment.

(ii) FAMILY COLLECTION SHORTFALL.—20 percent of the family collection shortfall add-on (computed under section 6107 for such class).

(C) CREDITS AND DISCOUNTS.—The amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) ALLIANCE CREDIT.—The amount of the alliance credit under section 6103(a).

(ii) INCOME RELATED DISCOUNT.—The amount of any income-related discount provided under section 6104(a)(1).

(iii) EXCESS PREMIUM CREDIT.—The amount of any excess premium credit provided under section 6105.

(iv) CORPORATE ALLIANCE OPT-IN CREDIT.—The amount of any corporate alliance opt-in credit provided under section 6106.

(v) ADDITIONAL CREDIT FOR SSI AND AFDC RECIPIENTS.—In the case of an SSI or AFDC family or for whom the amount described in clause (ii) is equal to the amount described in section 6104(b)(1)(A), the amount described in subparagraph (B)(ii).

(D) LIMIT ON MISCELLANEOUS CREDITS.—In no case shall the family share, due to credits under subparagraph (C), be less than zero.

(3) CORPORATE ALLIANCE.—

(A) IN GENERAL.—The amount specified in this paragraph for a health plan based on a class of family enrollment is the sum of the premium described in subparagraph (B) reduced (but not below zero) by the sum of the amounts described in subparagraph (C).

(B) PREMIUM.—The premium described in this subparagraph (for a plan for a class of enrollment) is premium specified under section 1364 with respect to the plan and class of enrollment involved.

(C) CREDITS AND DISCOUNTS.—The amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) ALLIANCE CREDIT.—The amount of the alliance credit under section 6103(b).

(ii) INCOME RELATED DISCOUNT.—The amount of any income-related discount provided under section 6104(a)(2).

SEC. 6102. AMOUNT OF PREMIUM.

(a) REGIONAL ALLIANCE.—The amount of the premium charged by a regional alliance for all families in a class of family enrollment under a regional alliance health plan offered by the alliance is equal to the product of—

(1) the final accepted bid for the plan (as defined in section 6000(a)(2)),

(2) the uniform per capita conversion factor (established under section 1341(b)) for the alliance; and

(3) the premium class factor established by the Board for that class under section 1531.

(b) REFERENCE TO CORPORATE ALLIANCE PREMIUM PROVISIONS.—The amount of the premium charged by a corporate alliance for all families in a class of family enrollment under a corporate alliance health plan offered by the alliance is specified under section 1364.

(c) SPECIAL RULES FOR DIVIDED FAMILIES.—In the case of an individual who is a qualifying employee of an employer and the individual has a spouse or child who is not treated as part of the individual's family because of section 1012—

(1) the combined premium for both families under this section shall be computed as though such section had not applied,

(2) the regional alliance shall divide such premium between the families proportionally (consistent with rules established by the Board), and

(3) credits and other amounts shall be prorated in a manner consistent with rules established by the Board.

SEC. 6103. ALLIANCE CREDIT.

(a) REGIONAL ALLIANCES.—The credit provided under this section for a family enrolled in a regional alliance health plan through a regional alliance for a class of family enrollment is equal to 80 percent of the weighted average premium (as defined in section 6000(c)) for health plans offered by the alliance for the class.

(b) CORPORATE ALLIANCES.—The credit provided under this section for a family enrolled in a health corporate alliance health plan for a class of family enrollment is equal to the minimum employer premium payment required under section 6131 with respect to the family.

SEC. 6104. PREMIUM DISCOUNT BASED ON INCOME.

(a) IN GENERAL.—

(1) ENROLLEES IN REGIONAL ALLIANCE HEALTH PLANS.—Each family enrolled with a regional alliance health plan is entitled to a premium discount under this section, in the amount specified in subsection (b), if the family—

(A) is an AFDC or SSI family,

(B) is determined, under subpart B of part 2 of subtitle B of title D of title I, to have family adjusted income below 150 percent of the applicable poverty level, or

(C) is a family described in subsection (c)(3) for which the family obligation amount under this subsection for the year would otherwise exceed a specified percent of family adjusted income described in such subsection.

(2) ENROLLEES IN CORPORATE ALLIANCE HEALTH PLANS.—

(A) IN GENERAL.—Subject to subparagraph (B), each family enrolled with a corporate alliance health plan in a class of family enrollment by virtue of the full-time employment of a low-wage employee (as defined in subparagraph (B)) is entitled to a premium discount under this section in the amount (if any) by which—

(i) 95 percent of the premium (specified in section 1364) for the least expensive corporate alliance health plan that is offered to the employee and that is a low or combination cost sharing plan (as defined in section 1903( )) for that class, exceeds

(ii) the alliance credit under section 6103 for that class.

(B) LOW-WAGE EMPLOYEE DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "low-wage employee" means, with respect to an employer, an employee who is employed on a full-time basis and who is receiving wages (as defined in section 1902( )) for employment for the employer, as determined under clause (ii), at an annual rate of less than $15,000 (as adjusted under clause (ii)).

(ii) INDEXING.—For a year after 1994, the dollar amount specified in clause (i) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI (described in section 1902( )) for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31, 1993.

(C) TIMING OF DETERMINATION.—

(i) IN GENERAL.—The determination of whether or not an employee is a low-wage employee shall be made, in accordance with rules of the Secretary of Labor, at the time of initial enrollment and shall also be made at the time of each subsequent open enrollment period, on the basis of the wages payable by the employer at that time.

(ii) EFFECTIVE DATE.—Such determination shall apply as of the effective date of the initial enrollment, or, in the case of an open enrollment period, as of the effective date of changes in enrollment during such period.

(3) NO LIABILITY FOR INDIANS AND CERTAIN VETERANS AND MILITARY PERSONNEL.—

(A) IN GENERAL.—In the case of an individual described in subparagraph (B), because the applicable health plan does not impose any premium for such an individual, the individual is not eligible for any premium discount under this section.

(B) INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is—

(i) an electing veteran (as defined in section 1012(d)(1)) who is enrolled under a health plan of the Department of Veterans Affairs and who, under the laws and rules as in effect as of December 31, 1994, has a service-connected disability or who is unable to defray the expenses of necessary care as determined under section 1722(a) of title 38, United States Code,

(ii) active duty military personnel (as defined in section 1012(d)(2)), and

(iii) an electing Indian (described in section 1012(d)(3)).

(b) AMOUNT OF PREMIUM DISCOUNT FOR REGIONAL ALLIANCE HEALTH PLANS.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the amount of premium discount under this subsection for a family enrolled in a regional alliance health plan under a class of family enrollment is equal to—

(A) 20 percent of the weighted average premium for regional alliance health plans offered by the regional alliance for that class of enrollment, increased by any amount provided under paragraph (2); reduced (but not below zero) by

(B) the sum of—

(i) the family obligation amount described in subsection (c), and

(ii) the amount of any employer payment (not required under part 2) towards the family share of premiums for covered members of the family.

(2) INCREASE TO ASSURE ENROLLMENT IN LOWER-THAN-AVERAGE-COST PLAN.—If a regional alliance determines that a family eligible for a discount under this section is unable to enroll in a lower-than-average-cost plan (as defined in paragraph (3)) that serves the area in which the family resides, the amount of the premium discount under this subsection is increased but only to such amount as will permit the family to enroll in a regional alliance health plan without the need to pay a family share of premium under this part in excess of the sum described in paragraph (1)(B).

(3) LOWER-THAN-AVERAGE-COST PLAN DEFINED.—In this section, the term "lower-than-average-cost plan" means a regional alliance health plan the premium for which does not exceed, for the class of family enrollment involved, the weighted average premium for the regional alliance.

(c) FAMILY OBLIGATION AMOUNT.—

(1) DETERMINATION.—Subject to paragraphs (2) and (3), the family obligation amount under this subsection is determined as follows:

(A) NO OBLIGATION IF INCOME BELOW INCOME THRESHOLD AMOUNT OR IF AFDC OR SSI FAMILY.—If the family adjusted income (as determined under section 1332(a)) of the family is less than the income threshold amount (specified in paragraph (4)) or if the family is an AFDC or SSI family, the family obligation amount is zero.

(B) INCOME ABOVE INCOME THRESHOLD AMOUNT.—If such income is at least such income threshold amount and the family is not an AFDC or SSI family, the family obligation amount is the sum of the following:

(i) FOR INCOME (ABOVE INCOME THRESHOLD AMOUNT) UP TO THE POVERTY LEVEL.—The product of the initial marginal rate (specified in paragraph (2)(A)) and the amount by which—

(I) the family adjusted income (not including any portion that exceeds the applicable poverty level for the class of family involved), exceeds

(II) such income threshold amount.

(ii) GRADUATED PHASE OUT OF DISCOUNT UP TO 150 PERCENT OF POVERTY LEVEL.—The product of the final marginal rate (specified in paragraph (2)(B)) and the amount by which the family adjusted income exceeds 100 percent (but is less than 150 percent) of the applicable poverty level.

(2) MARGINAL RATES.—In paragraph (1)—

(A) INDIVIDUAL MARGINAL RATES.—For a year for an individual class of enrollment—

(i) INITIAL MARGINAL RATE.—The initial marginal rate is the ratio of—

(I) 3 percent of the applicable poverty level for the individual class of enrollment for the year, to

(II) the amount by which such poverty level exceeds such income threshold amount.

(ii) FINAL MARGINAL RATE.—The final marginal rate is the ratio of—

(I) the amount by which the general family share (as defined in subparagraph (C)) for an individual class of enrollment exceeds 3 percent of the applicable poverty level (for an individual class of enrollment for the year); to

(ii) 50 percent of such poverty level.

(B) FAMILY MARGINAL RATES.—For a year for a family class of enrollment (as defined in section 1011(c)(2)(A))—

(i) INITIAL MARGINAL RATE.—The initial marginal rate is the ratio of—

(I) 3 percent of the applicable poverty level for a dual parent class of enrollment for the year, to

(II) the amount by which such poverty level exceeds such income threshold amount.

(ii) FINAL MARGINAL RATE.—The final marginal rate is the ratio of—

(I) the amount by which the general family share (as defined in subparagraph (C)) for a dual parent class of enrollment exceeds 3 percent of the applicable poverty level (for such a class for the year); to

(ii) 50 percent of such poverty level.

(C) GENERAL FAMILY SHARE.—In subparagraphs (A) and (B), the term "general family

share" means, for a class, the weighted average premium for the class minus the alliance credit (determined without regard to this section).

(3) LIMITATION TO 3.9 PERCENT FOR ALL FAMILIES.—

(A) IN GENERAL.—In the case of a family with family adjusted income of less than $40,000 (adjusted under subparagraph (B)) for a year, in no case shall the family obligation amount under this subsection for the year exceed 3.9 percent (adjusted under subparagraph (C)) of the amount of such adjusted income.

(B) INDEXING OF DOLLAR AMOUNTS.—

(i) IN GENERAL.—For a year after 1994, the dollar amounts specified in subparagraph (A) and in section 6113(d)(1)(B) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI (described in section 1902( )) for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31, 1993.

(ii) ROUNDING.—The dollar amounts adjusted under this subparagraph shall be rounded each year to the nearest multiple of $100.

(C) INDEXING OF PERCENTAGE.—

(i) IN GENERAL.—The percentage specified in subparagraph (A) shall be adjusted for any year after 1994 so that the percentage for the year bears the same ratio to the percentage so specified as the ratio of—

(I) 1 plus general health care inflation factor (as defined in section 6001(a)(3)) for the year, bears to

(II) 1 plus the percentage increase or decrease specified in section 1136(b) (relating to indexing of dollar amounts related to cost sharing) for the year.

(ii) ROUNDING.—Any adjustment under clause (i) for a year shall be rounded to the nearest multiple of 1/10 of 1 percentage point.

(4) INCOME THRESHOLD AMOUNT.—

(A) IN GENERAL.—For purposes of this subtitle, the income threshold amount specified in this paragraph is $1,000 (adjusted under subparagraph (B)).

(B) INDEXING.—For a year after 1994, the income threshold amount specified in subparagraph (A) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI (described in section 1902( )) for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31, 1993.

(C) ROUNDING.—Any increase or decrease under subparagraph (B) for a year shall be rounded to the nearest multiple of $10.

SEC. 6105. EXCESS PREMIUM CREDIT.

(a) IN GENERAL.—If plan payment reductions are made for one or more regional alliance health plans offered by a regional alliance for plan payments in a year under section 6021, the alliance shall provide for a credit under this section, in the amount described in subsection (b), in the case of each family enrolled in a regional alliance health plan offered by the alliance for premiums in the year.

(b) AMOUNT OF CREDIT.—

(1) IN GENERAL.—Subject to paragraph (2), the amount of the credit under this subsection, for a family enrolled in a class of family enrollment for a regional alliance for a year, is the amount that would be the weighted average premium for such alliance, class, and year, if the per capita excess premium amount (determined under subsection (c)) for the alliance for the year were substituted for the reduced weighted average accepted bid for the regional alliance for the year.

(2) ADJUSTMENT TO ACCOUNT FOR USE OF ESTIMATES.—Subject to section 1361(b)(3), if the total payments made by a regional alliance to all regional alliance health plans in a year under section 1351(b) exceeds (or is less than) the total of such payments estimated by the alliance (based on the reduced weighted average accepted bid under subsection (c)(1)), because of a difference between—

(A) the alliance's estimate of the distribution of enrolled families between excess premium plans and other plans, and

(B) the actual distribution of such enrolled families among such plans,

the amount of the credit under this section in the second succeeding year shall be reduced (or increased, respectively) by the amount of such excess (or deficit) in the total of such payments made by the alliance to all such plans.

(c) PER CAPITA EXCESS PREMIUM AMOUNT.—The per capita excess premium amount, for a regional alliance for a year, is the amount by which—

(1) the reduced weighted average accepted bid for the alliance for the year, exceeds

(2) the regional alliance per capita target for the alliance for the year.

SEC. 6106. CORPORATE ALLIANCE OPT-IN CREDIT.

(a) IN GENERAL.—If a regional alliance is owed a payment adjustment under section 6124 for a year, then the alliance shall provide for a credit under this section, equal to 20 percent of the amount described in subsection (b), in the case of each family enrolled in a regional alliance plan offered by the alliance.

(b) AMOUNT OF CREDIT.—The amount described in this subsection, for a family enrolled in a class of family enrollment for a regional alliance for a year, is the amount that would be the weighted average premium for such alliance, class, and year, if the per capita corporate alliance opt-in amount (determined under subsection (c)) for the alliance for the year were substituted for the reduced weighted average accepted bid for the regional alliance for the year.

(c) PER CAPITA CORPORATE ALLIANCE OPT-IN AMOUNT.—The per capita corporate alliance opt-in amount, for a regional alliance for a year, is—

(1) the total amount of the payment adjustments owed for the year under section 6124, divided by

(2) the estimated average number of regional alliance eligible individuals in the regional alliance during the year (reduced by the average number of such individuals whose family share of premiums, determined without regard to this section and section 6107, is zero).

SEC. 6107. FAMILY COLLECTION SHORTFALL ADD-ON.

(a) IN GENERAL.—The family collection shortfall add-on, for a regional alliance for a class of enrollment for a year, is the amount that would be the weighted average premium for such alliance, class, and year, if the per capita collection shortfall amount (determined under subsection (b)) for the alliance for the year were substituted for the reduced weighted average accepted bid for the regional alliance for the year.

(b) COMPUTATION OF PER CAPITA ADJUSTMENT FOR COLLECTION SHORTFALLS.—

(1) PER CAPITA COLLECTION SHORTFALL AMOUNT .—The per capita collection shortfall amount, for a regional alliance for a year, under this subsection is equal to—

(A) the amount estimated under paragraph (2)(A) for the year, divided by

(B) the estimated average number of regional alliance eligible individuals in the regional alliance during the year (reduced by the average number of such individuals whose family share of premiums, determined without regard to this section and section 6106, is zero).

(2) AGGREGATE COLLECTION SHORTFALL.—

(A) IN GENERAL.—Each regional alliance shall estimate, for each year (beginning with the first year) the total amount of payments which the alliance can reasonably identify as owed to the alliance under this Act (taking into account any premium reduction or discount under this subtitle and including amounts owed under subpart B and not taking into account any penalties) for the year and not likely to be collected (after making collection efforts described in section 1345) during a period specified by the Secretary beginning on the first day of the year.

(B) EXCLUSION OF GOVERNMENT DEBTS.—The amount under subparagraph (A) shall not include any payments owed to a regional alliance by the Federal, State, or local governments.

(C) ADJUSTMENT FOR PREVIOUS SHORTFALL ESTIMATION DISCREPANCY.—Subject to section 1361(b)(3), the amount estimated under this paragraph for a year shall be adjusted to reflect over (or under) estimations in the amounts so computed under this paragraph for previous years (based on actual collections), taking into account interest payable based upon borrowings (or savings) attributable to such over or under estimations.

Subpart B—Repayment of Alliance Credit by Certain Families

SEC. 6111. REPAYMENT OF ALLIANCE CREDIT BY CERTAIN FAMILIES.

(a) IN GENERAL.—Subject to the succeeding provisions of this subpart, each family which is provided an alliance credit under section 6103 for a class of enrollment is liable to the regional alliance for repayment of the amount of such credit in accordance with section 1343.

(b) REDUCTION FOR SELF-EMPLOYMENT PAYMENTS.—The liability of a family under this section for a year shall be reduced (but not below zero) by the amount of any employer payments made in the year under section 6126 based on the net earnings from self-employment of a family member.

SEC. 6112. NO LIABILITY FOR FAMILIES EMPLOYED FULL-TIME; REDUCTION IN LIABILITY FOR PART-TIME EMPLOYMENT.

(a) IN GENERAL.—The amount of any liability under section 6111 shall be reduced, in accordance with rules established by the National Health Board consistent with this section, based on employer premiums payable, under section 6121, with respect to the employment of a family member who is a qualifying employee or with respect to a family member. In no case shall the reduction under this section result in any payment owing to a family.

(b) CREDIT FOR FULL-TIME AND PART-TIME EMPLOYMENT.—

(1) IN GENERAL.—Under such rules, in the case of a family enrolled under a class of family enrollment, if a family member is a qualifying employee for a month and the employer is liable for payment under section 6121 based on such employment—

(A) FULL-TIME EMPLOYMENT CREDIT.—If the employment is on a full-time basis (as defined in section 1902(b)(2)) the liability under section 6111 shall be reduced by the credit amount described in subparagraph (C).

(B) PART-TIME EMPLOYMENT CREDIT.—If the employment is on a part-time basis (as defined in section 6121(d)) the liability under

section 6111 shall be reduced by the employment ratio (as defined in section 6121(d)) of the credit amount described in subparagraph (C).

(C) FULL-TIME MONTHLY CREDIT.—The amount of the credit under this subparagraph, with respect to employment by an employer in a month, is 1/12 (or, if applicable, the fraction described in paragraph (2)) the amount owed under section 6111, based on the class of enrollment, for the year.

(2) COVERAGE DURING ONLY PART OF A YEAR.—In the case of a family that is not enrolled in a regional alliance health plan for all the months in a year, the fraction described in this paragraph is 1 divided by the number of months in the year in which the family was enrolled in such a plan.

(3) AGGREGATION OF CREDITS.—

(A) INDIVIDUALS.—In the case of an individual who is a qualifying employee of more than one employer in a month, the credit for the month shall equal the sum of the credits earned with respect to employment by each employer. Such sum may exceed the credit amount described in paragraph (1)(C).

(B) COUPLES.—In the case of a couple each spouse of which is a qualifying employee in a month, the credit for the month shall equal the sum of the credits earned with respect to employment by each spouse. Such sum may exceed the credit amount described in paragraph (1)(C).

(c) TREATMENT OF CHANGE OF ENROLLMENT STATUS.—In the case of a family for which the class of family enrollment changes during a year, the Board shall establish rules for appropriate conversion and allocation of the credit amounts under the previous provisions of this section in a manner that reflects the relative values of the base employment monthly premiums (as determined under section 6122) among the different classes of family enrollment.

SEC. 6113. LIMITATION OF LIABILITY BASED ON INCOME.

(a) IN GENERAL.—In the case of an eligible family described in subsection (b), the repayment amount required under this subpart (after taking into account any work credit earned under section 6112) with respect to a year shall not exceed the amount of liability described in subsection (c) for the year.

(b) ELIGIBLE FAMILY DESCRIBED.—An eligible family described in this subsection is a family which is determined, under subpart B of part 2 of subtitle D of title I by the regional alliance for the alliance area in which the family resides, to have wage-adjusted income (as defined in subsection (d)) below 250 percent of the applicable poverty level.

(c) AMOUNT OF LIABILITY.—

(1) DETERMINATION.—Subject to paragraph (2), in the case of a family enrolled in a class of enrollment with wage-adjusted income (as defined in subsection (d)), the amount of liability under this subsection is determined as follows:

(A) NO OBLIGATION IF INCOME BELOW INCOME THRESHOLD AMOUNT OR IF AFDC OR SSI FAMILY.—If such income is than the income threshold amount (specified in section 6104(c)(4)) or if the family is an AFDC or SSI family, the amount of liability is zero.

(B) INCOME ABOVE INCOME THRESHOLD AMOUNT.—If such income is at least such income threshold amount and the family is not an AFDC or SSI family, the amount of liability is the sum of the following:

(i) 5.5 PERCENT OF INCOME (ABOVE INCOME THRESHOLD AMOUNT) UP TO THE POVERTY LEVEL.—The initial marginal rate (specified in paragraph (2)(A)) of the amount by which—

(I) the wage-adjusted income (not including any portion that exceeds the applicable poverty level for the class of family involved), exceeds

(II) such income threshold amount.

(ii) GRADUATED PHASE OUT OF DISCOUNT UP TO 250 PERCENT OF POVERTY LEVEL.—The final marginal rate (specified in paragraph (2)(B)) of the amount by which the wage-adjusted income exceeds 100 percent of the applicable poverty level.

(2) MARGINAL RATES.—In paragraph (1)—

(A) INITIAL MARGINAL RATE.—The initial marginal rate, for a year for a class of enrollment, is the ratio of—

(i) 5.5 percent of the applicable poverty level for the class of enrollment for the year, to

(ii) the amount by which such poverty level exceeds such income threshold amount.

(B) FINAL MARGINAL RATE.—The final marginal rate, for a year for a class of enrollment, is the ratio of—

(i) the amount by which (I) the amount of the alliance credit exceeds (II) 5.5 percent of the applicable poverty (for the class and year); to

(ii) 150 percent of such poverty level.

(C) APPLICATION FOR FAMILY ENROLLMENT BASED ON DUAL PARENT ENROLLMENT.—The marginal rates under this paragraph for any family class of enrollment shall be determined based on the applicable poverty level for a dual parent class of enrollment.

(d) WAGE-ADJUSTED INCOME DEFINED.—In this subtitle, the term "wage-adjusted income" means, for a family, family adjusted income of the family (as defined in section 1372(d)(1)), reduced by the sum of the following:

(1)(A) Subject to subparagraph (B), the amount of any wages included in such family's income that is received for employment which is taken into account in the computation of the amount of employer premiums under section 6121 (without consideration of section 6126).

(B) The reduction under subparagraph (A) shall not exceed for a year $5,000 (adjusted under section 6104(c)(3)(B)) multiplied by the number of months (including portions of months) of employment with respect to which employer premiums were payable under section 6121 (determined in a manner consistent with section 6121(e)).

(2) The amount of net earnings from self employment of the family taken into account under section 6126).

(3) The amount of unemployment compensation included in income under section 85 of the Internal Revenue Code of 1986.

(e) DETERMINATIONS.—A family's wage-adjusted income and the amount of liability under subsection (c) shall be determined by the applicable regional alliance upon application by a family under under subpart B of part 2 of subtitle D of title I.

(f) NO LIABILITY FOR INDIANS AND CERTAIN VETERANS AND MILITARY PERSONNEL.—The provisions of paragraph (3) of section 6104(a) shall apply to the reduction in liability under this section in the same manner as such paragraph applies to the premium discount under section 6104.

SEC. 6114. SPECIAL TREATMENT OF CERTAIN RETIREES AND QUALIFIED SPOUSES AND CHILDREN.

(a) TREATMENT AS FULL-TIME EMPLOYEE.—Subject to subsection (d), an individual who is an eligible retiree (as defined in subsection (b)) or a qualified spouse or child (as defined in subsection (c)) for a month in a year (beginning with 1998) is considered, for purposes of section 6112, to be a full-time employee described in such section in such month.

(b) ELIGIBLE RETIREE DEFINED.—In subsection (a), the term "eligible retiree" means, for a month, an individual who establishes to the satisfaction of the regional alliance (for the alliance area in which the individual resides), pursuant to rules of the Secretary, that the individual, as of the first day of the month—

(1) is at least 55, but less than 65, years of age,

(2) is not employed on a full-time basis (as defined in section 6121(d)(1)(A)),

(3) would be eligible (under section 226(a) of the Social Security Act) for hospital insurance benefits under part A of title XVIII of such Act if the individual were 65 years of age based only on the employment of the individual, and

(4) is not a medicare-eligible individual.

(c) QUALIFIED SPOUSE OR CHILD DEFINED.—In subsection (a), the term "qualified spouse or child" means, in relation to an eligible retiree for a month, an individual who establishes to the satisfaction of the regional alliance (for the alliance area in which the individual resides) under rules of the Secretary that the requirements in one of the following paragraphs is met with respect to the individual:

(1) The individual (A) is under 65 years of age and is (and has been for a period of at least one year) married to an eligible retiree or (B) is a child of the eligible retiree.

(2) In the case of a person who was an eligible retiree at the time of the person's death—

(A) the individual was (and had for a period of at least one year been) married to the retiree at the time of the person's death,

(B) the individual is under 65 years of age,

(C) the individual is not employed on a full-time basis (as defined in section 6121(d)(1)(A)),

(D) the individual is not remarried, and

(E) the deceased spouse would still be an eligible retiree in the month if such spouse had not died.

(3) The individual is a child of an individual described in paragraph (2).

(d) INDIVIDUALS DISQUALIFIED.—Subsection (a) shall not apply to an individual for a month in a year if the individual would be subject to section 59B of the Internal Revenue Code of 1986 as a taxpayer in the year if the individual were covered under Medicare part B for any month during the year.

(e) APPLICATION.—An individual may not be determined to be an eligible retiree or qualified spouse or child unless an application has been filed with the regional alliance. Such application shall contain such information as the Secretary may require to establish such status and verify information in the application. Any material misrepresentation in the application is subject to a penalty in the same manner as a misrepresentation described in section 1374(h)(2).

SEC. 6115. SPECIAL TREATMENT OF CERTAIN MEDICARE BENEFICIARIES.

In the case of an individual who would be a medicare-eligible individual in a month but for the application of section 1012(a) on the basis of employment (in the month or a previous month) of the individual or the individual's spouse, the individual (or spouse, as the case may be) so employed is considered, for purposes of section 6112, to be a full-time employee described in such section in such month.

PART 2—EMPLOYER PREMIUM PAYMENTS

Subpart A—Regional Alliance Employers

SEC. 6121. EMPLOYER PREMIUM PAYMENT REQUIRED.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each regional alliance employer described in paragraph (2) for a month shall pay to the regional alliance that provides health coverage to a qualifying employee of the employer an employer premium in a amount at least equal to the amount specified in subsection (b). Such payments shall be made in accordance with section 1345.

(2) EMPLOYER DESCRIBED.—An employer described in this paragraph for a month, is an employer that in the month employs one or more qualifying employees (as defined in section 1902(b)(1)).

(3) TREATMENT OF CERTAIN EMPLOYMENT BY CORPORATE ALLIANCE EMPLOYERS.—A corporate alliance employer shall be deemed, for purposes of this subpart, to be a regional alliance employer with respect to qualifying employees who are not corporate alliance eligible individuals.

(b) PREMIUM PAYMENT AMOUNT.—

(1) IN GENERAL.—Except as provided in section 6123 (relating to a discount for certain employers), section 6124 (relating to large employers electing coverage in a regional alliance), and section 6125 (relating to the employer collection shortfall add-on), the amount of the employer premium payment, for a month for qualifying employees of the employer who reside in an alliance area, is the sum of the payment amounts computed under paragraph (2) for each class of family enrollment with respect to such employees in such area.

(2) PAYMENT AMOUNT FOR ALL EMPLOYEES IN A CLASS OF FAMILY ENROLLMENT.—Subject to paragraph (3), the payment amount under this paragraph, for an employer for a class of family enrollment for a month for qualifying employees residing in an alliance area, is the product of—

(A) the base employer monthly premium determined under section 6122 for the class of family enrollment for the previous month for the regional alliance, and

(B) the number of full-time equivalent employees (determined under section 1901(b)(2)) enrolled in that class of family enrollment for the previous month and residing in the alliance area.

(3) TREATMENT OF CERTAIN EMPLOYEES.—In applying this subpart in the case of a qualifying employee (other than a medicare-eligible individual) who is not enrolled in any alliance health plan—

(A) the employee is deemed enrolled in a regional alliance health plan (for the alliance area in which the individual resides) in the dual parent class of enrollment, and

(B) if the employee's residence is not known, the employee is deemed to reside in the alliance area in which the employee principally is employed for the employer.

(4) TRANSITIONAL RULES FOR FIRST MONTH IN FIRST YEAR FOR A STATE.—In the case of an employer for a State in the first month of the State's first year—

(A) the premium amount for such month shall be computed by substituting "month" for "previous month" in paragraph (2);

(B) payment for such month shall be made on the first of the month based on an estimate of the payment for such month;

(C) an adjustment shall be made to the payment in the following month to reflect the difference between the payment in the first month and the payment in the following month (calculated without regard to the adjustment under this subparagraph); and

(D) the reconciliation of premiums for such first month under section 1602(c) shall be included in the reconciliation of premiums for the following 12 months.

(5) SPECIAL RULES FOR DIVIDED FAMILIES.—In the case of an individual who is a qualifying employee of an employer and the individual has a spouse or child who is not treated as part of the individual's family because of section 1012—

(A) the employer premium payment under this section shall be computed as though such section had not applied, and

(B) the regional alliance shall make proportional payments (consistent with rules established by the Secretary) to the health plans (if different) of the qualifying employee and of the employee's spouse and children.

(c) APPLICATION DURING TRANSITION PERIOD.—

(1) IN GENERAL.—For purposes of applying this subpart in the case of an employer described in paragraph (3), there shall only be taken into account qualifying employees (and wages of such employees) who reside in a participating State.

(2) EXCEPTION.—Paragraph (1) shall not apply in determining the average number of full-time equivalent employees or whether an employer is a small employer.

(3) EMPLOYER DESCRIBED.—An employer described in this paragraph is an employer that employs one or more qualifying employees in a participating State and one or more qualifying employees in a State that is not a participating State.

SEC. 6122. COMPUTATION OF BASE EMPLOYMENT MONTHLY PREMIUM.

(a) IN GENERAL.—Each regional alliance shall provide for the computation for each year (beginning with the first year) of a base employment monthly premium for each class of family enrollment equal to 1/12 of 80 percent of—

(1) the weighted average premium for such regional alliance and class of enrollment, reduced by the amount described in section 6106(b), divided by

(2)(A) in the case of a class of enrollment that does not include a couple, 1, or

(B) in the case of a couple class of enrollment, the average number of premium payments per family, as determined under subsection (b), for families receiving coverage within such class from regional alliance health plans offered by the regional alliance.

(b) DETERMINATION OF AVERAGE EMPLOYER PREMIUM PAYMENTS PER FAMILY FOR COUPLES CLASSES.—

(1) IN GENERAL.—Subject to paragraph (4), the regional alliance shall determine, for each couple class of family enrollment and in a manner specified by the Board, an average, annual, estimated number of premium payments per family equal to—

(A) the alliance-wide monthly average number of premium payments (as determined under paragraph (2)) for covered families (as defined in paragraph (3)) within such class of enrollment, divided by

(B) the monthly average number of covered families receiving coverage through regional alliance health plans within such class of employment.

(2) COMPUTATION OF ALLIANCE-WIDE MONTHLY AVERAGE NUMBER.—

(A) IN GENERAL.—In determining the alliance-wide monthly average number of premium payments under paragraph (1)(A), a covered family shall count for a month as 1, or, if greater, the number computed under subparagraph (B) (but in no case greater than 2).

(B) COUNTING OF FAMILIES IN WHICH BOTH SPOUSES ARE QUALIFYING EMPLOYEES.—The number computed under this subparagraph over all families within a couple class of enrollment in which both spouses are qualifying employees, is determined on an alliance-wide basis based on the following:

(i) For such a spouse, determine, using the rules under section 1902(b)(2)(A), how many full-time equivalent employees the spouse is counted as, but not to exceed 1 for either spouse.

(ii) Add the 2 numbers determined under clause (i) for spouses in such families.

(3) COVERED FAMILY DEFINED.—In this subsection, the term "covered family" means a family other than—

(A) an SSI family or AFDC family,

(B) a family in which a spouse is a medicare-eligible individual, or

(C) a family that is enrolled in a health plan other than a regional alliance health plan.

(4) ADJUSTMENT TO ACCOUNT FOR USE OF ESTIMATES.—Subject to section 1361(b)(3), if the total receipts of a regional alliance to all regional alliance health plans in a year under this subpart exceeds, or is less than, the total of such receipts estimated by the alliance (based on the base employment monthly premium under subsection (a)), because of a difference between—

(A) the alliance's estimate of the average, annual, estimated number of premium payments per family for the alliance, and

(B) the actual number of premium payments per family for the alliance,

the average, annual, estimated number of premium payments per family to be applied under this section in the second succeeding year shall be reduced, or increased, respectively, in a manner that results in total receipts of the alliance under this subpart in such succeeding year being increased or decreased by the amount of such excess (or deficit).

(c) BASIS FOR DETERMINATIONS.—

(1) PREMIUMS.—The determinations of premiums and families under plans under this section shall be made in a manner determined by the Board and based on the premiums and families used by the Board in carrying out subtitle A (relating to cost containment) and shall be based on estimates on an annualized basis.

(2) EMPLOYMENT.—

(A) FOR FIRST YEAR.—The determinations of employment under this section for the first year for a State shall be based on estimates of employment established by the regional alliance in accordance with standards promulgated by the Secretary of Labor in consultation with the National Health Board.

(B) FOR SUBSEQUENT YEARS.—The determinations of employment under this section for a year after the first year for a State shall be based on estimates of employment established by the regional alliance in accordance with standards promulgated by the Secretary of Labor in consultation with the National Health Board.

(3) REPORTS.—In accordance with rules established by the Secretary of Labor in consultation with the National Health Board, a regional alliance may require regional alliance employers to submit such periodic information on employment as may be necessary to monitor the determinations made under subsections (a) and (c), including months and extent of employment.

(d) TIMING OF DETERMINATION.—Determinations under this section for a year shall be made by not later than December 1, or such other date as the Board may specify, before the beginning of the year.

SEC. 6123. PREMIUM DISCOUNT FOR CERTAIN EMPLOYERS.

(a) EMPLOYER DISCOUNT.—

(1) IN GENERAL.—Subject to section 6124(c) (relating to phase in for certain large corporate alliance employers) and section 6125 (relating to the employer collection shortfall add-on), the amount of the employer premium payment required under this part for a regional alliance employer for any year shall not exceed the limiting percentage (as defined in subsection (b)) of the employer's wages for that year.

(2) EXCLUSION OF GOVERNMENTAL EMPLOYERS AND CERTAIN CORPORATE ALLIANCE EMPLOYERS.—Paragraph (1) shall not apply to—

(A) the Federal Government, a State government, or a unit of local government, or a unit or instrumentality of such government, before 2002; and

(B) a corporate alliance employer which is treated as a regional alliance employer under section 6131(a)(2).

(b) LIMITING PERCENTAGE DEFINED.—In subsection (a)—

(1) ANY EMPLOYER.—For an employer that is not a small employer (as defined in subsection (c)), the limiting percentage is 7.9 percent.

(2) SMALL EMPLOYERS.—For an employer that is a small employer and that has an average number of full-time equivalent employees and average annual wages per full-time equivalent employee (as determined under subsection (d)), the limiting percentage is the applicable percentage determined based on following table:

Limiting Percentage

Average number of full-time equivalent employees	Employer's average annual wages per full-time equivalent employee are:				
	$0–$12,000	$12,001–$15,000	$15,001–$18,000	$18,001–$21,000	$21,001–$24,000
Fewer than 25	3.5%	4.4%	5.3%	6.2%	7.1%
25 but fewer than 50	4.4%	5.3%	6.2%	7.1%	7.9%
50 but fewer than 75	5.3%	6.2%	7.1%	7.9%	7.9%

(c) SMALL EMPLOYER DEFINED.—

(1) IN GENERAL.—In this section—

(A) the term "small employer" means an employer that does not employ, on average, more than 75 full-time equivalent employees; and

(B) subject to subsection (b)(3)(C)(i), the average number of full-time equivalent employees shall be determined by averaging the number of full-time equivalent employees employed by the employer in each countable month during the year.

(2) COUNTABLE MONTH.—In paragraph (1), the term "countable month" means, for an employer, a month in which the employer employs any qualifying employee.

(3) DETERMINATIONS.—The number of full-time equivalent employees shall be determined using the rules under section 1902(b)(2).

(d) AVERAGE ANNUAL WAGES DEFINED.—

(1) IN GENERAL.—In this section, the term "average annual wages" means, for an employer for a year—

(A) the total wages paid in the year to individuals who, at the time of payment of the wages, are qualifying employees of the employer; divided by

(B) the number of full-time equivalent employees of the employer in the year.

(2) DETERMINATION.—The Board may establish rules relating to the computation of the average annual wages for employers.

(e) DETERMINATIONS.—For purposes of this section, the number of employees and average wages shall be determined on an annual basis.

(f) TREATMENT OF CERTAIN SELF-EMPLOYED INDIVIDUALS.—In the case of an individual who is a partner in a partnership, is a 2-percent shareholder in an S corporation (within the meaning of section 1372 of the Internal Revenue Code of 1986), or is any other individual who carries on a trade or business as a sole proprietorship, for purposes of this section—

(1) the individual is deemed to be an employee of the partnership, S corporation, or proprietorship, and

(2) the individual's net earnings from self employment attributable to the partnership, S corporation, or sole proprietorship are deemed to be wages from the partnership, S corporation, or proprietorship.

(g) APPLICATION TO EMPLOYERS.—An employer that claims that this section applies—

(1) shall provide notice to the regional alliance involved of the claim at the time of making payments under this part; and

(2) shall make available such information (and provide access to such information) as the regional alliance may require (in accordance with regulations of the Secretary of Labor) to audit the determination of—

(A) whether the employer is a small employer, and, if so, the average number of full-time equivalent employees and average annual wages of the employer; and

(B) the total wages paid by the employer for qualifying employees.

SEC. 6124. PAYMENT ADJUSTMENT FOR LARGE EMPLOYERS ELECTING COVERAGE IN A REGIONAL ALLIANCE.

(a) APPLICATION OF SECTION.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, this section shall apply to the employer premium payments for full-time employees in a State of an employer if—

(A)(i) the employer is an eligible sponsor described in section 1311(b)(1)(A), (ii) the employer elected to be a corporate alliance under section 1312(a)(1), and (iii) the election is terminated under section 1313;

(B)(i) the employer is such an eligible sponsor as of the first day of the first year of the State, and (ii) the employer did not provide the notice required under section 1312(a)(1) (with respect to an election to become a corporate alliance); or

(C) the employer is such an eligible sponsor, (ii) the employer subsequently became a large employer and elected to be a corporate alliance under section 1312(a)(2), and (iii) the election was terminated under section 1313.

(2) EFFECTIVE DATE.—In the case of an employer described in—

(A) paragraph (1)(A) or (1)(C), this section shall first apply on the effective date of the termination of the election under section 1313, or

(B) paragraph (1)(B), this section shall first apply as of January 1, 1996 (or, if later with respect to a State, the first day of the first year for the State).

(3) TREATMENT OF EMPLOYEES IN SMALL ESTABLISHMENTS.—This section shall not apply to the payment of premiums for full-time employees of an employer described in paragraph (1)(A) or (1)(C), if the employees are employed at an establishment with respect to which the option described in section 1311(b)(1)(C) was exercised.

(4) SUNSET.—This section shall cease applying to an employer with respect to employment in a State after the 7th year in which this section applies to the employer in the State.

(5) LARGE EMPLOYER DEFINED.—In this section, the term "large employer" has the meaning given such term in section 1311(d)(3).

(b) ADDITIONAL AMOUNT.—

(1) IN GENERAL.—If an employer subject to this section for a year has an excess risk percentage (as defined in paragraph (3)) of greater than zero with respect to an alliance area, then the employer shall provide, on a monthly basis, for payment to the regional alliance for such area of an amount equal to 1/12 of the excess amount described in paragraph (2) for the year.

(2) EXCESS AMOUNT.—The excess amount described in this paragraph, for an employer for a year with respect to an alliance area, is equal to the product of the following:

(A) The reduced weighted average accepted bid for the regional alliance for the area for the year.

(B) The total average number of alliance eligible individuals who—

(i) were full-time employees (or family members of such employees) of the employer, and

(ii) residing in the regional alliance area,

in the year before the first year in which this section applies to the employer.

(C) The extra risk proportion (specified in paragraph (3)) for the employer for such area.

(D) The phase-down percentage (specified in paragraph (4)) for the year.

(3) EXTRA RISK PROPORTION.—

(A) IN GENERAL.—The "extra risk proportion", specified in this paragraph, with respect to an employer and an alliance area, is a percentage that reflects, for the year before the first year in which this section applies to the employer, the amount by which—

(i) the average demographic risk for employees (and family members) described in paragraph (2)(B) residing in the alliance area, exceeds

(ii) the average demographic risk for all regional alliance eligible individuals residing in the area.

(B) MEASUREMENT OF DEMOGRAPHIC RISK.—

(i) IN GENERAL.—Demographic risk under subparagraph (A) shall be measured, in a manner specified by the Board, based on the demographic characteristics described in section 6001(c)(1)(A), that relate to the actuarial value of the comprehensive benefit package.

(ii) PROVISION OF INFORMATION.—Each employer to which this section applies shall

submit, to each regional alliance for which an additional payment is required under this section, such information (and at such time) as the Board may require in order to determine the demographic risk referred to in subparagraph (A)(i).

(4) PHASE-DOWN PERCENTAGE.—The phase down percentage, specified in this paragraph for an employer for—

(A) each of the first 4 years to which this section applies to the employer, is 100 percent,

(B) the fifth such year, is 75 percent,

(C) the sixth such year, is 50 percent, and

(D) the seventh such year, is 25 percent.

(c) PHASE IN OF EMPLOYER PREMIUM DISCOUNT.—For—

(1) each of the first 4 years in which this section applies to such employer, section 6123 shall not apply to the employer;

(2) the fifth such year, section 6123 shall apply to the employer but the reduction in premium payment effected by such section shall be 25 percent of the reduction that would otherwise apply (but for this subsection);

(3) the sixth such year, section 6123 shall apply to the employer but the reduction in premium payment effected by such section shall be 50 percent of the reduction that would otherwise apply (but for this subsection);

(4) the seventh such year, section 6123 shall apply to the employer but the reduction in premium payment effected by such section shall be 75 percent of the reduction that would otherwise apply (but for this subsection); or

(5) a subsequent year, section 6123 shall apply to the employer without any reduction under this subsection.

SEC. 6125. EMPLOYER COLLECTION SHORTFALL ADD-ON.

(a) IN GENERAL.—The amount payable by an employer under this subpart shall be increased by the amount computed under subsection (b).

(b) AMOUNT.—The amount under this subsection for an employer is equal to the premium payment amount that would be computed under section 6121(b)(2) if the per capita collection shortfall amount (computed under section 6107(b)(1)) for the year were substituted for the reduced weighted average accepted bid for the year.

(c) DISCOUNT NOT APPLICABLE.—Section 6123 shall not apply to the increase in the amount payable by virtue of this section.

SEC. 6126. APPLICATION TO SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—A self-employed individual (as defined in section 1901(6)) shall be considered, for purposes of this subpart to be an employer of himself or herself and to pay wages to himself or herself equal to the amount of net earnings from self-employment (as defined in section 1901(c)(1)).

(b) CREDIT FOR EMPLOYER PREMIUMS.—

(1) IN GENERAL.—In the case of a self-employed individual, the amount of any employer premium payable by virtue of subsection (a) in a year shall be reduced (but not below zero) by the sum of the following:

(A) Subject to paragraph (2), the amount of any employer premiums payable under this subpart (determined not taking into account any adjustment in the premium amounts under section 6123 or 6124) with respect to the employment of that individual in the year.

(B) The product of (i) the number of months in the year the individual was employed on a full-time basis by a corporate alliance employer, and (ii) the employer premium that would have been payable for such months under this subpart (determined not taking into account any adjustment in the premium amounts under section 6123 or 6124) for the class of enrollment if such employer had been a regional alliance employer.

(2) SPECIAL RULE FOR CERTAIN CLOSELY-HELD BUSINESSES.—

(A) IN GENERAL.—In the case of an individual who—

(i) has wage-adjusted income (as defined in section 6113(d), determined without regard to paragraphs (1)(B) and (2) thereof) that exceeds 250 percent (or such higher percentage as the Board may establish) of the applicable poverty level, and

(ii) is both a substantial owner and an employee of a closely held business,

the amount of any reduction under paragraph (1)(A) that is attributable to the individual's employment by that business shall be appropriately reduced in accordance with rules prescribed by the Board, in order to prevent individuals from avoiding payment of the full amount owed through sham or secondary employment arrangements.

(B) CLOSELY HELD BUSINESS.—For purposes of subparagraph (A), a business is "closely held" if it is an employer that meets the requirements of section 542(a)(2) of the Internal Revenue Code of 1986 or similar requirements as appropriate in the case of a partnership or other entity.

Subpart B—Corporate Alliance Employers

SEC. 6131. EMPLOYER PREMIUM PAYMENT REQUIRED.

(a) PER EMPLOYEE PREMIUM PAYMENT.—Subject to section 6124, each corporate alliance employer of a corporate alliance that in a month in a year employs a qualifying employee who is—

(1) enrolled in a corporate alliance health plan offered by the alliance, shall provide for a payment toward the premium for the plan in an amount at least equal to the corporate employer premium specified in subsection (b); or

(2) is not so enrolled, shall make employer premium payments with respect to such employment under subpart A in the same manner as if the employer were a regional alliance employer (except as otherwise provided in such subpart).

(b) CORPORATE EMPLOYER PREMIUM.—

(1) AMOUNT.—

(A) IN GENERAL.—Except as provided in paragraph (2), the amount of the corporate employer premium for a month in a year for a class of family enrollment for a family residing in a premium area (established under section 1364(b)) is 80 percent of the weighted average monthly premium of the corporate alliance health plans offered by the corporate alliance for that class of enrollment for families residing in that area.

(B) APPLICATION TO SELF-INSURED PLANS.—In applying this paragraph in the case of one or more corporate alliance health plans that are self-insured plans—

(i) the "premium" for the plan is the actuarial equivalent of such premium, based upon the methodology (or such other consistent methodology) used under section 6021(a) (relating to application of cost containment to corporate alliance health plans), and

(ii) the premium amount, for different classes and, if applicable, for different premium areas, shall be computed in a manner based on such factors as may bear a reasonable relationship to costs for the provision of the comprehensive benefit package to the different classes in such areas.

The Secretary of Labor shall establish rules to carry out this subparagraph.

(2) LOW-WAGE EMPLOYEES.—In the case of a low-wage employee entitled to a premium discount under section 6104(a)(2), the amount of the employer premium payment for a month in a year for a class of family enrollment shall be increased by the amount of such premium discount.

(c) DETERMINATIONS.—

(1) BASIS.—Determinations under this section shall be made based on such information as the Secretary of Labor shall specify.

(2) TIMING.—Determinations of the monthly premiums under this section for months in a year shall be made not later than December 1 of the previous year.

Subtitle C—Payments to Regional Alliance Health Plans

SEC. 6201. COMPUTATION OF BLENDED PLAN PER CAPITA PAYMENT AMOUNT.

(a) IN GENERAL.—For purposes of section 1342, the blended plan per capita payment amount for a regional alliance health plan for enrollments in an alliance for a year is equal to the sum of the 3 components described in subsection (b), multiplied by any adjustment factor applied for the year under subsection (d).

(b) SUM OF PRODUCTS.—The 3 components described in this subsection are:

(1) PLAN BID COMPONENT FOR THAT PLAN.—The product of—

(A) the final accepted bid for plan (as defined in section 6000(a)(2)) for the year, and

(B) the plan bid proportion determined under section 6202(a)(1) for the year.

(2) AFDC COMPONENT FOR ALLIANCE.—The product of—

(A) the AFDC per capita premium amount for the regional alliance for the year (determined under section 9012), and

(B) the AFDC proportion determined under section 6202(a)(2) for the year.

(3) SSI COMPONENT FOR ALLIANCE.—The product of—

(A) the SSI per capita premium amount for the regional alliance for the year (determined under section 9013) for the year, and

(B) the SSI proportion determined under section 6202(a)(3) for the year.

SEC. 6202. COMPUTATION OF PLAN BID, AFDC, AND SSI PROPORTIONS.

(a) IN GENERAL.—For purposes of this subtitle:

(1) PLAN BID PROPORTION.—The "plan bid proportion" is, for a type of enrollment, 1 minus the sum of (A) the AFDC proportion, and (B) the SSI proportion.

(2) AFDC PROPORTION.—The "AFDC proportion" is, for a class of family enrollment for a year, the ratio of—

(A) the average of the number of AFDC recipients (as determined under subsection (c)) enrolled in regional alliance health plans in that class of enrollment for the year, to

(B) the average of the total number of individuals enrolled in regional alliance health plans in that class of enrollment for the year.

(3) SSI PROPORTION.—The "SSI proportion" is, for a class of family enrollment for a year, the ratio of—

(A) the average of the number of SSI recipients (as determined under subsection (c)) enrolled in regional alliance health plans in that class of enrollment for the year, to

(B) the average described in paragraph (2)(B).

(b) COMPUTATION.—

(1) PROJECTIONS.—The proportions described in subsection (a) shall be determined and applied by the State, based upon the best available data, at least 1 month before the date bids are submitted under section 6004 before the beginning of the calendar year involved.

(2) ACTUAL.—For purposes of making adjustments under subsection (d), the regional alliance shall determine, after the end of each year, the actual proportions described in subsection (a).

(c) COUNTING OF AFDC AND SSI RECIPIENTS.—For purposes of subsections (a)(2)(A) and (a)(3)(A), the terms "SSI recipient" and "AFDC recipient" do not include a medicare-eligible individual.

(d) ADJUSTMENTS FOR DISCREPANCIES IN ESTIMATIONS.—

(1) IN GENERAL.—If the actual AFDC proportion or SSI proportion (as determined under subsection (a)) for a year (in this subsection referred to as the "reference year"), determined after the end of the year based upon actual number of AFDC recipients and SSI recipients in the year, is different from the projected AFDC and SSI proportions (as determined under subsection (b)(1)) used in computing the blended plan payment amount for the year, then, subject to section 1361(b)(3), the regional alliance shall adjust the blended plan payment amount in the second succeeding year (in this subsection referred to as the "applicable year") in the manner described in paragraph (2). By regulation the Secretary may apply the adjustment, based on estimated amounts, in the year before the applicable year, with final adjustment in the applicable year.

(2) ADJUSTMENT DESCRIBED.—

(A) POSITIVE CASH FLOW.—If the cash flow difference (as defined in paragraph (3)(A)) for the reference year is positive, then in the applicable year the blended plan payment amount shall be increased by the adjustment percentage described in paragraph (4).

(B) NEGATIVE CASH FLOW.—If the cash flow difference (as defined in paragraph (3)(A)) for the reference year is negative, then in the applicable year the blended plan payment amount shall be reduced by the adjustment percentage described in paragraph (4).

(3) CASH FLOW DIFFERENCE DEFINED.—In this subsection:

(A) IN GENERAL.—The term "cash flow difference" means, for a regional alliance for a reference year, the amount by which—

(i) the actual cash flow (as defined in subparagraph (B)) for the alliance for the year, exceeds

(ii) the reconciled cash flow (as defined in subparagraph (C)) for the alliance for the year.

(B) ACTUAL CASH FLOW.—The term "actual cash flow" means, for a regional alliance for a reference year, the total amount paid by the regional alliance to the regional alliance health plans in the year based on the blended plan payment amount (computed on the basis of projected AFDC and SSI proportions determined under subsection (b)(1).

(C) RECONCILED CASH FLOW.—The term "reconciled cash flow" means, for a regional alliance for a reference year, the total amount that would have been paid to regional alliance health plans in the year if such payments had been made based on the blended plan payment amount computed on the basis of the actual AFDC and SSI proportions for the year (determined under subsection (b)(2), rather than based on such payment amount computed on the basis of the projected AFDC and SSI proportions for the year (determined under subsection (b)(1)).

(4) PERCENTAGE ADJUSTMENT.—The percentage adjustment described in this paragraph for a regional alliance for an applicable year is the ratio (expressed as a percentage) of—

(A) the cash flow difference for the reference year, to

(B) the total payments estimated by the regional alliance to be paid to regional alliance health plans under this subtitle in the applicable year (determined without regard to any adjustment under this subsection).

TITLE VII—REVENUE PROVISIONS

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SEC. 7001. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Financing Provisions

PART 1—INCREASE IN TAX ON TOBACCO PRODUCTS

SEC. 7111. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended—

(1) by striking "$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)" in paragraph (1) and inserting "$49.50 per thousand", and

(2) by striking "$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)" in paragraph (2) and inserting "$103.95 per thousand".

(b) CIGARS.—Subsection (a) of section 5701 is amended—

(1) by striking "$1.125 cents per thousand (93.75 cents per thousand on cigars removed during 1991 or 1992)" in paragraph (1) and inserting "$38.62½ per thousand", and

(2) by striking "equal to" and all that follows in paragraph (2) and inserting "equal to 52.594 percent of the price for which sold but not more than $123.75 per thousand."

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 is amended by striking "0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)" and inserting "3.09 cents".

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 is amended by striking "1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)" and inserting "6.19 cents".

(e) SMOKELESS TOBACCO.—Subsection (e) of section 5701 is amended—

(1) by striking "36 cents (30 cents on snuff removed during 1991 or 1992)" in paragraph (1) and inserting "$12.86", and

(2) by striking "12 cents (10 cents on chewing tobacco removed during 1991 or 1992)" in paragraph (2) and inserting "$12.62".

(f) PIPE TOBACCO.—Subsection (f) of section 5701 is amended by striking "67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)" and inserting "$13.17½".

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after September 30, 1994.

(h) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States

which are removed before October 1, 1994, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on October 1, 1994, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on October 1, 1994, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before December 31, 1994.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on October 1, 1994, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, and such term shall include articles first subject to the tax imposed by section 5701 of such Code by reason of the amendments made by this Act.

(B) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or his delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 7112. MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.

(a) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR EXPORT.—

(1) Subsection (b) of section 5704 is amended by adding at the end thereof the following new sentence: "Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe."

(2) Section 5761 is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

"(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

"(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

"(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

"(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States."

(3) Subsection (a) of section 5761 is amended by striking "subsection (b)" and inserting "subsection (b) or (c)".

(4) Subsection (d) of section 5761, as redesignated by paragraph (2), is amended by striking "The penalty imposed by subsection (b)" and inserting "The penalties imposed by subsections (b) and (c)".

(5)(A) Subpart F of chapter 52 is amended by adding at the end thereof the following new section:

"SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

"(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d).

"(b) CROSS REFERENCE.—

"For penalty for the sale of cigarettes in the United States which are labeled for export, see section 5761(d)."

(B) The table of sections for subpart F of chapter 52 is amended by adding at the end thereof the following new item:

"Sec. 5754. Restriction on importation of previously exported tobacco products."

(b) IMPORTERS REQUIRED TO BE QUALIFIED.—

(1) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763(b) and (c) are each amended by inserting "or importer" after "manufacturer".

(2) The heading of subsection (b) of section 5763 is amended by inserting "QUALIFIED IMPORTERS," after "MANUFACTURERS,".

(3) The heading for subchapter B of chapter 52 is amended by inserting "and Importers" after "**Manufacturers**".

(4) The item relating to subchapter B in the table of subchapters for chapter 52 is amended by inserting "and importers" after "manufacturers".

(c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES OF CIGARETTE MANUFACTURERS.—

(1) Subsection (a) of section 5704 is amended—

(A) by striking "EMPLOYEE USE OR" in the heading, and

(B) by striking "for use or consumption by employees or" in the text.

(2) Subsection (e) of section 5723 is amended by striking "for use or consumption by their employees, or for experimental purposes" and inserting "for experimental purposes".

(d) REPEAL OF TAX-EXEMPT SALES TO UNITED STATES.—Subsection (b) of section 5704 is amended by striking "and manufacturers may similarly remove such articles for use of the United States;".

(e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 is amended by striking "On each book or set of cigarette papers containing more than 25 papers," and inserting "On cigarette papers,".

(f) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 is amended by inserting "under section 5704" after "internal revenue bond".

(g) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 is amended by striking "or" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

"(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe, or".

(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—Section 7652 is amended by adding at the end thereof the following new subsection:

"(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—For purposes of this section, with respect to taxes imposed under section 5701 or this section on any tobacco product or cigarette paper or tube, the amount covered into the treasuries of Puerto Rico and the Virgin Islands shall not exceed the rate of tax under section 5701 in effect on the article on the day before the date of the enactment of the Health Security Act."

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after September 30, 1994.

SEC. 7113. IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.

(a) IN GENERAL.—Section 5701 (relating to rate of tax) is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

"(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of $12.50 per pound (and a proportionate tax at the like rate on all fractional parts of a pound)."

(b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (relating to definitions) is amended by adding at the end thereof the following new subsection :

"(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and

likely to be offered to, or purchased by, consumers as tobacco for making cigarettes."

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (c) of section 5702 is amended by striking "and pipe tobacco" and inserting "pipe tobacco, and roll-your-own tobacco".

(2) Subsection (d) of section 5702 is amended—

(A) in the material preceding paragraph (1), by striking "or pipe tobacco" and inserting "pipe tobacco, or roll-your-own tobacco", and

(B) by striking paragraph (1) and inserting the following new paragraph:

"(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for his own personal consumption or use, and".

(3) The chapter heading for chapter 52 is amended to read as follows:

"CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES".

(4) The table of chapters for subtitle E is amended by striking the item relating to chapter 52 and inserting the following new item:

"Chapter 52. Tobacco products and cigarette papers and tubes."

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to roll-your-own tobacco removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after September 30, 1994.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before October 1, 1994, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

PART 2—HEALTH RELATED ASSESSMENT

SEC. 7121. ASSESSMENT ON CORPORATE ALLIANCE EMPLOYERS.

(a) IN GENERAL.—Subtitle C (relating to employment taxes) is amended by inserting after chapter 24 the following new chapter:

"CHAPTER 24A—ASSESSMENT ON CORPORATE ALLIANCE EMPLOYERS

"Sec. 3461. Assessment on corporate alliance employers.

"SEC. 3461. ASSESSMENT ON CORPORATE ALLIANCE EMPLOYERS.

"(a) IMPOSITION OF ASSESSMENT.—Every corporate alliance employer shall pay (in addition to any other amount imposed by this subtitle) for each calendar year an assessment equal to 1 percent of the payroll of such employer.

"(b) DEFINITIONS.—For purposes of this section—

"(1) CORPORATE ALLIANCE EMPLOYER.—The term 'corporate alliance employer' means any employer if any individual, by reason of being an employee of such employer, is provided with health coverage through any corporate alliance described in section 1311 of the Health Security Act.

"(2) PAYROLL.—The term 'payroll' means the sum of—

"(A) the wages (as defined in section 3121(a) without regard to paragraph (1) thereof) paid by the employer during the calendar year, plus

"(B)(i) in the case of a sole proprietorship, the net earnings from self-employment of the proprietor from such trade or business for the taxable year ending with or within the calendar year,

"(ii) in the case of a partnership, the aggregate of the net earnings from self-employment of each partner which is attributable to such partnership for the taxable year of such partnership ending with or within the calendar year, and

"(ii) in the case of an S corporation, the aggregate of the net earnings from self-employment of each shareholder which is attributable to such corporation for the taxable year of such corporation ending with or within the calendar year.

"(3) NET EARNINGS FROM SELF-EMPLOYMENT.—The term 'net earnings from self-employment' has the meaning given such term by section 1402; except that the amount thereof—

"(A) may never be less than zero, and

"(B) shall be determined without regard to any deduction for an assessment under this section.

"(4) EMPLOYER.—

"(A) IN GENERAL.—The term 'employer' means any person for whom an individual performs services, of whatever nature, as an employee (as defined in section 3401(c)).

"(B) SPECIAL RULES.—

"(i) An individual who owns the entire interest in an unincorporated trade or business shall be treated as his own employer.

"(ii) A partnership shall be treated as the employer of each partner who is an employee within the meaning of section 401(c)(1).

"(iii) An S corporation shall be treated as the employer of each shareholder who is an employee within the meaning of section 401(c)(1).

"(c) SPECIAL RULES.—For purposes of this section—

"(1) TREATMENT OF CERTAIN EMPLOYERS.—In the case of an employer who is a corporate alliance employer solely by reason of employees who are provided with health coverage through a corporate alliance the eligible sponsor of which is a multiemployer plan described in section 1311(b)(1)(B) of the Health Security Act, the payroll of such employer shall be determined by taking into account only such employees.

"(2) CONTROLLED GROUP RULES.—All persons treated as a single employer under section 1901 of the Health Security Act (relating to employer premiums for comprehensive health care) shall be treated as a single employer.

"(3) APPLICATION OF ASSESSMENT BEGINNING IN 1996.—

"(A) IN GENERAL.—Every employer eligible to elect to be an eligible sponsor under section 1311 of the Health Security Act shall be treated as a corporate alliance employer as of January 1, 1996, unless the employer waives such employer's rights ever to be treated as such a sponsor. The waiver under this subparagraph shall be irrevocable.

"(B) EXCEPTION.—Subparagraph (A) shall not apply to any employer referred to in paragraph (1).

"(4) TREATMENT OF FEDERAL GOVERNMENT.—Nothing in any provision of law shall be construed to exempt any agency or instrumentality of the United States from the assessment under this section.

"(d) ADMINISTRATIVE PROVISIONS.—

"(1) PAYMENT.—The assessment under this section shall be paid at the same time and manner as the tax imposed by chapter 21.

"(2) COLLECTION, ETC.—For purposes of subtitle F, the assessment under this section shall be treated as if it were a tax imposed by this subtitle."

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle C is amended by inserting after the item relating to chapter 24 the following new item:

"Chapter 24A. Assessment on corporate alliance employers."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

PART 3—RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES

SEC. 7131. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS.

(a) IN GENERAL.—Subchapter A of chapter 1 is amended by adding at the end thereof the following new part:

"PART VIII—CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS

"Sec. 59B. Recapture of certain health care subsidies.

"SEC. 59B. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES.

"(a) IMPOSITION OF RECAPTURE AMOUNT.—In the case of an individual, if the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount, such taxpayer shall pay (in addition to any other amount imposed by this subtitle) a recapture amount for such taxable year equal to the sum of—

"(1) the aggregate of the Medicare part B recapture amounts (if any) for months during such year that a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part, and

"(2) the aggregate reductions (if any) in the individual's liability for periods after December 31, 1999, under section 6111 of the Health Security Act (relating to repayment of alliance credit by certain families) pursuant to section 6114 of such Act (relating to special treatment of certain retirees and qualified spouses and children) for months during such year.

"(b) MEDICARE PART B PREMIUM RECAPTURE AMOUNT FOR MONTH.—For purposes of this section, the Medicare part B premium recapture amount for any month is the amount equal to the excess of—

"(1) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

"(2) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

"(c) PHASEIN OF RECAPTURE AMOUNT.—If the modified adjusted gross income of the taxpayer for any taxable year exceeds the threshold amount by less than $10,000, the recapture amount imposed by this section for such taxable year shall be an amount which bears the same ratio to the recapture amount which would (but for this subsection) be imposed by this section for such taxable year as such excess bears to $10,000.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $90,000,

"(B) $115,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married (as determined under section 7703) but does not file a joint return for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 135, 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) JOINT RETURNS.—In the case of a joint return—

"(A) the recapture amount under subsection (a) shall be the sum of the recapture amounts determined separately for each spouse, and

"(B) subsections (a) and (c) shall be applied by taking into account the combined modified adjusted gross income of the spouses.

"(4) COORDINATION WITH OTHER PROVISIONS.—

"(A) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the recapture amount imposed by this section shall be treated as if it were a tax imposed by section 1.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The recapture amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax under section 55."

(b) TRANSFERS TO SUPPLEMENTAL MEDICAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—There are hereby appropriated to the Supplemental Medical Insurance Trust Fund amounts equivalent to the aggregate increase in liabilities under chapter 1 of the Internal Revenue Code of 1986 which is attributable to the application of section 59B(a)(1) of such Code, as added by this section.

(2) TRANSFERS.—The amounts appropriated by paragraph (1) to the Supplemental Medical Insurance Trust Fund shall be transferred from time to time (but not less frequently than quarterly) from the general fund of the Treasury on the basis of estimates made by the Secretary of the Treasury of the amounts referred to in paragraph (1). Any quarterly payment shall be made on the first day of such quarter and shall take into account the recapture amounts referred to in such section 59B(a)(1) for such quarter. Proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(c) REPORTING REQUIREMENTS.—

(1)(A) Paragraph (1) of section 6050F(a) (relating to returns relating to social security benefits) is amended by striking "and" at the end of subparagraph (B) and by inserting after subparagraph (C) the following new subparagraph:

"(D) the number of months during the calendar year for which a premium was paid under part B of title XVIII of the Social Security Act for the coverage of such individual under such part, and".

(B) Paragraph (2) of section 6050F(b) is amended to read as follows:

"(2) the information required to be shown on such return with respect to such individual."

(C) Subparagraph (A) of section 6050F(c)(1) is amended by inserting before the comma "and in the case of the information specified in subsection (a)(1)(D)".

(D) The heading for section 6050F is amended by inserting "and medicare part b coverage" before the period.

(E) The item relating to section 6050F in the table of sections for subpart B of part III of subchapter A of chapter 61 is amended by inserting "and Medicare part B coverage" before the period.

(2)(A) Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by adding at the end thereof the following new section:

"SEC. 6050Q. RETURNS RELATING TO CERTAIN RETIREE HEALTH CARE SUBSIDIES.

"(a) IN GENERAL.—Every alliance (as defined in section 1301 of the Health Security Act) that reduces an individual's liability under section 6111 of such Act (relating to repayment of alliance credit by certain families) pursuant to section 6114 of such Act (relating to special treatment of certain retirees and qualified spouses and children) shall make a return (according to the forms and regulations prescribed by the Secretary) setting forth—

"(1) the aggregate amount of such reductions by such alliance with respect to any individual during such calendar year, and

"(2) the name and address of such individual.

"(b) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED TO BE REPORTED.—Every alliance required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(1) the name and address of such alliance, and

"(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished to the individual as soon as practicable after the close of the calendar year for which the return under subsection (a) was made."

(B) Subparagraph (B) of section 6724(d)(1) is amended by inserting after clause (viii) the following new clause (and by redesignating the following clauses accordingly):

"(ix) section 6050Q (relating to returns relating to certain retiree health care subsidies),".

(C) Paragraph (2) of section 6724(d) is amended by redesignating subparagraphs (Q) through (T) as subparagraphs (R) through (U), respectively, and by inserting after subparagraph (P) the following new subparagraph:

"(Q) section 6050Q(b) (relating to returns relating to certain retiree health care subsidies),".

(D) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end thereof the following new item:

"Sec. 6050Q. Returns relating to certain retiree health care subsidies."

(d) WAIVER OF ESTIMATED TAX PENALTIES FOR 1996.—No addition to tax shall be imposed under section 6654 of the Internal Revenue Code of 1986 (relating to failure to pay estimated income tax) for any period before—

(1) April 16, 1997, with respect to any underpayment to the extent that such underpayment resulted from section 59B(a)(1) of the Internal Revenue Code of 1986, as added by this section, and

(2) April 16, 2001, with respect to any underpayment to the extent that such underpayment resulted from section 59B(a)(2) of such Code, as added by this section.

(e) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end thereof the following new item:

"Part VIII. Certain health care subsidies received by high-income individuals."

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to periods after December 31, 1995, in taxable years ending after such date.

PART 4—OTHER PROVISIONS

SEC. 7141. MODIFICATION TO SELF-EMPLOYMENT TAX TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS AND PARTNERS.

(a) TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS.—

(1) AMENDMENT TO INTERNAL REVENUE CODE.—Section 1402 (relating to definitions) is amended by adding at the end thereof the following new subsection:

"(k) TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS.—

"(1) IN GENERAL.—In the case of any individual—

"(A) who is a 2-percent shareholder (as defined in section 1372(b)) of an S corporation for any taxable year of such corporation, and

"(B) who materially participates in the activities of such S corporation during such taxable year,

such shareholder's net earnings from self-employment for such shareholder's taxable year in which the taxable year of the S corporation ends shall include such shareholder's pro rata share (as determined under section 1366(a)) of the taxable income or loss of such corporation from service-related businesses carried on by such corporation.

"(2) CERTAIN EXCEPTIONS TO APPLY.—In determining the amount to be taken into account under paragraph (1), the exceptions provided in subsection (a) shall apply, except that, in the case of the exceptions provided in subsection (a)(5), the rules of subparagraph (B) thereof shall apply to shareholders in S corporations.

"(3) SERVICE-RELATED BUSINESS.—For purposes of this subsection, the term 'service-related business' means any trade or business described in subparagraph (A) of section 1202(e)(3)."

(2) AMENDMENT TO SOCIAL SECURITY ACT.—Section 211 of the Social Security Act is amended by adding at the end the following new subsection:

"Treatment of Certain S Corporation Shareholders

"(k)(1) In the case of any individual—

"(A) who is a 2-percent shareholder (as defined in section 1372(b) of the Internal Revenue Code of 1986) of an S corporation for any taxable year of such corporation, and

"(B) who materially participates in the activities of such S corporation during such taxable year,

such shareholder's net earnings from self-employment for such shareholder's taxable year in which the taxable year of the S corporation ends shall include such shareholder's pro rata share (as determined under section 1366(a) of such Code) of the taxable income or loss of such corporation from service-related businesses (as defined in section 1402(k)(3) of such Code) carried on by such corporation.

"(2) In determining the amount to be taken into account under paragraph (1), the

exceptions provided in subsection (a) shall apply, except that, in the case of the exceptions provided in subsection (a)(5), the rules of subparagraph (B) thereof shall apply to shareholders in S corporations.".

(b) TREATMENT OF CERTAIN LIMITED PARTNERS.—

(1) AMENDMENT OF INTERNAL REVENUE CODE.—Paragraph (13) of section 1402(a) is amended by striking "limited partner, as such" and inserting "limited partner who does not materially participate in the activities of the partnership".

(2) AMENDMENT OF SOCIAL SECURITY ACT.—Paragraph (12) of section 211(a) of the Social Security Act is amended by striking "limited partner, as such" and inserting "limited partner who does not materially participate in the activities of the partnership".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years of individuals beginning after December 31, 1995, and to taxable years of S corporations and partnerships ending with or within such taxable years of individuals.

SEC. 7142. EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) IN GENERAL.—

(1) APPLICATION OF HOSPITAL INSURANCE TAX.—Section 3121(u)(2) is amended by striking subparagraphs (C) and (D).

(2) COVERAGE UNDER MEDICARE.—Section 210(p) of the Social Security Act (42 U.S.C. 410(p)) is amended by striking paragraphs (3) and (4).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services performed after September 30, 1995.

(b) TRANSITION IN BENEFITS FOR STATE AND LOCAL GOVERNMENT EMPLOYEES AND FORMER EMPLOYEES.—

(1) IN GENERAL.—

(A) EMPLOYEES NEWLY SUBJECT TO TAX.—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual who performs services during the calendar quarter beginning October 1, 1995, the wages for which are subject to the tax imposed by section 3101(b) of the Internal Revenue Code of 1986 only because of the amendment made by subsection (a), the individual's medicare qualified State or local government employment (as defined in subparagraph (B)) performed before October 1, 1995, shall be considered to be "employment" (as defined for purposes of title II of such Act), but only for purposes of providing the individual (or another person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act for months beginning with October 1995.

(B) MEDICARE QUALIFIED STATE OR LOCAL GOVERNMENT EMPLOYMENT DEFINED.—In this paragraph, the term "medicare qualified State or local government employment" means medicare qualified government employment described in section 210(p)(1)(B) of the Social Security Act (determined without regard to section 210(p)(3) of such Act, as in effect before its repeal under subsection (a)(2)).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year on account of—

(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act solely by reason of paragraph (1),

(B) the additional administrative expenses resulting or expected to result therefrom, and

(C) any loss in interest to such Trust Fund resulting from the payment of those amounts, in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted.

(3) INFORMATION TO INDIVIDUALS WHO ARE PROSPECTIVE MEDICARE BENEFICIARIES BASED ON STATE AND LOCAL GOVERNMENT EMPLOYMENT.—Section 226(g) of the Social Security Act (42 U.S.C. 426(g)) is amended—

(A) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively,

(B) by inserting "(1)" after "(g)", and

(C) by adding at the end the following new paragraph:

"(2) The Secretary, in consultation with State and local governments, shall provide procedures designed to assure that individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(7) are fully informed with respect to (A) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (B) the requirements for, and conditions of, such eligibility, and (C) the necessity of timely application as a condition of becoming entitled under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity or retirement benefit and whose eligibility for such annuity or retirement benefit is based on a disability."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (A) of section 3121(u)(2) is amended by striking "subparagraphs (B) and (C)," and inserting "subparagraph (B),".

(2) Subparagraph (B) of section 210(p)(1) of the Social Security Act (42 U.S.C. 410(p)(1)) is amended by striking "paragraphs (2) and (3)." and inserting "paragraph (2)."

(3) Section 218 of the Social Security Act (42 U.S.C. 418) is amended by striking subsection (n).

(4) The amendments made by this subsection shall apply after September 30, 1995.

Subtitle B—Tax Treatment of Employer-Provided Health Care

SEC. 7201. LIMITATION ON EXCLUSION FOR EMPLOYER-PROVIDED HEALTH BENEFITS.

(a) GENERAL RULE.—Section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

"(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

"(b) INCLUSION OF CERTAIN BENEFITS NOT PART OF COMPREHENSIVE BENEFIT PACKAGE.—

"(1) IN GENERAL.—Effective on and after January 1, 2003, gross income of an employee shall include employer-provided coverage under any accident or health plan except to the extent that—

"(A) such coverage consists of comprehensive health coverage described in section 1101 of the Health Security Act, or

"(B) such coverage consists of permitted coverage.

"(2) PERMITTED COVERAGE.—For purposes of this subsection, the term 'permitted coverage' means—

"(A) any coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury,

"(B) any coverage providing for payments referred to in section 105(c),

"(C) any coverage provided to an employee or former employee after such employee has attained age 65, unless such coverage is provided by reason of the current employment of the individual (within the meaning of section 1862(b)(1)(A)(i)(I) of the Social Security Act) with the employer providing the coverage,

"(D) any coverage under a qualified long-term care insurance policy (as defined in section 7702B),

"(E) any coverage provided under Federal law to any individual (or spouse or dependent thereof) by reason of such individual being—

"(i) a member of the Armed Forces of the United States, or

"(ii) a veteran, and

"(F) any other coverage to the extent that the Secretary determines that the continuation of an exclusion for such coverage is not inconsistent with the purposes of this subsection.

"(3) SPECIAL RULES FOR FLEXIBLE SPENDING ARRANGEMENTS.—

"(A) IN GENERAL.—To the extent that any employer-provided coverage is provided through a flexible spending or similar arrangement, paragraph (1) shall be applied by substituting 'January 1, 1997,' for 'January 1, 2003'.

"(B) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this paragraph, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(i) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(ii) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 200 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

"(c) SPECIAL RULES FOR DETERMINING AMOUNT OF INCLUSION.—

"(1) IN GENERAL.—For purposes of this section, the value of any coverage shall be determined on the basis of the average cost of providing such coverage to the beneficiaries receiving such coverage.

"(2) SPECIAL RULE.—To the extent provided by the Secretary, cost determinations under paragraph (1) may be made on the basis of reasonable estimates.

"(d) POTENTIAL CASH PAYMENT NOT TO AFFECT EXCLUSION.—No amount shall be included in the gross income of an employee solely because the employee may select coverage under an accident or health plan which results in a cash payment referred to in section 1607 of the Health Security Act."

(b) EMPLOYMENT TAX TREATMENT.—

(1) SOCIAL SECURITY TAX.—

(A) Subsection (a) of section 3121 is amended by inserting after paragraph (21) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(B) Subsection (a) of section 209 of the Social Security Act is amended by inserting after paragraph (21) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under

section 106(b) of the Internal Revenue Code of 1986."

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) is amended by adding at the end thereof the following new sentence: "Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'compensation' any amount which is required to be included in gross income under section 106(b)."

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by inserting after paragraph (16) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(4) WAGE WITHHOLDING.—Subsection (a) of section 3401 is amended by adding at the end thereof the following new sentence:

"Nothing in the preceding provisions of this subsection shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 7202. HEALTH BENEFITS MAY NOT BE PROVIDED UNDER CAFETERIA PLANS.

(a) GENERAL RULE.—Subsection (f) of section 125 (defining qualified benefits) is amended by adding at the end thereof the following new sentence: "Such term shall not include any benefits or coverage (other than coverage described in section 106(b)(2)(A)) under an accident or health plan."

(b) CONFORMING AMENDMENT.—Subsection (g) of section 125 is amended by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 7203. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) PROVISION MADE PERMANENT.—

(1) IN GENERAL.—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to taxable years beginning after December 31, 1993.

(b) DEDUCTION LIMITED TO BASIC COVERAGE PURCHASED FROM HEALTH ALLIANCE.—

(1) IN GENERAL.—Paragraphs (1) and (2) of section 162(l) are amended to read as follows:

"(1) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents; but only to the extent such insurance is comprehensive health coverage described in section 1101 of the Health Security Act purchased from a qualified alliance described in section 1311 of such Act.

"(2) LIMITATIONS.—

"(A) LOWER PERCENTAGE IN CERTAIN CASES.—If—

"(i) the taxpayer has 1 or more employees in a trade or business with respect to which such taxpayer is treated as an employee within the meaning of section 401(c), and

"(ii) the taxpayer does not pay at least 100 percent of the weighted average premium applicable under the Health Security Act for each of such employees,

paragraph (1) shall be applied by substituting for '100 percent' the lowest percentage of such weighted average premium paid by the taxpayer for any of such employees.

"(B) DEDUCTION LIMITED TO EARNED INCOME.—No deduction shall be allowed under paragraph (1) to the extent that the amount of such deduction exceeds the taxpayer's earned income (within the meaning of section 401(c)).

"(C) OTHER COVERAGE.—Paragraph (1) shall not apply to amounts paid for coverage for any individual for any calendar month if such individual is employed on a full-time basis (within the meaning of section 1901 of the Health Security Act) by an employer during such month."

(2) CONFORMING AMENDMENT.—Subparagraph (A) of section 162(l)(5) is amended by striking "shall be treated as such individual's earned income" and inserting "shall be included in such individual's earned income".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the earlier of—

(A) January 1, 1997, or

(B) the first day on which the taxpayer could purchase comprehensive health coverage from a qualified alliance.

SEC. 7204. LIMITATION ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS.

(a) GENERAL RULE.—Subsection (d) of section 213 is amended by adding at the end thereof the following new paragraph:

"(10) LIMITATION ON PREPAYMENTS.—If the taxpayer pays a premium or other amount which constitutes medical care under paragraph (1), to the extent such premium or other amount is properly allocable to insurance coverage or care to be provided during periods more than 12 months after the month in which such payment is made, such premium shall be treated as paid ratably over the period during which such insurance coverage or care is to be provided. The preceding sentence shall not apply to any premium to which paragraph (7) applies nor to any premium paid under a qualified long-term care insurance policy."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid after December 31, 1996.

Subtitle C—Employment Status Provisions

SEC. 7301. DEFINITION OF EMPLOYEE.

(a) GENERAL RULE.—Chapter 25 (relating to general provisions applicable to employment taxes) is amended by adding at the end thereof the following new section:

"SEC. 3510. DEFINITION OF EMPLOYEE.

"(a) REGULATIONS.—The Secretary shall prescribe regulations setting forth rules for determining whether an individual is an employee for purposes of—

"(1) the employment taxes imposed under this subtitle, and

"(2) to the extent provided in such regulations, subtitle A.

"(b) OVERRIDE OF CURRENT RULES.—To the extent provided in the regulations prescribed in subsection (a), such regulations shall be in lieu of the rules (statutory or otherwise) otherwise applicable for the determination referred to in subsection (a). Nothing in such regulations shall override the provisions of section 3511."

(b) CLERICAL AMENDMENT.—The table of sections for chapter 25 is amended by adding at the end thereof the following new item:

"Sec. 3510. Definition of employee."

SEC. 7302. INCREASE IN SERVICES REPORTING PENALTIES.

(a) INCREASE IN PENALTY.—Section 6721(a) (relating to imposition of penalty) is amended by adding at the end the following new paragraph:

"(3) INCREASED PENALTY FOR RETURNS INVOLVING PAYMENTS FOR SERVICES.—

"(A) IN GENERAL.—Subject to the overall limitation of paragraph (1), the amount of the penalty under paragraph (1) for any failure with respect to any applicable return shall be equal to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported.

"(B) EXCEPTION WHERE SUBSTANTIAL COMPLIANCE.—Subparagraph (A) shall not apply to failures with respect to applicable returns required to be filed by a person during any calendar year if the aggregate amount which is timely and correctly reported on applicable returns filed by the person for the calendar year is at least 97 percent of the aggregate amount which is required to be reported on applicable returns by the person for the calendar year.

"(C) APPLICABLE RETURN.—For purposes of this paragraph, the term 'applicable return' means any information return required to be filed under—

"(i) section 6041(a) which relates to payments to any person for services performed by such person (other than as an employee), or

"(ii) section 6041A(a)."

(b) CONFORMING AMENDMENT.—Section 6721(a)(1) is amended by striking "In" and inserting "Except as provided in paragraph (3), in".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to returns the due date for which (without regard to extensions) is more than 30 days after the date of the enactment of this Act.

SEC. 7303. REVISION OF SECTION 530 SAFE HARBOR RULES.

(a) GENERAL RULE.—Chapter 25 (relating to general provisions applicable to employment taxes) is amended by adding at the end thereof the following new section:

"SEC. 3511. PROTECTION AGAINST RETROACTIVE EMPLOYMENT TAX RECLASSIFICATIONS.

"(a) GENERAL RULE.—If—

"(1) for purposes of employment taxes, the taxpayer treats an individual as not being an employee for any period,

"(2) for such period, the taxpayer meets—

"(A) the consistency requirements of subsection (b),

"(B) the return filing requirements of subsection (c), and

"(C) the safe harbor requirement of subsection (d), and

"(3) the Secretary has not notified the taxpayer in writing before the beginning of such period that the Secretary has determined that the taxpayer should treat such individual (or any individual holding a substantially similar position) as an employee,

then, for purposes of applying this subtitle for such period, the individual shall be deemed not to be an employee of the taxpayer.

"(b) CONSISTENCY REQUIREMENTS.—A taxpayer meets the consistency requirements of this subsection with respect to any individual for any period if the taxpayer treats such individual (and all other individuals holding substantially similar positions) as not being an employee for purposes of the employment taxes for such period and all prior periods.

"(c) RETURN FILING REQUIREMENTS.—

"(1) IN GENERAL.—The taxpayer meets the return filing requirements of this subsection with respect to any individual for any period

if all Federal tax returns (including information returns) required to be filed by the taxpayer for such period with respect to such individual (and all other individuals holding substantially similar positions) are timely filed on a basis consistent with the taxpayer's treatment of such individuals as not being employees.

"(2) SPECIAL RULES.—For purposes of paragraph (1)—

"(A) any return filed for which the penalty under section 6721(a) is reduced or waived pursuant to subsection (b) or (c) of section 6721 shall be considered timely filed, and

"(B) a taxpayer shall not be considered as failing to meet the requirements of paragraph (1) solely because the taxpayer failed to timely file accurate information returns in respect of payments to individuals holding substantially similar positions if the taxpayer satisfies the requirements of section 6721(a)(3)(B) for such period.

"(d) SAFE HARBORS.—

"(1) IN GENERAL.—The taxpayer meets the safe harbor requirement of this subsection with respect to any individual for any period if the taxpayer's treatment of such individual as not being an employee for such period was—

"(A) in reasonable reliance on a written determination (as defined in section 6110(b)(1)) issued to or in respect of the taxpayer that addressed the employment status of the individual or an individual holding a substantially similar position;

"(B) in reasonable reliance on a concluded Internal Revenue Service audit of the taxpayer—

"(i) which was for a period in which the rules for determining employment status were the same as for the period in question, and

"(ii) in which the employment status of the individual or any individual holding a substantially similar position was examined without change to any such individual's status;

"(C) in reasonable reliance on a longstanding recognized practice of a significant segment of the industry in which the individual is engaged; or

"(D) supported by substantial authority.

For purposes of subparagraph (D), the term 'substantial authority' has the same meaning as when used in section 6662(d)(2)(B)(i); except that such term shall not include any private letter ruling issued to a person other than the taxpayer.

"(2) SPECIAL RULES.—

"(A) SUBSEQUENT AUTHORITY.—The taxpayer shall not be considered to meet the safe harbor requirement of paragraph (1)(B) with respect to any individual for any period if the treatment of such individual as not being an employee is inconsistent with any regulation, Revenue Ruling, Revenue Procedure, or other authority published by the Secretary before the beginning of such period and after the conclusion of the audit referred to in paragraph (1)(B).

"(B) TERMINATION OF INDUSTRY PRACTICE SAFE HARBOR.—The taxpayer shall not be considered to meet the safe harbor requirement of paragraph (1)(C) with respect to any individual for—

"(i) any period beginning after the date on which the Secretary prescribes regulations pursuant to section 3510, or

"(ii) any period if the treatment of such individual as not being an employee is inconsistent with any regulation, Revenue Ruling, Revenue Procedure, or other authority published by the Secretary before the beginning of such period.

"(e) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) EMPLOYMENT TAX.—The term 'employment tax' means any tax imposed by this subtitle.

"(2) TAXPAYER.—The term 'taxpayer' includes any person or entity (including a governmental entity) which is (or would be but for this section) liable for any employment tax. Such term includes any predecessor or successor to the taxpayer.

"(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out the purposes of this section."

(b) RULES TO APPLY FOR INCOME TAX PURPOSES.—Part I of subchapter B of chapter 1 is amended by adding at the end thereof the following new section:

"SEC. 69. DETERMINATION OF EMPLOYMENT STATUS.

"For purposes of this subtitle, an individual shall be treated as a self-employed individual with respect to any services performed by such individual for another person if, under the rules of section 3511, such individual is treated as not being an employee of such other person with respect to such services."

(c) CONFORMING AMENDMENT.—Section 530 of the Revenue Act of 1978 is hereby repealed.

(d) CLERICAL AMENDMENTS.—

(1) The table of sections for chapter 25 is amended by adding at the end thereof the following new item:

"Sec. 3511. Protection against retroactive employment tax reclassifications."

(2) The table of sections for part I of subchapter B of chapter 1 is amended by adding at the end thereof the following new item:

"Sec. 69. Determination of employment status."

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to all periods beginning after December 31, 1995.

(2) REPEAL OF LIMITATIONS ON REGULATIONS AND RULINGS.—The repeal made by subsection (c), insofar as it relates to section 530(b) of the Revenue Act of 1978, shall take effect on the date of the enactment of this Act.

Subtitle D—Tax Treatment of Funding of Retiree Health Benefits

SEC. 7401. POST-RETIREMENT MEDICAL AND LIFE INSURANCE RESERVES.

(a) MINIMUM PERIOD FOR WORKING LIVES.—Section 419A(c)(2) (relating to additional reserves for post-retirement medical and life insurance benefits) is amended by inserting "(but not less than 10 years)" after "working lives of the covered employees".

(b) SEPARATE ACCOUNTING.—

(1) REQUIREMENT.—Section 419A(c)(2) is amended by adding at the end the following new flush sentence:

"Such reserve shall be maintained as a separate account."

(2) USE OF RESERVE FOR OTHER PURPOSES.—Paragraph (1) of section 4976(b) (defining disqualified benefit) is amended by striking "and" at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting ", and", and by adding after subparagraph (C) the following new subparagraph:

"(D) any payment to which subparagraph (C) does not apply which is out of an account described in section 419A(c)(2) and which is not used to provide a post-retirement medical benefit or life insurance benefit."

(c) SPECIAL LIMITATIONS.—Section 419A(e) (relating to special limitations on reserves) is amended by adding at the end the following new paragraph:

"(3) BENEFITS MUST BE EXCLUDABLE.—Post-retirement medical benefits and life insurance benefits shall not be taken into account under subsection (c)(2) to the extent it may be reasonably anticipated that such benefits will be required to be included in gross income when provided."

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions paid or accrued after December 31, 1994, in taxable years ending after such date.

(2) SEPARATE ACCOUNTING.—The amendments made by subsection (b) shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

SEC. 7402. HEALTH BENEFITS ACCOUNTS MAINTAINED BY PENSION PLANS.

(a) TERMINATION OF ACCOUNTS.—

(1) IN GENERAL.—Section 401(h) (relating to medical, etc., benefits for retired employees and their spouses and dependents) is amended by adding at the end the following new paragraph:

"(2) TERMINATION.—

"(A) IN GENERAL.—In the case of a pension or annuity plan to which paragraph (1) applies—

"(i) no contributions may be made to the separate account described in paragraph (1)(C) other than allowable contributions, and

"(ii) such plan may pay benefits described in paragraph (1) only from funds attributable to allowable contributions and earnings allocable to such contributions.

"(B) ALLOWABLE CONTRIBUTION.—For purposes of subparagraph (A), the term 'allowable contribution' means—

"(i) any contribution made before January 1, 1995,

"(ii) in the case of a plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employees ratified on or before October 29, 1993, any contribution under such plan made before the earlier of—

"(I) the date on which the last of such agreements terminates (determined without regard to any extension after October 29, 1993), or, if later, January 1, 1995, or

"(II) January 1, 1998, or

"(iii) any qualified transfer under section 420."

(2) CONFORMING AMENDMENTS.—Section 401(h) is amended—

(A) by striking "Under" and inserting:

"(1) IN GENERAL.—Under",

(B) by redesignating paragraphs (1) through (6) as subparagraphs (A) through (F), respectively,

(C) by striking "paragraph (6)" and inserting "subparagraph (F)", and

(D) by striking "paragraph (1)" and inserting "subparagraph (A)".

(b) MINIMUM COST REQUIREMENTS OF EMPLOYER.—Paragraph (3) of section 420(c) (relating to minimum cost requirements) is amended by adding at the end the following new subparagraph:

"(E) ADJUSTMENT FOR COST SAVINGS UNDER HEALTH SECURITY ACT.—To the extent provided by the Secretary, a plan shall not be treated as failing to meet the requirements of this section to the extent such failure is attributable to a reduction in qualified current retiree health liabilities by reason of the enactment of the Health Security Act."

Subtitle E—Coordination With COBRA Continuing Care Provisions

SEC. 7501. COORDINATION WITH COBRA CONTINUING CARE PROVISIONS.

(a) PERIOD OF COVERAGE.—Clause (iv) of section 4980B(f)(2)(B) (defining period of coverage) is amended—

(1) by striking "or" at the end of subclause (I), by striking the period at the end of subclause (II) and inserting ", or", and by adding at the end the following new subclause:

"(III) eligible for comprehensive health coverage described in section 1101 of the Health Security Act.", and

(2) by striking "OR MEDICARE ENTITLEMENT" in the heading and inserting ", MEDICARE ENTITLEMENT, OR HEALTH SECURITY ACT ELIGIBILITY".

(b) QUALIFIED BENEFICIARY.—Section 4980B(g)(1) (defining qualified beneficiary) is amended by adding at the end the following new subparagraph:

"(E) SPECIAL RULE FOR INDIVIDUALS COVERED BY HEALTH SECURITY ACT.—The term 'qualified beneficiary' shall not include any individual who, upon termination of coverage under a group health plan, is eligible for comprehensive health coverage described in section 1101 of the Health Security Act."

(c) REPEAL UPON IMPLEMENTATION OF HEALTH SECURITY ACT.—

(1) IN GENERAL.—Section 4980B (relating to failure to satisfy continuation coverage requirements of group health care plans) is hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Section 414(n)(3)(C) is amended by striking "505, and 4980B" and inserting "and 505".

(B) Section 414(t)(2) is amended by striking "505, or 4980B" and inserting "or 505".

(C) The table of sections for chapter 43 is amended by striking the item relating to section 4980B.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the earlier of—

(A) January 1, 1998, or

(B) the first day of the first calendar year following the calendar year in which all States have in effect plans under which individuals are eligible for comprehensive health coverage described in section 1101 of this Act.

Such amendments shall not apply in determining the amount of any tax under section 4980B of the Internal Revenue Code of 1986 with respect to any failure occurring before the date determined under the preceding sentence.

Subtitle F—Tax Treatment of Organizations Providing Health Care Services and Related Organizations

SEC. 7601. TREATMENT OF NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) TREATMENT OF HOSPITALS AND OTHER ENTITIES PROVIDING HEALTH CARE SERVICES.—Section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

"(n) QUALIFICATION OF ORGANIZATIONS PROVIDING HEALTH CARE SERVICES AS CHARITABLE ORGANIZATIONS.—For purposes of subsection (c)(3), the provision of health care services shall not be treated as an activity that accomplishes a charitable purpose unless the organization providing such services, on a periodic basis (no less frequently than annually), and with the participation of community representatives—

"(1) assesses the health care needs of its community, and

"(2) develops a plan to meet those needs.

In the case of a health maintenance organization, the provision of health care services shall not be treated as an activity that accomplishes a charitable purpose for purposes of subsection (c)(3) unless, in addition to meeting the requirement of the preceding sentence, such services are provided as described in subsection (m)(3)(B)(i)."

(b) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—Section 501(m) is amended by adding at the end thereof the following new paragraph:

"(6) INSURANCE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS.—

"(A) CERTAIN INSURANCE NOT TREATED AS COMMERCIAL-TYPE INSURANCE.—Health insurance provided by a health maintenance organization shall not be treated as commercial-type insurance if such insurance relates to care provided other than pursuant to a pre-existing arrangement with such organization. In applying the preceding sentence, care described in subparagraph (B)(iv) shall not be taken into account.

"(B) CERTAIN INSURANCE TREATED AS COMMERCIAL-TYPE INSURANCE.—Health insurance provided by a health maintenance organization shall be treated as commercial-type insurance if it relates to—

"(i) care provided by such organization to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization,

"(ii) primary care provided by a health care professional to a member of such organization on a basis under which the amount paid to such professional does not vary with the amount of care provided to such member,

"(iii) services other than primary care provided pursuant to a pre-existing arrangement with such organization, or

"(iv) emergency care provided to a member of such organization at a location outside such member's area of residence."

(c) TREATMENT OF PARENT ORGANIZATIONS OF HEALTH CARE PROVIDERS.—Section 509(a) (defining private foundation) is amended by striking "and" at the end of paragraph (3), by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

"(4) an organization which is organized and operated for the benefit of, and which directly or indirectly controls, an organization described in section 170(b)(1)(A)(iii), and".

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on January 1, 1995.

(2) SUBSECTIONS (b) AND (c).—The amendments made by subsections (b) and (c) shall take effect on the date of the enactment of this Act.

SEC. 7602. TAX TREATMENT OF TAXABLE ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.

(a) GENERAL RULE.—Section 833 is amended to read as follows:

"SEC. 833. TREATMENT OF ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.

"(a) GENERAL RULE.—Any organization to which this section applies shall be taxable under this part in the same manner as if it were an insurance company other than a life insurance company.

"(b) ORGANIZATIONS TO WHICH SECTION APPLIES.—This section shall apply to any organization—

"(1) which is not exempt from taxation under this subtitle, and

"(2) the primary and predominant business activity of which during the taxable year consists of 1 or more of the following:

"(A) Issuing accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts.

"(B) Operating as a health maintenance organization.

"(C) Entering into arrangements under which—

"(i) fixed payments or premiums are received as consideration for the organization's agreement to provide or arrange for the provision of health care services, regardless of how the health care services are provided or arranged to be provided, and

"(ii) such fixed payments or premiums do not vary depending on the amount of health care services provided."

(b) CONFORMING AMENDMENTS.—

(1) Subsection (c) of section 56 is amended by striking paragraph (3).

(2) The table of sections for part II of subchapter L of chapter 1 is amended by striking the item relating to section 833 and inserting the following:

"Sec. 833. Treatment of organizations providing health insurance and other prepaid health care services."

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1996.

(2) TRANSITION RULES FOR BLUE CROSS AND BLUE SHIELD ORGANIZATIONS.—

(A) PRIOR FRESH START PRESERVED.—The adjusted basis of any asset determined under section 1012(c)(3)(A)(ii) of the Tax Reform Act of 1986 shall not be affected by the amendments made by this section nor by reason of any failure to qualify in taxable years beginning after December 31, 1996, as an existing Blue Cross or Blue Shield organization (as defined in section 833(c)(2) of the Internal Revenue Code of 1986, as in effect on the day before the date of the enactment of this Act).

(B) RECOUPMENT OF PRIOR RESERVE BENEFIT.—In the case of any organization entitled to the benefits of section 833(a)(3) of the Internal Revenue Code of 1986 (as in effect on the day before the date of the enactment of this Act) for such organization's last taxable year beginning before January 1, 1997, the amount determined under paragraph (4) of section 832(b) of such Code for each of such organization's first 6 taxable years beginning after December 31, 1996, shall be increased by an amount equal to 3 ⅓ percent of its unearned premiums on outstanding business as of the close of such organization's last taxable year beginning before January 1, 1997.

(C) PHASE-OUT OF SPECIAL DEDUCTION FOR CERTAIN ORGANIZATIONS.—

(i) IN GENERAL.—In the case of an organization which meets the requirements of clause (ii)—

(I) such organization shall continue to be entitled to the deduction provided under section 833(b) of the Internal Revenue Code of 1986 (as in effect on the day before the date of the enactment of this Act) for its first 2 taxable years beginning after December 31, 1996, except that

(II) the amount of such deduction for such organization's taxable year beginning in 1997 shall be 67 percent of the amount which would have been determined under such section 833(b) as so in effect, and the amount of such deduction for organization's taxable year beginning in 1998 shall be 33 percent of

the amount which would have been so determined.

Notwithstanding the amendment made by subsection (b)(1), any deduction under the preceding sentence shall not be allowable in computing alternative minimum taxable income.

(ii) REQUIREMENTS.—An organization meets the requirements of this clause if, for each of its taxable years beginning in 1995 and 1996, such organization—

(I) was an organization to which section 833 of such Code (as so in effect) applied, and

(II) met the requirements of subparagraph (A) of section 833(c)(3) of such Code (as so in effect).

(3) TRANSITIONAL RULES FOR OTHER COMPANIES.—

(A) ORGANIZATIONS TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any organization to which section 833 of the Internal Revenue Code of 1986 (as amended by subsection (a)) applies for such organization's first taxable year beginning after December 31, 1996; except that this paragraph shall not apply if such organization treated itself as an insurance company taxable under part II of subchapter L of chapter 1 of such Code on its original Federal income tax return for its taxable year beginning in 1992 and for all of its taxable years thereafter beginning before January 1, 1997.

(B) TREATMENT OF CURRENTLY TAXABLE COMPANIES.—Except as provided in subparagraph (C), in the case of any organization to which this paragraph applies—

(i) the amendments made by this section shall be treated as a change in the method of accounting, and

(ii) all adjustments required to be taken into account under section 481 of the Internal Revenue Code of 1986, shall be taken into account for such company's first taxable year beginning after December 31, 1996.

(C) TREATMENT OF CURRENTLY TAX EXEMPT COMPANIES.—In the case of any organization to which this paragraph applies and which was exempt from tax under chapter 1 of the Internal Revenue Code of 1986 for such organization's last taxable year beginning before January 1, 1997—

(i) no adjustment shall be made under section 481 (or any other provision) of such Code on account of a change in its method of accounting required by this section for its first taxable year beginning after December 31, 1996, and

(ii) for purposes of determining gain or loss, the adjusted basis of any asset held by such organization on the first day of such taxable year shall be treated as equal to its fair market value as of such day.

SEC. 7603. EXEMPTION FROM INCOME TAX FOR REGIONAL ALLIANCES.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by adding at the end thereof the following new paragraph:

"(26) Any regional alliance described in section 1301 of the Health Security Act. Such an alliance shall be treated as not described in any other paragraph of this subsection."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after the date of the enactment of this Act.

Subtitle G—Tax Treatment of Long-term Care Insurance and Services

SEC. 7701. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking "or" at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

"(C) for qualified long-term care services (as defined in subsection (g)), or".

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to the deduction for medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

"(g) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, curing, mitigating, treating, preventive, therapeutic, and rehabilitative services, and maintenance and personal care services (whether performed in a residential or nonresidential setting) which—

"(A) are required by an individual during any period the individual is an incapacitated individual (as defined in paragraph (2)),

"(B) have as their primary purpose—

"(i) the provision of needed assistance with 1 or more activities of daily living (as defined in paragraph (3)), or

"(ii) protection from threats to health and safety due to severe cognitive impairment, and

"(C) are provided pursuant to a continuing plan of care prescribed by a licensed professional (as defined in paragraph (4)).

"(2) INCAPACITATED INDIVIDUAL.—The term 'incapacitated individual' means any individual who—

"(A) is unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), at least 2 activities of daily living as defined in paragraph (3), or

"(B) has severe cognitive impairment as defined by the Secretary in consultation with the Secretary of Health and Human Services.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless a licensed professional within the preceding 12-month period has certified that such individual meets such requirements.

"(3) ACTIVITIES OF DAILY LIVING.—Each of the following is an activity of daily living:

"(A) Eating.

"(B) Toileting.

"(C) Transferring.

"(D) Bathing.

"(E) Dressing.

"(4) LICENSED PROFESSIONAL.—The term 'licensed professional' means—

"(A) a physician or registered professional nurse, or

"(B) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

"(5) CERTAIN SERVICES NOT INCLUDED.—The term 'qualified long-term care services' shall not include any services provided to an individual—

"(A) by a relative (directly or through a partnership, corporation, or other entity) unless the relative is a licensed professional with respect to such services, or

"(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in paragraphs (1) through (8) of section 152(a)."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended to read as follows:

"(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in—

"(i) subparagraphs (A) and (B), or

"(ii) subparagraph (C), but only if such insurance is provided under a qualified long-term care insurance policy (as defined in section 7702B(b)) and the amount paid for such insurance is not disallowed under section 7702B(d)(4)."

(2) Paragraph (6) of section 213(d) is amended—

(A) by striking "subparagraphs (A) and (B)" and inserting "subparagraph (A), (B), and (C)", and

(B) by striking "paragraph (1)(C)" in subparagraph (A) and inserting "paragraph (1)(D)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7702. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE.

"(a) IN GENERAL.—For purposes of this title—

"(1) a qualified long-term care insurance policy (as defined in subsection (b)) shall be treated as an accident and health insurance contract,

"(2) amounts (other than policyholder dividends (as defined in section 808) or premium refunds) received under a qualified long-term care insurance policy shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

"(3) any plan of an employer providing coverage under a qualified long-term care insurance policy shall be treated as an accident and health plan with respect to such coverage,

"(4) amounts paid for a qualified long-term care insurance policy providing the benefits described in subsection (b)(6)(B) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

"(5) a qualified long-term care insurance policy shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

"(b) QUALIFIED LONG-TERM CARE INSURANCE POLICY.—For purposes of this title—

"(1) IN GENERAL.—The term 'qualified long-term care insurance policy' means any long-term care insurance policy (as defined in section 2304 of the Health Security Act) that—

"(A) satisfies the requirements of subpart B of part 3 of subtitle B of title II of the Health Security Act,

"(B) limits benefits under such policy to individuals who are certified by a licensed professional (as defined in section 213(g)(4)) within the preceding 12-month period as being unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), 2 or more activities of daily living (as defined in section 213(g)(3)), or who have a severe cognitive impairment (as defined in section 213(g)(2)(B)), and

"(C) satisfies the requirements of paragraphs (2), (3), (4), (5), and (6).

"(2) PREMIUM REQUIREMENTS.—The requirements of this paragraph are met with respect

to a policy if such policy provides that premium payments may not be made earlier than the date such payments would have been made if the contract provided for level annual payments over the life expectancy of the insured or 20 years, whichever is shorter. A policy shall not be treated as failing to meet the requirements of the preceding sentence solely by reason of a provision in the policy providing for a waiver of premiums if the insured becomes an individual certified in accordance with paragraph (1)(B).

"(3) PROHIBITION OF CASH VALUE.—The requirements of this paragraph are met if the policy does not provide for a cash value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed, other than as provided in paragraph (4).

"(4) REFUNDS OF PREMIUMS AND DIVIDENDS.—The requirements of this paragraph are met with respect to a policy if such policy provides that—

"(A) policyholder dividends are required to be applied as a reduction in future premiums or, to the extent permitted under paragraph (6), to increase benefits described in subsection (a)(2), and

"(B) refunds of premiums upon a partial surrender or a partial cancellation are required to be applied as a reduction in future premiums, and

"(C) any refund on the death of the insured, or on a complete surrender or cancellation of the policy, cannot exceed the aggregate premiums paid under the contract.

Any refund on a complete surrender or cancellation of the policy shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

"(5) COORDINATION WITH OTHER ENTITLEMENTS.—The requirements of this paragraph are met with respect to a policy if such policy does not cover expenses incurred to the extent that such expenses are also covered under title XVIII of the Social Security Act or are covered under comprehensive health coverage described in section 1101 of the Health Security Act.

"(6) MAXIMUM BENEFIT.—

"(A) IN GENERAL.—The requirements of this paragraph are met if the benefits payable under the policy for any period (whether on a periodic basis or otherwise) shall not exceed the dollar amount in effect for such period.

"(B) NONREIMBURSEMENT PAYMENTS PERMITTED.—Benefits shall include all payments described in subsection (a)(2) to or on behalf of an insured individual without regard to the expenses incurred during the period to which the payments relate. For purposes of section 213(a), such payments shall be treated as compensation for expenses paid for medical care.

"(C) DOLLAR AMOUNT.—The dollar amount in effect under this paragraph shall be $150 per day (or the equivalent amount within the calendar year in the case of payments on other than a per diem basis).

"(D) ADJUSTMENTS FOR INCREASED COSTS.—

"(i) IN GENERAL.—In the case of any calendar year after 1996, the dollar amount in effect under subparagraph (C) for any period or portion thereof occurring during such calendar year shall be equal to the sum of—

"(I) the amount in effect under subparagraph (C) for the preceding calendar year (after application of this subparagraph), plus

"(II) the product of the amount referred to in subclause (I) multiplied by the cost-of-living adjustment for the calendar year of the amount under subclause (I).

"(ii) COST-OF-LIVING ADJUSTMENT.—For purposes of clause (i), the cost-of-living adjustment for any calendar year is the percentage (if any) by which the cost index under clause (iii) for the preceding calendar year exceeds such index for the second preceding calendar year.

"(iii) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1997, establish a cost index to measure increases in costs of nursing home and similar facilities. The Secretary may from time to time revise such index to the extent necessary to accurately measure increases or decreases in such costs.

"(iv) SPECIAL RULE FOR CALENDAR YEAR 1997.—Notwithstanding clause (ii), for purposes of clause (i), the cost-of-living adjustment for calendar year 1997 is the sum of 1 ½ percent plus the percentage by which the CPI for calendar year 1996 (as defined in section 1(f)(4)) exceeds the CPI for calendar year 1995 (as so defined).

"(E) PERIOD.—For purposes of this paragraph, a period begins on the date that an individual has a condition which would qualify for certification under subsection (b)(1)(B) and ends on the earlier of the date upon which—

"(i) such individual has not been so certified within the preceding 12-months, or

"(ii) the individual's condition ceases to be such as to qualify for certification under subsection (b)(1)(B).

"(F) AGGREGATION RULE.—For purposes of this paragraph, all policies issued with respect to the same insured shall be treated as one policy.

"(c) TREATMENT OF LONG-TERM CARE INSURANCE POLICIES.—For purposes of this title, any amount received or coverage provided under a long-term care insurance policy that is not a qualified long-term care insurance policy shall not be treated as an amount received for personal injuries or sickness or provided under an accident and health plan and shall not be treated as excludible from gross income under any provision of this title.

"(d) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by rider on a life insurance contract—

"(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract or policy.

"(2) PREMIUMS AND CHARGES FOR LONG-TERM CARE COVERAGE.—Premium payments for coverage under a long-term care insurance policy and charges against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage shall be treated as premiums for purposes of subsection (b)(2).

"(3) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

"(A) by the sum of any charges (but not premium payments) described in paragraph (2) made to that date under the contract, less

"(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

"(4) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the coverage provided by the rider is a qualified long-term care insurance policy under subsection (b).

For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a long-term care insurance policy.

"(e) PROHIBITION OF DISCRIMINATION.—

"(1) IN GENERAL.—Notwithstanding subsection (a)(3), any plan of an employer providing coverage under a qualified long-term care insurance policy shall qualify as an accident and health plan with respect to such coverage only if—

"(A) the plan allows all employees, except as provided in paragraph (2), to participate, and

"(B) the benefits provided under the plan are identical for all employees that choose to participate.

"(2) EXCLUSION OF CERTAIN EMPLOYEES.—For purposes of paragraph (1), there may be excluded from consideration—

"(A) employees who have not completed 3 years of service;

"(B) employees who have not attained age 25;

"(C) part-time or seasonal employees; and

"(D) employees who are nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)).

"(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing long-term care insurance coverage under a life insurance contract and to provide for the proper allocation of amounts between the long-term care and life insurance portions of a contract.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

"Sec. 7702B. Treatment of long-term care insurance.".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to policies issued after December 31, 1995. Solely for purposes of the preceding sentence, a policy issued prior to January 1, 1996, that satisfies the requirements of a qualified long-term care insurance policy as set forth in section 7702B(b) shall, on and after January 1, 1996, be treated as being issued after December 31, 1995.

(2) TRANSITION RULE.—If, after the date of enactment of this Act and before January 1, 1996, a policy providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance policy (as defined in section 7702B(b)), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance policy, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a policy providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance policy within 60 days thereafter shall be treated as an exchange.

(3) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of determining whether section 7702 or 7702A of the Internal Revenue Code of 1986 applies to any contract, the issuance, whether before, on, or after December 31, 1995, of a rider on a life insurance contract providing long-term care insurance coverage shall not be treated as a modification or material change of such contract.

SEC. 7703. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end thereof the following new subsection:

"(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

"(1) IN GENERAL.—For purposes of this section, any amount distributed to an individual under a life insurance contract on the life of an insured who is a terminally ill individual (as defined in paragraph (3)) shall be treated as an amount paid by reason of the death of such insured.

"(2) NECESSARY CONDITIONS.—

"(A) Paragraph (1) shall not apply to any distribution unless—

"(i) the distribution is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

"(ii) the percentage derived from dividing the cash surrender value of the contract, if any, immediately after the distribution by the cash surrender value of the contract immediately before the distribution is equal to or greater than the percentage derived by dividing the death benefit immediately after the distribution by the death benefit immediately before the distribution.

"(B) The present value of the reduction in the death benefit occurring on the distribution must be determined by—

"(i) using as the discount rate a rate not to exceed the highest rate set forth in subparagraph (C), and

"(ii) assuming that the death benefit (or the portion thereof) would have been paid at the end of a period that is no more than the insured's life expectancy from the date of the distribution or 12 months, whichever is shorter.

"(C) RATES.—The rates set forth in this subparagraph are the following:

"(i) the 90-day Treasury bill yield,

"(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto for the calendar month ending 2 months before the date on which the rate is determined,

"(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum, and

"(iv) the maximum permissible interest rate applicable to policy loans under the contract.

"(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who the insurer has determined, after receipt of an acceptable certification by a licensed physician, has an illness or physical condition which can reasonably be expected to result in death within 12 months of the date of certification.

"(4) APPLICATION OF SECTION 72(e)(10).—For purposes of section 72(e)(10) (relating to the treatment of modified endowment contracts), section 72(e)(4)(A)(i) shall not apply to distributions described in paragraph (1).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1993.

SEC. 7704. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end thereof the following new subsection:

"(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

"(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

"(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract which provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined in section 101(g)(3)).

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—Paragraph (5)(A) of section 7702(f) is amended by striking "or" at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

"(v) any qualified accelerated death benefit rider (as defined in section 818(g)), or".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1993.

(2) TRANSITIONAL RULE.—For purposes of determining whether section 7702 or 7702A of the Internal Revenue Code of 1986 applies to any contract, the issuance, whether before, on, or after December 31, 1993, of a rider on a life insurance contract permitting the acceleration of death benefits (as described in section 101(g) of such Code) shall not be treated as a modification or material change of such contract.

Subtitle H—Tax Incentives for Health Services Providers

SEC. 7801. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 22 the following new section:

"SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.

"(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of—

"(1) the number of months during such taxable year—

"(A) during which the taxpayer is a qualified primary health services provider, and

"(B) which are within the taxpayer's mandatory service period, and

"(2) $1,000 ($500 in the case of a qualified practitioner who is not a physician).

"(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means, with respect to any month, any qualified practitioner who—

"(1) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is commencing the providing of primary health services,

"(2) is providing primary health services full time in the health professional shortage area identified in such certification, and

"(3) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

For purposes of paragraph (2), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area when the provider commenced providing services in the area.

"(c) MANDATORY SERVICE PERIOD.—For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider. A taxpayer shall not have more than 1 mandatory service period.

"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) BUREAU.—The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

"(2) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

"(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

"(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

"(5) CERTIFIED NURSE-MIDWIFE.—The term 'certified nurse-midwife' has the meaning given to such term by section 1861(gg)(2) of the Social Security Act.

"(6) PRIMARY HEALTH SERVICES.—The term 'primary health services' has the meaning given such term by section 330(b)(1) of the Public Health Service Act.

"(7) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term by section 332(a)(1)(A) of the Public Health Service Act.

"(e) RECAPTURE OF CREDIT.—

"(1) IN GENERAL.—If there is a recapture event during any taxable year, then—

"(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

"(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

"(i) the applicable percentage, and

"(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

"(2) APPLICABLE RECAPTURE PERCENTAGE.—

"(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

"If the recapture event occurs during:	The applicable recapture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Months 61 and thereafter	0.

"(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

"(3) RECAPTURE EVENT DEFINED.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified primary health services provider for any month during the taxpayer's mandatory service period.

"(B) CESSATION OF DESIGNATION.—The cessation of the designation of any area as a health professional shortage area after the beginning of the mandatory service period for any taxpayer shall not constitute a recapture event.

"(C) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Services, may waive any recapture event caused by extraordinary circumstances.

"(4) NO CREDITS AGAINST TAX; MINIMUM TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part or for purposes of section 55."

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 22 the following new item:

"Sec. 23. Primary health services providers."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 7802. EXPENSING OF MEDICAL EQUIPMENT.

(a) IN GENERAL.—Paragraph (1) of section 179(b) (relating to dollar limitation on expensing of certain depreciable business assets) is amended to read as follows:

"(1) DOLLAR LIMITATION.—

"(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $17,500.

"(B) HEALTH CARE PROPERTY.—The aggregate cost which may be taken into account under subsection (a) shall be increased by the lesser of—

"(i) the cost of section 179 property which is health care property placed in service during the taxable year, or

"(ii) $10,000."

(b) DEFINITION.—Section 179(d) (relating to definitions) is amended by adding at the end the following new paragraph:

"(11) HEALTH CARE PROPERTY.—For purposes of this section, the term 'health care property' means section 179 property—

"(A) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment,

"(B) which is owned (directly or indirectly) and used by a physician (as defined in section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), and

"(C) substantially all the use of which is in such area."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service after December 31, 1994.

Subtitle I—Miscellaneous Provisions

SEC. 7901. CREDIT FOR COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 23 the following new section:

"SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

"(a) ALLOWANCE OF CREDIT.—

"(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the personal assistance expenses paid or incurred by the taxpayer during such taxable year.

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means 50 percent reduced (but not below zero) by 10 percentage points for each $5,000 by which the modified adjusted gross income (as defined in section 59B(d)(2)) of the taxpayer for the taxable year exceeds $45,000. In the case of a married individual filing a separate return, the preceding sentence shall be applied by substituting '$2,500' for '$5,000' and '$22,500' for '$45,000'.

"(b) LIMITATION.—The amount of personal assistance expenses incurred for the benefit of an individual which may be taken into account under subsection (a) for the taxable year shall not exceed the lesser of—

"(1) $15,000, or

"(2) such individual's earned income (as defined in section 32(c)(2)) for the taxable year. In the case of a joint return, the amount under the preceding sentence shall be determined separately for each spouse.

"(c) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual (other than a nonresident alien) who, by reason of any medically determinable physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, is unable to engage in any substantial gainful activity without personal assistance services appropriate to carry out activities of daily living. An individual shall not be treated as an eligible individual unless such individual furnishes such proof thereof (in such form and manner, and at such times) as the Secretary may require.

"(d) OTHER DEFINITIONS.—For purposes of this section—

"(1) PERSONAL ASSISTANCE EXPENSES.—The term 'personal assistance expenses' means expenses for—

"(A) personal assistance services appropriate to carry out activities of daily living in or outside the home,

"(B) homemaker/chore services incidental to the provision of such personal assistance services,

"(C) in the case of an individual with a cognitive impairment, assistance with life skills,

"(D) communication services,

"(E) work-related support services,

"(F) coordination of services described in this paragraph,

"(G) assistive technology and devises, including assessment of the need for particular technology and devices and training of family members, and

"(H) modifications to the principal place of abode of the individual to the extent the expenses for such modifications would (but for subsection (e)(2)) be expenses for medical care (as defined by section 213) of such individual.

"(2) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means the activities referred to in section 213(g)(3).

"(e) SPECIAL RULES.—

"(1) PAYMENTS TO RELATED PERSONS.—No credit shall be allowed under this section for any amount paid by the taxpayer to any person who is related (within the meaning of section 267 or 707(b)) to the taxpayer.

"(2) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Any amount taken into account in determining the credit under this section shall not be taken into account in determining the amount of the deduction under section 213.

"(3) BASIS REDUCTION.—For purposes of this subtitle, if a credit is allowed under this section for any expense with respect to any property, the increase in the basis of such property which would (but for this paragraph) result from such expense shall be reduced by the amount of the credit so allowed.

"(f) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning after 1996, the $45,000 and $22,500 amounts in subsection (a)(2) and the $15,000 amount in subsection (b) shall be increased by an amount equal to—

"(1) such dollar amount, multiplied by

"(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 1995' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of $1,000, such increase shall be rounded to the nearest multiple of $1,000."

(b) TECHNICAL AMENDMENT.—Subsection (a) of section 1016 is amended by striking "and" at the end of paragraph (24), by striking the period at the end of paragraph (25) and inserting ", and", and by adding at the end thereof the following new paragraph:

"(26) in the case of any property with respect to which a credit has been allowed under section 23, to the extent provided in section 23(e)(3)."

(c) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 22 the following new item:

"Sec. 23. Cost of personal assistance services required by employed individuals."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7902. DENIAL OF TAX-EXEMPT STATUS FOR BORROWINGS OF HEALTH CARE-RELATED ENTITIES.

(a) IN GENERAL.—Paragraph (6) of section 141(b) (relating to private business use) is amended by adding at the end thereof the following new subparagraph:

"(C) CERTAIN HEALTH CARE-RELATED ENTITIES.—Use by—

"(i) any regional alliance described in section 1301 of the Heath Security Act,

"(ii) any corporate alliance described in section 1311 of such Act, and

"(iii) any guaranty fund described in section 1204 of such Act,

shall be treated as private business use by an organization that is not a 501(c)(3) organization."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to obligations issued after the date of the enactment of this Act.

SEC. 7903. DISCLOSURE OF RETURN INFORMATION FOR ADMINISTRATION OF CERTAIN PROGRAMS UNDER THE HEALTH SECURITY ACT.

(a) IN GENERAL.—Subparagraph (D) of section 6103(l)(7) (relating to disclosure of return information to Federal, State, and local agencies administering certain programs) is

amended by striking "and" at the end of clause (viii), by striking the period at the end of clause (ix) and inserting "; and", and by inserting after clause (ix) the following new clause:

"(x) assistance provided under the Health Security Act."

(b) INFORMATION NOT AVAILABLE TO LOCAL AGENCIES.—Subparagraph (D) of section 6103(l)(7) is amended by adding at the end thereof the following new sentence: "Subparagraphs (A) and (B) shall be applied without regard to any reference to any local agency with respect to the program referred to in clause (x)."

TITLE VIII—HEALTH AND HEALTH-RELATED PROGRAMS OF THE FEDERAL GOVERNMENT

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SEC. 8001. UNIFORMED SERVICES HEALTH PLANS.

(a) ESTABLISHMENT OF PLANS.—(1) Chapter 55 of title 10, United States Code, is amended by inserting after section 1073 the following new section:

"§ 1073a. Uniformed Services Health Plans: establishment and coordination with national health care reform

"(a) ESTABLISHMENT AUTHORIZED.—(1) The Secretary of Defense, in consultation with the other administering Secretaries, may establish one or more Uniformed Services Health Plans pursuant to this section in order to provide health care services to members of the uniformed services on active duty for a period of more than 30 days and persons described in subsection (e)(2).

"(2) The establishment and operation of a Uniformed Services Health Plan shall be carried out in accordance with regulations prescribed by the Secretary of Defense, in consultation with the other administering Secretaries. The Secretary shall assure that such regulations conform, to the maximum extent practicable, to the requirements for health plans set forth in the Health Security Act.

"(b) USE OF UNIFORMED SERVICES FACILITIES AND OTHER HEALTH CARE PROVIDERS.—(1) A Uniformed Services Health Plan may rely upon the use of facilities of the uniformed services for the provision of health care services to persons enrolled in the plan, supplemented by the use of civilian health care providers or health plans under agreements entered into by the Secretary of Defense.

"(2) An agreement with a civilian health care provider or a health plan under paragraph (1) may be entered into without regard to provisions of law requiring the use of competitive procedures. An agreement with a health plan may provide for the sharing of resources with the health plan that is a party to the agreement.

"(c) HEALTH CARE SERVICES UNDER A PLAN.—(1) Subject to paragraph (2), a Uniformed Services Health Plan shall provide to persons enrolled in the plan the items and services in the comprehensive benefit package under the Health Security Act.

"(2)(A) In addition, a Uniformed Services Health Plan shall guarantee to each person described in subparagraph (B) who is enrolled in the plan those health care services that the person would be entitled to receive under this chapter in the absence of this section. In the case of a person described in subparagraph (B) who is a covered beneficiary, such health care services shall consist of the types of health care services described in section 1079(a) of this title.

"(B) A person referred to in subparagraph (A) is a member of the uniformed services on active duty for a period of more than 30 days as of December 31, 1994, or any person who is a covered beneficiary as of that date, who is (or afterwards becomes) enrolled in a Uniformed Services Health Plan.

"(d) PREEMPTION OF CONFLICTING STATE REQUIREMENTS.—In carrying out responsibilities under the Health Security Act, a State (or State-established entity)—

"(1) may not impose any standard or requirement on a Uniformed Services Health Plan that is inconsistent with this section or any regulation prescribed under this section or other Federal law regarding the operation of this section; and

"(2) may not deny certification of a Uniformed Services Health Plan as a health plan under the Health Security Act on the basis of a conflict between a rule of a State or health alliance and this section or any regulation prescribed under this section or other Federal law regarding the operation of this section.

"(e) ENROLLMENT.—(1) Except as authorized by the administering Secretary concerned, each member of a uniformed service on active duty for a period of more than 30 days shall be required to enroll in a Uniformed Services Health Plan available to the member.

"(2) After enrolling members described in paragraph (1), opportunities for further enrollment in a Uniformed Services Health Plan shall be offered by the administering Secretaries to covered beneficiaries in the following order of priority:

"(A) Spouses and children of members of the uniformed services who are on active duty for a period of more than 30 days.

"(B) Persons described in subsection (c) of section 1086 of this title. The administering Secretary concerned may disregard the exclusion set forth in subsection (d)(1) of such section in the case of a person described in subsection (c) of such section who is enrolled in the supplementary medical insurance program under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.).

"(3) With respect to a member described in paragraph (1) or a covered beneficiary described in paragraph (2) who enrolls in a Uniformed Services Health Plan, participation in such a plan shall be the exclusive source of health care services available to the member or person under this chapter.

"(f) EFFECT OF FAILURE TO ENROLL.—(1) Except as provided in paragraph (2), if a person described in subsection (e)(2) declines the opportunity offered by the administering Secretaries to enroll in a Uniformed Services Health Plan, the person shall not be entitled or eligible for health care services in facilities of the uniformed services or pursuant to a contract entered into under this chapter. However, nothing in this paragraph shall be construed to effect the right of a person to a premium payment by the Secretary of Defense if the person is enrolled in another health plan under the Health Security Act and is otherwise entitled to such a payment under subsection (h).

"(2) A person described in subsection (e)(2) who is enrolled with a health plan that is not a Uniformed Services Health Plan may receive the items and services in the comprehensive benefit package in a facility of the uniformed services only if—

"(A) the Secretary of Defense authorizes the provision of a particular item or service in the package to the person;

"(B) the Secretary determines that the provision of the item or service involved will not interfere with the provision of health care services to members of the uniformed services or persons enrolled in a Uniformed Services Health Plan; and

"(C) the health plan in which the person is enrolled agrees to pay the actual and full cost of the items and services in the package actually provided to the person.

"(3) The administering Secretaries shall assure that all rights and entitlements under this chapter of any person described in subsection (e)(2) are fully preserved if the person—

"(A) is not offered the opportunity to enroll in a Uniformed Services Health Plan; and

"(B) is not otherwise enrolled in a health plan provided through a health alliance under the Health Security Act.

"(g) SPECIAL RULE FOR OTHER PAYERS.—(1)(A) In the case of a person who is enrolled

in the supplementary medical insurance program under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) and who is also enrolled in a Uniformed Services Health Plan, Medicare shall be responsible for making a premium payment on behalf of the person. The Secretary of Defense and the Secretary of Health and Human Services shall enter into an agreement specifying the payment responsibilities of Medicare under this paragraph, except that the amount of the premium payment may not exceed the expected per capita costs that Medicare would bear for the person if the person remained in the Medicare program. A premium payment by Medicare under this paragraph shall be the person's exclusive benefit under Medicare.

"(B) In this paragraph, the term 'Medicare' means any plan administered under title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.).

"(2) Nothing in this section shall affect the payment of the retiree discount under the Health Security Act on behalf of a person who is enrolled in a Uniformed Services Health Plan if the person is otherwise eligible for the retiree discount.

"(h) PAYMENT RESPONSIBILITIES OF THE SECRETARY.—(1) In the case of a person described in subsection (e)(2) who is not enrolled in a Uniformed Services Health Plan, the Secretary may make a premium payment for the person's enrollment through a health alliance in another health plan. In determining the amount of the payment, the Secretary shall consider the amount of any retiree discount payable under the Health Security Act on behalf of the person and the amount of any premium credits attributable to employer payments with respect to employment of the person.

"(2) The Secretary shall not make a payment pursuant to this subsection in connection with any person enrolled in a health plan of the Department of Veterans Affairs or a health program of the Indian Health Service.

"(i) PAYMENT RESPONSIBILITIES OF PERSONS ENROLLED IN A UNIFORMED SERVICES HEALTH PLAN.—(1) In the case of an active duty member who is enrolled in a Uniformed Services Health Plan, the administering Secretaries may not impose or collect from the member a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) other than subsistence charges authorized under section 1075 of this title.

"(2) Subject to paragraph (3), persons described in subsection (e)(2) who are enrolled in a Uniformed Services Health Plan shall be required to pay a family share under section 1342 of a premium and cost sharing. Payment obligations established under this paragraph may not exceed those obligations otherwise required under the national standards for health plans established pursuant to the Health Security Act.

"(3)(A) Persons described in subsection (e)(2) who enroll in a Uniformed Services Health Plan and who (in the absence of this section) would be covered beneficiaries under section 1079 or 1086 of this title continuously since December 31, 1994, shall have, as a group, out-of-pocket costs in 1995 no greater than the lesser of—

"(i) the out-of-pocket costs in effect for such beneficiaries under section 1075, 1078, 1079(b), or 1086(b) of this title (whichever applies) on December 31, 1994; and

"(ii) those obligations otherwise required under the national standards for health plans established pursuant to the Health Security Act.

"(B) Members of the uniformed services on active duty as of December 31, 1994, who afterward become covered beneficiaries under section 1079 or 1086 of this title (or would become covered beneficiaries in the absence of this section) without a break in eligibility for health care services under this chapter shall have, as a group, out-of-pocket costs as covered beneficiaries no higher than the out-of-pocket costs in effect for similarly situated covered beneficiaries described in subparagraph (A).

"(C) The limitation on out-of-pocket costs established pursuant to subparagraph (A) may be adjusted for years after 1995 by an appropriate economic index, as determined by the Secretary of Defense.

"(4) The Secretary of Defense shall establish the payment requirements under paragraph (2), and enforce the limitations on such requirements specified in paragraph (3), in regulations prescribed pursuant to subsection (a).

"(j) FINANCIAL ACCOUNT.—There is hereby established in the Department of Defense a financial account to which shall be credited all premium payments and other receipts from other payers and beneficiaries made in connection with any person enrolled in a Uniformed Services Health Plan. The account shall be administered by the Secretary of Defense, and funds in the account may be used by the Secretary for any purpose directly related to the delivery and financing of health care services under this chapter, including operations, maintenance, personnel, procurement, contributions toward construction projects, and related costs. Funds in the account shall remain available until expended.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1073 the following new item:

"1073a. Uniformed Services Health Plans: establishment and coordination with national health care reform.".

(b) DEFINITION.—Section 1072 of such title is amended by adding at the end the following new paragraph:

"(6) The term 'Uniformed Services Health Plan' means a plan established by the Secretary of Defense under section 1073a(a) of this title in order to provide health care services to members of the uniformed services on active duty and other covered beneficiaries under this chapter.".

(c) REPORT ON ESTABLISHMENT.—If the Secretary of Defense determines to establish any Uniformed Services Health Plan under section 1073a of title 10, United States Code, as added by subsection (a), the Secretary shall submit to Congress a report describing the Plans proposed to be initially offered under such section. The report required by this subsection shall be submitted not later than 30 days before the date on which the Secretary first issues proposed rules under subsection (a) of such section to establish any such Plan.

Subtitle B—Department of Veterans Affairs

SEC. 8101. BENEFITS AND ELIGIBILITY THROUGH DEPARTMENT OF VETERANS AFFAIRS MEDICAL SYSTEM.

(a) DVA AS A PARTICIPANT IN HEALTH CARE REFORM.—

(1) IN GENERAL.—Title 38, United States Code, is amended by inserting after chapter 17 the following new chapter:

"CHAPTER 18—ELIGIBILITY AND BENEFITS UNDER HEALTH SECURITY ACT

"SUBCHAPTER I—GENERAL

"1801. Definitions.

"SUBCHAPTER II—ENROLLMENT

"1811. Enrollment: veterans.

"1812. Enrollment: CHAMPVA eligibles.

"1813. Enrollment: family members.

"SUBCHAPTER III—BENEFITS

"1821. Benefits for VA enrollees.

"1822. Chapter 17 benefits described.

"1823. Entitlement to chapter 17 benefits for certain veterans.

"1824. Supplemental benefits packages and policies.

"1825. Limitation regarding veterans enrolled with health plans outside Department.

"SUBCHAPTER IV—FINANCIAL MATTERS

"1831. Premiums, copayments, etc..

"1832. Medicare coverage and reimbursement.

"1833. Recovery of cost of certain care and services.

"1834. Health Plan Funds.

"SUBCHAPTER I—GENERAL

"§ 1801. Definitions

"For purposes of this chapter:

"(1) The term 'health plan' means an entity that has been certified under the Health Security Act as a health plan.

"(2) The term 'VA health plan' means a health plan that is operated by the Secretary under section 7341 of this title.

"(3) The term 'VA enrollee' means an individual enrolled under the Health Security Act in a VA health plan.

"SUBCHAPTER II—ENROLLMENT

"§ 1811. Enrollment: veterans

"Each veteran who is an eligible individual within the meaning of section 1001 of the Health Security Act may enroll with a VA health plan. A veteran who wants to receive the comprehensive benefit package through the Department shall enroll with a VA health plan.

"§ 1812. Enrollment: CHAMPVA eligibles

"An individual who is eligible for benefits under section 1713 of this title and who is eligible to enroll in a health plan pursuant to section 1001 of the Health Security Act may enroll under that Act with a VA health plan in the same manner as a veteran.

"§ 1813. Enrollment: family members

"(a) The Secretary may authorize a VA health plan to enroll members of the family of an enrollee under section 1811 or 1812 of this title, subject to payment of premiums, deductibles, copayments, and coinsurance as required under the Health Security Act.

"(b) For purposes of subsection (a), an enrollee's family is those individuals (other than the enrollee) included within the term 'family' as defined in section 1011(b) of the Health Security Act.

"SUBCHAPTER III—BENEFITS

"§ 1821. Benefits for VA enrollees

"The Secretary shall ensure that each VA health plan provides to each individual enrolled with it the items and services in the comprehensive benefit package under the Health Security Act.

"§ 1822. Chapter 17 benefits described

"The Secretary shall provide to each veteran described in section 1823(a) of this title the care and services that are authorized to be provided under chapter 17 of this title in accordance with the terms and conditions applicable to that care under such chapter, notwithstanding that such care and services are not included in the comprehensive benefit package.

"§ 1823. Entitlement to chapter 17 benefits for certain veterans

"(a) The following veterans are eligible for additional care and services as described in section 1822 of this title:

"(1) Any veteran with a service-connected disability.

"(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

"(3) Any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

"(4) Any veteran who is a former prisoner of war.

"(5) Any veteran of the Mexican border period or World War I.

"(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

"(b) In the case of a veteran who is eligible to receive care or services under section 1710(a)(1)(G) of this title for a disability which may be associated with exposure to a toxic substance, radiation, or environmental hazard, the Secretary shall furnish such care or services to that veteran.

"(c) A veteran covered by subsection (a) or (b)—

"(1) is eligible for care and services described in that subsection whether or not such veteran is a VA enrollee; and

"(2) shall not be subject to any charge or any other cost for such care and services.

"§ 1824. Supplemental benefits packages and policies

"(a)(1) In order to meet the special needs of veterans, the Secretary may offer to veterans supplemental health benefits packages for health care services not included in the comprehensive benefit package. A veteran eligible under section 1823 of this title to receive the health care services described in section 1822 of this title may not be offered a supplemental health benefits package under this subsection. The supplemental health benefits packages offered under this subsection may consist of any or all of the benefits that the Secretary may provide under chapter 17 of this title that are not included in the comprehensive benefit package.

"(2) The Secretary shall charge a premium for a supplemental health benefits package under this subsection. The amount of such premium shall be established so as to cover the actual and full costs of such care.

"(b) A VA health plan may offer supplemental health benefits policies for health care services not provided under chapter 17 of this title and cost sharing policies consistent with the requirements of part 2 of subtitle E of title I of the Health Security Act.

"§1825. Limitation regarding veterans enrolled with health plans outside Department

"A veteran who is residing in a regional alliance area in which the Department operates a health plan and who is enrolled in a health plan that is not operated by the Department may be provided the items and services in the comprehensive benefit package by a VA health plan only if the plan is reimbursed for the actual and full cost of the care provided.

"SUBCHAPTER IV—FINANCIAL MATTERS

"§ 1831. Premiums, copayments, etc.

"(a) In the case of a veteran described in section 1823(a) of this title who is a VA enrollee, the Secretary may not impose or collect from the veteran a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge). The Secretary shall make such arrangements as necessary with health alliances in order to carry out this subsection.

"(b) For other VA enrollees, the Secretary shall charge premiums and establish copayments, deductibles, and coinsurance amounts. The premium rate, and the rates for deductibles and copayments, for each VA health plan shall be established by that health plan based on rules established by the health alliance under which it is operating.

"§ 1832. Medicare coverage and reimbursement

"(a) For purposes of any program administered by the Secretary of Health and Human Services under title XVIII of the Social Security Act, a VA health plan or Department facility shall be deemed to be a Medicare provider.

"(b)(1) The Secretary of Health and Human Services shall enter into an agreement with a VA health plan or Department health-care facility to treat such plan or facility as a Medicare HMO in any case in which that health plan or facility seeks to enter into such an agreement.

"(2) For purposes of this section, the term 'Medicare HMO' means an eligible organization under section 1876 of the Social Security Act.

"(c) In the case of care provided to a veteran other than a veteran described in section 1823(a) of this title who is eligible for benefits under the Medicare program under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall reimburse a VA health plan or Department health-care facility providing services as a Medicare provider or Medicare HMO on the same basis as that Secretary reimburses other Medicare providers or Medicare HMOs, respectively. The Secretary of Health and Human Services shall include with each such reimbursement a Medicare explanation of benefits.

"(d) When the Secretary provides care to a veteran for which the Secretary receives reimbursement under this section, the Secretary shall require the veteran to pay to the Department any applicable deductible or copayment that is not covered by Medicare.

"§ 1833. Recovery of cost of certain care and services

"(a) In the case of an individual provided care or services through a VA health plan who has coverage under a supplemental health insurance policy pursuant to part 2 of subtitle E of title I of the Health Security Act or under any other provision of law, or who has coverage under a Medicare supplemental health insurance plan (as defined in the Health Security Act) or under any other provision of law, the Secretary has the right to recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the care or services had not been furnished by a department or agency of the United States.

"(b) The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims by the United States under subsection (a) in the same manner as they apply to claims under subsection (a) of that section.

"§ 1834. Health Plan Funds

"(a) The Secretary shall establish for each VA health plan a separate revolving fund.

"(b) Any amount received by the Department by reason of the furnishing of health care by a VA health plan or the enrollment of an individual with a VA health plan (including amounts received as premiums, premium discount payments, copayments or coinsurance, and deductibles, amounts received as third-party reimbursements, and amounts received as reimbursements from another health plan for care furnished to one of its enrollees) shall be credited to the revolving fund of that health plan.

"(c) Notwithstanding subsection (b), a VA health plan may not retain amounts received for care furnished to a VA enrollee in a case in which the costs of such care have been covered by appropriations. Such amounts shall be deposited in the General Fund of the Treasury.

"(d) Each revolving fund for a health plan shall be managed by that health plan.

"(e) Amounts in a revolving fund for a health plan are hereby made available for the expenses of the delivery of the items and services in the comprehensive benefit package by the health plan.".

(2) The table of chapters at the beginning of part II of title 38, United States Code, is amended by inserting after the item relating to chapter 17 the following new item:

"18. Benefits and Eligibility Under Health Security Act ..... 1801.".

(b) PRESERVATION OF EXISTING BENEFITS FOR FACILITIES NOT OPERATING AS HEALTH PLANS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1704 the following new section:

"§ 1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans

"The provisions of this chapter shall apply with respect to the furnishing of care and services—

"(1) by any facility of the Department that is not operating as or within a health plan certified as a health plan under the Health Security Act; and

"(2) to any veteran who is an eligible individual with the meaning of section 1001 of the Health Security Act.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1704 the following new item:

"1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans.".

SEC. 8102. ORGANIZATION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES AS HEALTH PLANS.

(a) IN GENERAL.—Chapter 73 of title 38, United States Code, is amended—

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"§ 7341. Organization of health care facilities as health plans

"(a) The Secretary shall organize health plans and operate Department facilities as or within health plans under the Health Security Act. The Secretary shall prescribe regulations establishing standards for the operation of Department health care facilities as

or within health plans under that Act. In prescribing those standards, the Secretary shall assure that they conform, to the maximum extent practicable, to the requirements for health plans generally set forth in part 1 of subtitle E of title I of the Health Security Act.

"(b) Within a geographic area or region, health care facilities of the Department located within that area or region may be organized to operate as a single health plan encompassing all Department facilities within that area or region or may be organized to operate as several health plans.

"(c) In carrying out responsibilities under the Health Security Act, a State (or a State-established entity)—

"(1) may not impose any standard or requirement on a VA health plan that is inconsistent with this section or any regulation prescribed under this section or other Federal laws regarding the operation of this section; and

"(2) may not deny certification of a VA health plan under the Health Security Act on the basis of a conflict between a rule of a State or health alliance and this section or regulations prescribed under this section or other Federal laws regarding the operation of this section.

"§ 7342. Contract authority for facilities operating as or within health plans

"The Secretary may enter into a contract (without regard to provisions of law requiring the use of competitive procedures) for the provision of services by a VA health plan in any case in which the Secretary determines that such contracting is more cost-effective than providing such services directly through Department facilities or when such contracting is necessary because of geographic inaccessibility.

"§ 7343. Resource sharing authority: facilities operating as or within health plans

"The Secretary may enter into agreements under section 8153 of this title with other health care plans, with health care providers, and with other health industry organizations, and with individuals, for the sharing of resources of the Department through facilities of the Department operating as or within health plans.

"§ 7344. Administrative and personnel flexibility

"(a) In order to carry out this subchapter, the Secretary may—

"(1) carry out administrative reorganizations of the Department without regard to those provisions of section 510 of this title following subsection (a) of that section; and

"(2) enter into contracts for the performance of services previously performed by employees of the Department without regard to section 8110(c) of this title.

"(b) The Secretary may establish alternative personnel systems or procedures for personnel at facilities operating as or with health plans under the Health Security Act whenever the Secretary considers such action necessary in order to carry out the terms of that Act.

"(c) Subject to the provisions of section 1404 of the Health Security Act, the Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within health plans. Such activities may only be carried out using nonappropriated funds.

"§ 7345. Funding provisions: grants and other sources of assistance

"The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations and that but for this section is unavailable to facilities of the Department or to health plans operated by the Government if funds obtained through the grant or other source of funding will be used through a facility of the Department operating as or within a health plan.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"7341. Organization of health care facilities as health plans.

"7342. Contract authority for facilities operating as or within health plans.

"7343. Resource sharing authority: facilities operating as or within health plans.

"7344. Administrative and personnel flexibility.

"7345. Funding provisions: grants and other sources of assistance.

"SUBCHAPTER V—RESEARCH CORPORATIONS".

Subtitle C—Federal Employees Health Benefits Program

SEC. 8201. DEFINITIONS.

Except as otherwise specifically provided, in this subtitle:

(1) ABROAD.—The term "abroad" means outside the United States.

(2) ANNUITANT, ETC.—The terms "annuitant", "employee", and "Government", have the same respective meanings as are given such terms by section 8901 of title 5, United States Code.

(3) EMPLOYEES HEALTH BENEFITS FUND.—The term "Employees Health Benefits Fund" means the fund under section 8909 of title 5, United States Code.

(4) FEHBP.—The term "FEHBP" means the health insurance program under chapter 89 of title 5, United States Code.

(5) FEHBP PLAN.—The term "FEHBP plan" has the same meaning as is given the term "health benefits plan" by section 8901(6) of title 5, United States Code.

(6) FEHBP TERMINATION DATE.—The term "FEHBP termination date" means the date (specified in section 8202) after which FEHBP ceases to be in effect.

(7) RETIRED EMPLOYEES HEALTH BENEFITS FUND.—The term "Retired Employees Health Benefits Fund" means the fund under section 8 of the Retired Federal Employees Health Benefits Act (Public Law 86-724; 74 Stat. 851).

(8) RFEHBP.—The term "RFEHBP" means the health insurance program under the Retired Federal Employees Health Benefits Act.

SEC. 8202. FEHBP TERMINATION.

Chapter 89 of title 5, United States Code, is repealed effective as of December 31, 1997, and all contracts under such chapter shall terminate not later than such date.

SEC. 8203. TREATMENT OF FEDERAL EMPLOYEES, ANNUITANTS, AND OTHER INDIVIDUALS (WHO WOULD OTHERWISE HAVE BEEN ELIGIBLE FOR FEHBP) UNDER HEALTH PLANS.

(a) APPLICABILITY.—This section sets forth rules applicable, after the FEHBP termination date, with respect to individuals who—

(1) are eligible individuals under section 1001; and

(2) but for this subtitle, would be eligible to enroll in a FEHBP plan.

(b) FEDERAL EMPLOYEES.—

(1) SAME TREATMENT AS NON-FEDERAL EMPLOYEES.—A Federal employee shall be treated in the same way, for purposes of provisions of this Act outside of this subtitle, as if that individual were a non-Federal employee, including for purposes of any requirements relating to enrollment, individual or family premium payments, and employer premium payments.

(2) EMPLOYER PREMIUM PAYMENTS.—Any employer premium payment required with respect to the employment of a Federal employee shall be payable from the appropriation or fund from which any Government contribution on behalf of such employee would have been payable under FEHBP.

(3) OPTIONAL OFFER OF FEHBP SUPPLEMENTAL PLANS.—The Federal Government may, but is not required to—

(A) offer to Federal employees one or more FEHBP supplemental plans developed under subsection (f)(1); and

(B) make a Government contribution with respect to the premium for such a plan.

Any Government contribution under subparagraph (B) shall be payable from the same appropriation or fund as would a Government contribution under paragraph (2) on behalf of the Federal employee involved.

(4) DEFINITIONS.—In this subsection:

(A) FEDERAL EMPLOYEE.—The term "Federal employee" means an "employee" as defined by section 8201.

(B) NON-FEDERAL EMPLOYEE.—The term "non-Federal employee" means an "employee" as defined by section 1901.

(c) ANNUITANTS.—

(1) HEALTH PLAN.—

(A) AUTHORITY TO MAKE CERTAIN WITHHOLDINGS FROM ANNUITIES.—The Office of Personnel Management may, on the request of an annuitant enrolled in a health plan, withhold from the annuity of such annuitant any premiums required for such enrollment. The Office shall forward any amounts so withheld to the appropriate fund or as otherwise indicated in the request. A request under this subparagraph shall contain such information, and otherwise be made in such form and manner, as the Office shall by regulation prescribe.

(B) PAYMENT OF ALLIANCE CREDIT LIABILITY FOR ANNUITANTS BELOW AGE 55.—In the case of an annuitant who does not satisfy the eligibility requirements under section 6115, a Government contribution shall be made equal to such amount as is necessary to reduce the employee's liability under section 6111 to zero.

(2) FEHBP SUPPLEMENTAL PLAN.—

(A) CURRENT ANNUITANTS.—

(i) IN GENERAL.—Each current annuitant—

(I) shall be eligible to enroll in FEHBP supplemental plans developed under subsection (f)(1); and

(II) shall be eligible for the Government contribution amount described in clause (ii) toward the premium for such a plan.

(ii) GOVERNMENT CONTRIBUTION AMOUNT.—The Office of Personnel Management shall specify a level of Government contribution under this paragraph for a FEHBP supplemental plan. Such level—

(I) shall reasonably reflect the portion of the Government contributions (last provided under FEHBP) attributable to the portion of FEHBP benefits which the plan is designed to replace; and

(II) shall be applied toward premiums for such a plan.

(B) FUTURE ANNUITANTS.—In the case of a future annuitant, the Federal Government may, but is not required—

(i) to offer to such an annuitant one or more FEHBP supplemental plans developed under subsection (f)(1); and

(ii) to make a Government contribution with respect to the premium for such a plan.

(C) DEFINITIONS.—In this paragraph:

(i) CURRENT ANNUITANT.—The term "current annuitant" means an individual who is residing in a State on January 1, 1998, and, on the day before such date, was—

(I) enrolled in a FEHBP plan as an annuitant; or

(II) covered under a FEHBP plan as a family member (but only if such individual would otherwise have been eligible to enroll in a FEHBP plan as an annuitant).

(ii) FUTURE ANNUITANT.—The term "future annuitant" means an annuitant who is not a current annuitant.

(d) INDIVIDUALS WHO WOULD NOT BE ELIGIBLE FOR A GOVERNMENT CONTRIBUTION UNDER FEHBP.—

(1) IN GENERAL.—In the case of an individual described in paragraph (2)—

(A) the Federal Government may, but is not required to, offer one or more FEHBP supplemental plans developed under subsection (f)(1); and

(B) no Government contribution shall be payable with respect to the premium for such a plan.

(2) APPLICABILITY.—This subsection shall apply with respect to any individual who (but for this subtitle) would be eligible to enroll in a FEHBP plan, but would not be eligible for a Government contribution toward any such plan.

(e) MEDICARE-ELIGIBLE INDIVIDUALS.—

(1) CURRENT MEDICARE-ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—Each current medicare-eligible individual—

(i) shall be eligible to enroll in medicare supplemental plans developed under subsection (f)(2); and

(ii) if such individual would (but for this subtitle) have been eligible for a Government contribution under FEHBP (assuming such individual were then enrolled thereunder), shall be eligible for the Government medicare contribution amount described in subparagraph (B) toward the premium for such a plan or toward the premium of a medicare select plan (as defined in paragraph (3)).

(B) MEDICARE CONTRIBUTION AMOUNT.—The Office of Personnel Management shall specify a level of Government contribution under this paragraph for a FEHBP medicare supplemental plan. Such level—

(i) shall reasonably reflect the portion of the Government contributions (last provided under FEHBP) attributable to the portion of FEHBP benefits which the plan is designed to replace; and

(ii) except as otherwise provided in paragraph (3), shall be applied toward premiums for such a plan.

(2) FUTURE MEDICARE-ELIGIBLE INDIVIDUALS.—In the case of a future medicare-eligible individual, the Federal Government may, but is not required to—

(A) offer to such a medicare-eligible individual one or more FEHBP medicare supplemental plans developed under subsection (f)(2); and

(B) make a Government contribution with respect to the premium for such a plan.

(3) APPLICATION OF CONTRIBUTION TOWARD MEDICARE HMO OPTION.—

(A) ELECTION.—A medicare-eligible individual may elect to have the amount of the Government contribution described in paragraph (1)(B) or referred to in paragraph (2)(B) applied toward premiums for enrollment with an eligible organization under a risk-sharing contract under section 1876 of the Social Security Act.

(B) LEVEL CONTRIBUTION RULE.—The level of such Government contribution on behalf of an individual shall be determined without taking into account any election under subparagraph (A).

(4) DEFINITIONS.—In this subsection:

(A) CURRENT MEDICARE-ELIGIBLE INDIVIDUAL.—The term "current medicare-eligible individual" means an individual who is residing in a State on January 1, 1998, and, on the day before such date, was a medicare-eligible individual.

(B) FUTURE MEDICARE-ELIGIBLE INDIVIDUAL.—The term "future medicare-eligible individual" means a medicare-eligible individual who is not a current medicare-eligible individual.

(5) INAPPLICABILITY.—Subsections (b) through (d) shall not apply with respect to a medicare-eligible individual.

(f) DEVELOPMENT OF SUPPLEMENTAL PLANS.—

(1) FEHBP SUPPLEMENTAL PLANS.—The Office of Personnel Management shall develop one or more FEHBP supplemental plans which are supplemental health benefit policies or cost sharing policies (as defined in section 1421(b)). Each such plan shall—

(A) be consistent with the applicable requirements of part 2 of subtitle E of title I (including the requirements under section 1423(f)); and

(B) reflect (taking into consideration the benefits in the comprehensive benefit package) the overall level of benefits generally afforded under FEHBP (as last in effect).

(2) FEHBP MEDICARE SUPPLEMENTAL PLANS.—The Office of Personnel Management shall develop one or more medicare supplemental plans. Each such plan shall—

(A) offer benefits which shall include the core group of basic benefits identified under section 1882(p)(2) of the Social Security Act; and

(B) reflect (taking into consideration the benefits provided under the medicare program) the overall level of benefits generally afforded under FEHBP (as last in effect).

(g) AUTHORIZATION OF APPROPRIATIONS.—The Government contributions authorized by this section on behalf of an annuitant (including an annuitant who is a medicare-eligible individual) shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(h) FUND.—

(1) ESTABLISHMENT.—There shall be established in the Treasury of the United States a fund into which shall be paid all contributions relating to any—

(A) FEHBP supplemental plan developed under subsection (f)(1);

(B) FEHBP medicare supplemental plan developed under subsection (f)(2); or

(C) health insurance program established under section 8204.

(2) ADMINISTRATION AND USE.—The fund shall be administered by the Office of Personnel Management, and any monies in the fund shall be available for purposes of the plan or program (referred to in paragraph (1)) to which they are attributable.

SEC. 8204. TREATMENT OF INDIVIDUALS RESIDING ABROAD.

(a) IN GENERAL.—After the FEHBP termination date, individuals residing abroad who (but for this subtitle) would be eligible to enroll in a FEHBP plan shall be eligible for health insurance under a program which the Office of Personnel Management shall by regulation establish.

(b) REQUIREMENT.—To the extent practicable, coverage and benefits provided to individuals under such program shall be equal to the coverage and benefits which would be available to them if they were residing in the United States.

(c) GOVERNMENT CONTRIBUTIONS.—Any Government contribution payable under such program shall be made from the appropriation or fund from which any Government contribution would have been payable under FEHBP (if any) on behalf of the individual involved, except that, in the case of an annuitant, any such contribution shall be payable from amounts appropriated pursuant to section 8203(g).

SEC. 8205. TRANSITION AND SAVINGS PROVISIONS.

(a) EMPLOYEES HEALTH BENEFITS FUND.—

(1) TEMPORARY CONTINUED AVAILABILITY.—Notwithstanding section 8202, the Employees Health Benefits Fund shall be maintained, and amounts in such Fund shall remain available, after the FEHBP termination date, for such period of time as the Office of Personnel Management considers necessary in order to satisfy any outstanding claims.

(2) FINAL DISBURSEMENT.—After the end of the period referred to in paragraph (1), any amounts remaining in the Fund shall be disbursed (between the Government and former participants in FEHBP) in accordance with a plan which the Office shall prepare, consistent with the cost-sharing ratio between the Government and plan enrollees during the final contract term. The details of any such plan shall be submitted to the President and the Congress at least 1 year before the date of its proposed implementation.

(b) PROCEEDINGS.—After the FEHBP termination date, chapter 89 of title 5, United States Code (as last in effect) shall be considered to have remained in effect for purposes of any suit, action, or other proceeding with respect to any liability incurred or violation which occurred on or before such date.

(c) RFEHBA.—

(1) REPEAL.—The Retired Federal Employees Health Benefits Act (Public Law 86-724; 74 Stat. 849) is repealed effective as of the FEHBP termination date.

(2) RELATED PROVISIONS.—After the FEHBP termination date—

(A) the Retired Employees Health Benefits Fund shall temporarily remain available, and amounts in that fund shall subsequently be disbursed, in a manner comparable to that provided for under subsection (a); and

(B) retired employees who, but for this subtitle, would be eligible for coverage under the Retired Federal Employees Health Benefits Act shall be treated, for purposes of this subtitle, as if they were annuitants (subject to any differences in the overall level of coverage or benefits generally afforded them under FEHBP and RFEHBP, respectively, as last in effect).

(3) REGULATIONS.—Regulations prescribed under section 8206 to carry out this subsection shall include any necessary provisions relating to individuals residing abroad.

SEC. 8206. REGULATIONS.

The Office of Personnel Management shall prescribe any regulations which may be necessary to carry out this subtitle.

SEC. 8207. TECHNICAL AND CONFORMING AMENDMENTS.

(a) OPM'S ANNUAL REPORT ON FEHBP.—Subsection (c) of section 1308 of title 5, United States Code, is repealed.

(b) OTHER REFERENCES TO FEHBP.—Any reference in any provision of law to the health insurance program under chapter 89 of title 5, United States Code (or any aspect of such program) shall be considered to be a reference to the health insurance program

under subtitle C of title VIII of the Health Security Act (or corresponding aspect), subject to such clarification as may be provided, or except as may otherwise be provided, in regulations prescribed by the agency or other authority responsible for the administration of such provision.

(c) OMNIBUS BUDGET RECONCILIATION ACT OF 1993.—Effective as of the date of the enactment of this Act, section 11101(b)(3) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66; 107 Stat. 413) is amended by striking "September 30, 1998" and inserting "December 31, 1997".

(d) EFFECTIVE DATE.—Except as provided in subsection (c), this section and the amendments made by this section shall take effect on the day after the FEHBP termination date.

Subtitle D—Indian Health Service

SEC. 8301. DEFINITIONS.

For the purposes of this subtitle—

(1) the term "health program of the Indian Health Service" means a program which provides health services under this Act through a facility of the Indian Health Service, a tribal organization under the authority of the Indian Self-Determination Act or a self-governance compact, or an urban Indian program;

(2) the term "reservation" means the reservation of any federally recognized Indian tribe, former Indian reservations in Oklahoma, and lands held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.);

(3) the term "urban Indian program" means any program operated pursuant to title V of the Indian Health Care Improvement Act; and

(4) the terms "Indian", "Indian tribe", "tribal organization", "urban Indian", "urban Indian organization", and "service unit" have the same meaning as when used in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

SEC. 8302. ELIGIBILITY AND HEALTH SERVICE COVERAGE OF INDIANS.

(a) ELIGIBILITY.—An eligible individual, as defined in section 1001(c), is eligible to enroll in a health program of the Indian Health Service if the individual is—

(1) an Indian, or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the Indian community in which the individual lives, who resides on or near an Indian reservation or in a geographical area designated by statute as meeting the requirements of being on or near an Indian reservation notwithstanding the lack of an Indian reservation;

(2) an urban Indian; or

(3) an Indian described in section 809(b) of the Indian Health Care Improvement Act (25 U.S.C. 1679(b)).

(b) ELECTION.—An individual described in subsection (a) may elect a health program of the Indian Health Service instead of a health plan.

(c) ENROLLMENT FOR BENEFITS.—An individual who elects a health program of the Indian Health Service under subsection (b) shall enroll in such program through a service unit, tribal organization, or urban Indian program. An individual who enrolls in such program is not subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided under such program.

(d) PAYMENTS BY INDIVIDUALS WHO DO NOT ENROLL.—If an individual described in subsection (a) does not enroll in a health program of the Indian Health Service, no payment shall be made by the Indian Health Service to the individual (or on behalf of the individual) with respect to premiums charged for enrollment in an applicable health plan or any other cost of health services under the applicable health plan which the individual is required to pay.

SEC. 8303. SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS.

(a) IN GENERAL.—All individuals described in sections 8302(a) remain eligible for such benefits under the laws administered by the Indian Health Service as supplement the comprehensive benefit package. The individual shall not be subject to any charge or any other cost for such benefits.

(b) AUTHORIZATION OF APPROPRIATIONS.—In addition to amounts otherwise authorized to be appropriated, there is authorized to be appropriated to carry out this section $180,000,000 for fiscal year 1995, $200,000,000 for each of the fiscal years 1996 through 1999, and such sums as may be necessary for fiscal year 2000 and each fiscal year thereafter.

SEC. 8304. HEALTH PLAN AND HEALTH ALLIANCE REQUIREMENTS.

(a) COMPREHENSIVE BENEFIT PACKAGE.—The Secretary shall ensure that the comprehensive benefit package is provided by all health programs of the Indian Health Service effective January 1, 1999, notwithstanding section 1001(a).

(b) APPLICABLE REQUIREMENTS OF HEALTH PLANS.—In addition to subsection (a), the Secretary shall determine which other requirements relating to health plans apply to health programs of the Indian Health Service.

(c) CERTIFICATION.—Effective January 1, 1999, all health programs of the Indian Health Service must meet the certification requirements for health plans, as required by the Secretary under this section, as certified from time to time by the Secretary. Before January 1, 1999, all such health programs shall, to the extent practicable, meet such certification requirements.

(d) HEALTH ALLIANCE REQUIREMENTS.—The Secretary shall determine which requirements relating to health alliances apply to the Indian Health Service.

SEC. 8305. EXEMPTION OF TRIBAL GOVERNMENTS AND TRIBAL ORGANIZATIONS FROM EMPLOYER PAYMENTS.

A tribal government and a tribal organization under the Indian Self-Determination and Educational Assistance Act or a self-governance compact shall be exempt from making employer premium payments as an employer under section 6121.

SEC. 8306. PROVISION OF HEALTH SERVICES TO NON-ENROLLEES AND NON-INDIANS.

(a) CONTRACTS WITH HEALTH PLANS.—

(1) IN GENERAL.—A health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program may enter into a contract with a health plan for the provision of health care services to individuals enrolled in such health plan if the program, unit, or organization determines that the provision of such health services will not result in a denial or diminution of health services to any individual described in section 8302(a) who is enrolled for health services provided by such program, unit, or organization.

(2) REIMBURSEMENT.—Any contract entered into pursuant to paragraph (1) shall provide for reimbursement to such program, unit, or organization in accordance with the essential community provider provisions of section 1431(c), as determined by the Secretary.

(b) FAMILY TREATMENT.—

(1) DETERMINATION TO OPEN ENROLLMENT.—A health program of the Indian Health Service may open enrollment to family members of individuals described in section 8302(a).

(2) ELECTION.—If a health program of the Indian Health Service opens enrollment to family members of individuals described in section 8302(a), an individual described in that section may elect family enrollment in the health program instead of in a health plan.

(3) ENROLLMENT.—

(A) IN GENERAL.—An individual who elects family enrollment under paragraph (2) in a health program of the Indian Health Service shall enroll in such program.

(B) APPLICABLE INDIVIDUAL CHARGES.—The individual who enrolls in such program under subparagraph (A) is not subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided under such program attributable to the individual, but the family members who are not eligible for a health program of the Indian Health Service under section 8302(a) are subject to all such charges.

(C) APPLICABLE EMPLOYER CHARGES.—Employers, other than tribal governments and tribal organizations exempt under section 8305, are liable for making employer premium payments as an employer under section 6121 in the case of any family member enrolled under this subsection who is not eligible for a health program of the Indian Health Service under section 8302(a).

(4) PREMIUM.—

(A) ESTABLISHMENT AND COLLECTION.—The Secretary shall establish a premium for all family members enrolled in a health program of the Indian Health Service under this paragraph who are not eligible for a health program of the Indian Health Service under section 8302(a). The Secretary shall collect each premium payment owed under this paragraph.

(B) REDUCTION.—The Secretary shall provide for a process for premium reduction which is the same as the process, and uses the same standards, used by regional alliances for the areas in which individuals described in subparagraph (A), except that in computing the family share of the premiums the Secretary shall use the lower of the premium quoted or the reduced weighted average accepted bid for the reference regional alliance.

(C) PAYMENT BY SECRETARY.—The Secretary shall pay to each health program of the Indian Health Service, in the same manner as payments under section 6201, amounts equivalent to the amount of payments that would have been made to a regional alliance if the individuals described in subparagraph (A) were enrolled in a regional alliance health plan (with a final accepted bid equal to the reduced weighted average accepted bid premium for the regional alliance).

(c) ESSENTIAL COMMUNITY PROVIDER.—

(1) HEALTH SERVICES.—If a health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program elects to be an essential community provider under section 1431, an individual described in paragraph (2) enrolled in a health plan other than a health program of the Indian Health Service may receive health services from that essential community provider.

(2) INDIVIDUAL COVERED.—An individual referred to in paragraph (1) is an individual who—

(A) is described in section 8303(a)(1); or

(B) is a family member described in subsection (b) who does not enroll in a health program of the Indian Health Service.

SEC. 8307. PAYMENT BY OTHER PAYORS.

(a) PAYMENT FOR SERVICES PROVIDED BY INDIAN HEALTH SERVICE PROGRAMS.—Nothing in this subtitle shall be construed as amending section 206, 401, or 402 of the Indian Health Care Improvement Act (relating to payments on behalf of Indians for health services from other Federal programs or from other third party payors).

(b) PAYMENT FOR SERVICES PROVIDED BY CONTRACTORS.—Nothing in this subtitle shall be construed as affecting any other provision of law, regulation, or judicial or administrative interpretation of law or policy concerning the status of the Indian Health Service as the payor of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

SEC. 8308. CONTRACTING AUTHORITY.

Section 601(d)(1)(B) of the Indian Health Care Improvement Act (25 U.S.C. 1661(d)(1)(B)) is amended by inserting "(including personal services for the provision of direct health care services)" after "goods and services".

SEC. 8309. CONSULTATION.

The Secretary shall consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.

SEC. 8310. INFRASTRUCTURE.

(a) FACILITIES.—The Secretary, acting through the Indian Health Service, may expend amounts appropriated pursuant to section 8313 for the construction and renovation of hospitals, health centers, health stations, and other facilities for the purpose of improving and expanding such facilities to enable the delivery of the full array of items and services guaranteed in the comprehensive benefit package.

(b) CAPITAL FINANCING.—There is established in the Indian Health Service a revolving loan program. Under the program, the Secretary, acting through the Indian Health Service, shall provide guaranteed loans under such terms and conditions as the Secretary may prescribe to providers within the Indian Health System to improve and expand health care facilities to enable the delivery of the full array of items and services guaranteed in the comprehensive benefit package.

SEC. 8311. FINANCING.

(a) ESTABLISHMENT OF FUND.—Each health program of the Indian Health Service shall establish a comprehensive benefit package fund (hereafter in this section referred to as the "fund").

(b) DEPOSITS.—There shall be deposited into the fund the following:

(1) All amounts received as employer premium payments pursuant to section 1351(e)(3).

(2) All amounts received as family premium payments and premium discount payments pursuant to section 8306(b)(4).

(3) All amounts appropriated for the fund for the purpose of providing the comprehensive benefit package to individuals enrolled in a health program of the Indian Health Service.

(4) Any other amount received with respect to health services for the comprehensive benefit package.

(c) ADMINISTRATION AND EXPENDITURES.—

(1) MANAGEMENT.—The fund shall be managed by the health program of the Indian Health Service.

(2) EXPENDITURES.—Expenditures may be made from the fund to provide for the delivery of the items and services of the comprehensive benefit package under the health program of the Indian Health Service.

(3) AVAILABILITY OF FUNDS.—Amounts in the fund established by a service unit of the Indian Health Service under this section shall be available without further appropriation and shall remain available until expended for payments for the delivery of the items and services in the comprehensive benefit package.

SEC. 8312. RULE OF CONSTRUCTION.

Unless otherwise provided by this Act, no part of this Act shall be construed to rescind or otherwise modify any obligations, findings, or purposes contained in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) and in the Indian Self-Determination and Education Assistance Act.

SEC. 8313. AUTHORIZATIONS REGARDING PUBLIC HEALTH SERVICE INITIATIVES FUND.

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subtitle, there are authorized to be appropriated from the Public Health Service Initiatives Fund (established in section 3701) $40,000,000 for fiscal year 1995, $180,000,000 for fiscal year 1996, and $200,000,000 for each of the fiscal years 1997 through 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purposes described in such subsection.

Subtitle E—Amendments to the Employee Retirement Income Security Act of 1974

SEC. 8401. GROUP HEALTH PLAN DEFINED.

Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

"(42) The term 'group health plan' means an employee welfare benefit plan which provides medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.".

SEC. 8402. LIMITATION ON COVERAGE OF GROUP HEALTH PLANS UNDER TITLE I OF ERISA.

(a) IN GENERAL.—Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended—

(1) in subsection (a), by striking "subsection (b)" and inserting "subsections (b) and (c)";

(2) in subsection (b), by striking "The provisions" and inserting "Except as provided in subsection (c), the provisions"; and

(3) by adding at the end the following new subsection:

"(c) COVERAGE OF GROUP HEALTH PLANS.—

"(1) LIMITED INCLUSION.—This title shall apply to a group health plan only to the extent provided in this subsection.

"(2) COVERAGE UNDER CERTAIN PROVISIONS WITH RESPECT TO CERTAIN PLANS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), parts 1 and 4 of subtitle B shall apply to—

"(i) a group health plan which is maintained by—

"(I) a corporate alliance (as defined in section 1311(a) of the Health Security Act), or

"(II) a member of a corporate alliance (as so defined) whose eligible sponsor is described in section 1311(b)(1)(C) (relating to rural electric cooperatives and rural telephone cooperative associations), and

"(ii) a group health plan not described in subparagraph (A) which provides benefits which are permitted under paragraph (4) of section 1003 of the Health Security Act.

"(B) INAPPLICABILITY WITH RESPECT TO STATE-CERTIFIED HEALTH PLANS.—Subparagraph (A) shall not apply with respect to any plan or portion thereof which consists of a State-certified health plan (as defined in section 1400(c) of the Health Security Act). The Secretary shall provide by regulation for treatment as a separate group health plan of any arrangement which would otherwise be treated under this title as part of a group health plan to the extent necessary to carry out the purposes of this title.

"(3) CIVIL ACTIONS BY CORPORATE ALLIANCE PARTICIPANTS, BENEFICIARIES, AND FIDUCIARIES AND BY THE SECRETARY.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), in the case of a group health plan to which parts 1 and 4 of subtitle B apply under paragraph (2), section 502 shall apply with respect to a civil action described in such section brought—

"(i) by a participant, beneficiary, or fiduciary under such plan, or

"(ii) by the Secretary.

"(B) EXCEPTION WHERE REVIEW IS OTHERWISE AVAILABLE UNDER HEALTH SECURITY ACT.—Subparagraph (A) shall not apply with respect to any cause of action for which, under section 5202(d) of the Health Security Act, proceedings under sections 5203 and 5204 of such Act pursuant to complaints filed under section 5202(b) of such Act, and review under section 5205 of such Act of determinations made under such section 5204, are the exclusive means of review.

"(4) DEFINITIONS AND ENFORCEMENT PROVISIONS.—Sections 3, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, and 511 and the preceding provisions of this section shall apply to a group health plan to the extent necessary to effectively carry out, and enforce the requirements under, the provisions of this title as they apply pursuant to this subsection.

"(5) APPLICABILITY OF PREEMPTION RULES.—Section 514 shall apply in the case of any group health plan to which parts 1 and 4 of subtitle B apply under paragraph (2).".

(b) REPORTING AND DISCLOSURE REQUIREMENTS APPLICABLE TO GROUP HEALTH PLANS.—

(1) IN GENERAL.—Part 1 of subtitle B of title I of such Act is amended—

(A) in the heading for section 110, by adding "BY PENSION PLANS" at the end;

(B) by redesignating section 111 as section 112; and

(C) by inserting after section 110 the following new section:

"SPECIAL RULES FOR GROUP HEALTH PLANS

"SEC. 111. IN GENERAL.—The Secretary may by regulation provide special rules for the application of this part to group health plans which are consistent with the purposes of this title and the Health Security Act and which take into account the special needs of participants, beneficiaries, and health care providers under such plans.

"(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—Such special rules may include rules providing for—

"(1) reductions in the periods of time referred to in this part,

"(2) increases in the frequency of reports and disclosures required under this part, and

"(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries,

to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the purposes of this part and the Health Security Act as they relate to group health plans.

"(c) ADDITIONAL REQUIREMENTS.—Such special rules may include rules providing for reporting and disclosure to the Secretary and to participants and beneficiaries of additional information or at additional times with respect to group health plans to which this part applies under section 4(c)(2), if such reporting and disclosure would be comparable to and consistent with similar requirements applicable under the Health Security Act with respect to plans maintained by regional alliances (as defined in such section 1301 of such Act) and applicable regulations of the Secretary of Health and Human Services prescribed thereunder.".

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by striking the items relating to sections 110 and 111 and inserting the following new items:

"Sec. 110. Alternative methods of compliance by pension plans.
"Sec. 111. Special rules for group health plans.
"Sec. 112. Repeal and effective date.".

(d) EXCLUSION OF PLANS MAINTAINED BY REGIONAL ALLIANCES FROM TREATMENT AS MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—Section 3(40)(A) of such Act (29 U.S.C. 1002(40)(A)) is amended—

(1) in clause (ii), by striking "or";

(2) in clause (iii), by striking the period and inserting ", or"; and

(3) by adding after clause (iii) the following new clause:

"(iv) by a regional alliance (as defined in section 1301 of the Health Security Act).".

SEC. 8403. AMENDMENTS RELATING TO CONTINUATION COVERAGE.

(a) PERIOD OF COVERAGE.—Subparagraph (D) of section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161(2)) is amended—

(1) by striking "or" at the end of clause (i), by striking the period at the end of clause (ii) and inserting ", or", and by adding at the end the following new clause:

"(iii) eligible for coverage under a comprehensive benefit package described in section 1101 of the Health Security Act.", and

(2) by striking "OR MEDICARE ENTITLEMENT" in the heading and inserting ", MEDICARE ENTITLEMENT, OR HEALTH SECURITY ACT ELIGIBILITY".

(b) QUALIFIED BENEFICIARY.—Section 607(3) of such Act (29 U.S.C. 1167(2)) is amended by adding at the end the following new subparagraph:

"(D) SPECIAL RULE FOR INDIVIDUALS COVERED BY HEALTH SECURITY ACT.—The term 'qualified beneficiary' shall not include any individual who, upon termination of coverage under a group health plan, is eligible for coverage under a comprehensive benefit package described in section 1101 of the Health Security Act."

(c) REPEAL UPON IMPLEMENTATION OF HEALTH SECURITY ACT.—

(1) IN GENERAL.—Part 6 of subtitle B of title I of such Act (29 U.S.C. 601 et seq.) is amended by striking sections 601 through 608 and by redesignating section 609 as section 601.

(2) CONFORMING AMENDMENTS.—

(A) Section 502(a)(7) of such Act (29 U.S.C. 1132(a)(7)) is amended by striking "609(a)(2)(A)" and inserting "601(a)(2)(A)".

(B) Section 502(c)(1) is amended by striking "paragraph (1) or (4) of section 606".

(C) Section 514 of such Act (29 U.S.C. 1144) is amended by striking "609" each place it appears in subsections (b)(7) and (b)(8) and inserting "601".

(D) The table of contents in section 1 of such Act is amended by striking the items relating to sections 601 through 609 and inserting the following new item:

"Sec. 601. Additional standards for group health plans."

(d) EFFECTIVE DATE.—

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall take effect on the earlier of—

(A) January 1, 1998, or

(B) the first day of the first calendar year following the calendar year in which all States have in effect plans under which individuals are eligible for coverage under a comprehensive benefit package described in section 1101 of this Act.

SEC. 8404. ADDITIONAL AMENDMENTS RELATING TO GROUP HEALTH PLANS.

(a) REGULATIONS OF THE NATIONAL HEALTH BOARD REGARDING CASES OF ADOPTION.—Section 601(c) of such Act (as redesignated by section 8403) is amended by adding at the end the following new subsection:

"(4) REGULATIONS BY NATIONAL HEALTH BOARD.—The preceding provisions of this subsection shall apply except to the extent otherwise provided in regulations of the National Health Board under the Health Security Act.".

(b) COVERAGE OF PEDIATRIC VACCINES.—Section 601(d) of such Act (as redesignated by section 8403) is amended by adding at the end the following new sentence: "The preceding sentence shall cease to apply to a group health plan upon becoming a corporate alliance health plan pursuant to an effective election of the plan sponsor to be a corporate alliance under section 1311 of the Health Security Act.".

(c) TECHNICAL CORRECTIONS.—

(1) Subsection (a)(2)(B)(ii) of section 601 of such Act (as redesignated by section 8403) is amended by striking "section 13822" and inserting "section 13623".

(2) Subsection (a)(4) of such section 601 is amended by striking "section 13822" and inserting "section 13623".

(3) Subsection (d) of such section 601 is amended by striking "section 13830" and inserting "section 13631".

SEC. 8405. PLAN CLAIMS PROCEDURES.

Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting "(a) IN GENERAL.—" after "SEC. 503."; and

(2) by adding at the end the following new subsection:

"(b) GROUP HEALTH PLANS.—In addition to the requirements of subsection (a), a group health plan to which parts 1 and 4 apply under section 4(c)(2) shall comply with the requirements of section 5201 of the Health Security Act (relating to health plan claims procedure).".

SEC. 8406. EFFECTIVE DATES.

Except as otherwise provided in this subtitle, the amendments made by this subtitle shall take effect on the earlier of—

(1) January 1, 1998, or

(2) such date or dates as may be prescribed in regulations of the National Health Board in connection with plans whose participants or beneficiaries reside in any State which becomes a participating State under the Health Security Act before January 1, 1998.

Subtitle F—Special Fund for WIC Program

SEC. 8501. ADDITIONAL FUNDING FOR SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC).

(a) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS.—There is hereby authorized to be appropriated for the special supplemental food program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966, in addition to amounts otherwise authorized to be appropriated for such program, such amounts as are necessary for the Secretary of the Treasury to fulfill the requirements of subsection (b).

(b) WIC FUND.—

(1) CREDIT.—For each of fiscal years 1996 through 2000, the Secretary of the Treasury shall credit to a special fund of the Treasury an amount equal to—

(A) $254,000,000 for fiscal year 1996,

(B) $407,000,000 for fiscal year 1997,

(C) $384,000,000 for fiscal year 1998,

(D) $398,000,000 for fiscal year 1999, and

(E) $411,000,000 for fiscal year 2000.

(2) AVAILABILITY.—Subject to paragraph (3), amounts in such fund—

(A) shall be available only for the program authorized under section 17 of the Child Nutrition Act of 1966, exclusive of activities authorized under section 17(m) of such Act, and

(B) shall be paid to the Secretary of Agriculture for such purposes.

(3) LIMITATION.—For a fiscal year specified in paragraph (1), the amount credited to such fund for the fiscal year shall be available for use in such program only if appropriations Acts for the fiscal year, without the addition of amounts provided under subsection (a) for the fund, provide new budget authority for the program of no less than—

(A) $3,660,000,000 for fiscal year 1996,

(B) $3,759,000,000 for fiscal year 1997,

(C) $3,861,000,000 for fiscal year 1998,

(D) $3,996,000,000 for fiscal year 1999, and

(E) $4,126,000,000 for fiscal year 2000.

TITLE IX—AGGREGATE GOVERNMENT PAYMENTS

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Subtitle A—Aggregate State Payments

PART 1—STATE MAINTENANCE OF EFFORT PAYMENT

SEC. 9001. STATE MAINTENANCE-OF-EFFORT PAYMENT RELATING TO NON-CASH ASSISTANCE RECIPIENTS.

(a) PAYMENT.—

(1) IN GENERAL.—Subject to paragraph (2), each participating State shall provide for each year (beginning with State's first year) for payment to regional alliances in the State in the amounts specified in subsection (b).

(2) EXCEPTION.—The amounts specified in subsection (b) that are attributable to the element of the non-cash, non-DSH baseline amount described in section 9002(a)(1)(C) shall be paid to the Federal Government.

(b) AMOUNT.—Subject to sections 6005, 9023, and 9201(c)(2), the total amount of such payment for a year shall be equal to the following:

(1) FIRST YEAR.—In the case of the first year for a State, the sum of—

(A) the State non-cash, non-DSH baseline amount for the State, determined under section 9002(a)(1) and updated under section 9003(a)(1), and

(B) the State non-cash, DSH baseline amount for the State, determined under section 9002(a)(2) and updated under section 9003(a)(2).

(2) SUBSEQUENT YEAR.—In the case of any succeeding year, the sum computed under paragraph (1) for the first year updated to the year involved under section 9003(b) .

(c) DIVISION AMONG REGIONAL ALLIANCES.—In the case of a State with more than one regional alliance, the payment required to be made under this section shall be distributed among the regional alliances in an equitable manner (determined by the State) that takes into account, for each regional alliance, the proportion of the non-cash baseline amount (described in section 9002) that is attributable to individuals who resided in the alliance area of the regional alliance.

SEC. 9002. NON-CASH BASELINE AMOUNTS.

(a) BASELINE AMOUNTS.—

(1) NON-DSH AMOUNT.—The Secretary shall determine a non-cash, non-DSH baseline amount which is equal to the sum of the following:

(A) EXPENDITURES FOR COMPREHENSIVE BENEFIT PACKAGE FOR NON-CASH ASSISTANCE CHILDREN.—The aggregate State medicaid expenditures in fiscal year 1993 (as defined in subsection (b)(1)) for the comprehensive benefit package for non-cash assistance children (as defined in section 9004(a)).

(B) EXPENDITURES FOR COMPREHENSIVE BENEFIT PACKAGE FOR NON-CASH ASSISTANCE ADULTS.—The aggregate State medicaid expenditures in fiscal year 1993 for the comprehensive benefit package for non-cash assistance adults (as defined in section 9004(b)).

(C) EXPENDITURES FOR ADDITIONAL BENEFITS FOR CERTAIN CHILDREN.—The aggregate medicaid expenditures in fiscal year 1993 for all medically necessary items and services described in section 1905(a) (including items and services described in section 1905(r) but excluding long-term care services described in section 1933(c)) for qualified children described in section 1934(b)(1).

(2) DSH AMOUNT.—The Secretary shall determine a non-cash, DSH baseline amount which is equal to the DSH expenditures in fiscal year 1993 (as defined in subsection (b)(2)).

(b) STATE MEDICAID EXPENDITURES AND DSH EXPENDITURES DEFINED.—

(1) AGGREGATE STATE MEDICAID EXPENDITURES.—

(A) IN GENERAL.—In this section, the term "aggregate State medicaid expenditures" means, with respect to specified individuals and a State in fiscal year 1993, the amount of payments under the State medicaid plan with respect to medical assistance furnished for such individuals for calendar quarters in fiscal year 1993, less the amount of Federal financial participation paid to the State with respect to such assistance, and not including any DSH expenditures.

(B) LIMITED TO PAYMENTS FOR SERVICES.—In applying subparagraph (A), payments under the State medicaid plan shall not be included unless Federal financial participation is provided with respect to such payments under section 1903(a)(1) of the Social Security Act and such payments shall not include payments for medicare cost-sharing (as defined in section 1905(p)(3) of the Social Security Act).

(2) DSH EXPENDITURES.—In this section, the term "DSH expenditures" means, with respect to fiscal year 1993, payments made under section 1923 of the Social Security Act in fiscal year 1993 multiplied by proportion of payments for medical assistance for hospital services (including psychiatric hospital services) under the State medicaid plan in fiscal year 1993 that is attributable to non-cash assistance adults and non-cash asssistance children.

(3) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—If the Secretary finds that a State took an action that had the effect of shifting the timing of medical assistance payments under the State medicaid plan between quarters or fiscal years in a manner so that the payments made in fiscal year 1993 do not accurately reflect the value of the medical assistance provided with respect to items and services furnished in that fiscal year, the Secretary may provide for such adjustment in the amounts computed under this subsection as may be necessary so that the non-cash baseline amounts determined under this section accurately reflects such value.

(4) TREATMENT OF DISALLOWANCES.—The amounts determined under this subsection shall take into account amounts (or an estimate of amounts) disallowed.

(c) APPLICATION TO PARTICULAR ITEMS AND SERVICES IN COMPREHENSIVE BENEFIT PACKAGE.—For purposes of subsection (a)(1), in determining the aggregate State medicaid expenditures for a category of items and services (within the comprehensive benefit package) furnished in a State, there shall be counted only that proportion of such expenditures that were attributable to items and services included in the comprehensive benefit package (taking into account any limitation on amount, duration, or scope of items and services included in such package).

SEC. 9003. UPDATING OF BASELINE AMOUNTS.

(a) INITIAL UPDATE THROUGH THE FIRST YEAR.—

(1) NON-CASH, NON-DSH BASELINE AMOUNT.—The Secretary shall update the non-cash, non-DSH baseline amount determined under section 9002(a)(1) for each State from fiscal year 1993 through the first year, by the following percentage:

(A) If such first year is 1996, the applicable percentage is 56.6 percent.

(B) If such first year is 1997, the applicable percentage is 78.1 percent.

(C) If such first year is 1998, the applicable percentage is 102.2 percent.

(2) NON-CASH, DSH BASELINE AMOUNT.—The Secretary shall update the non-cash, DSH baseline amount determined under section 9002(a)(2) for each State from fiscal year 1993 through the first year, by the following percentage:

(A) If such first year is 1996, the applicable percentage is 45.9 percent.

(B) If such first year is 1997, the applicable percentage is 61.8 percent.

(C) If such first year is 1998, the applicable percentage is 79.0 percent.

(3) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—In determining the updates under paragraphs (1) and (2), the Secretary may provide for an adjustment in a manner similar to the adjustment permitted under section 9002(b)(3).

(b) UPDATE FOR SUBSEQUENT YEARS.—For each State for each year after the first year, the Board shall update the non-cash baseline amount (as previously updated under this subsection) by the product of—

(1) 1 plus the general health care inflation factor (as defined in section 6001(a)(3)) for the year, and

(2) 1 plus the annual percentage increase in the population of the United States of individuals who are under 65 years of age (as estimated by the Board based on projections made by the Bureau of Labor Statistics of the Department of Labor) for the year.

SEC. 9004. NON-CASH ASSISTANCE CHILD AND ADULT DEFINED.

(a) NON-CASH ASSISTANCE CHILD.—In this part, the term "non-cash assistance child" means a child described in section 1934(b)(1) of the Social Security Act (as inserted by section 4221(c)) who is not a medicare-eligible individual.

(b) NON-CASH ASSISTANCE ADULT.—In this part, the term "non-cash assistance adult" means an individual who is—

(1) over 21 years,

(2) is a citizen or national of the United States or an alien who is lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, and

(3) is not an AFDC or SSI recipient or a medicare-eligible individual.

PART 2—STATE PREMIUM PAYMENTS

SEC. 9011. STATE PREMIUM PAYMENT RELATING TO CASH ASSISTANCE RECIPIENTS.

(a) IN GENERAL.—Each participating State shall provide in each year (beginning with the State's first year) for payment to each regional alliance in the State of an amount equal to the State medical assistance percentage (as defined in subsection (b)) of 95 percent of the sum of the following products:

(1) AFDC PORTION.—The product of—

(A) the AFDC per capita premium amount for the regional alliance for the year (determined under section 9012(a)), and

(B) the number of AFDC recipients residing in the alliance area in the year (as determined under section 9014(b)(1)).

(2) SSI PORTION.—The product of—

(A) the SSI per capita premium amount for the regional alliance for the year (determined under section 9013), and

(B) the number of SSI recipients residing in the alliance area in the year (as determined under section 9014(b)(1)).

(b) STATE MEDICAL ASSISTANCE PERCENTAGE DEFINED.—In subsection (a), the term "State medical assistance percentage" means, for a State for a quarter in a fiscal year, 100 percent minus the Federal medical

assistance percentage (as defined in section 1905(b) of the Social Security Act) for the State for the fiscal year.

SEC. 9012. DETERMINATION OF AFDC PER CAPITA PREMIUM AMOUNT FOR REGIONAL ALLIANCES.

(a) IN GENERAL.—For each regional alliance in a State for each year, the Secretary shall determine an AFDC per capita premium amount in accordance with this section. Such amount is equal to—

(1) the per capita State medicaid expenditures for the comprehensive benefit package for AFDC recipients for the State for the year (as determined under subsection (b)), multiplied by

(2) the adjustment factor (determined under section 9015) for the year for the regional alliance.

(b) PER CAPITA STATE MEDICAID EXPENDITURES DEFINED.—The "per capita State medicaid expenditures for the comprehensive benefit package for AFDC recipients" for a State for a year is equal to the base per capita expenditures (described in subsection (c)), updated to the year involved under subsection (d)).

(c) BASE PER CAPITA EXPENDITURES.—The "base per capita expenditures" described in this subsection, for a State for a year, is—

(1) the baseline medicaid expenditures (as defined in subsection (e)) for the State, divided by

(2) the number of AFDC recipients enrolled in the State medicaid plan in fiscal year 1993, as determined under section 9014(a).

(d) UPDATING.—

(1) INITIAL UPDATE THROUGH YEAR BEFORE FIRST YEAR.—

(A) IN GENERAL.—The Secretary shall update the base per capita expenditures described in subsection (c) for each State from fiscal year 1993 through the year before first year, by the applicable percentage specified in paragraph (2).

(B) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage specified in this paragraph, in the case of a State in which the first year is—

(i) 1996 is 32.2 percent,

(ii) 1997 is 46.6 percent, or

(iii) 1998 is 62.1 percent.

(C) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—In determining the update under paragraph (1), the Secretary may provide for an adjustment in a manner similar to the adjustment permitted under section 9002(b)(3).

(2) UPDATE FOR SUBSEQUENT YEARS.—For each State for the first year and for each year after the first year, the Board shall update the base per capita expenditures described in subsection (c) (as previously updated under this subsection) by a factor equal to 1 plus the general health care inflation factor (as defined in section 6001(a)(3)) for the year.

(e) DETERMINATION OF BASELINE MEDICAID EXPENDITURES.—

(1) IN GENERAL.—For purposes of subsection (c)(1), the "baseline medicaid expenditures" for a State is the gross amount of payments under the State medicaid plan with respect to medical assistance furnished, for items and services included in the comprehensive benefit package, for AFDC recipients for calendar quarters in fiscal year 1993, but does not include such expenditures for which no Federal financial participation is provided under such plan.

(2) DISPROPORTIONATE SHARE PAYMENTS NOT INCLUDED.—In applying paragraph (1), payments made under section 1923 of the Social Security Act shall not be counted in the gross amount of payments.

(3) TREATMENT OF DISALLOWANCES.—The amount determined under this subsection shall take into account amounts (or an estimate of amounts) disallowed.

(f) APPLICATION TO PARTICULAR ITEMS AND SERVICES IN COMPREHENSIVE BENEFIT PACKAGE.—For purposes of this section, in determining the per capita State medicaid expenditures for a category of items and services (within the comprehensive benefit package) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients) that were attributable to items and services included in the comprehensive benefit package (taking into account any limitation on amount, duration, or scope of items and services included in such package).

SEC. 9013. DETERMINATION OF SSI PER CAPITA PREMIUM AMOUNT FOR REGIONAL ALLIANCES.

For each regional alliance in a State for each year, the Secretary shall determine an SSI per capita premium amount for each regional alliance in accordance with this section. Such amount shall be determined in the same manner as the AFDC per capita premium amount for the regional alliance is determined under section 9012 except that, for purposes of this section—

(1) any reference in such section (or in sections referred to in such section) to an "AFDC recipient" is deemed a reference to an "SSI recipient", and

(2) the following percents shall be substituted for the percents specified in section 9012(d)(1)(B):

(A) For 1996, 29.4 percent.

(B) For 1997, 43.7 percent.

(C) For 1998, 58.8 percent.

SEC. 9014. DETERMINATION OF NUMBER OF AFDC AND SSI RECIPIENTS.

(a) BASELINE.—For purposes of section 9012 and section 9013, the number of AFDC recipients and SSI recipients for a State for fiscal year 1993 shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not recipients for the entire fiscal year, the number shall take into account only the portion of the year in which they were such recipients. The Secretary may audit such reports.

(b) SUBSEQUENT YEARS.—

(1) PAYMENTS.—For purposes of section 9011(b), the number of AFDC and SSI recipients enrolled in regional alliance health plans for a regional alliance shall be determined on a monthly basis based on actual enrollment.

(2) COMPUTATION OF REGIONAL ADJUSTMENT FACTORS AND BLENDED PLAN PAYMENT RATES.—For purposes of computing regional alliance adjustment factors under section 9015 and the AFDC and SSI proportions under section 6202, the number of AFDC and SSI recipients for a regional alliance in a State for a year (beginning with 1997) shall be determined by the State before the date the State is required to compute AFDC and SSI proportions under section 6202 based on the best available estimate of such proportion in the previous year.

SEC. 9015. REGIONAL ALLIANCE ADJUSTMENT FACTORS.

(a) IN GENERAL.—If a State—

(1) has more than one regional alliance operating in the State for a year, the State shall compute under this section a regional alliance adjustment factor for each such regional alliance for the year in accordance with subsection (b), or

(2) has only one regional alliance for a year, the regional alliance adjustment factor under this section is 1.

(b) RULES.—The adjustment factors under subsection (a)(1) for a year shall be computed in a manner so that—

(1) such factors for the different regional alliances reflect—

(A) the variation in regional alliance per capita premium targets (determined under section 6003), and

(B) the variation in baseline per capita medicaid expenditures across regional alliances; and

(2) the weighted average of such factors is 1.

(c) USE OF SAME DATA.—The weighted average under subsection (b)(2) shall be determined based on the number of AFDC recipients or SSI recipients (as the case may be) enrolled in each regional alliance in a State (as determined for each regional alliance under section 9014(b)(2)).

(d) CLARIFICATION OF SEPARATE COMPUTATIONS.—Determinations of adjustment factors under this section shall be made separately for AFDC recipients and for SSI recipients.

PART 3—GENERAL AND MISCELLANEOUS PROVISIONS

SEC. 9021. TIMING AND MANNER OF PAYMENTS.

The provisions of paragraphs (1) and (2) of section 9101(b) apply to payments by a State under this subtitle in the same manner as they apply to payments by the Secretary under section 9101, and any reference in such provisions to the Secretary is deemed a reference to the State.

SEC. 9022. REVIEW OF PAYMENT LEVEL.

(a) IN GENERAL.—The National Health Board shall review from time to time the appropriateness of the levels of payments required of States under this subtitle.

(b) REPORT.—The Board may report to the Congress on such adjustments as should be made to assure an equitable distribution of State payments under this Act, taking into account the revenue base in each of the States.

(c) LIMIT ON AUTHORITY.—Nothing in this subtitle shall be construed as permitting the Board to change the amount of the payments required by States under the the previous sections in this subtitle.

SEC. 9023. SPECIAL RULES FOR PUERTO RICO AND OTHER TERRITORIES.

(a) WAIVER AUTHORITY.—Notwithstanding any other requirement of this title or title VI, the Secretary may waive or modify any requirement of this title or title VI (other than financial contribution and subsidy requirements) with respect to Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, consistent with this section, to accommodate their unique geographic and social conditions and features of their health care systems.

(b) TERRITORIAL MAINTENANCE OF EFFORT AND DIVISION OF FINANCIAL RESPONSIBILITY.—

(1) IN GENERAL.—In the case of such a territory, the Secretary shall determine an appropriate allocation of the payments described in paragraph (2) based on—

(A) payments that qualify for Federal financial participation under the medicaid program,

(B) payments would qualify for such participation in the absence of section 1108(c) of the Social Security Act, and

(C) other factors that the Secretary may consider.

(2) PAYMENTS DESCRIBED.—The payments described in this paragraph are—

(A) State cash assistance payments under section 9011;

(B) State maintenance of effort payments under section 9001;

(C) Federal payments under section 9101; and

(D) Federal payments under section 9111.

(3) CASH ASSISTANCE RECIPIENTS.—With respect to such territories, in this Act, the term "SSI recipient" means an individual receiving aid under a territorial program for the aged, blind, or disabled under the Social Security Act.

Subtitle B—Aggregate Federal Alliance Payments

SEC. 9101. FEDERAL PREMIUM PAYMENTS FOR CASH ASSISTANCE RECIPIENTS.

(a) AMOUNT.—

(1) IN GENERAL.—The Secretary shall provide each year (beginning with a State's first year) for payment to each regional alliance of an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) of 95 percent of the sum of the products described in section 9011(a) for that State for that fiscal year.

(2) SPECIAL RULES FOR SINGLE-PAYER STATES.—In determining the products referred to in paragraph (1) in the case of a single-payer State, the State is deemed to be a single regional alliance and the regional alliance adjustment factor (under section 9015) is deemed to be 1.

(b) TIMING AND MANNER OF PAYMENT.—

(1) IN GENERAL.—Amounts required to be paid under this section shall be paid on a periodic basis that reflects the cash flow requirements of regional alliances for payments under this section in order to meet obligations established under this Act.

(2) PERIODIC PROVISION OF INFORMATION.—Each regional alliance shall periodically transmit to the Secretary such information as the Secretary may require to make such payments.

(3) RECONCILIATION.—

(A) PRELIMINARY.—At such time after the end of each year as the Secretary shall specify, the State shall submit to the Secretary such information as the Secretary may require to do a preliminary reconciliation of the amounts paid under this section and the amounts due.

(B) FINAL.—No later than June 30 of each year, the Secretary shall provide for a final reconciliation for such payments for quarters in the previous year. Amounts subsequently payable are subject to adjustment to reflect the results of such reconciliation.

(C) AUDIT.—Payments under this section are subject to audits by the Secretary in accordance with rules established by the Secretary.

SEC. 9102. CAPPED FEDERAL ALLIANCE PAYMENTS.

(a) CAPPED ENTITLEMENT.—

(1) PAYMENT.—The Secretary shall provide for each calendar quarter (beginning on or after January 1, 1996) for payment to each regional alliance of an amount equal to the capped Federal alliance payment amount (as defined in subsection (b)(1)) for the regional alliance for the quarter.

(2) ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to regional alliances of the capped Federal alliance payment under this section.

(b) CAPPED FEDERAL ALLIANCE PAYMENT AMOUNT.—

(1) IN GENERAL.—In this section, the term "capped Federal alliance payment amount" means, for a regional alliance for a calendar quarter in a year and subject to subsection (e), the amount by which—

(A) ¼ of the total payment obligation (described in paragraph (2)) for the alliance for the year, exceeds

(B) ¼ of the total amounts receivable (described in paragraph (3)) by the alliance for the year.

(2) TOTAL PAYMENT OBLIGATION.—The total payment obligation described in this paragraph for an alliance for a year is the total amount payable by the alliance for the following:

(A) PLAN PAYMENTS (AND CERTAIN COST SHARING REDUCTIONS).—Payments to regional alliance health plans under section 1351 (including amounts attributable to cost sharing reductions under section 1371, not including a reduction under subsection (c)(2) thereof) not otherwise counted.

(B) ALLIANCE ADMINISTRATIVE EXPENSES.—Payments retained by the regional alliance for administration (in accordance with section 1352).

(3) TOTAL AMOUNTS RECEIVABLE.—The total amounts receivable by a regional alliance for a year is the sum of the following:

(A) PREMIUMS.—The amount payable to the regional alliance for the family share of premiums, employer premiums, and liabilities owed the alliance under subpart B of part 1, not taking into account any failure to make or collect such payments.

(B) OTHER GOVERNMENT PAYMENTS.—The amounts payable to the regional alliance under sections 9001, 9011, and 9101, and payable under section 1895 of the Social Security Act during the year.

(4) NO PAYMENT FOR CERTAIN AMOUNTS.—

(A) UNCOLLECTED ALLIANCE PREMIUMS.—Each regional alliance is responsible, under section 1345(a), for the collection of all amounts owed the alliance (whether by individuals, employers, or others and whether on the basis of premiums owed, incorrect amounts of discounts or premium, cost sharing, or other reductions made, or otherwise), and no amounts are payable by the Federal Goverment under this section with respect to the failure to collect any such amounts.

(B) ADMINISTRATIVE ERRORS.—

(i) IN GENERAL.—Each participating State is responsible, under section 1202(g), for the payment to regional alliances in the State of amounts attributable to administrative errors (described in clause (ii)).

(ii) ADMINISTRATIVE ERRORS DESCRIBED.—The administrative errors described in this clause include the following:

(I) An eligibility error rate for premium discounts, liability reductions, and cost sharing reductions under sections 6104 and 6123, section 6113, and section 1371, respectively, to the extent the applicable error rate exceeds the maximum permissible error rate, specified by the applicable Secretary under section 1361(b)(1)(C), with respect to the section involved.

(II) Misappropriations or other regional alliance expenditures that the Secretary finds are attributable to malfeasance or misfeasance by the regional alliance or the State.

(5) SPECIAL RULES FOR SINGLE-PAYER STATES.—In applying this subsection in the case of a single-payer State, the Secretary shall develop and apply a methodology for computing an amount of payment (with respect to each calendar quarter) that is equivalent to the amount of payment that would have been made to all regional alliances in the State for the quarter if the State were not a single-payer State.

(c) DETERMINATION OF CAPPED FEDERAL ALLIANCE PAYMENT AMOUNTS.—

(1) REPORTS.—At such time as the Secretary may require before the beginning of each fiscal year, each regional alliance shall submit to the Secretary such information as the Secretary may require to estimate the capped Federal alliance payment amount under this section for the succeeding calendar year (and the portion of such year that falls in such fiscal year).

(2) ESTIMATION.—Before the beginning of each year, the Secretary shall estimate for each regional alliance the capped Federal alliance payment amount for calendar quarters in such year. Such estimate shall be based on factors including prior financial experience in the alliance, future estimates of income, wages, and employment, and other characteristics of the area found relevant by the Secretary. The Secretary shall transmit to Congress, on a timely basis consistent with the timely appropriation of funds under this section, a report that specifies an estimate of the total capped Federal alliance payment amounts owed to States under this section for the fiscal and calendar year involved.

(d) PAYMENTS TO REGIONAL ALLIANCES.—Subject to subsection (e), the provisions of section 9101(b) apply to payments under this section in the same manner as they apply to payments under section 9101.

(e) CAP ON PAYMENTS.—

(1) IN GENERAL.—The total amount of the capped Federal alliance payments made under this section for quarters in a fiscal year may not exceed the cap specified under paragraph (2) for the fiscal year.

(2) CAP.—Subject to paragraphs (4) and (6)—

(A) FISCAL YEARS 1996 THROUGH 2000.—The cap under this paragraph—

(i) for fiscal year 1996, is $10.3 billion,

(ii) for fiscal year 1997, is $28.3 billion,

(iii) for fiscal year 1998, is $75.6 billion,

(iv) for fiscal year 1999, is $78.9 billion, and

(v) for fiscal year 2000, is $81.0 billion.

(B) SUBSEQUENT FISCAL YEAR.—The cap under this paragraph for a fiscal year after fiscal year 2000 is the cap under this paragraph for the previous fiscal year (not taking into account paragraph (4)) multiplied by the product of the factors described in subparagraph (C) for that fiscal year and for each previous year after fiscal year 2000.

(C) FACTOR.—The factor described in this subparagraph for a fiscal year is 1 plus the following:

(i) CPI.—The percentage change in the CPI for the fiscal year, determined based upon the percentage change in the average of the CPI for the 12-month period ending with May 31 of the previous fiscal year over such average for the preceding 12-month period.

(ii) POPULATION.—The average annual percentage change in the population of the United States during the 3-year period ending in the preceding calendar year, determined by the Board based on data supplied by the Bureau of the Census.

(iii) REAL GDP PER CAPITA.—The average annual percentage change in the real, per capita gross domestic product of the United States during the 3-year period ending in the preceding calendar year, determined by the Board based on data supplied by the Department of Commerce.

(3) CARRYFORWARD.—If the total of the capped Federal alliance payment amounts for all regional alliances for all calendar quarters in a fiscal year is less than the cap specified in paragraph (2) for the fiscal year, then the amount of such surplus shall be accumulated and will be available in the case of a year in which the cap would otherwise be breached.

(4) NOTIFICATION.—

(A) IN GENERAL.—If the Secretary anticipates that the amount of the cap, plus any carryforward from a previous year accumulated under paragraph (3), will not be sufficient for a fiscal year, the Secretary shall notify the President, the Congress, and each regional alliance. Such notification shall include information about the anticipated amount of the shortfall and the anticipated time when the shortfall will first occur.

(B) REQUIRED ACTION.—Within 30 days after receiving such a notice, the President shall submit to Congress a report containing specific legislative recommendations for actions which would eliminate the shortfall.

(5) CONGRESSIONAL CONSIDERATION.—

(A) EXPEDITED CONSIDERATION.—If a joint resolution the substance of which approves the specific recommendations submitted under paragraph (4)(A) is introduced, subject to subparagraph (B), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of the joint resolution in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(B) SPECIAL RULES.—For purposes of applying subparagraph (A) with respect to such provisions, any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of recommendations under paragraph (4)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Majority Leader of the Senate at the time of submission of such recommendations).

(6) METHOD FOR ADJUSTING THE CAP FOR CHANGES IN INFLATION.—If the inflation rate, as measured by the percentage increase in the CPI, is projected to be significantly different from the inflation rate projected by the Council of Economic Advisors to the President as of October 1993, the Secretary may adjust the caps under paragraph (2) so as to reflect such deviation from the projection.

Subtitle C—Borrowing Authority to Cover Cash-flow Shortfalls

SEC. 9201. BORROWING AUTHORITY TO COVER CASH-FLOW SHORTFALLS.

(a) IN GENERAL.—The Secretary shall make available loans to regional alliances in order to cover any period of temporary cash-flow shortfall attributable to any of the following:

(1) Any estimation discrepancy (including those described in subsection (e)(1)).

(2) A period of temporary cash-flow shortfall attributable to an administrative error (described in subsection (e)(2)).

(3) A period of temporary cash-flow shortfall relating to the relative timing during the year in which amounts are received and payments are required to be made.

(b) TERMS AND CONDITIONS.—

(1) IN GENERAL.—Loans shall be made under this section under terms and conditions, consistent with this subsection, specified by the Secretary, in consultation with the Secretary of the Treasury and taking into account Treasury cash management rules.

(2) PERIOD.—Loans under this section shall be repayable with interest over a period of not to exceed 2 years.

(3) INTEREST RATE.—The rate of interest on such loans shall be at a rate, determined by the Secretary of the Treasury taking into consideration the current average rate on outstanding marketable obligations of the United States.

(4) APPROPRIATE PAYMENT ADJUSTMENTS.—As a condition of providing a loan under subsection (a)(1), the Secretary shall require the regional alliance to make such adjustments under the appropriate estimation adjustment provision (described in subsection (f)) in order to assure the repayment of the amount so borrowed.

(c) REPAYMENT.—

(1) ESTIMATION DISCREPANCIES AND TIMING.—Loans made under paragraphs (1) and (3) of subsection (a) shall be repaid through a reduction in the payment amounts otherwise required to be made under section 9102 to the regional alliance.

(2) ADMINISTRATIVE ERROR.—Loans made under subsection (a)(2) shall be repaid through a temporary increase in the amount of the State maintenance-of-effort payment required under section 9001.

(d) REPORTS.—The Secretary shall annually report to Congress on the loans made (and loan amounts repaid) under this section.

(e) SOURCES OF ERROR DESCRIBED.—

(1) ESTIMATION DISCREPANCIES.—The estimation discrepancies described in this paragraph are discrepancies in estimating the following:

(A) The average premium payments per family under section 6122(b).

(B) The AFDC and SSI proportions under section 6202.

(C) The distribution of enrolled families in different risk categories for purposes of under section 1343(b)(2).

(D) The distribution of enrollment in excess premium plans (for purposes of calculating and applying the reduced weighted average accepted bid under section 6105(c)(1)).

(E) The collection shortfalls (used in computing the family collection shortfall add-on under section 6107).

(2) ADMINISTRATIVE ERRORS.—The administrative errors described in this paragraph include the following:

(A) An eligibility error rate for premium discounts and liability reductions under sections 6104 and 6113, to the extent such rate exceeds the maximum permissible error rate established for the alliance under subpart B of part 3 of subtitle D of title I.

(B) Misappropriations or other regional alliance expenditures that are determined to be attributable to malfeasance or misfeasance by the regional alliance or the State.

(f) ESTIMATION ADJUSTMENT PROVISIONS DESCRIBED.—The estimation adjustment provisions, referred to in subsection (b)(3)) are the following adjustments (corresponding to the respective estimation discrepancies specified in subsection (d)(1)):

(1) Adjustments for average premium payments per family under section 6122(b) under section 6122(b)(4).

(2) Adjustments in the AFDC and SSI proportions under section 6202(d).

(3) Adjustments pursuant to methodology described in section 1541(b)(8).

(4) Adjustments in excess premium credit pursuant to section 6105(b)(2).

(5) Adjustment in the collection shortfall add-on under section 6017(b)(2)(C)).

TITLE X—COORDINATION OF MEDICAL PORTION OF WORKERS COMPENSATION AND AUTOMOBILE INSURANCE

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Subtitle A—Workers Compensation Insurance

SEC. 10000. DEFINITIONS.

In this subtitle:

(1) INJURED WORKER.—The term "injured worker" means, with respect to a health plan, an individual enrolled under the plan who has a work-related injury or illness for which workers compensation medical benefits are available under State law.

(2) SPECIALIZED WORKERS COMPENSATION PROVIDER.—The term "specialized workers compensation provider" means a health care provider that specializes in the provision of treatment relating to work-related injuries or illness, and includes specialists in industrial medicine, specialists in occupational therapy, and centers of excellence in industrial medicine and occupational therapy.

(3) WORKERS COMPENSATION MEDICAL BENEFITS.—The term "workers compensation medical benefits" means, with respect to an enrollee who is an employee subject to the workers compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee.

(4) WORKERS COMPENSATION CARRIER.—The term "workers compensation carrier" means an insurance company that underwrites workers compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits.

(5) WORKERS COMPENSATION SERVICES.—The term "workers compensation services" means items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term care services) commonly used for treatment of work-related injuries and illnesses.

PART 1—HEALTH PLAN REQUIREMENTS RELATING TO WORKERS COMPENSATION

SEC. 10001. PROVISION OF WORKERS COMPENSATION SERVICES.

(a) PROVISION OF BENEFITS.—Subject to subsection (b)—

(1) REQUIREMENT FOR CERTAIN HEALTH PLANS.—

(A) IN GENERAL.—Each health plan that provides services to enrollees through participating providers shall enter into such contracts and arrangements as are necessary (in accordance with subparagraph (B)) to provide or arrange for the provision of workers compensation services to such enrollees, in return for payment from the workers compensation carrier under section 10002.

(B) PROVISION OF SERVICES.—For purposes of this paragraph, a health plan provides (or arranges for the provision of) workers compensation services with respect to an enrollee if the services are provided by—

(i) a participating provider in the plan,

(ii) any other provider with whom the plan has entered into an agreement for the provision of such services, or

(iii) a specialized workers compensation provider (designated by the State under 10011), whether or not the provider is a provider described in clause (i) or (ii).

(2) INDIVIDUAL REQUIREMENT.—An individual entitled to workers compensation medical benefits and enrolled in a health plan (whether or not the plan is described in paragraph (1)(A)) shall receive workers compensation services through the provision (or arrangement for the provision) of such services by the health plan.

(3) EXCEPTIONS.—

(A) EMERGENCY SERVICES.—Paragraphs (1) and (2) shall not apply in the case of emergency services.

(B) ELECTING VETERANS, MILITARY PERSONNEL, INDIANS, AND PRISONERS.—Paragraphs (1) and (2) shall not apply in the case of an individual described in section 1004(b) and making an election described in such section.

(4) USE OF SPECIALIZED WORKERS COMPENSATION PROVIDERS.—If a participating State has designated under section 10011 specialized workers compensation providers with respect to one or more types of injuries or illnesses for a geographic area, either a health plan or an injured worker who has an injury or illness of such type may elect to provide or receive the benefits under this subsection through such a provider.

(b) ALTERNATIVE PERMITTED.—Subsection (a) shall not be construed as preventing an injured worker and a workers compensation carrier from agreeing that workers compensation services shall be provided other than by or through the health plan in which the worker is enrolled.

(c) COORDINATION.—

(1) DESIGNATION OF CASE MANAGER.—Each health plan shall employ or contract with one or more individuals, such as occupational nurses, with experience in the treatment of occupational illness and injury to provide case management services with respect to workers compensation services provided through the plan under this section.

(2) FUNCTIONS OF CASE MANAGER.—The health plan (through the case manager described in paragraph (1)) is responsible for ensuring that—

(A) there is plan of treatment (when appropriate) for each enrollee who is an injured worker designed to assure appropriate treatment and facilitate return to work;

(B) the plan of treatment is coordinated with the workers compensation carrier, the employer, or both;

(C) the health plan (and its providers) comply with legal duties and requirements under State workers compensation law; and

(D) if the health plan is unable to provide a workers compensation service needed to treat a work-related injury or illness, that the injured worker is referred (in consultation with the workers compensation carrier) to an appropriate provider.

SEC. 10002. PAYMENT BY WORKERS COMPENSATION CARRIER.

(a) PAYMENT.—

(1) IN GENERAL.—Except as provided in subsection (b), each workers compensation carrier that is liable for payment for workers compensation services furnished by or through a health plan, regardless of whether or not the services are included in the comprehensive benefit package, shall make payment for such services.

(2) USE OF REGIONAL ALLIANCE FEE SCHEDULE.—Such payment shall be made in accordance with the applicable fee schedule established under section 1322(c) or section 10013.

(b) ALTERNATIVE PAYMENT METHODOLOGIES.—Subsection (a) shall not apply—

(1) in the case of a regional alliance or participating State that establishes an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for workers compensation services; or

(2) in the case in which a workers compensation carrier and the health plan negotiate alternative payment arrangements.

(c) LIMITATION OF LIABILITY OF INJURED WORKER.—Nothing in this subpart shall be construed as requiring an injured worker to make any payment (including payment of any cost sharing or any amount in excess of the applicable fee schedule) to any health plan or health care provider for the receipt of workers compensation services.

PART 2—REQUIREMENTS OF PARTICIPATING STATES

SEC. 10011. COORDINATION OF SPECIALIZED WORKERS COMPENSATION PROVIDERS.

(a) IN GENERAL.—Each participating State shall coordinate access to specialized workers compensation providers on behalf of health plans, providing coverage to individuals residing in the State, under part 1.

(b) OPTIONAL DESIGNATION OF SPECIALIZED WORKERS COMPENSATION PROVIDERS.—A participating State may designate such specialized workers compensation providers, as the State determines to be appropriate, to provide under part 1 workers compensation services that—

(1) are not included in the comprehensive benefit package, or

(2) are so included but are specialized services that are typically provided (as determined by the State) by specialists in occupational or rehabilitative medicine.

Injured workers and health plans may elect to use such providers under section 10001(a)(4).

SEC. 10012. PREEMPTION OF STATE LAWS RESTRICTING DELIVERY OF WORKERS COMPENSATION MEDICAL BENEFITS.

(a) IN GENERAL.—Subject to section 10011(b), no State law shall have any effect that restricts the choice, or payment, of providers that may provide workers compensation services for individuals enrolled in a health plan.

(b) DISPUTE RESOLUTION.—A State law may provide for a method for resolving disputes among parties related to—

(1) an individual's entitlement to workers compensation medical benefits under State law,

(2) the necessity and appropriateness of workers compensation services provided to an injured worker, and

(3) subject to section 10002, the reasonableness of charges or fees charged for workers compensation services.

SEC. 10013. DEVELOPMENT OF SUPPLEMENTAL SCHEDULE.

Each participating State shall develop a fee schedule applicable to payment for workers compensation services for which a fee is not included in the applicable fee schedule established under section 1322(c).

SEC. 10014. CONSTRUCTION.

(a) IN GENERAL.—Nothing in this subtitle shall be construed as altering—

(1) the effect of a State workers compensation law as the exclusive remedy for work-related injuries or illnesses,

(2) the determination of whether or not a person is an injured worker and entitled to workers compensation medical benefits under State law,

(3) the scope of items and services available to injured workers entitled to workers compensation medical benefits under State law, or

(4) the eligibility of any individual or class of individuals for workers compensation medical benefits under State law.

(b) EARLY INTEGRATION.—Nothing in this subtitle shall prevent a State from integrating or otherwise coordinating the payment for workers compensation medical benefits with payment for benefits under health insurance or health benefit plans before the date the Commission submits its report under section 10201(e).

PART 3—APPLICATION OF INFORMATION REQUIREMENTS; REPORT ON PREMIUM REDUCTIONS

SEC. 10021. APPLICATION OF INFORMATION REQUIREMENTS.

(a) IN GENERAL.—The provisions of—

(1) part 3 of subtitle B of title V (relating to use of standard forms), and

(2) section 5101(e)(9) (relating to provision of data on quality),

apply to the provision of workers compensation services in the same manner as such provisions apply with respect to the provision of services included in the comprehensive benefit package.

(b) RULES.—The Secretary of Labor shall promulgate rules to clarify the responsibilities of health plans and workers compensation carriers in carrying out the provisions referred to in subsection (a).

SEC. 10022. REPORT ON REDUCTION IN WORKERS COMPENSATION PREMIUMS.

(a) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Labor shall provide for a study of the impact of the provisions of this subtitle on the premium rates charged to employers for workers compensation insurance. Such study shall use information supplied by States relating to workers compensation premiums and such other information as such Secretary finds appropriate.

(2) REPORT.—Such Secretary shall submit to the Congress, by not later than 2 years after the date that this subtitle applies in all States, a report on the findings of the study.

(b) WORKERS COMPENSATION CARRIER FILINGS.—

(1) IN GENERAL.—Within six months after the date this subtitle is effective in a participating State, each workers compensation carrier (other than a self-funded employer) providing workers compensation insurance in the State shall make a filing with an agency designated by the State. Such filing shall describe the manner in which such carrier has modified (or intends to modify) its premium rates for workers compensation insurance provided in the State to reflect the changes brought about by the provisions in this subtitle. The filing shall include such actuarial projections and assumptions as necessary to support the modifications of such rates.

(2) REPORT TO SECRETARY.—Each participating State shall provide to the Secretary of Labor such information on filings made under paragraph (1) as such Secretary may specify.

PART 4—DEMONSTRATION PROJECTS

SEC. 10031. AUTHORIZATION.

The Secretary of Health and Human Services and the Secretary of Labor are authorized to conduct demonstration projects under this part in one or more States with respect to treatment of work-related injuries and illnesses.

SEC. 10032. DEVELOPMENT OF WORK-RELATED PROTOCOLS.

(a) IN GENERAL.—Under this part, the Secretaries, in consultation with States and such experts on work-related injuries and illnesses as the Secretaries find appropriate, shall develop protocols for the appropriate treatment of work-related conditions.

(b) TESTING OF PROTOCOLS.—The Secretaries shall enter into contracts with one or more health alliances to test the validity of the protocols developed under subsection (a).

SEC. 10033. DEVELOPMENT OF CAPITATION PAYMENT MODELS.

Under this part, the Secretaries shall develop, using protocols developed under section 10032 if possible, methods of providing for payment by workers compensation carriers to health plans on a per case, capitated payment for the treatment of specified work-related injuries and illnesses.

Subtitle B—Automobile Insurance

SEC. 10100. DEFINITIONS.

In this subtitle:

(1) INJURED INDIVIDUAL.—The term "injured individual" means, with respect to a health plan, an individual enrolled under the plan who has an injury or illness sustained in an automobile accident for which automobile insurance medical benefits are available.

(2) AUTOMOBILE INSURANCE MEDICAL BENEFITS.—The term "automobile insurance medical benefits" means, with respect to an enrollee, the comprehensive medical benefits for injuries or illnesses sustained in automobile accidents.

(3) AUTOMOBILE INSURANCE CARRIER.—The term "automobile insurance carrier" means an insurance company that underwrites automobile insurance medical benefits and includes an employer or fund that is financially at risk for the provision of automobile insurance medical benefits.

(4) AUTOMOBILE INSURANCE MEDICAL SERVICES.—The term "automobile insurance medical services" means items and services included in automobile insurance medical benefits and includes items and services (such as rehabilitation services and long-term care services) commonly used for treatment of injuries and illnesses sustained in automobile accidents.

PART 1—HEALTH PLAN REQUIREMENTS RELATING TO AUTOMOBILE INSURANCE

SEC. 10101. PROVISION OF AUTOMOBILE INSURANCE MEDICAL BENEFITS THROUGH HEALTH PLANS.

(a) IN GENERAL.—An individual entitled to automobile insurance medical benefits and enrolled in a health plan shall receive automobile insurance medical services through the provision (or arrangement for the provision) of such services by the health plan.

(b) REFERRAL FOR SPECIALIZED SERVICES.—Each health plan shall provide for such referral for automobile insurance medical services as may be necessary to assure appropriate treatment of injured individuals.

(c) EXCEPTIONS.—Subsections (a) and (b) shall not apply in the case of an individual described in section 1004(b) and making an election described in such section.

(d) ALTERNATIVE PERMITTED.—Subsection (a) shall not be construed as preventing an injured individual and an automobile insurance carrier from agreeing that automobile insurance medical services shall be provided other than by or through the health plan in which the individual is enrolled.

SEC. 10102. PAYMENT BY AUTOMOBILE INSURANCE CARRIER.

(a) PAYMENT.—

(1) IN GENERAL.—Except as provided in subsection (b), each automobile insurance carrier that is liable for payment for automobile insurance medical services furnished by or through a health plan, regardless of whether or not the services are included in the comprehensive benefit package, shall make payment for such services.

(2) USE OF REGIONAL ALLIANCE FEE SCHEDULE.—Such payment shall be made in accordance with the applicable fee schedule established under section 1322(c) or section 10111.

(b) ALTERNATIVE PAYMENT METHODOLOGIES.—Subsection (a) shall not apply—

(1) in the case of a regional alliance or participating State that establishes an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for automobile insurance medical services; or

(2) in the case in which a automobile insurance carrier and the health plan negotiate alternative payment arrangements.

(c) LIMITATION OF LIABILITY OF INJURED INDIVIDUAL.—Nothing in this part shall be construed as requiring an injured individual to make any payment (including payment of any cost sharing or any amount in excess of the applicable fee schedule) to any health plan or health care provider for the receipt of automobile insurance medical services.

PART 2—REQUIREMENT OF PARTICIPATING STATES

SEC. 10111. DEVELOPMENT OF SUPPLEMENTAL SCHEDULE.

Each participating State shall develop a fee schedule applicable to payment for automobile insurance medical services for which a fee is not included in the applicable fee schedule established under section 1322(c).

SEC. 10112. CONSTRUCTION.

Nothing in this subtitle shall be construed as altering—

(1) the determination of whether or not a person is an injured individual and entitled to automobile insurance medical benefits under State law, or

(2) the scope of items and services available to injured individuals entitled to automobile insurance medical benefits under State law.

PART 3—APPLICATION OF INFORMATION REQUIREMENTS.

SEC. 10121. APPLICATION OF INFORMATION REQUIREMENTS.

(a) IN GENERAL.—The provisions of—

(1) part 3 of subtitle B of title V (relating to use of standard forms), and

(2) section 5101(e)(9) (relating to provision of data on quality),

apply to the provision of automobile insurance medical services in the same manner as such provisions apply with respect to the provision of services included in the comprehensive benefit package.

(b) RULES.—The Secretary of Labor shall promulgate rules to clarify the responsibilities of health plans and automobile insurance carriers in carrying out the provisions referred to in subsection (a).

Subtitle C—COMMISSION ON INTEGRATION OF HEALTH BENEFITS

SEC. 10201. COMMISSION.

(a) ESTABLISHMENT.—There is hereby created a Commission on Integration of Health Benefits (in this section referred to as the "Commission").

(b) COMPOSITION.—

(1) IN GENERAL.—The Commission shall consist of 15 members appointed jointly by the Secretaries of Health and Human Services and the Secretary of Labor.

(2) NO COMPENSATION EXCEPT TRAVEL EXPENSES.—Members of the Commission shall serve without compensation, but the Secretaries shall provide that each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(c) DUTIES.—The Commission shall study the feasibility and appropriateness of transferring financial responsibility for all medical benefits (including those currently covered under workers compensation and automobile insurance) to health plans.

(d) STAFF SUPPORT.—The Secretaries shall provide staff support for the Commission.

(e) REPORT.—The Commission shall submit a report to the President by not later than July 1, 1995. If such report recommends the integration of financial responsibility for all medical benefits in health plans, such report shall provide for a detailed plan as to how (and when) such an integration should be effected under this Act.

(f) TERMINATION.—The Commission shall terminate 90 days after the date of submission of its report under subsection (e).

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle D—Federal Employees' Compensation Act

SEC. 10301. APPLICATION OF POLICY.

(a) IN GENERAL.—Chapter 81 of title 5, United States Code, known as the Federal Employees' Compensation Act shall be interpreted and administered consistent with the provisions of subtitle A.

(b) CONSTRUCTION.—In applying subsection (a), subtitle A shall be applied as if the following modifications had been made in subtitle A:

(1) Any reference in section 10000, section 10001(c)(2)(C), section 10012(b), or section 10014 to a State law is deemed to include a reference to chapter 81 of title 5, United States Code.

(2) The term "workers compensation carrier" includes the Employees Compensation Fund (established under section 8147 of title 5, United States Code).

Subtitle E—Davis-Bacon Act and Service Contract Act

SEC. 10401. COVERAGE OF BENEFITS UNDER HEALTH SECURITY ACT.

(a) DAVIS-BACON ACT.—Section 1(b)(2) of the Davis Bacon Act (40 U.S.C. 276a(b)(2)) is amended in the matter following subparagraph (B) by inserting after "local law" the following: "(other than benefits provided pursuant to the Health Security Act)".

(b) SERVICE CONTRACT ACT OF 1965.—The second sentence of section 2(a)(2) of the Service Contract Act of 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after "local law" the following: "(other than benefits provided pursuant to the Health Security Act)".

Subtitle F—Effective Dates

SEC. 10501. REGIONAL ALLIANCES.

The provisions of subtitles A and B of this title apply to regional alliances, and regional alliance health plans, in a State 2 years after the State's first year (as defined in section 1902(17)).

SEC. 10502. CORPORATE ALLIANCES.

The provisions of subtitles A and B of this title apply to corporate alliances, and corporate alliance health plans, on January 1, 1998.

SEC. 10503. FEDERAL REQUIREMENTS.

The provisions of subtitle D of this title shall take effect on January 1, 1998.

TITLE XI—TRANSITIONAL INSURANCE REFORM

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SEC. 11001. IMPOSITION OF REQUIREMENTS.

(a) IN GENERAL.—The Secretary and the Secretary of Labor shall apply the provisions of this title to assure, to the extent possible, the maintenance of current health care coverage and benefits during the period between the enactment of the Health Security Act and the dates its provisions are implemented in the various States.

(b) ENFORCEMENT.—

(1) HEALTH INSURANCE PLANS.—The Secretary shall enforce the requirements of this title with respect to health insurance plans. The Secretary shall promulgate regulations to carry out the requirements under this title health insurance plans. The Secretary shall promulgate regulations with respect to section 11004 within 90 days after the date of the enactment of this Act.

(2) SELF-INSURED PLANS.—The Secretary of Labor shall enforce the requirements of this title with respect to self-insured plans. Such Secretary shall promulgate regulations to carry out the requirements under this title as they relate to self-funded plans.

(3) ARRANGEMENTS WITH STATES.—The Secretary and the Secretary of Labor may enter into arrangements with a State to enforce the requirements of this title with respect to health insurance plans and self-insured plans issued or sold, or established and maintained, in the State.

(c) PREEMPTION.—The requirements of this title do not preempt any State law unless State law directly conflicts with such requirements. The provision of additional protections under State law shall not be considered to directly conflict with such requirements. The Secretary (or, in the case of a self-insured plan, the Secretary of Labor) may issue letter determinations with respect to whether this Act preempts a provision of State law.

(d) INTERIM FINAL REGULATIONS.—Section 1911 shall apply to regulations issued to carry out this title. The Secretary may consult with States and the National Association of Insurance Commissioners in issuing regulations and guidelines under this title.

(e) CONSTRUCTION.—The provisions of this title shall be construed in a manner that assures, to the greatest extent practicable, continuity of health benefits under health benefit plans in effect on the effective date of this Act.

(f) SPECIAL RULES FOR ACQUISITIONS AND TRANSFERS.—The Secretary may issue regulations regarding the application of this title in the case of health insurance plans (or groups of such plans) which are transferred from one insurer to another insurer through assumption, acquisition, or otherwise.

SEC. 11002. ENFORCEMENT.

(a) IN GENERAL.—Any health insurer or health benefit plan sponsor that violates a requirement of this title shall be subject to civil money penalties of not more than $25,000 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(b) EQUITABLE REMEDIES.—

(1) IN GENERAL.—A civil action may be brought by the applicable Secretary—

(A) to enjoin any act or practice which violates any provision of this title, or

(B) to obtain other appropriate equitable relief (i) to redress such violations, or (ii) to enforce any provision of this title, including, in the case of a wrongful termination of (or refusal to renew) coverage, reinstating coverage effective as of the date of the violation.

SEC. 11003. REQUIREMENTS RELATING TO PRESERVING CURRENT COVERAGE.

(a) PROHIBITION OF TERMINATION.—

(1) GROUP HEALTH INSURANCE PLANS.—Each health insurer that provides a group health insurance plan may not terminate (or fail to renew) coverage for any covered employee if the employer of the employee continues the plan, except in the case of—

(A) nonpayment of required premiums,

(B) fraud, or

(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(2) INDIVIDUAL HEALTH INSURANCE PLANS.—Each health insurer that provides coverage to a covered individual under an individual health insurance plan may not terminate (or fail to renew) coverage for such individual (or a covered dependent), except in the case of—

(A) nonpayment of required premiums,

(B) fraud, or

(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(2) EFFECTIVE DATE OF TITLE.—

(A) IN GENERAL.—This subsection shall take effect on the effective date of this title and shall apply to coverage on or after such date.

(B) DEFINITION.—Except as otherwise provided, in this title the term "effective date of this title" means the date of the enactment of this Act.

(b) ACCEPTANCE OF NEW MEMBERS IN A GROUP HEALTH INSURANCE PLAN.—

(1) IN GENERAL.—In the case of a health insurer that provides a group health insurance plan that is in effect on the effective date of this title, the insurer is required—

(A) to accept all individuals, and their eligible dependents, who become full-time employees (as defined in section 1901(b)(2)(C)) of an employer covered after such effective date;

(B) to establish and apply premium rates that are consistent with section 11004(b); and

(C) to limit the application of pre-existing condition restrictions in accordance with section 11005.

(2) CONSISTENT APPLICATION OF RULES RELATING TO DEPENDENTS AND WAITING PERIODS.—In this subsection, the term "eligible dependent", with respect to a group health insurance plan, has the meaning provided under the plan as of the date of introduction of the Health Security Act or, in the case of a plan not established as of such date, as of the date of establishment of the plan.

SEC. 11004. RESTRICTIONS ON PREMIUM INCREASES DURING TRANSITION.

(a) DIVISION OF HEALTH INSURANCE PLANS BY SECTOR.—For purposes of this section, each health insurer shall divide its health insurance business into the following 3 sectors:

(1) Health insurance for groups with at least 100 covered lives (in this section referred to as the "large group sector")

(2) Health insurance for groups with fewer than 100 covered lives (in this section referred as the "small group sector").

(3) Health insurance for individuals, and not for groups (in this section referred to as the "individual sector").

(b) PREMIUM CHANGES TO REFLECT CHANGES IN GROUP OR INDIVIDUAL CHARACTERISTICS OR TERMS OF COVERAGE.—

(1) APPLICATION.—The provisions of this subsection shall apply to changes in premiums that reflect—

(A) changes in the number of individuals covered under a plan;

(B) changes in the group or individual characteristics (including age, gender, family composition or geographic area but not including health status, claims experience or duration of coverage under the plan) of individuals covered under a plan;

(C) changes in the level of benefits (including changes to in cost-sharing) under the plan; and

(D) changes in any material terms and conditions of the health insurance plan (other than factors related to health status, claims experience and duration).

(2) SPECIFICATION OF REFERENCE RATE FOR EACH SECTOR.—Each health insurer shall calculate a reference rate for each such sector. The reference rate for a sector shall be calculated so that, if it were applied using the rate factors specified under paragraph (3), the average premium rate for individuals

and groups in that sector would approximate the average premium rate charged individuals and groups in the sector as of the effective date of this title.

(3) SINGLE SET OF RATE FACTORS WITHIN EACH SECTOR.—

(A) IN GENERAL.—Each health insurer shall develop for each sector a single set of rate factors which will be used to calculate any changes in premium that relate to the reasons described in subparagraphs (B) through (D) of paragraph (1).

(B) STANDARDS.—Such rate factors—

(i) shall relate to reasonable and objective differences in demographic characteristics, in the design and in levels of coverage, and in other terms and conditions of a contract,

(ii) shall not relate to expected health status, claims experience, or duration of coverage of the one or more groups or individuals, and

(iii) shall comply with regulations established under subsection (f).

(4) COMPUTATION OF PREMIUM CHANGES.—

(A) IN GENERAL.—Changes in premium rates that relate to the reasons described in paragraph (1) shall be calculated using the rate factors developed pursuant to paragraph (3).

(B) APPLICATION TO CHANGES IN NUMBER OF COVERED INDIVIDUALS.—In the case of a change in premium rates related to the reason described in paragraph (1)(A), the change in premium rates shall be calculated to reflect, with respect to the enrollees who enroll or disenroll in a health insurance plan, the sum of the products, for such individuals, of the reference rate (determined under paragraph (2)) and the rate factors (specified under paragraph (3)) applicable to such enrollees.

(C) APPLICATION OF OTHER FACTORS.—

(i) IN GENERAL.—In the case of a change in premium rates related to a reason described in subparagraph (B), (C), or (D) of paragraph (1), the change in premium rates with respect to each health insurance plan in each sector shall reflect the rate factors specified under paragraph (3) applicable to the reason as applied to the current premium charged for the health insurance plan. Such rate factors shall be applied in a manner so that the resulting adjustment, to the extent possible, reflects the premium that would have been charged under the plan if the reason for the change in premium had existed at the time that the current premium rate was calculated.

(ii) NO REFLECTION OF CHANGE IN HEALTH STATUS.—In applying the rate factors under this subparagraph, the adjustment shall not reflect any change in the health status, claims experience or duration of coverage with respect to any employer or individual covered under the plan.

(5) LIMITATION ON APPLICATION.—This subsection shall only apply—

(A) to changes in premiums occurring on or after the date of the enactment of this Act to groups and individuals covered as of such date, and

(B) with respect to groups and individuals subsequently covered, to changes in premiums subsequent to such coverage.

(6) APPLICATION TO COMMUNITY-RATED PLANS.—Nothing in this subsection shall require the application of rate factors related to individual or group characteristics with respect to community-rated plans.

(c) LIMITATIONS ON CHANGES IN PREMIUMS RELATED TO INCREASES IN HEALTH CARE COSTS AND UTILIZATION.—

(1) APPLICATION.—The provisions of this subsection shall apply to changes in premiums that reflect increases in health care costs and utilization.

(2) EQUAL INCREASE FOR ALL PLANS IN ALL SECTORS.—

(A) IN GENERAL.—Subject to subparagraph (B), the annual percentage increase in premiums by a health insurer for health insurance plans in the individual sector, small group sector, and large group sector, to the extent such increase reflect increases in health care costs and utilization, shall be the same for all such plans in those sectors.

(B) SPECIAL RULE FOR LARGE GROUP SECTOR.—The annual percentage increase in premiums by a health insurer for health insurance plans in the large group sector may vary among such plans based on the claims experience of such employer (to the extent the experience is credible), so long as the weighted average of such increases for all such plans in the sector complies with the requirement of subparagraph (A).

(C) GEOGRAPHIC APPLICATION.—Subparagraphs (A) and (B)—

(i) may be applied on a national level, or

(ii) may vary based on geographic area, but only if (I) such areas are sufficiently large to provide credible data on which to calculate the variation and (II) the variation is due to reasonable factors related to the objective differences among such areas in costs and utilization of health services.

(D) EXCEPTIONS TO ACCOMMODATE STATE RATE REFORM EFFORTS.—Subparagraphs (A) and (B) shall not apply, in accordance with guidelines of the Secretary, to the extent necessary to permit a State to narrow the variations in premiums among health insurance plans offered by health insurers to similarly situated groups or individuals within a sector.

(E) EXCEPTION FOR RATES SUBJECT TO PRIOR APPROVAL.—Subparagraphs (A) and (B) shall not apply to premiums that are subject to prior approval by a State insurance commissioner (or similar official) and are approved by such official.

(F) OTHER REASONS SPECIFIED BY THE SECRETARY.—The Secretary may specify through regulations such other exceptions to the provisions of this subsection as the Secretary determines are required to enhance stability of the health insurance market and continued availability of coverage.

(3) EVEN APPLICATION THROUGHOUT A YEAR.—In applying the provisions of this subsection to health insurance plans that are renewed in different months of a year, the annual percentage increase shall be applied in a consistent, even manner so that any variations in the rate of increase applied in consecutive months are even and continuous during the year.

(4) PETITION FOR EXCEPTION.—A health insurer may petition the Secretary (or a State acting under a contract with the Secretary under section 11001(b)(3)) for an exception from the application of the provisions of this subsection. The Secretary may approve such an exception if—

(A) the health insurer demonstrates that the application of this subsection would threaten the financial viability of the insurer, and

(B) the health insurer offers an alternative method for increasing premiums that is not substantially discriminatory to any sector or to any group or individual covered by a health insurance plan offered by the insurer.

(d) PRIOR APPROVAL FOR CERTAIN RATE INCREASES.—

(1) IN GENERAL.—If the percentage increase in the premium rate for the individual and small group sector exceeds a percentage specified by the Secretary under paragraph (2), annualized over any 12-month period, the increase shall not take effect unless the Secretary (or a State acting under a contract with the Secretary under section 11001(b)(3)) has approved the increase.

(2) PERCENTAGE.—The Secretary shall specify, for each 12-month period beginning after the date of the enactment of this Act, a percentage that will apply under paragraph (1). Such percentage shall be determined taking into consideration the rate of increase in health care costs and utilization, previous trends in health insurance premiums, and the conditions in the health insurance market. Within 30 days after the date of the enactment of this Act, the Secretary shall first specify a percentage under this paragraph.

(e) DOCUMENTATION OF COMPLIANCE.—

(1) PERIOD FOR CONFORMANCE.—Effective 1 year after the date of the enactment of this Act, the premium for each policy shall be conformed in a manner that complies with the provisions of this section.

(2) METHODOLOGY.—Each health insurer shall document the methodology used in applying subsections (b) and (c) with respect to each sector (and each applicable health plan). Such documentation shall be sufficient to permit the auditing of the application of such methodology to determine if such application was consistent with such subsections.

(3) CERTIFICATION.—For each 6-month period in which this section is effective, each health insurer shall file a certification with the Secretary (or with a State with which the Secretary has entered into an arrangement under section 11001(b)(3)) that the insurer is in compliance with such requirements.

(f) REGULATIONS.—The Secretary shall establish regulations to carry out this section. Such regulations may include guidelines relating to the permissible variation that results from the use of demographic or other characteristics in the development of rate factors. Such guidelines may be based on the guidelines currently used by States in applying rate limitations under State insurance regulations.

(g) EFFECTIVE PERIOD.—This section shall apply to premium increases occurring during the period beginning on the date of the enactment of this Act and ending, for a health insurance plan provided in a State, on the first day of the State's first year.

SEC. 11005. REQUIREMENTS RELATING TO PORTABILITY.

(a) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a group health benefit plan may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns or in the case of a plan that did not apply such exclusions as of the effective date of this title.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A group health benefit plan shall provide that if an individual covered under such plan is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) DEFINITIONS.—As used in this paragraph:

(i) PERIOD OF CONTINUOUS COVERAGE.—The term "period of continuous coverage" means, with respect to particular services, the period beginning on the date an individual is enrolled under a group or individual health benefit plan, self-insured plan, the medicare program, a State medicaid plan, or other health benefit arrangement which provides benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(ii) PREEXISTING CONDITION.—The term "preexisting condition" means, with respect to coverage under a health benefits plan, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(b) WAITING PERIODS.—A self-insured plan, and an employer with respect to a group health insurance plan, may not discriminate among employees in the establishment of a waiting period before making health insurance coverage available based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of the employee or the employee's dependents.

SEC. 11006. REQUIREMENTS LIMITING REDUCTION OF BENEFITS.

(a) IN GENERAL.—A self-insured sponsor may not make a modification of benefits described in subsection (b).

(b) MODIFICATION OF BENEFITS DESCRIBED.—

(1) IN GENERAL.—A modification of benefits described in this subsection is any reduction or limitation in coverage, effected on or after the effective date of this title, with respect to any medical condition or course of treatment for which the anticipated cost is likely to exceed $5,000 in any 12-month period.

(2) TREATMENT OF TERMINATION.—A modification of benefits includes the termination of a plan if the sponsor, within a period establishes a substitute plan that reflects the reduction or limitation described in paragraph (1).

(c) REMEDY.—Any modification made in violation of this section shall not be effective and the self-insured sponsor shall continue to provide benefits as though the modification (described in subsection (b)) had not occurred.

SEC. 11007. NATIONAL TRANSITIONAL HEALTH INSURANCE RISK POOL.

(a) ESTABLISHMENT.—In order to assure access to health insurance during the transition, the Secretary is authorized to establish a National Transitional Health Insurance Risk Pool (in this section referred to as the "national risk pool") in accordance with this section.

(b) ADMINISTRATION.—

(1) IN GENERAL.—The Secretary may administer the national risk pool through contracts with—

(A) one or more existing State health insurance risk pools,

(B) one or more private health insurers, or

(C) such other contracts as the Secretary deems appropriate.

(2) COORDINATION WITH STATE RISK POOLS.—The Secretary may enter into such arrangements with existing State health insurance risk pools to coordinate the coverage under such pools with the coverage under the national risk pool. Such coordination may address eligibility and funding of coverage for individuals currently covered under State risk pools.

(c) ELIGIBILITY FOR COVERAGE.—The national risk pool shall provide health insurance coverage to individuals who are unable to secure health insurance coverage from private health insurers because of their health status or condition (as determined in accordance with rules and procedures specified by the Secretary).

(d) BENEFITS.—

(1) IN GENERAL.—Benefits and terms of coverage provided through the national risk pool shall include items and services, conditions of coverage, and cost sharing (subject to out-of-pocket limits on cost sharing) comparable to the benefits and terms of coverage available in State health insurance risk pools.

(2) PAYMENT RATES.—Payments under the national risk pool for covered items and services shall be made at rates (specified by the Secretary) based on payment rates for comparable items and services under the medicare program. Providers who accept payment from the national risk pool shall accept such payment as payment in full for the service, other than for cost sharing provided under the national risk pool.

(e) PREMIUMS.—

(1) IN GENERAL.—Premiums for coverage in the national risk pool shall be set in a manner specified by the Secretary.

(2) VARIATION.—Such premiums shall vary based upon age, place of residence, and other traditional underwriting factors other than on the basis of health status or claims experience.

(3) LIMITATION.—The premiums charged individuals shall be set at a level that is no less than 150 percent of the premiums that the Secretary estimates would be charged to a population of average risk for the covered benefits.

(f) TREATMENT OF SHORTFALLS.—

(1) ESTIMATES.—The Secretary shall estimate each year the extent to which the total premiums collected under subsection (c) in the year are insufficient to cover the expenses of the national risk pool with respect to the year.

(2) TEMPORARY BORROWING AUTHORITY.—The Secretary of the Treasury is authorized to advance to the Secretary amounts sufficient to cover the amount estimated under paragraph (1) during the year before assessments are collected under paragraph (3). The Secretary shall repay such amounts, with interest at a rate specified by the Secretary of the Treasury, from the assessments under paragraph (3).

(3) ASSESSMENTS.—

(A) IN GENERAL.—Each health benefit plan sponsor shall be liable for an assessment in the amount specified in subparagraph (C).

(B) AMOUNT.—For each year for which amounts are advanced under paragraph (2), the Secretary shall—

(i) estimate the total amount of premiums (and premium equivalents) for health benefits under health benefit plans for the succeeding year, and

(ii) calculate a percentage equal to (I) the total amounts repayable by the Secretary to the Secretary of the Treasury under paragraph (2) for the year, divided by the amount determined under clause (i).

(C) ASSESSMENT AMOUNT.—The amount of an assessment for a sponsor of a health benefit plan for a year shall be equal to the percentage calculated under subparagraph (B)(ii) (or, if less, ½ of 1 percent) of the total amount of premiums (and premium equivalents) for health benefits under the plan for the previous year.

(D) SELF-INSURED PLANS.—The amount of premiums (and premium equivalents) under this paragraph shall be estimated—

(i) by the Secretary for health insurance plans, and

(ii) by the Secretary of Labor for self-insured plans.

Such estimates may be based on a methodology that requires plans liable for assessment to file information with the applicable Secretary.

SEC. 11008. DEFINITIONS.

In this title:

(1) APPLICABLE SECRETARY.—The term "applicable Secretary" means—

(A) the Secretary with respect to health insurance plans and insurers, or

(B) the Secretary of labor with respect to self-insured plans and self-insured plan sponsors.

(2) COVERED EMPLOYEE.—The term "covered employee" means an employee (or dependent of such an employee) covered under a group health benefits plan.

(3) COVERED INDIVIDUAL.—The "covered individual" means, with respect to a health benefit plan, an individual insured, enrolled, eligible for benefits, or otherwise covered under the plan.

(4) GROUP HEALTH BENEFITS PLAN.—The term "group health benefits plan" means a group health insurance plan and a self-insured plan.

(5) GROUP HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—The term "group health insurance plan" means a health insurance plan offered primarily to employers for the purpose of providing health insurance to the employees (and dependents) of the employer.

(B) INCLUSION OF ASSOCIATION PLANS AND MEWAS.—Such term includes—

(i) any arrangement in which coverage for health benefits is offered to employers through an association, trust, or other arrangement, and

(ii) a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), whether funded through insurance or otherwise.

(6) HEALTH BENEFITS PLAN.—The term "health benefits plan" means health insurance plan and a self-insured health benefit plan.

(7) HEALTH BENEFIT PLAN SPONSOR.—The term "health benefit plan sponsor" means, with respect to a health insurance plan or self-insured plan, the insurer offering the plan or the self-insured sponsor for the plan, respectively.

(8) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance plan" means any contract of health insurance, including any hospital or medical service policy or certificate, any major medical policy or certificate, any hospital or medical service plan contract, or health maintenance organization subscriber contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

(i) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical-payment insurance,

or any combination thereof.

(C) STOP LOSS INSURANCE NOT COVERED.—Such term does not include any aggregate or

specific stop-loss insurance or similar coverage applicable to a self-insured plan. The Secretary may develop rules determining the applicability of this subparagraph with respect to minimum premium plans or other partially insured plans.

(9) HEALTH INSURER.—The term "health insurer" means a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or other entity providing a plan of health insurance or health benefits with respect to which the State insurance laws are not preempted under section 514 of the Employee Retirement Income Security Act of 1974.

(10) INDIVIDUAL HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—The term "individual health insurance plan" means any health insurance plan directly purchased by an individual or offered primarily to individuals (including families) for the purpose of permitting individuals (without regard to an employer contribution) to purchase health insurance coverage.

(B) INCLUSION OF ASSOCIATION PLANS.—Such term includes any arrangement in which coverage for health benefits is offered to individuals through an association, trust, list-billing arrangement, or other arrangement in which the individual purchaser is primarily responsible for the payment of any premium associated with the contract.

(C) TREATMENT OF CERTAIN ASSOCIATION PLANS.—In the case of a health insurance plan sponsored by an association, trust, or other arrangement that provides health insurance coverage both to employers and to individuals, the plan shall be treated as—

(i) a group health insurance plan with respect to such employers, and

(ii) an individual health insurance plan with respect to such individuals.

(11) SELF-INSURED PLAN.—The term "self-insured plan" means an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides benefits with respect to some or all of the items and services included in the comprehensive benefit package (as in effect as of January 1, 1995) that is funded in a manner other than through the purchase of one or more health insurance plans. such term shall not include a group health insurance plan (as defined in paragraph (5)(B)(ii)).

(12) SELF-INSURED SPONSOR.—The term "self-insured sponsor" includes, with respect to a self-insured plan, any entity which establishes or maintains the plan.

(13) STATE COMMISSIONER OF INSURANCE.—The term "State commissioner of insurance" includes a State superintendent of insurance.

SEC. 11009. TERMINATION.

(a) HEALTH INSURANCE PLANS.—The provisions of this title shall not apply to a health insurance plan provided in a State on and after the first day of the first year for the State.

(b) SELF-INSURED PLANS.—The provisions of this title shall not apply to a self-insured plan that—

(1) is sponsored by a sponsor that is an eligible sponsor of a corporate alliance (described in section 1311(b)(1)), as of the effective date of the election under section 1312(c).

(2) is sponsored by a sponsor that is not such an eligible sponsor, with respect to individuals or groups in a State on and after the first day of the first year for the State.

TITLE XII—TEMPORARY ASSESSMENT ON EMPLOYERS WITH RETIREE HEALTH BENEFIT COSTS

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Sec. 1201. Temporary assessment on employers with retiree health benefit costs.
Sec. 1202. Recapture of retiree subsidy beginning in 1998.

SEC. 1201. TEMPORARY ASSESSMENT ON EMPLOYERS WITH RETIREE HEALTH BENEFIT COSTS.

(a) IN GENERAL.—Subtitle C (relating to employment taxes) is amended by inserting after chapter 24A the following new chapter:

"CHAPTER 24B—TEMPORARY ASSESSMENT ON EMPLOYERS WITH RETIREE HEALTH BENEFIT COSTS

"Subchapter A. Temporary assessment.
"Subchapter B. Definitions and administrative provisions.

"Subchapter A—Temporary Assessment

"Sec. 3463. Temporary assessment on employers with retiree health benefit costs.

"SEC. 3463. TEMPORARY ASSESSMENT ON EMPLOYERS WITH RETIREE HEALTH BENEFIT COSTS.

"(a) IMPOSITION OF ASSESSMENT.—Every employer with base period retiree health costs shall pay (in addition to any other amount imposed by this subtitle) for each calendar year to which this section applies an assessment equal to the amount determined under subsection (b).

"(b) AMOUNT OF ASSESSMENT.—For purposes of subsection (a), the amount determined under this subsection with respect to any employer for any calendar year is 50 percent of the greater of—

"(1) the adjusted base period retiree health costs of such employer for such calendar year, or

"(2) the amount (determined in the manner prescribed by the Secretary) by which such employer's applicable retiree health costs for such calendar year were reduced by reason of the enactment of the Health Security Act.

"(c) DEFINITIONS.—For purposes of this section—

"(1) BASE PERIOD RETIREE HEALTH COSTS.—The term 'base period retiree health costs' means the average of the applicable retiree health costs of the employer for calendar years 1991, 1992, and 1993.

"(2) ADJUSTED BASE PERIOD RETIREE HEALTH COSTS.—

"(A) IN GENERAL.—The term 'adjusted base period retiree health costs' means, with respect to any employer for any calendar year, the base period retiree health costs of the employer adjusted in the manner prescribed by the Secretary to reflect increases in the medical care component of the Consumer Price Index during the period after 1992 and before such calendar year.

"(B) ADJUSTMENTS FOR ACQUISITIONS AND DISPOSITIONS.—Rules similar to the rules of subparagraphs (A) and (B) of section 41(f)(3) shall apply to acquisitions and dispositions after December 31, 1993.

"(3) APPLICABLE RETIREE HEALTH COSTS.—

"(A) IN GENERAL.—The term 'applicable retiree health costs' means, with respect to any employer for any calendar year, the aggregate cost (including administrative costs) of the health benefits or coverage provided during such calendar year (whether directly by the employer or through a plan described in section 401(h) or a welfare benefit fund as defined in section 419(e)) to individuals who are entitled to receive such benefits or coverage by reason of being retired employees of such employer (or by reason of being a spouse or other beneficiary of such an employee).

"(B) ONLY BENEFITS AND COVERAGE AFTER AGE 55 AND BEFORE AGE 65 TAKEN INTO ACCOUNT.—In applying subparagraph (A), there shall be taken into account only health benefits and coverage provided after the date the retired employee attained age 55 and before the date such employee attained (or, but for the death of such employee, would have attained) age 65.

"(d) YEARS TO WHICH ASSESSMENT APPLIES.—This section shall apply to calendar years 1998, 1999, and 2000.

"Subchapter B—Definitions and Administrative Provisions

"SEC. 3464. DEFINITIONS AND ADMINISTRATIVE PROVISIONS

"(a) EMPLOYER.—For purposes of this chapter—

"(1) IN GENERAL.—The term 'employer' means any person or governmental entity for whom an individual performs services, of whatever nature, as an employee (as defined in section 3401(c)).

"(2) SPECIAL RULES.—

"(A) An individual who owns the entire interest in an unincorporated trade or business shall be treated as his own employer.

"(B) A partnership shall be treated as the employer of each partner who is an employee within the meaning of section 401(c)(1).

"(C) An S corporation shall be treated as the employer of each shareholder who is an employee within the meaning of section 401(c)(1).

"(b) ASSESSMENT TO APPLY TO GOVERNMENTAL AND OTHER TAX-EXEMPT ENTITIES.—Notwithstanding any other provision of law or rule of law, none of the following shall be exempt from the assessment imposed by this chapter:

"(1) The United States, any State or political subdivision thereof, the District of Columbia, and any agency or instrumentality of any of the foregoing.

"(2) Any other entity otherwise exempt from tax under chapter 1.

"(c) ADMINISTRATIVE PROVISIONS.—

"(1) PAYMENT.—Any assessment under section 3463 for any calendar year shall be paid on or before March 15 of the following calendar year; except that the Secretary may require quarterly estimated payments of such assessment in a manner similar to the requirements of section 6655.

"(2) COLLECTION, ETC.—For purposes of subtitle F, any assessment under this subchapter shall be treated as if it were a tax imposed by this subtitle."

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle C is amended by inserting after the item relating to chapter 24A the following new item:

"Chapter 24B. Temporary Assessment on Employers With Retiree Health Benefit Costs."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1998.

SEC. 1202. RECAPTURE OF RETIREE SUBSIDY BEGINNING IN 1998.

(a) IN GENERAL.—Paragraph (2) of section 59B(a) (relating to recapture of certain health care subsidies), as added by title VII of this Act, is amended by striking "December 31, 1999" and inserting "December 31, 1997".

(b) TECHNICAL AMENDMENT.—Paragraph (2) of section 7131(d) of this Act is amended by striking "December 31, 2001" and inserting "December 31, 1999".

THE COMMISSION ON CLOSURE AND RELOCATION OF THE LORTON CORRECTIONAL COMPLEX

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. WOLF. Mr. Speaker, yesterday the Washington Post reported that D.C. Mayor Sharon Pratt Kelly wants to build an additional maximum-security prison in Lorton, VA. The District of Columbia is plagued by violent crime and a comprehensive approach to corrections can be part of the solution.

Merely adding more beds at Lorton will not help the crime problem in the District. That is why today I am reintroducing legislation I introduced in the 102d Congress which would establish a commission to consider the closing and relocation of the Lorton Correctional Complex.

In 1908, President Theodore Roosevelt established a commission to study overcrowding at the District jail and to make recommendations to correct overcrowding at the District jail.

In providing Congress with the results of that commission's work in 1909, President Roosevelt wrote:

> The report sets forth vividly the really outrageous conditions in the workhouse and jail. The overcrowding is great in the workhouse, and greater still in the jail where, of the six hundred inmates, five hundred are serving sentences in absolute idleness, with no employment and no exercise * * * It is no longer a question as to what shall be done, but only a question whether something shall be done, for it is quite impossible that the existing condition should continue. The present antiquated and unsatisfactory plan ought not to be considered for a moment.

The parallels between the present situation and those described by President Roosevelt in 1908 are remarkable. Today, more than 80 years later, District prisoners still serve their sentences in absolute idleness and many of the concerns that led to the establishment of Lorton 80 years ago still exist. We need a comprehensive approach to deal with the crime epidemic in the District. I believe the District needs a state-of-the-art facility which will aid in rehabilitating criminals and humanely incarcerating them instead of releasing individuals who become even more violent while imprisoned.

The Lorton Correctional Complex is a graduate school for criminals. It is a finishing school from which inmates depart unprepared to deal with life in society, but highly trained to commit crime.

The victims of this system are residents of the District of Columbia who are terrorized by the crime that has swept this city for the past few years. Ironically, it is these same District residents whose tax dollars are being spent to arrest, convict, and incarcerate these individuals.

Serious crimes are being committed at record levels in Washington. Andcertainly while not every crime in D.C. is being committed by people who have previously served at Lorton, a substantial and troubling number are.

Columnist Jack Anderson has commented that Lorton is a "graduate school for Washington drug merchants." "They may go in with a high school education in crime, but they come out with a doctorate."

A 1986 U.S. General Accounting Office [GAO] report supports his contention. The report found that nearly 7 of 10—68 percent—of adult inmates at Lorton at the time of the study has previously been convicted of a felony offense in the District of Columbia and incarcerated at Lorton. About one-third of the adult inmates had been previously convicted and incarcerated at Lorton more than once.

In simple terms these individuals are committing serious crimes, serving time at Lorton, leaving Lorton and returning to the District of Columbia to commit more crimes. A comprehensive examination of Lorton's housing, drug treatment programs, education programs, vocational training programs, and work programs is required to stop the revolving door of criminals who pass in and out of the gates of Lorton daily.

There is general agreement among experts the field of corrections that there are serious problems at Lorton.

Numerous reports have cited problems including: cronic overcrowding; inmate idleness; widespread drug use among inmates; poor inmate living conditions; aging facilities and housing sometimes inappropriate for dangerous inmates; inadequate education and training programs; insufficient work programs; and frequent violence aimed at fellow inmates and guards.

Each of these problems play on the others. For example, the problem of overcrowding increases the likelihood of violence among inmates as does drug use among inmates. Limited educational and rehabilitation programs mean that inmates leave the institution unprepared for life in society and often fall back into lives of crime which in turn worsens the problem of overcrowding.

The problems at Lorton are not unique among similar institutions nationwide. Because of the number of factors—for example, high incarceration rates, aging facilities, etc.—the problems at Lorton are sometimes of greater magnitude than other institutions.

I believe that the D.C. Department of Corrections has done a good job with limited resources and my remarks today are not meant in any way to criticize them. I believe that nothing short of radical reform is required, and am prepared to work with the Mayor on embarking on an ambitious plan to stop the revolving crime door at Lorton.

In his second annual message to the Nation, President Roosevelt wrote:

> The correctional system of the district should receive consideration at the hands of Congress to the end that they may embody the results of the most advanced thought in the fields.

I agree with President Roosevelt. To that end, the legislation I am introducing would establish a commission to develop a plan for the establishment of a new "model" prison facilities to be located at sites within the District of Columbia and for the closure of Lorton.

The commission would have 21 members, 9 appointed by Mayor Kelly, 9 appointed by the Fairfax County Board of Supervisors, and 3 appointed by the President.

The commission will have three responsibilities:

First, developing a plan for new model prison facilities located in the District of Columbia: The Commission will also be charged with developing a plan for establishing a new model prison in the District of Columbia to replace Lorton.

The commission will inventory existing potential sites in the District, perhaps Bolling Air Force Base, St. Elizabeths Hospital, or some other area, and select appropriate sites for the new prison facilities.

The new prison should be a model prison. It should incorporate the most advanced, progressive, and imaginative ideas in the field of corrections in both design and operation. It should be an example from which other prison systems across the country can draw new ideas and solutions and should be an institution which others throughout the country, seek to emulate.

Model programs in alcohol and drug abuse treatment, education, vocational training and rehabilitation must be included in the new facilities. The newest thinking in the area of prison industries should also be incorporated so that inmates develop skills that will enable them to secure jobs upon leaving prison.

Second, developing a plan for closing Lorton: The Commission will be charged with developing a comprehensive plan for closing the Lorton Correctional Complex by the year 2010 and in the plan shall identify and recommend options for the use of the land on which the complex is located such as a community park.

Third, steps for improving operations at Lorton: Last, the commission should identify and recommend appropriate strategies for improving the effectiveness of operations of Lorton until a new D.C. facility is built.

Clearly, these are big ideas. Closing and building prisons are not easy tasks. But a new prison in the District of Columbia will make a difference.

A new model prison will allow for the development of academic and vocational training programs to help inmates develop basic life skills and a trade that can be used upon release to avoid a future life of crime. Crowded conditions could be relieved. Living conditions could be improved. Security conditions could be strengthened within the prison.

It is in the interest of Fairfax County, the Commonwealth of Virginia, the District of Columbia, and the Federal Government to work together in resolving the problems at Lorton. As partners, contributing to the establishment of a new prison, these goals can be accomplished.

Mr. Speaker, President William Howard Taft, who succeeded Theodore Roosevelt as President, commented on the D.C. jail in 1909:

> It is a reproach to the National Government that almost under the shadow of the Capitol Dome prisoners should be confined in a building destitute of the ordinary decent appliances requisite to cleanliness and sanitary conditions.

That condition, and worse, still exists today at Lorton. Establishment of this commission will be the first step in the process, and I am

committed to working with District officials toward that end.

H.R. —

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Commission on Closure and Relocation of the Lorton Correctional Complex Act".

SEC. 2. ESTABLISHMENT

There is established a commission to be known as the Commission on Closure and Relocation of the Lorton Correctional Complex (in this Act referred to as the "Commission").

SEC. 3. DUTIES OF COMMISSION.

The Commission shall carry out the following:

(1) COMPREHENSIVE PLAN FOR CLOSING THE LORTON CORRECTIONAL COMPLEX BY 2010.—Because of the serious operational and safety problems at the Lorton Correctional Complex which adversely affect the inmates of the complex, employees of the District of Columbia Department of Corrections, and residents of the District of Columbia and Fairfax County, Virginia, the Commission shall develop a comprehensive plan for closing the Lorton Correctional Complex by the year 2010 and in the plan shall identify and recommend options for the use of the land on which the complex is located.

(2) PLAN FOR NEW PRISON FACILITIES LOCATED WITHIN THE DISTRICT OF COLUMBIA.—The Commission shall develop a comprehensive plan for the establishment of new model prison facilities within the District of Columbia to replace the Lorton Correctional Complex when it is closed in accordance with the plan developed under paragraph (1). The plan shall identify and recommend—

(A) appropriate sites for the new prison facilities,

(B) strategies for financing, including Federal funding for, the new facilities,

(C) plans for expeditiously phasing in the operations of the new facilities, and

(D) plans for ensuring that the new facilities will be models in education, vocational training, and rehabilitation of the inmates of the facilities.

(3) STEPS FOR IMPROVING OPERATIONS AT THE LORTON CORRECTIONAL COMPLEX.—The Commission, using existing knowledge, resources and experience, shall identify and recommend appropriate strategies for improving the effectiveness and safety of operations at the Lorton Correctional Complex before it is closed under the plan developed under paragraph (1) and the new facilities are established under the plan developed under paragraph (2).

SEC. 4. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 21 members appointed as follows:

(1) The Fairfax County Board of Supervisors shall appoint 9 members.

(2) The Mayor of the District of Columbia shall appoint 9 members.

(3) The President shall appoint 3 members.

(b) REQUIREMENTS FOR CERTAIN MEMBERS.—

(1) MEMBERS APPOINTED BY THE FAIRFAX COUNTY BOARD OF SUPERVISORS.—Of the members of the Commission appointed under subsection (a)(1)—

(A) at least one member shall be an individual who is a member of a local civic association in northern Virginia,

(B) at least one member shall be an employee of the Virginia Department of Corrections who is knowledgeable about the establishment of new prison facilities,

(C) at least one member shall be a member of the Fairfax County Board of Supervisors,

(D) at least one member shall be a member of a chamber of commerce in northern Virginia.

(E) at least one member shall be an employee of the Fairfax County Sheriff's Department, and

(F) at least one member shall be an employee of the Fairfax County Police Department.

(2) MEMBERS APPOINTED BY THE MAYOR OF THE DISTRICT OF COLUMBIA.—Of the members of the Commission appointed under subsection (a)(2)—

(A) at least one member shall be a member of a local civic association in the District of Columbia.

(B) at least one member shall be an employee of the District of Columbia Department of Corrections who is knowledgeable about the establishment of new prison facilities.

(C) at least one member shall be either the Mayor of the District of Columbia or a member of the District of Columbia City Council,

(D) at least one member shall be a member of a chamber of commerce in the District of Columbia or the Washington Board of Trade, and

(E) at least 2 members shall be employees of the District of Columbia Metropolitan Police Department.

(3) MEMBERS APPOINTED BY THE PRESIDENT.—Of the members of the Commission appointed under subsection (a)(3)—

(A) one member shall be the Director of the Bureau of Prisons, and

(B) one member shall be the Director of the National Institute of Corrections.

(c) CONTINUATION OF MEMBERSHIP.—

(1) GENERAL RULE.—Except as provided in paragraph (2), if a member was appointed to the Commission because the member was an officer or employee of any government or if member is appointed to the Commission and later becomes an officer or employee of a government, that member may continue as a member for not longer than the 30-day period beginning on the date that member ceases to be such an officer or employee of becomes such an officer or employee, as the case may be.

(2) EXCEPTION.—Service as a member of the Commission shall not be discontinued because of paragraph (1) if an individual has served as a member of the Commission for not less than 3 months.

(d) TERMS.—Each member of the Commission shall be appointed for the life of the Commission.

(e) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(f) COMPENSATION.—Members of the Commission may not receive additional pay, allowances, or benefits by reason of their service on the Commission.

(g) QUORUM.—11 members of the Commission shall constitute a quorum but a lesser number may hold hearings.

(h) CHAIRPERSON; VICE CHAIRPERSON.—The Chairperson and Vice Chairperson of the Commission shall be elected by a majority of the members of the Commission.

SEC. 5. DIRECTOR AND STAFF OF COMMISSION; EXPERTS AND CONSULTANTS.

(a) DIRECTOR.—The Commission shall, without regard to section 5311(b) of title 5, United States Code, have a Director who shall be appointed by the Commission and paid at the rate of basic pay payable for level III of the Executive Schedule.

(b) APPOINTMENT AND PAY OF STAFF.—The Commission may appoint personnel as it considers appropriate without regard to the provisions of title 5, United States Code, governing appointment to the competitive service. Such personnel shall be paid in accordance with the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification and General Schedule pay rates.

(c) EXPERTS AND CONSULTANTS.—The Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(d) STAFF OF FEDERAL AGENCIES.—Upon request the Commission, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of that department or agency to the Commission to assist it in carrying out its duties under section 3.

SEC. 6. POWER OF COMMISSION.

(a) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this Act, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate. The Commission may administer oaths or affirmations to witnesses appearing before it.

(b) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action which the Commission is authorized to take by this section.

(c) INFORMATION.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out section 3. Upon request of the Chairperson or Vice Chairperson of the Commission, the head of that department or agency shall furnish that information to the Commission to the extent otherwise permitted by law.

(d) GIFTS AND DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(e) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(f) ADMINISTRATIVE SUPPORT SERVICES.—The Administrator of General Services shall provide to the Commission, on a reimbursable basis, such administrative support services as the Commission may request.

SEC. 7. REPORTS.

(a) INTERIM REPORTS.—The Commission shall submit to the Fairfax County Board of Supervisors, the Mayor of the District of Columbia, and appropriate Committees of Congress interim reports. Such reports shall be submitted at the end of the 6th and 12th month after the date of the enactment of this Act.

(b) FINAL REPORT.—The Commission shall transmit a final report to the Fairfax County Board of Supervisors, the Mayor of the District of Columbia, the President, and appropriate committees of the Congress not later than 18 months after the date of the enactment of this Act. The final report shall contain a detailed statement of the findings and conclusions of the Commission, together with its recommendations for legislation or administrative actions it considers appropriate.

SEC. 8. TERMINATION.

The Commission shall terminate 90 days after submitting its final report pursuant to section 7.

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SEC. 9. AUTHORIZATION.

To carry out this Act there is authorized to be appropriated an amount not to exceed $1,000,000.

STONE RIDGE SCHOOL OF THE SACRED HEART IN BETHESDA, MD, HONORED

HON. CONSTANCE A. MORELLA

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mrs. MORELLA. Mr. Speaker, I rise to congratulate the teachers, students, and parents of Stone Ridge School of the Sacred Heart in Bethesda, MD, on winning the Blue Ribbon Excellence in Education Award from the Department of Education school recognition program.

According to Sister Anne Dyer, headmistress of the school, part of Stone Ridge's success this year in winning the award is attributable to the school's marked improvement in math and science. Sister Anne also cites several other factors that contributed to Stone Ridge's success; nearly 50 percent of this year's senior class earned commended status or better in the National Merit Scholarship Qualifying Test; 42 percent of the faculty members hold advanced degrees, including 7 at the doctorate level; and students may choose from 12 advanced placement courses in 9 different subjects.

As a former teacher, I am delighted that Stone Ridge is receiving the recognition that it deserves. Mr. Speaker, it is a proud moment for me to pay tribute to the students, the devoted faculty, and supportive parents of this outstanding school for their commitment and responsiveness. I congratulate Stone Ridge School of the Sacred Heart on receiving national recognition from the Department of Education, and I wish the winning combination of faculty, students, and parents at the school's continued success in achieving excellence in education.

TRIBUTE TO MAJOR GENERAL DAVID W. EINSEL, JR.

HON. PAUL E. GILLMOR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. GILLMOR. Mr. Speaker, I rise today to ask my colleagues to join me in recognizing Maj. Gen. David W. Einsel, Jr., of Tiffin, OH, on the occasion of his induction into the U.S. Army Chemical Corps Hall of Fame.

The Chemical Corps Hall of Fame in McClellan, AL, honors individuals who have made significant contributions to the corps and who have abetted national security in important ways.

General Einsel was recognized for his more than 40 years of service to the Nation. During this time he had impact on all aspects of the Nation's nuclear, biological, and chemical offensive and defensive capabilities. He is the 19th person and the 10th general officer to be inducted in to the Hall of Fame.

Although General Einsel is now retired from the U.S. Army, he continues to seek out ways to serve his country. Each fall, General Einsel volunteers his time to serve as a member of my district academy advisory board in support of my nominations selection process for the U.S. service academies.

Since 1989, the general has also served as a consultant on nuclear, biological, and chemical matters to the Director of Central Intelligence.

Mr. Speaker, I ask my colleagues to join me in congratulating General Einsel for his continuing outstanding service to our country.

CHICKEN LITTLE?

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. CRANE. Mr. Speaker, Vice President AL GORE has clearly demonstrated that he believes that the world is in serious peril from so-called greenhouse gases. The theory which the Vice President propagates claims that, as a result of an abundance of gases which trap the Sun's heat, the average temperature of the Earth will climb, resulting in disaster of the global ecosystem. That is the prediction, not the reality.

In reality, although satellites and computers have greatly aided in weather prediction, scientists cannot accurately predict the possibility of rain next week. Vice President GORE, and others attempts to predict the weather patterns of the next century. Based on these predictions, the White House will mandate a shift away from fossil fuels to environmentally safe fuels and from cars to mass transit systems. The costs of these ideas to taxpayers will be $1.9 billion for the Department of Energy to ride roughshod over fuel conversion and more than $68 billion to the private sector for new technologies. Given the uncertainty of the aforementioned doom and gloom predictions, these federally mandated expenditures can certainly be better spent elsewhere.

In the October 22, 1993 Wall Street Journal, Kent Jeffreys thoroughly explains the facts and fallacies of the Vice President's plans. I would like to commend this article to Member's attention so that they may understand what the White House means when it says change.

The article follows:

[From the Wall Street Journal, Oct. 22, 1993]

MORE HOT AIR ON GREENHOUSE GASES

(By Kent Jeffreys)

It's been said that no scientific theory gains public acceptance until it has been thoroughly discredited. Nowhere is that notion better illustrated than in the debate over so-called greenhouse gas emissions, which was given new life on Tuesday by the Clinton administration's announcement of its plan to reduce these emissions. While the plan has been treated to uncritical press coverage, few have questioned its foundation and the massive costs its will impose on the American public.

Vice President Al Gore's speech announcing the plan declared that "climate change is the highest-risk environmental problem the world faces today." This dire assessment is the driving force behind the plan, which seeks to reduce the emission of greenhouse gases to 1990 levels. To achieve this mighty goal, the administration has proposed about 50 specific policy proposals to reduce energy and material use and increase reliance and politically correct energy sources.

The seeming harmlessness of the proposals helps explain why the administration's plan has so far been given a free ride. But a bigger factor in how the plan has been received stems from the administration's promise that most of what it is suggesting is strictly "voluntary." Notwithstanding that this assertion is a classic Clintonian half-truth, one might ask of the administration, if such policies are truly necessary to avert a climate catastrophe, why are they presented as voluntary?

The reality, however, is that the American public will be in for a rude shock when it finds out that due to previous agreements signed by President Bush it will have to comply with a number of restrictive environmental policies. President Bush signed the United Nations Framework Convention on Climate Change at the Rio environmental summit in 1992.

This treaty is expected to become fully effective sometime early next year (36 of the required 50 nations have signed the treaty) and would require signatories to adopt binding national policies to reduce greenhouse gas emissions. In other words, the "voluntary" nature of the Clinton plan will soon become mandatory, regardless of the wishes of businesses or voters. Katie McGinty, director of the White House Office of Environmental Policy, has indicated that if the plan does not produce the desired results, other measures will be considered.

Perhaps the reasons for the "voluntary" nature of the White House plan is its huge price tag. Mr. Clinton wants the private sector to put up most of the money, in this case about $68 billion for investments in new technologies. While some of these would occur without the administration's push, it simply reflects the degree to which government has become a partner in business ventures. The direct costs to the federal government are estimated at a "mere" $1.9 billion. The Energy Department alone expects to spend $200 million annually to encourage fuel switching and energy efficiency.

Indeed, the largely "voluntary" nature of the plan masks some significant mandatory features. One of the most costly aspects will be the move to encourage mass transit. As usual, the disappointing performance of publicly owned mass transit systems is blamed on a lack of sufficient funding and the "subsidy" given to workers in the form of "free" parking. The tax code will be altered to treat parking spaces as personal income, to the tune of $2.2 billion in new federal revenues.

Although not stressed in the initial coverage, household appliances will be required to achieve higher levels of energy efficiency, raising the price of home air conditioners, water heaters, stoves and even television sets.

Why is the administration pushing this plan when many higher priority issues remain unaddressed? To give them the benefit of the doubt, the predictions of global warming have been pretty scary and, if true, warrant some sort of reaction. But are they true?

Despite its complexity, the global warming scare can be boiled down to a few essential points. There is no debate over the simple observation that certain gases in the atmosphere are incrementally increasing due to

human activities such as fossil fuel burning, deforestation and agricultural practices. Scientists also agree that increases in these gases (primarily carbon dioxide, the gas we all exhale with every breath) will cause a very slight increase in the global average temperature. There really is no dispute up to this point: The Earth is expected to warm one or two degrees in average temperature over the next century or so due to the direct emissions of anthropogenic (or human generated gases.

After this point, tempers go up even if temperatures do not. Some scientists argue that feedback mechanisms in the climate system (primarily water vapor and clouds) will greatly magnify this marginal rise in temperature, resulting in catastrophically rapid warming. Those assertions are based on computer programs called general circulation models, or GCMs. GCMs are notoriously bad at predicting the weather for the next month, yet they are being used to forecast the climate of the next century. Little wonder that many researchers dispute the apocalyptic claims of radical environmentalists.

In fact, the data strongly support those who reject the doom-and-gloom scenarios. Precise satellite measurements of the entire globe indicate no net warming over the past 15 years. Of the total warming estimated for the past century (about one degree Fahrenheit), most of it occurred prior to significant emissions of greenhouse gases by mankind. Yet despite the lack of any real threat to the planet's climate, major reductions in greenhouse gases are demanded.

Interestingly, in the mid-1970s, there was a similar debate raging over climate. At that time, the fear was of an impending ice age, rather than an inferno. This might be an amusing footnote of little historical interest but for one thing. The policies proposed to save us from ice were identical to those now being proposed to save us from fire. The predictions have changed but the prescriptions have not: Government must grow so that energy consumption will shrink.

TRIBUTE TO THE CHALDEAN FEDERATION OF AMERICA

HON. DAVID E. BONIOR

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. BONIOR. Mr. Speaker, I rise today to pay tribute to the Chaldean Federation of American [CFA] on the event of its first annual awards banquet. An umbrella organization of five Chaldean churches and seven civic organizations, the Chaldean Federation represents more than 65,000 Chaldean-Americans in metro Detroit.

The Chaldean Federation of America devotes the majority of its efforts to promoting education. The Federation encourages Chaldean youth not only to remain in school, but to strive for academic excellence and achievement. In pursuit of this goal, the CFA raises funds to host a commencement program and scholarship awards banquet. During this year's banquet held on June 9, 1993, they recognized over 250 high school and college graduates. Because of their success, the Chaldean community, Michigan and the United States will all benefit.

In addition to recognizing students and awarding scholarships, the Federation encourages volunteerism and provides numerous social services. The CFA sponsors language classes and develops educational materials that promote cross-cultural understanding. They assist in the citizenship applications of newly arrived Chaldean-Americans and sponsor an annual food drive during the Christmas holiday season. In the Mosaic that is America, the Chaldean Federation works hard to build bridges between our many ethnic and religious communities.

Today's gala will be attended by over 500 merchants, professionals, and civic and religious leaders. It represents the high point of cultural, social and fund raising activities in the Chaldean community. I commend the Chaldean Federation for its contributions to America and I urge my colleagues to join me in saluting the CFA on the event of their first annual awards banquet.

LEGISLATION TO PROTECT UNEMPLOYMENT TRUST FUND

HON. JILL L. LONG

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Ms. LONG. Mr. Speaker, today Congressman BARCIA, Congressman JACOBS, and I are introducing legislation to move the Unemployment Trust Fund [UTF] from the unified budget. While the House passed legislation to reform the Unemployment Compensation Program last year, the final version of the bill lacked one crucial element—the provision to remove the UTF from the Federal unified budget and deficit calculations.

Currently, funds to pay for the administration of the unemployment program are counted against the discretionary spending caps. Our legislation would exempt disbursements from the UTF and correspondingly reduce the discretionary spending limits under section 601 of the Congressional Budget Act of 1974. We believe that there are several compelling reasons to take this important step in reforming the unemployment compensation system.

The UTF has three distinctive characteristics making it unique in the Federal budget and justifying special budgetary treatment. First of all, the UTF is the only part of the Federal budget which includes State tax revenues and expenditures. Since the UTF contains revenue from the States, we believe that it is deceitful to count the UTF in the Federal budget. Our legislation would assure that State revenues are not counted in the Federal budget.

Second, the UTF is self-financed with dedicated revenue. State and Federal tax revenue used for the administration of the unemployment program build up in the UTF. While there may be money in the UTF to pay for costs associated with administering the program, these funds are scored as discretionary spending and subject to the spending caps. Furthermore, any legislation affecting the Unemployment Compensation Program is subject to the pay-go rules imposed by the rules of the Budget Enforcement Act of 1990. This act makes no distinction between programs financed with general revenues and programs financed with dedicated revenue, such as the Unemployment Compensation Program. Our legislation would make this important distinction.

In the past, many States experienced severe shortfalls in attempting to administer their unemployment compensation programs, thereby delaying the delivery of benefits for weeks. For example, in 1990, when unemployment was increasing and the economy was in recession, Indiana was forced to close 41 unemployment offices. These closings delayed the delivery of unemployment compensation and caused severe hardships on many of my constituents. Our legislation would remove any temptation to underfund the administrative costs of the unemployment program.

Third, the Unemployment Compensation Program is designed, in part, to counter the adverse economic impact during a recessionary downturn. When economic growth falters and unemployment increases, the Unemployment Compensation Program is designed to provide a safety net to unemployed individuals while stimulating the economy by injecting resources into the economy, thereby stimulating demand and economic growth. The UTF should be allowed to serve its macroeconomic function by spending down its reserves during a recession. Our legislation would allow the unemployment compensation system to pump money into the economy during times of recession without running into procedural difficulties posed by various Budget Acts.

We believe it is time to remove the only activity in the Federal budget that includes State tax revenues. Taking this step would help bring integrity to the budget process while protecting the Unemployment Compensation Program from funding shortfalls.

GOVERNMENT REFORM ACT OF 1993 INTRODUCED

HON. RICHARD A. GEPHARDT

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. GEPHARDT. Mr. Speaker, today, I am pleased to introduce the Government Reform Act of 1993. This legislation is the first installment of the National Performance Review recommendations offered by Vice President GORE's Reinventing Government Task Force. This package will achieve $9.1 billion in savings by consolidating and streamlining agency operations, eliminating unnecessary programs and unneeded subsidies, improving financial management and debt collection, reducing the burdens resulting from statutory reporting requirements, and improving the dissemination of Government information.

While individual Members may not unanimously agree on each specific recommendation, surely we all agree that something must be done to improve the efficiency of our Government.

Reinventing Government represents the will of the American people—achieving a Government that works better and costs less. The Government Reform Act will put us on the path to a more effective Government that performs better for its customers. I look forward

to working with President Clinton, Vice President GORE and my colleagues in the Congress, on both sides of the aisle, to achieve this laudable goal.

TRIBUTE TO EARL "COACH" BANKS

HON. KWEISI MFUME

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. MFUME. Mr. Speaker, a leader has left us. Earl Banks, a football Hall of Famer and former coach of Morgan State University's Bears, passed away in Baltimore, MD, on the morning of October 27. I rise today to celebrate the life of Earl Banks. Not just a coach, but a leader of men.

Earl was a motivator, an institution, a man with a heart as big as the football field he often stood upon. It was in his blood to promote and expand the minds and abilities of young people. Morgan State's Coach Banks is in the College Football Hall of Fame with one of the highest winning percentages in college football. His competitive coaching style gave him a record of 95 wins, 30 losses, and 2 ties. Earl Banks instilled the belief in his players not only could they play but they could compete. And that not only could they compete, but they could win. And they did.

Not only could his players compete and win on the collegiate level—no fewer than 40 of his players went on to succeed in the National Football League. Running back Leroy Kelly, former Colt tight end Raymond Chester and Pro Football Hall of Fame linebacker Willie Lanier were Banks' young proteges at Morgan.

But Earl was also more than a coach. In times such as these where it appears that all collegiate athletics demand of its coaches every-increasing numbers in the win column, it can seem anachronistic for a coach to take a personal interest in his players. But Earl Banks did.

Alumni, both players and fans, recall fondly how coach Banks helped players make it through tough times, both personally and financially. Perhaps it's because he knew hard times himself. Banks grew up in the projects of Chicago, without a father, and worked his way through the city's public school system before he fought his way to a guard position for the University of Iowa football team.

Earl made his mark in Iowa—he left an All-American, and played for the New York Yankees of that era's All-American Football Conference. Like many players, knee injuries cut short Earl Banks' promising professional career.

Undaunted by this temporary obstacle, his love of football took him to the Eastern Shore, where at Maryland State University, he taught them how to win. After 8½ years, Banks moved to Morgan to take over from retiring Coach Eddie Hurt and take the Golden Bears to another level.

Through his example and work, Earl has made significant contributions to this Nation. Mr. Speaker, Coach Earl Banks died this week, and something will not be the same. He was more than a teacher, he was a builder. He built the bodies and minds of the men who may now call themselves his legacy. He was a leader of men, and from those men he has been honored with the simplest and most elegant of titles: the right to be called their coach.

TRIBUTE TO JULIE RAE MEYER

HON. JILL L. LONG

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Ms. LONG. Mr. Speaker, I rise today to congratulate a constituent of the Fourth Congressional District of Indiana, Julie Rae Meyer, on winning the Veterans of Foreign Wars Voice of Democracy scriptwriting contest. In addition to being named as the State winner for Indiana, she will receive a $1,000 scholarship to the college of her choice.

After graduating from college, Julie plans on a career as a teacher. Like me, Julie believes that a strong educational system will be the key to our Nation's success. In her script, she speaks about what drives her to be a future educator, and how she plans to use motivation to teach her students. She will motivate her students to: seek further education; to improve their communities through voluntarism; to respect others regardless of race or creed; and to believe in themselves and in their country.

I am proud that Julie is a constituent of mine and proud that she will be entering such a noble profession that is invaluable to our country's future.

MUTUAL FUNDS

HON. RICHARD E. NEAL

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. NEAL of Massachusetts. Mr. Speaker, today, I am introducing legislation that addresses a particular concern of mine, mutual fund sales. In the last few months, banks have increased their sale of mutual funds. For the first time in history, assets of mutual funds have exceeded assets of deposits. More than one-third of all banks are now in the business of selling mutual funds.

This legislation would require financial institutions to disclose in writing information about mutual funds. More specifically, the disclosure should explain that mutual funds are not covered by the Federal deposit insurance system. Many depositors are unaware of what is covered by the Federal deposit insurance system.

In the last few years, there were several bank failures particularly in the New England area. I heard from numerous constituents who had more than $100,000 in their accounts. Several of these constituents were not aware of the $100,000 limit. This leads me to believe many depositors are not clear on which types of deposits are covered by Federal deposit insurance.

The Federal Deposit Insurance Corporation [FDIC] released a statement on the sale of mutual funds. The FDIC is concerned depositors may confuse mutual funds with certificates of deposit. Certificates of deposit are protected by Federal deposit insurance. Currently, mutual funds are sold without any disclosure that addresses deposit insurance. The sale of mutual funds is conducted in the same manner as accounts covered by deposit insurance. The FDIC believes banks should establish procedures that address these concerns.

Recently, several banks have voluntarily let customers know mutual funds are not covered by deposit insurance. This is an important step. However, I believe there should be legislation that requires institutions to let customers know in writing mutual funds are not covered by the Federal deposit insurance system. Advertising material and promotional material must include notice that these funds are not covered by Federal deposit insurance. This legislation would protect depositors and eliminate the confusion surrounding the sale of mutual funds by banks.

I urge you to protect depositors by joining me as cosponsors of the Depository Institution Mutual Fund Sales Act.

TRIBUTE TO JACK SPRINGER

HON. PAUL E. GILLMOR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. GILLMOR. Mr. Speaker, it gives me great pleasure to take this opportunity to pay tribute to Jack Springer of Sandusky, OH, for his 50 years of service as a member of the Firelands Community Hospital board of trustees.

As we debate reforms to our system of health care in this body, it is crucial we recognize those individuals who have ensured that Americans enjoy the highest quality medical care in the world. Jack Springer is one of these people.

In the 1940's, Jack provided the leadership that assured the financial stability of Erie County's largest health care provider. Joining the Good Samaritan Hospital board of trustees at that time, Jack quickly became involved on hospital committees, including the chairmanship of both the board's public health center committee and the committee on organization. As a member of the hospital's fund board of trustees, Jack served as secretary of the corporation for a number of years.

With one of the longest board tenures at Firelands Community Hospital, Jack currently holds membership on the Firelands Community Hospital Corp. board of trustees, maintaining trustee emeritus status on the hospital's Decatur Street facility and Hayes Avenue facility boards of trustees.

In addition to his commitment to health care, Jack's exemplary community service has earned recognition from a number of organizations, including most recently the Red Triangle Award from the Sandusky Area YMCA, and the Distinguished Citizen Award from the Firelands Chapter of the Boy Scouts of America.

Mr. Speaker, I ask my colleagues to join me in congratulating Jack Springer on his achievements, and encouraging him to continue to hold himself to the high standards of

integrity that the citizens of Erie County have come to expect.

TRIBUTE TO IMAGING TECHNOLOGY BRANCH AT NASA AMES RESEARCH CENTER

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Ms. ESHOO. Mr. Speaker, I rise today in recognition of and to pay tribute to the Imaging Technology Branch at NASA Ames Research Center, Moffett Field, CA. The Department of Energy recently announced the bestowal of their 1993 Federal Energy Water Conservation Award to this prestigious program which is in recognition of outstanding contributions made in increased energy efficiency and conservation in the Federal sector.

I would like to specifically praise the efforts of Ms. Patryce Farrel and Mr. Jorge Rios who will accept this award for NASA Ames tonight. They succeeded in implementing an online water recycling system that has provided for the reuse of 60 percent of the photographic washwater in their laboratory. In addition, they have helped the research center avoid the discharge of 300,000 gallons of contaminated wastewater while processing over 200,000 feet of film.

By treating and reusing water rather than discharging it into the sewer system, the employees at the Imaging Technology Branch have demonstrated that organizations can find solutions to environmental hazards through their own ingenuity. I salute the innovation they have displayed and congratulate everyone involved in bringing this great award to the Imaging Technology Branch at NASA Ames.

THANKS TO DONALD N. TRELOAR FOR THREE DECADES OF SERVICE TO THE COMMUNITY

HON. DONALD M. PAYNE

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. PAYNE of New Jersey. Mr. Speaker, I would like to bring to the attention of my colleagues, the service of a man who likens his community service career to that of a politician who is a priest—a great combination when you're working in the interest of others. This man is Donald N. Treloar. Don is director of contributions for the Prudential Insurance Co. On Monday, November 1, he will retire with 30 years of service.

Don Treloar is a man whose life has been the lives of others since June 7, 1971, when he joined the community affairs department after a stint with Prudential's group annuity department. He was instrumental the development and implementation of many programs that benefited the citizens of New Jersey, particularly Newark, NJ.

He developed and assisted educational programs that ranged from finding a home for School Within a School; establishing a tutoring/enrichment program at Prudential's headquarters for students of an alternative school; introducing College in the company, a program that brought college courses to company facilities in an effort to encourage employees to continue their education toward a baccalaureate to having Newark selected as the 1994 site of the U.S. Academic Decathlon, a 10 event academic competition among high school students within all 50 States.

He has also been actively involved in employment issues. Don introduced a program dubbed Senior Citizens Workshops which gave seniors an opportunity to have part-time temporary employment in the private sector which would supplement this income but not affect their social security; helped create the Essex County Urban League ULTRA program, a job training program for youth and other people who need retraining; and created a program to help small businesses employ youth from their local neighborhoods over the summer.

Believing in the power of voluntarism, Don initiated and organized the first ever volunteer fair at Prudential where 50 agencies set up boots to describe their volunteer opportunities to Prudential employees. Over 300 employees signed on with Newark agencies. Prudential's office of volunteers was an outgrowth of this effort.

Don's legacy to serving New Jersey's communities will be felt for many years through the work of the Partnership in Philanthropy Program he created. This program selects struggling nonprofits from around the State and matchs them with professional development people who analyze the agency, create a tailormade development program and together with the agency implement their new fund raising program.

Mr. Speaker, Donald N. Treloar's three decades of service demonstrate his strong commitment to youth, education, volunteers, older citizens, and nonprofits serving New Jersey's communities. I am pleased to recognize this commitment for the annals of U.S. history. I am sure my colleagues will want to join me as I extend my best wishes to Don and his wife, Nancy, whom I had the pleasure of working with, as they plan Don's next career which I am sure will be as successful.

TRIBUTE TO SCREEN ACTORS GUILD FOUNDATION

HON. HENRY A. WAXMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. WAXMAN. Mr. Speaker, I ask my colleagues to join me in saluting the Screen Actors Guild Foundation, which received the distinguished U.S. Commission on Libraries and Information Science's 1993 Recognition Award on October 16, 1993 at the historic central library in Los Angeles.

The Screen Actors Guild Foundation received this prestigious award in recognition of its renowned national in-school reading program, "Book PALS"—Performing Artists for Literacy in Schools—and in appreciation of the program's volunteer readers.

Charles Reid, Chair Emeritus of the U.S. National Commission on Libraries and Information Science, presented the award to Barbara Bain, national chair of Book PALS, and Philip Sterling, president of the Screen Actors Guild Foundation.

The Screen Actors Guild Foundation also received a certificate of appreciation and commendation from State librarian Gary Strong, which was presented by Los Angeles city librarian Elizabeth Martinez. In addition, the Foundation was presented a commendation on behalf of Mayor Richard Riordan by Julia Wu, Commissioner of the U.S. Commission on Libraries and Information Science.

Other distinguished guests included Janice Sands, executive director of the Screen Actors Guild Foundation; Norma Connolly, a member of its board of directors; Godfrey Cooper-Smith, its program director; and Barbara Neder with the Community Literacy Program.

Please join me in congratulating the Screen Actors Guild Foundation for this great honor and in wishing its members continued success with this valuable program.

TRIBUTE TO AN OUTSTANDING PUBLIC DEFENDER: WILBUR FORREST LITTLEFIELD

HON. LUCILLE ROYBAL-ALLARD

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise today to pay tribute to the outstanding service Wilbur F. Littlefield has given to Los Angeles County during his long and illustrious legal career. He is retiring after 36 years with the office of the public defender of Los Angeles County. For 17 of those years he has been head of the department.

In the public defender's office, Mr. Littlefield has distinguished himself as a dedicated and skillful trial attorney. He defended some of the most notorious and difficult cases in the history of Los Angeles. During his years of leadership the office has become the largest of its kind in the country and is recognized as among the finest indigent service providers in the world.

His legal career began after his military service during World War II. A war hero, he fought with distinction in the Pacific. After the war, Mr. Littlefield worked his way through Hastings College of the Law as a longshoreman.

Throughout his career, Mr. Littlefield has made outstanding contributions to his profession and his community. He has been involved in numerous organizations and has received recognition on the national, State, and local levels. He has also distinguished himself as a teacher. For many years he has been a clinical professor of psychiatry and behavioral science in the School of Medicine at the University of Southern California.

Above all else, Wilbur F. Littlefield will always be respected and admired by those who know him, both personally and professionally, for his honesty, his integrity and work ethic, his unending commitment to providing equal justice for all, and his genuine compassion for humankind.

MARITIME DECLINE DOCUMENTED IN CONROE COURIER SERIES

HON. JACK FIELDS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. FIELDS of Texas. Mr. Speaker, those of us familiar with the decline of America's maritime industry have long been frustrated by congressional, and executive, inaction to reverse that decline. During Democratic and Republican administrations, and for many Congresses, the American maritime industry has continued its uninterrupted decline which, if allowed to continue, could deny the United States—the world's only remaining military and economic superpower—the sea lift power our Nation would need in time of war or national emergency. It would be ironic if we, the world's only remaining superpower, allowed our maritime industry to decline to Third-World status.

We must not allow this decline to continue. As the ranking member of the House Merchant Marine and Fisheries Committee, I've enjoyed the opportunity to work with Chairman GERRY STUDDS and the other members of the Merchant Marine and Fisheries Committee to devise policies to halt, and then reverse, the dangerous decline of our Nation's merchant marine.

Mr. Speaker, Nancy Darnell, a reporter at the Conroe Courier newspapers in my congressional district, recently prepared an outstanding series that documents the decline of America's maritime industry and suggests solutions to the problem.

Over the next 3 days, I intend to submit Ms. Darnell's three-part series in the RECORD to give you, and my colleagues, the opportunity to better understand the seriousness of the problem—and the serious ramifications for our country if we permit our maritime industry to continue to spiral downward. I commend Nancy Darnell for her excellent series on this issue, and I hope my colleagues will take time from their schedules to read her articles and consider whether we as a Nation can afford to allow our domestic maritime industry to continue to decline. For my part, I say we cannot.

FIELDS ISSUES WARNING ON U.S. FLEET'S DECLINE

(By Nancy Darnell)

U.S. Rep. Jack Fields has embarked on a course designed to put a fresh breeze in the sails of this country's declining commercial sea power.

As the senior GOP member of a congressional panel, Fields is a key player in the first maritime reform legislation in 23 years.

Fields, who only this year began representing Montgomery County in Washington, likes the assignment because Houston is a port city. As the port goes, so goes part of the Houston-area economy.

Montgomery County is connected to the maritime industry by businesses located here which export and import goods and county residents who work in the maritime and related industries, such as energy and oil and gas exploration.

County residents with family members serving in the U.S. military also have a silent interest in the U.S. commercial fleet, because the bulk of military supplies—more than 90 percent during Desert Storm—travel overseas aboard merchant ships.

The goal is to reverse what Field's office describes as "the dangerous decline in the domestic merchant marine industry" and to "ensure that the United States has the sea lift power it would need in time of war or national emergency."

The immediacy of the objective is shaped by the continued cutbacks throughout the fleet, both in commercial and Navy ships. The merchant fleet is being reduced by attrition as aging ships are retired, and as American companies reflag their vessels, placing them under foreign flags.

The Navy cutback is the result of slashes in the Department of Defense budget. Both the size of the Navy fleet and manpower are being reduced as the Clinton administration carries out plans to cut $127 billion in defense funding over the next five years.

The Navy, which once had targeted having a fleet of 600 ships, is shrinking its fleet by half now that the former Soviet Union—particularly Russia—for the moment appears not to be a military threat to the U.S.

In order to have enough ships afloat in times of national emergency—or merely to tend to one of the skirmishes erupting in pockets around the world—Fields believes a commercial fleet is required.

In previous times of conflict, ships have come from both the commercial fleet and the Navy.

"If we have another crisis, moving U.S. troops may be much more difficult than it has been in the past," said a member of Field's staff.

The commercial fleet has been in steady decline for decades, after peaking at the end of World War II. An observer of the industry in this area said right after the war, the Maritime Administration was still granting construction subsidies and operating subsidies to U.S. flag ships.

The trend for U.S. companies to foreign flag vessels grew in the 1950s, as shipping magnates trying to cut costs turned to countries where the U.S. maintained control of the registries. In the industry, they were called "flags of convenience".

Foreign flag operators started chipping away at the U.S. commercial fleet as costs to American companies continued to mount, U.S. wages climbed steeply and the costs of union wage increases were passed along to the companies.

Passenger traffic across the Atlantic disappeared. Air traffic took over not only passengers, but also delivered the goods.

Industry observers agree there never has been a clear White House maritime policy, and by the 1980s the lack of that clear policy was taking its toll.

A former shipping company executive estimates the industry still would have thrived as late as the 1980s, had the federal government increased the operating differential by as little as five percent, at the most ten percent.

Instead, the growth of the industry fostered by President Roosevelt in the 1940s, and supported by President Eisenhower in the 1950s, was over by the 1980s.

Not a single president in recent times has defined the shipping industry in terms of the national defense of the United States, although some—such as President Clinton and President Bush—have had staff members allude to the need to establish maritime priorities.

This administrative failure to define the nation's needs on the oceans can be seen as the current administration tries to reinvent government. The military wants to have its own sea lift vessels, instead of calling on the merchant fleet, but the cost difference to the taxpayer is remarkable.

Instead of spending in the millions each year on a merchant ship, the Navy plan would require spending billions of dollars yearly, according to an industry observer.

Under this concept, the Navy would obtain only a handful of ships, built in a foreign shipyard, while nearly idle American shipyards campaign overseas for more work here.

The military would like to have the roll-on roll-off vessels Gen. Colin Powell, chairman of the Joint Chiefs of Staff, found so successful in action in the Persian Gulf.

These, to be operated by the Navy, would cost $2 billion to build in a foreign shipyard, according to industry estimates. Five new "RO/ROs," as they are called, would hardly complete the team for delivery of the massive amount of military supplies needed in a military crisis.

Fields is using as his vehicle for change his seat on the House Merchant Marine and Fisheries Committee which has passed the reform legislation designed to save American jobs in the maritime and ship-building industries.

The House Appropriations Committee earlier this year told the Pentagon to switch $200 million from defense to commercial ship-building.

"This bill is the cornerstone of the effort mounted by our committee to preserve and revitalize the American maritime industry," Fields said.

"This legislation will ensure that our children and grandchildren see the 'stars and stripes' flying from the stern of merchant vessels. And it will allow them to treasure the grand heritage of American merchant seamen and American shipyard workers, just as we do."

THE INDIA EARTHQUAKE

HON. ERIC FINGERHUT

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. FINGERHUT. Mr. Speaker, on September 30, 1993, the worst earthquake to hit India since 1935 struck southcentral India at 3:56 a.m. local time. The earthquake measured 6.4 on the Richter scale. It has killed an estimated 10,000 people, 15,566 are reported injured and over 150,000 have been affected by the disaster.

India has historically not requested assistance to cope with natural disasters. However, the magnitude of this disaster prompted the Government of India to seek assistance for the initially 50,000 presumed dead. Within 48 hours after the earthquake the U.S. Government deployed Raymond Flynn, the U.S. Ambassador to the Vatican, along with $1.7 million worth of shelter material and other emergency assistance.

This disaster reminds us of the natural disasters that have occurred in the United States recently. Hurricanes Hugo and Andrew, the San Francisco bay earthquake, and most recently the floods of the Midwest. We are reminded of how quickly these catastrophes occur and how extensive the damage can be.

We have all been proud to watch rescue teams save lives and to see the generosity of

our neighbors pour into the devastated communities. Although we cannot prevent natural disasters from occurring, we must work together as a nation to alleviate the pain and suffering caused from all these tragedies.

I would urge us to take this moment to remember those who have suffered from the earthquake in India. As the people of India rebuild and restore their lives, let us be reminded and take example of how a quick and efficient response can help lessen the tremendous blow natural disasters cause.

TRIBUTE TO COUNCILMAN RICHARD M. CURLEY

HON. DAVID E. BONIOR

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. BONIOR. Mr. Speaker, I rise today to pay tribute to a truly outstanding citizen, Councilman Richard M. Curley of Marysville, MI. He will be recognized at a retirement dinner in his honor after 36 years of dedicated public service.

Councilman Curley's father served on the Marysville City Council for 11 years and his mother served as treasurer for 10 years, so the choice to run for public office seemed natural. In 1956, Councilman Curley ran for and won election to the Marysville City Council, thus beginning a dedicated career of civic participation. However, during these 36 years, his contributions to the community have not been limited to his service on the council. He has served on numerous committees including the city planning commission, as well as the historical commission where his time and effort are immeasurable.

As councilman and community leader, Councilman Curley has shown a special interest in educating the youth of Marysville. He has served on numerous school improvement and millage renewal committees. However, he is best known in the Marysville school system for Government Day. He began Government Day by going into classrooms and explaining the purpose, responsibilities, and benefits of city government. His colleague, Marysville Mayor Deem Boldyreff, likes to say that Councilman Curley has a lifetime appointment as director of Government Day because he has helped it become a annual event in Marysville schools.

Fortunately, for the city of Marysville, Councilman Curley is not retiring completely from civil service. Though his distinguished career as city councilman is drawing to a close, he intends to stay an active member of both the planning and historical commissions. Jean, his wife of 50 years, his four sons and three daughters share with us our great pride in his hard work and dedication.

So, Mr. Speaker, I ask my colleagues to join me in not only saluting Councilman Richard M. Curley, but also in thanking him for his 36 years of unselfish service.

GOOD COUNSEL HIGH SCHOOL IN WHEATON, MD, HONORED

HON. CONSTANCE A. MORELLA

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mrs. MORELLA. Mr. Speaker, I rise to congratulate the teachers, students, and parents of Good Counsel High School in Wheaton, MD, on winning the Blue Ribbon Excellence in Education Award from the Department of Education school recognition program.

Good Counsel attributes its success to the outstanding teachers at this small school. Under the leadership of the principal, Michael Murphy, the faculty goes beyond fulfilling its duties in the classroom. Teachers give freely of their time and energy outside the classroom to assist students at the junior retreat, which is a requirement for students to graduate. These retreats take place during the school week, giving the students and faculty members time to explore the issues of relationships with self, parents, and God.

Good Counsel also puts emphasis on advanced technology in order to prepare the students for the 21st century. Two computer labs provide students with the equipment, both hardware and software, that is found in today's business settings.

As a former teacher, I am delighted that Good Counsel High School is receiving the recognition that it deserves. Mr. Speaker, it is a proud moment for me to pay tribute to the students, the devoted faculty, and supportive parents of this outstanding school for their commitment and their responsiveness. I congratulate Good Counsel on receiving national recognition from the Department of Education, and I wish the winning combination of faculty, students, and parents at the Good Counsel continued success in achieving excellence in education.

THE TECHNOLOGY FOR EXCELLENCE IN EDUCATION ACT

HON. WILLIAM F. GOODLING

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. GOODLING. Mr. Speaker, today I am pleased to introduce, with my colleagues, Representative STEVE GUNDERSON and Representative MIKE CASTLE, legislation, the Technology for Excellence in Education Act, to address the growing need for a coordinated approach to the use of technology in our Nation's schools.

No one will doubt the growing impact and importance of technology of all kinds—computers, video, audio, distance learning—on education at all levels. A recent survey found that computers are already installed in about 52 percent of classrooms today. That percentage will certainly grow as will society's and the business world's demand for people who are technology friendly.

Despite these trends, there is little coordination and planning for the changes that technology is bringing about and most conclude that we are not doing an adequate job in training our teachers to teach with technology.

The Federal role in this effort is already deceptively large. A recent study indicated that during the 1992–93 school year almost 50 percent of all funds used to purchase software, integrated learning systems, and hardware were Federal dollars. For the same school year, the study noted, $350 million of Federal chapter 1 funds—the education for the disadvantaged program—and $125 to $150 million of Federal chapter 2 funds, were spent for technology purposes. Despite this, there is no centralized coordination of the Federal effort within the Department of Education.

We have introduced this legislation as a benchmark for the presently on-going renewal of the Elementary and Secondary Education Act. While some have concluded that a separate program on educational technology within the new act is necessary, we see many opportunities within current programs and statutes to establish a Federal effort in this area. We also believe the Federal response to educational technology must be primarily targeted on planning and coordination—with an eye toward acquisition, training and research issues—without spreading its wings too widely to the multitude aspects of education technology.

Our proposal includes four primary focuses. First, it directs the Secretary of Education to appoint a director of Educational Technology within the Department of Education to coordinate the Federal effort. Second, it establishes one-time State planning grants which require participating States to establish comprehensive technology in education plans for their States within a year.

Tied to that State planning effort are local challenge grants for States which have completed their plans. Local school districts can be awarded 3-year grants to implement various technology systems and strategies outlined in the State plan. Finally, our legislation amends numerous current Federal education statutes to make the acquisition of and training in technology an explicitly permissible use for school districts.

As the Committee on Education and Labor, and the House and Senate, continue efforts to rewrite the Nation's elementary and secondary laws and programs, we intend to promote the concepts and ideas presented in the Technology for Excellence in Education Act.

THE ILLINOIS HOUSE SUPPORTS FORT SHERIDAN CEMETERY

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. CRANE. Mr. Speaker, years after the decision was made to close the gates of Fort Sheridan, just outside Chicago, there still is no finalized plan for disposing of the land. While there has been much debate over the relative merits of golf courses, condominiums, and public parks, recent discussion has ignored what I believe to be the best use for a portion of the land—as a veterans cemetery to honor Illinois veterans.

Since the Pentagon has recently stated that it is no longer interested in trading land at Fort Sheridan for an Arlington, VA, site to be used as an Army museum, I believe we must reopen discussion over the veterans cemetery. I am inserting for the RECORD a copy of a resolution passed by the Illinois House of Representatives which calls for the Federal Government to create a cemetery at Fort Sheridan.

The Department of Veterans Affairs has stated that the Chicago area is in need of a new cemetery, and has identified Fort Sheridan as the optimal site. State government in Illinois supports the creation of a cemetery on this historic site. Chicago-area veterans groups strongly support Fort Sheridan as the location for a new cemetery. It is time that Washington listened to those who will be most affected by this decision, and dedicate a new veterans cemetery at Fort Sheridan.

HOUSE RESOLUTION NO. 1415

(Offered by Representative Kubik)

Whereas, The Congress of the United States enacted Public Law 93-43 on June 18, 1973, which provides that "the remains of (any veteran, and certain others) may be buried in any open national cemetery in the National Cemetery System"; and

Whereas, Through this Public Law, all veterans, by virtue of their service to their country, have a right to be interred in a national cemetery; and

Whereas, It has been reported that the national cemeteries in Illinois have the following numbers of spaces available: Alton, 10; Camp Butler, 6,712; Danville, 8,209; Mound City, 1,201; Quincy, 70; and Rock Island, 2,168; and

Whereas, There are millions of Illinois veterans who have the right to interment in a national cemetery; and

Whereas, After the remaining 18,000 cemetery spaces in Illinois are used, the families of Illinois veterans will have to go out of the State to find space in a national cemetery; and

Whereas, When a deceased veteran is interred a long distance from home, the veteran's family will face additional hardship in reaching the burial site and may be unable to visit the grave and show their respect; and

Whereas, The families of veterans in the State of Illinois are aggrieved that there is no national cemetery near the Chicago area, where millions of veterans live with their families; and

Whereas, There is an existing army cemetery at Fort Sheridan which would accommodate the needs of the veterans who are desirous of a national cemetery in the Chicago area; therefore be it

Resolved, by the House of Representatives of the Eighty-Eighth General Assembly of the State of Illinois, that we respectfully urge our federal government leaders to work together to designate the cemetery at Fort Sheridan a national cemetery for use by all veterans; and be it further

Resolved, That suitable copies of this preamble and resolution be forwarded to President Bill Clinton and to each member of the Illinois congressional delegation.

REDLAND MIDDLE SCHOOL IN ROCKVILLE, MD, HONORED

HON. CONSTANCE A. MORELLA

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mrs. MORELLA. Mr. Speaker, I rise to congratulate the teachers, students, and parents of Redland Middle School in Rockville, MD, on winning the Blue Ribbon Excellence in Education Award from the Department of Education school recognition program.

Redland Middle School's success for every student program is designed to provide students with a spirited, demanding curriculum suited to individual needs and abilities. These goals are accomplished through broad course offerings and ongoing teacher support of the individual student. The school has several other programs that were designed to help students. Student support programs include mentoring by staff members, a support room program, guidance programs, peer mediation, and peer tutoring. In addition to these, there are several after-school activities such as clubs, homework help, and intramural sports. There are also several programs, like the computer genius club and C.A.R.E., that include community partnerships with local business.

As a former teacher, I am delighted that Redland Middle School is receiving the recognition that it deserves. Mr. Speaker, it is a proud moment for me to pay tribute to the devoted faculty and supportive parents of this outstanding school for their commitment and their responsiveness in providing a quality education. I congratulate Redland Middle School on receiving national recognition from the Department of Education, and I wish the winning combination of faculty, students, and parents at the school continued success in achieving excellence in education.

TRIBUTE TO POLISH HOME CLUB

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. CARDIN. Mr. Speaker, today I rise to pay special tribute to the Polish Home Club in Baltimore on its 75th anniversary. Located on Broadway, in the heart of Baltimore's Polish community, the Polish Home Club is a social and cultural landmark. It has hosted thousands of meetings, banquets, weddings, and celebrations and is an important part of Baltimore's thriving Polish community.

The Polish Home Association was first organized in 1906 by Wladyslaw Urbanski. It took the Polish community many years to raise the funds necessary to purchase the club and make the needed repairs on the structure. In 1918—75 years ago—the Polish Home Club officially opened its doors to the community.

Since then, the Polish Home Club has provided help to the needy, support to new immigrants, and has become a social outlet and a community meeting place. The club has been, and still remains, a fixture within the Polish community in Baltimore. It has provided the needed cohesiveness to keep this community strong, and it also has provided an opportunity for non-Poles to participate in events within the Polish community.

Mr. Speaker, I urge all my colleagues will join me in recognizing the important contribution the Polish Home Club has made and continues to make in Baltimore.

IN HONOR OF A MEMORIAL VIGIL COMMEMORATING THE 244 MEMBERS OF THE 101ST AIRBORNE WHO DIED IN SERVICE TO THEIR COUNTRY AT GANDER, NEWFOUNDLAND, ON DECEMBER 12, 1985

HON. NANCY L. JOHNSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mrs. JOHNSON of Connecticut. Mr. Speaker, it is with great pride that I rise to pay tribute to the 244 courageous peacekeepers of the 101st Airborne Division who were unexpectedly taken from the line of duty in a tragic plane crash at Gander, Newfoundland, on December 12, 1985. A memorial vigil, held by the Connecticut Yankee All-Airborne Chapter of the 82d Airborne Association, Inc., will take place in Hartford, CT, on the east steps of the State capitol, 1 p.m. on Sunday, December 12, 1993.

Since colonial times, American men and women have served with honor and distinction, protecting the basic freedoms that are conferred upon all citizens from the moment of birth. This has been at the core of American values since our forefathers landed in Plymouth, MA, in 1620. Since that time, this Nation and its Armed Forces have fought around the world in the hope that one day freedom and democracy might ring for all to hear. In fulfilling this dream, members of the 101st Airborne died in service to our Nation. For this, they forever deserve our sincere gratitude and respect.

On the occasion of this memorial vigil, there will still be people who are unable to enjoy the freedoms of democracy. Accordingly, I ask that we all take a moment to give thanks to those who have risked their lives so that people all over the world may live under a system as open and free as our own.

I would also like to take this opportunity to express my appreciation to all the families of these service men and women who demonstrated great strength in their loss. Indeed, this memorial vigil is as much a tribute to their courage as it is to those who have served in uniform. It is my hope that these men and women will forever serve as an inspiration to us all.

END GLOBAL OCEAN DUMPING OF RADIOACTIVE WASTES

HON. MIKE SYNAR

OF OKLAHOMA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. SYNAR. Mr. Speaker, I rise today to urge the Clinton administration to seize an important opportunity for global environmental leadership. At the upcoming meeting of parties of the London Dumping Convention the important issue of ocean dumping of radioactive waste will be addressed.

The dumping of high-level radioactive waste has been prohibited since the adoption of the London Convention in 1972. I urge the administration to support a similar ban on the dumping of low-level radioactive waste and to encourage the 70 other countries who are party to this treaty to do likewise.

Mr. Speaker, we are all aware of the recent incident involving the dumping of low-level radioactive waste into the Sea of Japan by the Russian Federation. In late August, it was my privilege to serve as a member of the U.S. delegation to a meeting of GLOBE, the Global Legislators Organization for a Balanced Environment, in Tokyo. At the GLOBE meeting we received a dramatic report from our Russian colleagues regarding the dumping of radioactive waste by the former Soviet Union into the Sea of Japan, the Arctic Ocean, and the Atlantic and Pacific Oceans over the past three decades. Responsible political leaders cannot allow this practice to continue.

Dispersing these wastes into the environment in an uncontrolled and irretrievable fashion, as is the case with ocean dumping, simply does not make sense. It is time to bring international law into conformity with U.S. policy in this area.

I urge the administration to seize this rare and important opportunity to achieve important environmental foreign policy benefits and demonstrate leadership on the protection of the global marine environment. The dumping of radioactive wastes into the sea must end. The U.S. position in the upcoming London meetings should lead the world toward that objective.

TRIBUTE TO SAM YONO

HON. DAVID E. BONIOR

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. BONIOR. Mr. Speaker, I rise today to pay tribute to my friend Sam Yono. Sam is chairman of the Chaldean Federation of America, an umbrella organization of 5 Chaldean churches and 7 civic organizations, which represents more than 65,000 Chaldean-Americans in the Metropolitan Detroit area.

The Chaldean Federation of America's primary goal is to encourage Chaldean youths to stay in school and strive for academic excellence and achievement. The federation, under Sam's leadership, also encourages volunteerism and provides numerous social services. This evening, the federation is holding its first annual awards banquet. Sam helped organize this event which will be attended by 500 merchants, professionals, and civic and religious leaders. Most recently, Sam has been working with me to dramatize the plight of Chaldean refugees in the Middle East.

Sam has been active in both the Chaldean and the larger metropolitan Detroit community for many years. As a businessman and entrepreneur, Sam has donated his time and talents to numerous civic and governmental agencies. As a member of their Ethnic Community Response Network, Sam's insights have benefited the Detroit Police Department. He has also served as a member of the Governor's Advisory Committee for Southeastern Michigan to the Michigan Department of Agriculture. Currently, Sam is a member of the Wayne County Executive's Arab Advisory Committee. Sam also serves as a board member for Oakland Community College, the college's foundation, the Southeast Michigan Coalition of Governments [SEMCOG] and New Detroit.

Sam's tireless commitment to the community is an inspiration to us all. And so, on the occasion of the Chaldean Federation of America's First Annual Dinner Banquet, I ask my colleagues to join me in saluting Sam Yono.

TRIBUTE TO NANCY NORRIS

HON. JERRY LEWIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. LEWIS of California. Mr. Speaker, I would like to bring to your attention the fine work and outstanding public service of Nancy Norris of Encino, CA. Nancy will be recognized for her civic and charitable involvement, her contributions to business, and her role as a supportive wife and mother at a celebration in her honor on November 6.

Nancy Norris is truly a renaissance woman. As the sole proprietor of Nancy Orman Interiors for 17 years, she has played an integral role in the business community. In 1986, she was selected as the winner of the ELAN Award of Merit and in 1990, Nancy received the MIRM Award for best interior design.

Her contributions to our community are well known. She is a lifetime member of Hadassah and has been actively involved in numerous activities in several chapters. She is the founder and president of the South Valley chapter, the founder and president of the Shirim chapter, the current treasurer of the Greater Valleys chapter, the program vice president of the Pacific Coast region and the chapter member of the Valley Coordinating Cabinet. In addition, she was the local office coordinator for the National Hadassah Convention held earlier this year.

Nancy has also been greatly involved in charitable work and civic affairs. She is the president and founder of the Baldy View Auxiliary of BIA, the life director of the NAHB Auxiliary, and spends time giving to others as a volunteer at the Chaparral School and at Kadima Hebrew Academy. In addition, Nancy enjoys memberships with the NAHB Auxiliary, the NAHB Capitol Club, the Los Angeles County Museum of Art, and the Los Angeles Zoo.

Mr. Speaker, I ask that you join me, our colleagues, Nancy's husband Ira, and their four children in recognizing the vast and diverse contributions of this wonderful woman. Her dedication to our community and her many contributions to business are certainly worthy of our admiration and respect. It is fitting that the House pay tribute to Nancy Norris today.

HEBREW ACADEMY OF GREATER WASHINGTON IN SILVER SPRING, MD HONORED

HON. CONSTANCE A. MORELLA

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mrs. MORELLA. Mr. Speaker, I rise to congratulate the teachers, students, and parents of the Hebrew Academy of Greater Washington in Silver Spring, MD, on winning the Blue Ribbon Excellence in Education Award from the Department of Education School Recognition Program. The Hebrew Academy is in fact two different schools, a middle school and a high school. Both have won the award this year for their excellence in education.

The Academy attributes its success to the outstanding teachers at this small school. Under the able auspices of Miss Deena Levine, principal of the high school, the faculty goes beyond fulfilling the duties of the classroom. The dedicated teachers at the Hebrew Academy spend extra hours coaching the mock trial team, which made the semi-finals in Montgomery County's mock trial competition. The hard work of students and faculty on the newspaper and yearbook has brought recognition from Columbia University for excellence in high school publications.

As a former teacher, I am delighted that the Hebrew Academy of Greater Washington is receiving the recognition that it deserves. Mr. Speaker, it is a proud moment for me to pay tribute to the devoted faculty and supportive parents of this outstanding school for their commitment and their responsiveness in providing a quality education. I congratulate the Hebrew Academy of Greater Washington on receiving national recognition from the Department of Education, and I wish the winning combination of faculty, students, and parents at the academy continued success in achieving excellence in education.

HOME OFFICE DEDUCTION ACT INTRODUCED

HON. PETER HOAGLAND

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. HOAGLAND. Mr. Speaker, together with a bipartisan group of my colleagues, I am introducing the Home Office Deduction Act today. This initiative will clarify the tax status of America's home-based businesses.

The legislation has the support of the Small Business Legislative Council, the National Association of the Self-Employed, the American

Institute of Certified Public Accountants, the National Society of Public Accountants, the National Association of the Remodeling Industry, the National Association of Small Business Investment Companies, the Direct Selling Association, the Specialty Advertising Association International, and the Illinois Women's Economic Development Summit.

Home-based business mean opportunity and job creation. The livelihoods of many working families in my State and across the country depend on home-based business. For many entrepreneurs, it is the American dream. Home-based businesses make sense from a variety of perspectives.

For startup small businesses as well as people reentering the work force after a job loss, the very viability of a new enterprise can depend on whether or not it can be started up as a home-based business.

For many people with historically poor access to capital, like women and minorities, and for many people for whom traditional office environments or commuting pose problems, such as the elderly and the disabled, the home-based business can be an important road to economic independence.

For parents with young children to supervise, the home-based business helps avoid the loss of a second income.

Modern telecommunications equipment like faxes, modems, and computer networks allow businesses which have traditionally required an office setting to operate from the home.

The Supreme Court's recent decision in Commissioner versus Soliman substantially narrowed the availability of the home office deduction. Previously, home office expenses were deductible if: First, the space in the home was devoted to the "sole and exclusive use" of the office; second, the taxpayer used no other office for the business; and third, the business generated enough income to cover the deduction.

The Supreme Court in effect added two additional conditions to the eligibility of most taxpayers for the home office deduction: (4) the customers of the home-based business must physically visit the home office; and (5) that the business revenue must be produced within the home office itself.

As a result of the Soliman decision, certain expenses which are deductible for other business will not be deductible for home-based businesses. A business owner who rents a storefront is not required to have customers visit it or generate all the business revenue within its four walls in order to claim the storefront as a deduction.

Many entrepreneurs who run their business from their home have been thrown into confusion about the implications of the Soliman case. Entire categories of home-based businesses will lose their deduction under this case. These range from independent sales representatives to rural veterinarians to home remodelers and plumbers—small businesses that must sell their products and services outside the home office because of the nature of the business or because of competitive pressures. Many other home-based businesses cannot bring customers into their homes for a variety of reasons, such as local zoning ordinances or security considerations. For many small enterprises, the loss of this deduction may mean the difference between growth or retrenchment, the difference between job creation or bankruptcy.

The Home Office Deduction Act keeps intact the three previous criteria for the deduction, while making clear that essential administrative and management activities—such as tax preparation, bookkeeping and billing, and soliciting business—are legitimate uses of business time and office space for the purpose of deducting the expenses of a home office.

We want to make the law clear and simple to allow entrepreneurs who operate in the home the ability to deduct the same expenses that they would be allowed to deduct if they rent space. That's only fair. However, we do not want to open up the Tax Code to abuse. It is very difficult to find the right balance between these two objectives in an area that is as fact-sensitive as home offices. But the recent Supreme Court decision clearly does not strike a correct balance by requiring that customers of a home-based business must physically visit the home office or that business revenue must be produced within the home office itself to be deductible. I think this bill is a good start in restoring balance. Before the legislative process is all over, I am sure we will have added many refinements and clarified any ambiguities, and in the process I hope we can devise a workable policy that treats people who operate home offices fairly.

For example, I am concerned about some reservations expressed about whether the requirement that the office be used "regularly and systematically" may not be a fair standard for individuals whose business travel is not of a predictable pattern, and therefore whose time spent in a home office may not fall within a common sense definition of systematic, but whose business nevertheless requires the use of office space in the home. This is only one example of the tensions we face in attempting to draw a line between legitimate uses of home office space as opposed to simple tax avoidance.

I am sensitive to the impact this legislation will have on Federal revenues. However, I believe we must first try to make a sensible decision about the proper policy to which home-based businesses should be subjected and then consider the fiscal impact. To do otherwise is putting the cart before the horse.

PUERTO RICAN STATEHOOD

HON. GERALD B.H. SOLOMON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. SOLOMON. Mr. Speaker, I rise today to call the attention of this body to what is shaping up to be an American Constitutional crisis. On November 14, 1993, the people of Puerto Rico will cast a vote on the status of the island. They will be asked to choose statehood, independence, or to maintain their current status as a Commonwealth. What the Puerto Rican people are being told during this campaign bears no relation to the facts. The campaign's rhetoric defies all historic precedent.

First, there are people telling Puerto Rico that statehood would still allow them to function as virtually an independent nation—complete with their own flag and national anthem. Any review of our history would note that Texas was an independent nation prior to its joining the union. But while my friends in Texas have stayed independent in many ways, the American flag flies above all others there.

Second, there are people telling Puerto Rico that statehood would not affect the use of Spanish in Puerto Rico. Again, a review of American history shows that Louisiana was a French-speaking colony before it joined our Union. However, Louisiana now prints its laws and conducts its government business in the same language used in the rest of the United States—English.

Should Puerto Rico opt for statehood, I fear that the troubles Canada confronts with French-speaking Quebec will seem tame. After all, until this year, Puerto Rico had only one official language—Spanish. When Puerto Rico's statehood party decided to make English a second official language this year, they provoked a near riot. According to the New York Times, "tens of thousands of Puerto Ricans opposing the language bill took part in a march on the Capitol" This group, estimated at 80,000 to 100,000, chanted "Ingles, no!"

As Puerto Rico will follow the same procedure as every other nation has in the pursuit of statehood, I firmly believe that these people will not be pleased with reality. In our English-speaking union, life is vastly different than that being portrayed by some in Puerto Rico. English has always been America's de facto official language. And, if H.R. 739 is passed, English will be America's de jure official language as well. I am a proud cosponsor of that bill. Nearly all Americans support making English our official language. When this bill passes, it will apply just as strictly to the State of Puerto Rico as it would to the State of New York.

Third, some members of the Puerto Rican society are claiming that under a State of Puerto Rico citizens will pay less in taxes. In 1917, Congress gave Puerto Ricans American citizenship. In 1952, Puerto Ricans voted to become a Commonwealth and the United States and Puerto Rico entered into a compact which defined the Commonwealth status. Under this status, Puerto Rico, although not a State, has limited access to our welfare programs but is exempt from paying Federal taxes. Statehood would take away this fortunate exemption. Puerto Ricans would pay the same Federal income taxes, gas taxes, and estate taxes as every other citizen of every other State in America.

Furthermore, Puerto Rican's per capita income is less than half that of Mississippi, the poorest State in our union. Statehood would also remove all caps Congress has placed on Federal welfare payments to Puerto Rico. The New York Times has estimated this removal would cost the U.S. Treasury a minimum of an additional $3 billion annually. As a State, the Puerto Rican citizenry will have to pay their share of these added Government costs. Taxes will not decrease; in fact, it is highly probable that they will increase as all of Government entities, both local and Federal, scramble to finance these added fiscal burdens.

Statehood is a permanent thing. The United States has already fought one civil war over that matter. Statehood means equal treatment for all States. Yes, it grants benefits, but more importantly it bestows responsibility. Those who tell Puerto Rico things will be different for them are telling the voters a pleasant fairy tale. I fear a rude awakening for both the United States and Puerto Rico should the statehood process proceed in this manner.

TRIBUTE TO J. BARRIE MUNROE

HON. DOUGLAS "PETE" PETERSON

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. PETERSON of Florida. Mr. Speaker, it is my sincere pleasure to have this opportunity to pay a special tribute to an outstanding individual from Florida's Second Congressional District who is retiring from the Occidental Chemical Corp. after 21 years of exceptional service. Mr. J. Barrie Munroe has not only risen to the level of vice president of manufacturing and technology during his tenure at Oxy, along the way he has served his country admirably in the armed services, as a world-class track athlete, as an environmentalist, community leader, and perhaps most importantly, as an outstanding family man.

A native of Florida, Mr. Munroe left his home to serve in the U.S. Army where he earned a distinguished record and rose to the rank of staff sergeant. It was during this period that he represented the U.S. Armed Forces in the 1955 European Track Championships, where his time of 10.7 seconds in the 100 meter dash brought him within fractions of a second of setting a world record. Since that time he has continued his interest in the sport and has competed in a number of well-known marathons.

Upon returning to Florida after his military service, Mr. Munroe pursued an education at the University of Florida. Giving his academic studies the same dedication that has steadfastly accompanied him through all his endeavors, he was ranked fourth in his class when he graduated with a Bachelor of Science Degree in Chemical Engineering.

With his diploma in hand, he embarked on an impressive career within the field of chemical process technology and manufacturing. Management positions with Proctor & Gamble Co. and Lonza, Inc., led him to becoming a corporate officer at Occidental Chemical Corp., where he stayed for a very productive 21 years.

Occidental has certainly been blessed by having the foresight to engage Mr. Munroe's talents. He was instrumental in opening the doors for Occidental sales to the former Soviet Union and was very active as a leader of the Florida Phosphate Council. Under his leadership, Oxy has mined 42 million tons of phosphate rock, resulting in the production of 15 million tons of fertilizer and 4 million tons of animal feed supplement. That high level of production made Occidental one of the largest employers in north Florida, with 2,000 individuals on the payroll.

During this period of amazing growth, Barrie Munroe never lost sight of the need to protect the environment. He successfully oversaw the reclamation of over 5,000 acres of previously mined lands, which included 1,600 acres of sensitive wetlands in Hamilton County. These areas are now beautiful pineforests, meadows, and recreation tracts preserved for generations to come.

Along those same lines, he created the North Florida Environmental Advisory Committee. Through this organization he has established an atmosphere of cooperation between industry interests and concerns of environmental groups, which has resulted in positive environmental enhancements for the region.

Never losing sight of assisting those in need, Mr. Munroe was one of the principal organizers of Oxy's efforts for the United Way. It was with his inspiration and leadership that Oxy has regularly provided approximately 50 percent of all contributions received by the United Way in Suwannee, Hamilton, and Columbia Counties.

He has also been extremely active with educators on a variety of levels. Within that arena, he has made Oxy's Adopt a School Program a top priority for the company in Hamilton County. This program has enriched the county's six schools by providing financial and human resource support for facility improvements and strengthening recreational activities. For example, when the middle-school was in need of new goal posts for a playing field, it was through this program that Occidental provided the funding assistance necessary to purchase the posts and the skilled labor needed to erect them.

As an active alumni, he has served for a number of years as the president of the University of Florida's Advisory Committee for the Department of Chemical Engineering. Within that capacity he has acted as a good-will ambassador on behalf of the university and has been of invaluable assistance in recruiting and advising prospective students.

In spite of all these demanding enterprises, Barrie was always there for his family. He and his lovely wife of 36 years, Myrna Turner Munroe, have raised four beautiful children, Dallas, Brad, Barrie Suzanne, and Brian, all of whom are clearly destined to contribute to their professions and communities in much the same way as their father.

In view of his many outstanding contributions, it was with mixed feelings that I learned of Mr. Munroe's plans to retire from Occidental at the end of this year. However, although he will be deeply missed by the residents of Hamilton County and its surrounding areas, no one can begrudge his desire to retire to St. Petersburg Beach so that he and Myrna might pursue the enviable activities of boating, golfing, and flying.

Barrie Munroe is leaving behind a legacy of hard work, innovative thinking, and aggressive accomplishment of the many and varied tasks he has undertaken. A finer and more upstanding individual is rarely seen. As he retires, I join the men and women of Occidental Chemical Corp. as well as the citizens of north Florida in extending our fondest gratitude and our sincere wishes of a long and prosperous future.

CONGRATULATIONS TO THE DENVER RTD

HON. PATRICIA SCHROEDER

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mrs. SCHROEDER. Mr. Speaker, I rise today to congratulate the Denver Regional Transportation District [RTD], which provides public transportation services in a six county area. At its recent annual meeting, the American Public Transit Association presented RTD with its prestigious Public Transportation System Outstanding Achievement Award. We in Colorado have long been proud of RTD's many contributions to improving public mobility and enhancing our quality of life. To be named the No. 1 public transportation agency in the United States is a crowning achievement for the Regional Transportation District. Three cheers for the RTD Board and to each one of the nearly 2,000 full and part-time employees.

RTD operates one of the largest transit districts in the Nation covering 6 counties and 39 municipalities over a 2,300 square-mile district. It operates a bus fleet of 800 vehicles with an on-time performance record of 88 percent and is presently constructing a new 5.3 mile light rail line financed wholly with local resources and slated to enter into revenue operation next fall. A new downtown express bus/high occupancy vehicle lane will also open at that time. RTD is one of the only transit agencies in the Nation with nearly 100 percent wheelchair accessible buses. Moreover, RTD operates both curb-to-curb transportation service for the districts 30,000 disabled citizens and an access-a-ride program providing demand-responsive service to eligible riders.

Similarly, RTD is in the forefront among transit agencies in testing state-of-the-art air pollution control measures, including operating buses with particulate traps, methanol, and compressed natural gas. RTD also developed the world's only EPA certified heavy duty engine high altitude emissions research center.

In making the award, APTA cited RTD's increased ridership, human resources development, fiscal responsibility, air quality research, advancement of minorities and women, rapid transit development, and total quality management. Notably, RTD has experienced ridership growth at a time when many transit agencies are witnessing slipping or stagnate ridership numbers. Its proactive marketing strategies have attracted more than 60 million passengers onto RTD a year.

RTD is one of the most fiscally stable and cost effective public transportation agencies in the Nation. This is evidenced by RTD's recently upgraded bond rating, and its recognition by the Government Finance Officers Association of the United States and Canada for its current fiscal year budget. The award presented by this prestigious organization is the highest form of recognition in governmental budgeting.

RTD is one of our State's most progressive employers. In 1991, it was awarded Minority Enterprises Incorporated's Corporation of the Year Award. Illustrative of this commitment, RTD boasts an impressive 67 percent minorities and women among its transportation division managers.

Mr. Speaker, the heart of a transit agency's operation is the service it provides. RTD has offered the public many nationally recognized programs. Its Eco Pass program allows employers to provide workers with discounted transit passes. RTD operates discounted services for University of Colorado students, special shuttle bus service to professional football and baseball events, an inexpensive service to tour 21 cultural and historical sites throughout Denver, special services for senior citizens, and a night stop program that allows passengers be dropped-off closer to their homes or in safer, well-lit areas.

Mr. Speaker, I applaud the Nation's No. 1 transit agency: the Denver RTD!

COMMERICAL EXPORT ADMINISTRATION ACT OF 1993

HON. TOBY ROTH

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 28, 1993

Mr. ROTH. Mr. Speaker, today, I am introducing the first comprehensive revision of our nation's export control laws since 1979—nearly 15 years ago. This bill has broad support in America's high technology industries, and it will gain wide support in Congress. Congressman JAMES OBERSTAR has joined me as the lead co-sponsor of this bill, and he is playing a key role in this effort to revise export control policy.

The Subcommittee on Economic Policy, Trade and Environment, on which I am the ranking Republican, will mark-up export control legislation early next year, and this bill will form the basis for much of what we bring to the full House for a vote. In our hearings this year, the need for this legislation has been made crystal clear.

Export controls date from the beginning of the cold war and they are completely out of synch.

The current export control system has become a major obstacle for American high technology exports, and it undercuts American leadership in these industries.

High technology is the key to our economic future, and unless we replace the current system, that growth will be stunted. Under the current law, we are still conducting economic warfare against cold war adversaries that either no longer exist, or which are now essential partners for us in trade and global security.

On the one hand, we are sending billions to support Boris Yeltsin and build Russia's economy.

But as Yeltsin complained to President Clinton at the Vancouver Summit, Export controls still are targeted against Russia.

We want China's help in dealing with North Korea's nuclear weapons, program, but why should the Chinese cooperate when they are still the targets of export controls.

Some argue that with a little fine-tuning, the current system can be re-directed to controlling weapons proliferation. But look at what has happened with Iran.

For almost a year, the United States has tried to target Iran with export controls, but even our closest allies will not go along.

The United States and Germany are now criticizing each other in the world press, with no impact on Iran at all.

A third problem with the current export control system is its bias toward unilateral action by the United States—when all else fails, we impose export sanctions by ourselves.

That's what we did with China 2 months ago. We shut off satellite exports because we don't like China's arms transfers to Pakistan.

And what has been the result?

Within a week of the sanctions, representatives of German andFrench competitors were in Beijing, offering the same technology that the United States has blocked.

The United States company has lost over $1 billion in sales to China, with no effect on China at all.

We made the same mistake with India. For 2 years, the United States denied the sale of a supercomputer to India.

As a result, India went out and developed their own model, and has sold 14 units around the world, taking those sales away from our own company and creating a new competitor for American exports.

These examples show that export controls are very effective in interfering with American exports, but virtually irrelevant in controlling proliferation, or as a diplomatic lever.

According to testimony before our subcommittee, we are losing $10 to $20 billion in exports every year because of this outmoded law.

That translates into 200,000 jobs which can be gained by freeing American companies from the outmoded burden of export controls. President Clinton agrees that our export controls must be changed, and he has taken some administrative actions to reduce controls on computers and telecommunications.

But we need an entirely new approach, and that requires legislation.

Both Secretary Brown and Secretary Christopher have told our committee that the administration will send up legislation on export controls—but that legislation is not drafted yet. I believe our bill is an approach that the President can and should support, and I will ask for his endorsement.

This bill reflects the recommendations of a task force of experts from our Nation's premier high-technology companies in computers, electronics, aerospace, machine tools, and telecommunications. They worked for some 18 months, analyzing the problems with the current system.

They consulted with leaders of these industries, with scholars and with key Government officials.

Mr. Howard Lewis, vice president of the National Association of Manufacturers, guided the work of the task force, which was chaired by Mr. Christopher Padilla of AT&T.

America's high-technology industries are indebted to Howard and Chris, to N.A.M. president Jerry Jasinowski, and to the task force members for this breakthrough.

This bill also incorporates recommendations that our subcommittee has received in the four hearings that we have held over the past 5 months.

Our subcommittee chairman, SAM GEJDENSON, is leading the congressional effort to rewrite export controls, and I am working with him on a bipartisan basis on this issue. The result of the task force and our hearings is this legislation, which ends the cold war basis for export controls; establishes a new policy that export controls for proliferation goals must be multilateral; sharply restricts the use of unilateral controls; ends the fruitless use of export controls for diplomatic leverage; and which streamlines the export control system, focusing on a much smaller list of items that are in reality controllable in the real world—and that have a direct role in dangerous weapons systems.

With introduction of this bill, we will enter the next stage of our work. Together, I, Congressman OBERSTAR, and our high-technology executives will contact Members of Congress to sign up sponsors. I will discuss this with the President and seek his support as his people begin writing their bill. And when we come to mark up next February, we will see major elements of this bill incorporated in our subcommittee's legislation.

By next June, we will see most of this bill become law. And we will have done something truly important for our high-technology industries, and for our national security.