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House of Representatives

The House met at 10 a.m.
The Chaplain, Rev. James David Ford, D.D., offered the following prayer:

We recognize, O God, that we as a people have been blessed with means both spiritual and material, that we have been given knowledge and insight into the workings of the world and the revelations of the human spirit. Yet, we know too that we have not always aspired to use our resources in ways that strengthen our land and give vision and hope to every person. May Your word, O God, speak to us, may Your spirit inspire us, and may Your grace encircle us this day and every day. Amen.

T H E J U R N A L

The SPEAKER. The Chair has examined the Journ.al of the last day’s proceedings and announces to the House his approval thereof.
Pursuant to clause 1, rule I, the Journ.al stands approved.

P L E D G E O F A L L E G I A N C E

The SPEAKER. Will the gentlewoman from Missouri [Ms. McCARTHY] come forward and lead the House in the Pledge of Allegiance.
Ms. McCARTHY 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.

M E S S A G E F R O M T H E S E N A T E

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate agreed to the following resolution:

S. Res. 234

Whereas, the Senate fondly remembers former Secretary of State; former Governor of Maine, and former Senator from Maine, Edmund S. Muskie;
Whereas, Edmund S. Muskie served six years in the Maine House of Representatives, becoming minority leader;
Whereas, in 1958, voters made Edmund S. Muskie the State’s first Democratic Governor in 20 years;
Whereas, after a second two-year term, he went on in 1964 to become the first popularly elected Democratic Senator in Maine’s history;
Whereas, Edmund S. Muskie in 1966 was chosen as Democratic Vice-Presidential nominee;
Whereas, Edmund S. Muskie left the Senate to become President Carter’s Secretary of State; and
Whereas, Edmund S. Muskie served with honor and distinction in each of these capacities: Now, therefore, be it

Resolved, that the Senate has heard with profound sorrow and deep regret the announcement of the death of the Honorable Edmund S. Muskie, formerly a Senator from the State of Maine.
Resolved, that the Secretary communicate these resolutions to the House of Representatives and transmit an enrolled copy thereof to the family of the deceased.
Resolved, that when the Senate adjourns today, it adjourns as a further mark of respect to the memory of the deceased Senator.
The message also announced that the Senate had passed without amendment concurrent resolutions of the House of the following titles:

H. Con. Res. 146. Concurrent resolution authorizing the 1996 Special Olympics Torch Relay to be run through the Capitol Grounds; and
The message also announced that the Senate had passed a concurrent resolution of the following title, in which the concurrence of the House is requested:

S. Con. Res. 49. Concurrent resolution providing for certain corrections to be made in the enrollment of the bill (H.R. 2854) to modify the operation of certain agricultural programs.

A N N O U N C E M E N T B Y T H E S P E A K E R

The SPEAKER. The Chair will recognize 15 Members on each side for 1-minute.


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

Mr. BALLENGER. Mr. Speaker, most working men and women in this country prefer the Republican vision of the future. They support a change in the way the Federal Government works and operates, they want a change in the way the welfare system operates, they want an end to race and gender preferences on the job and in our schools, and they want to decide who spends their money and on what. Yet, the self-proclaimed champions of “working men and women” resist this popular agenda at every turn.

On Monday, a group of elite, liberal, big union bosses levied a $35 million tax increase on the men and women of the AFL-CIO, money they will use to attack the pro-family, pro-middle-class agenda of change offered by this Republican-led Congress. Despite their efforts, the union bosses better be wary, because it is only a matter of time before the rank and file throws them out and replaces them.


(Mr. TRAFICANT asked and was given permission to address the House, and was recognized for 1 minute.)

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for 1 minute and to revise and extend his remarks.)

Mr. TRAFICANT. Mr. Speaker, I will support the health reform bill today; portability is long overdue. But I do have a question. What good is portability to many Americans who do not have a job?

It is about jobs, Congress, and around here jobs has become an absolute four-letter word to the highest degree.

Check out some of the new high paying jobs American workers could apply for: Deep fried foods specialist. Gizzard skin remover. Corn cob pipe assembler. Pantyhose crotch closer machine operator. How about a poultry impregnator? Tell me, Mr. Speaker, what exactly is a poultry impregnator?

I am going to vote for the health reform bill, but it is a help to those who have, but it does absolutely nothing for those that have not. A job, that is.

Think about that.

THE REFUSE-TO-LOSE BASKETBALL OF MY UMASS MINUTEMEN

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

Mr. TORKILDSEN. Mr. Speaker, I rise today to recognize the extraordinary accomplishments of the all-but-ordinary UMass Minutemen, the best basketball team in the country.

Center Marcus Camby has dominated as a scorer, rebounder, and shot-blocker, and is the best player in the country.

Starting guards Carmelo Travieso and Edgar Padilla personify teamwork. They combine their unique talents, under any circumstance, to make an assist, shoot a three, steal a ball, or steal a game.

Donta Bright is the best finisher in the country. And Dana Dingle is one of the quietest threats in college ball, average games.

But no description of the UMass team would be complete without recognizing the enormous contribution made by Coach John Calipari, the best coach in the country. As the Minutemen sprinted from Midnight Madness to March Madness, Coach Cal reminded America that through hard work and determination, good guys can finish first.

As the only UMass-Amherst graduate ever to serve in Congress, I share great pride in our team.

And for all those who marvel at the success of refuse-to-lose basketball, and UMass itself, there is only one message: The best is yet to come.

WHO DO WE TRUST?

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

Mr. HAYWORTH. Mr. Speaker, I listened with great interest to my colleague from Missouri. Many things she said I agree with: the notion of health insurance being able to be taken from job to job; the notion of affordability and portability is important. But again my friends on the other side would rather play politics and indulge in name calling than deal with sound policy.

No, it is not extreme to let the American people have medical savings accounts so that they can decide how to spend their health care dollars. Mr. Speaker, the fact is that will help American taxpayers and the hard-working men and women of America immensely, and once again, Mr. Speaker, it comes down to this basic question: Who do we trust; the people of the United States or the Washington bureaucracy?

Mr. Speaker, I trust the people of the United States.

END HEALTH CARE INSURANCE DISCRIMINATION

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

Mr. BENTSEN. Mr. Speaker, the House later today can do something that has really been quite rare in this Congress. What is the legislation that will actually help average Americans, and I would say to the gentleman from Arizona, we can pass legislation that 191 Members of this House on both sides of the aisle support, that was introduced by a Member of the gentleman’s side of the aisle, the 55 Members of the other body, a majority of the other body, support, that every group, from the American Medical Association and the American Hospital Association to the independent insurance agents and the National Association of Manufacturers support.

We can pass legislation that does away with insurance discrimination for preexisting conditions, that says, if someone loses their job or gets sick, they can still retain their right to buy insurance that has common sense market reform, that everyone should agree with, and not load it up with special interests’ gobbledygook which will kill this bill forever.

This Congress has accomplished virtually nothing, but today we have an opportunity to get something passed that the other body will pass in April, that the President will sign, and do right by the American people.

So the gentleman from Arizona [Mr. HAYWORTH] is way off base with what he is saying. Let us do right by the American people and pass a democratic substitute of health care reform.

FOOD AND DRUG ADMINISTRATION REFORM

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

Mr. BURR. Mr. Speaker, the United States has the best health care system in the world. It is unthinkable for Americans to have anything less than superior access to lifesaving drugs. By safety streamlining the drug approval process we can not only help families and seniors by lowering drug prices and keeping high paying jobs on American soil, but we will generate billions of dollars in the world. It is unthinkable for Americans to have anything less than superior access to lifesaving treatments.

Yesterday patients from across this country came to Washington and told us their hard stories about being denied access to drugs that may, in fact, save their lives. It is these courageous people that inspire us to reform the Food and Drug Administration.

America’s health care industry and patients are chained to a FDA process that provides no flexibility, no common sense, and has no human face. The average time for the drug approval in this country is a whopping 13 to 15 years. For terminally ill patients with no hope that timetable simply will not do.

I urge my colleagues to watch FDA reform as it comes to this House floor later this month.

DO NOT KILL HEALTH CARE REFORM

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

Mr. PALLONE. Mr. Speaker, by adding these medical savings accounts to
the health care reform bill today, the Republican leadership is essentially killing health care reform. What they are doing is making it possible for the wealthy and the healthiest among us to get into these medical savings accounts and take away their contribution from the risk pool, so that what is left is that the average person’s premiums are going to go up, because if someone is not wealthy and they are not healthy and they have to stay in the traditional health insurance pool, they are virtually going to have to pay more, and the bill is going to be less affordable.

Do not load down this bill. Just listen to this quote from Senator Robert Bennett, a Republican who says, “The Republicans on the House side are going to turn this bill into the vehicle to attach MSA’s and other things, and they are actually going to have to pay more, and the bill is going to be less affordable.

That is what the Republican leadership is doing today, killing this bill with all this extraneous material that only helps wealthy people and exposes the rest of the country to higher premiums for their health insurance.

VOTE FOR THE REPUBLICAN HEALTH CARE REFORM PLAN

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

Mr. KINGSTON. Mr. Speaker, when it comes to this health care debate, we have to ask ourselves: What are the Washington liberal Democrats afraid of? Why are the Democrats so anticonsumer choice? Why are they so against power to the people? Why are they doing everything possible to defeat medical savings accounts, which would allow their own constituents to have more health care choices without the edicts and interference of insurance companies, health care agencies, managed care business types? Why are Democrats afraid of consumer choice?

It is simple. If the Democrats find out that they are in a better position to make choices that suit themselves better than what Washington liberals want them to do, then their consumers and constituents are going to figure that out, too. We do not need all the bureaucracy that the Democrats keep taxing us for. In fact, we do not need these Democrats. They will probably invite them to come home. That, Mr. Speaker, seems to be why they are so afraid of anything that would give more decision-making power to the American consumers and less to the Washington bureaucracy. Vote for the Republican health care reform plan.

SUPPORT GOOD HEALTH CARE REFORM: SUPPORT THE KENNEDY-KASSEBAUM BILL

(Ms. JACKSON-LEE of Texas asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in the name of bipartisanship and good health reform, but I wonder if many of us know the story of Robin Hood and the seven thieves, because that is just what we have today. The whole issue of health reform has already gotten bipartisan support by putting on benefits for the wealthy. Just like the tax breaks, here they come again. These medical savings accounts are basically a boondoggle to benefit wealthy, healthy people. They take their money and put it in savings accounts and get a tax advantage. That leaves the rest of us, who are poor, who are sick, the regular working guy, to pay higher insurance rates. That is not right.

Every major editorial paper in this country has criticized these medical savings accounts because they only benefit a few wealthy people. We need bipartisanship. We have an opportunity. Please, Republicans, do not ruin it.

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LaSALLE LANCERS: 1996 OHIO STATE DIVISION I HIGH SCHOOL BASKETBALL CHAMPIONS

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

Mr. CHABOT. Mr. Speaker, I want to take a moment this morning to pay tribute to the 1996 Ohio State Division I high school basketball champions, the LaSalle Lancers of Cincinnati, OH. After finishing in last place in their league during the regular season, LaSalle refused to give up. The team confounded the experts by going all the way to Columbus, knocking off powerhouse Toledo St. John’s in the State championship game on Saturday night and winning the entire State championship.

I will admit to some personal bias in this instance. LaSalle High School is not only in my congressional district, it is in my alma mater. In fact, I got my start in politics at LaSalle running for student council office. I realize some people probably still hold LaSalle responsible for getting my political career off the ground, but that is life.

Coach Fleming and Coach Scott Tillet, about whom a wonderful front page article appeared in the Cincinnati Enquirer yesterday, and all of the fine young men that were on the team at LaSalle, they brought so much glory to our hometown, they certainly are entitled for more.

I want to thank the LaSalle Lancers and congratulate them for winning the State championship this year. Way to go, Lancers.
tax deductibility for the self-employed, authorizing small employers' purchasing pools, and allowing Americans to have medical savings accounts. We are going to accomplish this without increasing government bureaucracy or writing thousands of new regulations.

Mr. Speaker, we are increasing access while lowering costs. Should that not be the goal of any health care legislation? Are we doing it with as little government influence as possible, or interfering by using our colleagues to implement it? Do we have medical savings accounts? Where in medical savings accounts, the patients suddenly become more prudent and discriminating consumers, both the provider and the patient, are not the ones picking up the tab, and in medical savings accounts, the patients suddenly become more prudent and discriminating consumers?

The health care inflation in this Nation would be a huge benefit to our economy, a huge benefit to our industries, and a huge benefit for our competitiveness in the international markets. It is good for consumers. Support the Republican health care bill.

Because it was not a Washington command and control idea, they do not like it. Because it does not limit your choices, the other side does not like it. Because it is not an old government idea or solution, they do not like it. Mr. Speaker, I rise to address the House for 1 minute and to revise and extend her remarks. Mr. Speaker, this is a new idea. It saves costs. It saves premiums. It is a good idea. It is time for it.

THE HEALTH CARE REFORM BILL

Ms. MCKINNEY. Mr. Speaker, last Friday was political payday for the NRA with a vote to repeal the assault weapons ban. Yesterday was political payday for the antichoice crowd with a vote to ban an extremely rare abortion procedure. And today, Mr. Speaker, is political payday for the Golden Rule Insurance Co. and its medical savings account scheme.

Today we will vote on a health insurance reform bill which includes medical savings accounts, at a cost of $2 billion to taxpayers. It is no coincidence, however, that the Golden Rule Insurance Co. has given more than $14 million to Republicans.

This chart, Mr. Speaker, demonstrates how a few large, well-placed contributions to the GOP resulted in today's vote on medical savings accounts. Mr. Speaker, the old saying is true: He who has the gold, rules. And while the American people want serious health insurance reform, all they are getting from the GOP is cash-and-carry government.

SUPPORT NEEDED AMENDMENT TO HEALTH CARE REFORM TO PROVIDE FOR LONG-TERM CARE

Mr. ENSIGN. Mr. Speaker, the Senate bill was, frankly, inadequate. I offered an amendment in the Committee on Ways and Means, which was accepted, which will address long-term health care for Americans. Most elderly Americans are unaware of the magnitude of long-term care costs and of the limits of Government assistance. Mr. Speaker, I strongly urge that Government programs and their inflation will cover the costs of any long-term care services they might need. The reality is that the cost of
long-term care can quickly wipe out the assets of even those who have worked and saved for a lifetime.

For example, the average cost of nursing home care is now over $38,000 a year. If you happen to need such care, your options are limited under the current system. Only about 2 percent of long-term care costs are handled by private insurance. Normally, everyone else pays out of pocket or is forced to Medicaid, to the degree that nearly 40 percent of Medicaid costs are swallowed by long-term care components.

This bill now includes the language that allows tax deductions for long-term care services, as is allowable for medical services. I urge the support of this amendment and the support of this bill.

URGING PASSAGE OF THE KASSEBAUM-KENNEDY-ROUKEMA HEALTH CARE REFORM BILL

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

Mr. OLIVER. Mr. Speaker, American families are losing their health insurance because of downsizing. The original Kennedy-Kassebaum health insurance bill was bipartisan common-sense reform that gave families a few simple protections. It cut down on denials due to preexisting conditions, it helped people get individual coverage when they lost group or COBRA coverage, it began chipping away at job lock, where fear of losing health insurance keeps people from changing jobs.

But the House Republican leadership is turning straightforward reform into a gooie bag for a privileged few. Medical savings accounts, a payoff to a fat cat contributor to the majority. Limits on malpractice awards to people whose lives and dreams have been ruined.

The Republican leadership has demonstrated once again they just do not care about average working people. We should pass the Kennedy-Kassebaum-Roukema bill and not a special interest spinoff. It is the very least we can do.

CHANGE THE RULES ON OIL

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

Mr. SAM JOHNSON of Texas. Mr. Speaker, it has been 5 years since the gulf war, and we have done nothing to end our dependence on oil, foreign oil.

Today the United States imports more than 50 percent of its oil from foreign countries, not because we want to, but because our laws have forced us to. When we mandate that all companies have to get 1,000 permits and regulations to drill just one well, anytime we increase the regulatory cost by $37 billion, when we close off their access to oil-rich land and when we support a destructive tax code that contains provisions like the alternative minimum tax, we are just asking for lost jobs and foreign dependence.

Is it any wonder our oil companies have lost over 50,000 jobs since 1972, closed 40 refineries and moved to Vietnam, China, and Russia? Mr. Speaker, we must change the rules to allow our oil industry to flourish, create jobs and provide a strong and secure America for us and our children.

HEALTH CARE REFORM

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

Mrs. KENNELLY. Mr. Speaker, today we have a choice. We can take a simple, single step to ensure people who change their jobs or lose their jobs that they can take their health insurance with them. Or we can let this simple, necessary piece of legislation get totally complicated in a maze of complications.

It cannot be said too often. Everybody agrees that individuals who change their job should be able to take their health insurance with them. People who are in a job should not be locked in that job because they are afraid they will lose their health insurance. Mr. Speaker, in my book entitled Autobiography by Ronald Reagan, he went on to say: And the President needs a line-item veto to cut unnecessary spending.

The number of producing wells in the United States imports over $38,000 a year. In 1991 we imported 45 percent of Medicaid costs are swallowed by long-term care components. No nation can be secure with such dependency, and because 60 percent of America's oil wells, 60 percent, Mr. Speaker, are developed not by major oil companies but by independent producers, it is in America's national interest to do all that we can to provide an independent producers of petroleum.

HEALTH CARE REFORM

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

Ms. De LAURO. Mr. Speaker, today we have a golden opportunity to pass health care reform which, in fact, will be a first step to improving the lives of hard-working Americans. People that I hear from every day in my community say to me they are scared to death that, if they change their jobs, they will lose their health care or, if they or their children develop an illness which they have managed to survive, that in fact insurance companies will deny them insurance because of a pre-existing condition.

The piece of legislation that we talk about today, a bipartisan piece of legislation, can help begin to change that fact in the lives of working families today. What is stopping this event? The Republican leadership has decided to load this up with special goodies for their special interests.

Mr. Speaker, let me just quote the Washington Times. Do not take my word for it. The Washington Times, not a liberal newspaper, says that riders imperil health reforms. That is what this is about.

My Republican colleague of the Committee on Commerce, Mr. Bliley, the chairman, said yesterday, and I quote, 'The more you load the wagon, the heavier it is to move.' Do not let them pass this bill with these riders. It will end health care for working families in this country.

THE LINE-ITEM VETO

(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 and my colleagues, today is perhaps the most exciting day in my 18-year career here in this Congress, as it is for another former President, President Ronald Reagan. President Reagan, I hope you are listening. You said in your book entitled Autobiography by Ronald Reagan, on American life with the following paragraphs, you said: And yet, as I reflected on what we had accomplished, I had a sense of completeness, that there was still work to be done.

President needs a line-item veto to cut out unnecessary spending.
Today, the Congress is agreeing, the Senate has already acted. We will act in the next hour, and we will send to the President a true line-item veto that is going to put a dent in this big-spending Congress once and for all, and the American people are going to yell hooray, hooray, hooray.

PREEMPTION OF STATE PROTECTIONS IS A BAD IDEA
(Mr. GENE GREEN of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GENE GREEN of Texas. Mr. Speaker, today the House Republicans will pass up a golden opportunity to advance realistic bipartisan health care reform when it considers H.R. 3103, instead of sponsoring and passing the Roukema-Kassebaum-Kennedy health reform bill that I cosponsored.

The bill which the House considers today has disastrous consequences for consumers. Carefully crafted State insurance laws will be replaced by a uniform standard developed and implemented by the Department of Labor here in Washington. That is right. We are taking away States’ ability to regulate and move it here to Washington. They want to move it to an agency that one of my Republican colleagues said was led by what he thought was a Communist.

What does this mean to the average American family? State statutes and rules requiring certain benefits be covered by health insurance policies may no longer apply. For instance, many States like Texas, where I am from, have statutes requiring the inclusion of newborn infant coverage in their State law. That will be wiped out if this bill passes today.

Under the Republican health plan, this may no longer apply. This is moving from State control to Washington control. That must have been in the fine print of the Contract With America.

A GREAT DAY FOR AMERICA
(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, I think that the gentleman from New York [Mr. SOLOMON] said it very well. This is a historic day in this body. We are going to pass the line-item veto today. It is something that we have worked hard on and long on, and we finally are in a position where we are going to deliver a version of the line-item veto which works.

This is part of the new majority here. We are getting spending under control. This matters to America, so I hope America tuned.

It is also remarkable to me that on the very same day we are doing this historic event, we are also going to be bringing forward the first meaningful health care reform in many, many a year for the people of this country who need access to affordable health care. That is in the agenda for today as well, and I believe we are going to get that done, too. A great day for America.

HEALTH CARE REFORM
(Mr. ROMERO-BARCELÓ asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. ROMERO-BARCELÓ. Mr. Speaker, today, the House will begin consideration of the Health Coverage Availability Act. As we embark on this very important discussion, I would like to urge my colleagues on the other side of the aisle not to pass up on what is a truly golden opportunity to advance realistic, bipartisan health care reform legislation.

History has shown us that past efforts to tackle this issue have failed largely because they tried to accomplish too much. Unfortunately, by giving in to special interest groups, the majority seems to be headed down that same path once again.

Let’s keep things simple. The Roukema-Kassebaum-Kennedy [RKK] bill is a sound piece of legislation that has broad bipartisan support. By helping millions of Americans keep their health insurance when they switch jobs, regardless of their health condition, it provides a much needed and relatively noncontroversial solution that a vast majority of the Members of this Chamber can agree on.

The demands of the moment require both Democrats and Republicans to unite behind the RKK bill if there is to be any realistic possibility for health reform during this Congress. Let us pass RKK now. The other issues can be worked out separately and moved separately.

REPUBLICANS PAY BACK TO SPECIAL INTERESTS
(Mr. VOLKMER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. VOLKMER. Mr. Speaker, the Republicans are at it again. No different than we have done in the past here, my colleagues take a good bill, one that every single House Republican has supported to pass, the Senate supports it, the President supports it. It is known as the Roukema-Kassebaum-Kennedy bill. It provides for portability, it provides for health care for preexisting conditions. And then my colleagues take that good bill and they put a terrible piece of legislation along with it, because they think well, we cannot pass that terrible piece of legislation by itself, and we can only pass it if we tack along.

Mr. Speaker, this is what they are doing. They are tacking it on. And what is it? It is payoff time. It is payoff time to the special interests of this House, the people that are paying for the Republicans’ campaign. That is what it is.

What does the Washington Times say about it? “Riders imperil health reforms.”

So really, do they want to do health reform? No; they want to pass something for their special interests. That is what they want to do. Let us vote them down.

PERMISSION FOR SUNDRY COMMITTEES AND THEIR SUBCOMMITTEES TO SIT TODAY DURING THE 5-MINUTE RULE
Mr. SOLOMON. Mr. Speaker, I ask unanimous consent that the following committees and their subcommittees be permitted to sit today while the House is meeting in the Committee of the Whole under the 5-minute rule. Those committees are the Committee on Banking and Financial Services, the Committee on Commerce, the Committee on Economic and Educational Opportunities, the Committee on Government Reform and Oversight, the Committee on International Relations, the Committee on the Judiciary, the Committee on National Security, the Committee on Resources, the Committee on Science, the Committee on Transportation and Infrastructure, and the Permanent Select Committee on Intelligence.

Mr. Speaker, it is my understanding that the minority has been consulted and that there are no objections to this request.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Is there objection to the request of the gentleman from New York?

There was no objection.

PROVIDING FOR CONSIDERATION OF H.R. 3136, CONTRACT WITH AMERICA ADVANCEMENT ACT OF 1996
Mr. SOLOMON. Mr. Chairman, by direction of the Committee on Rules, I call up House Resolution 391 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 391
Resolved, That upon the adoption of this resolution it shall be in order without intervention of any point of order (except those arising under section 425(a) of the Congressional Budget Act of 1974) to consider in the House the bill (H.R. 3136) to provide for the enactment of the Senior Citizens’ Right to Work Act of 1996, the Line Item Veto Act, and the Small Business Growth and Fairness Act of 1996, and to provide for a permanent increase in the public debt limit. The amendments specified in the report of the Committee on Rules accompanying this resolution shall be considered as ordered on the bill, as amended, and on any further amendment thereto to final passage without intervening motion except pursuant to a motion for a period of debate on the bill, as amended, equally divided and controlled by the chairman and
ranking minority member of the Committee on Ways and Means; (2) a further amendment, if offered by the chairman of the Committee on Ways and Means, which shall be in order with the previous question of any point of order (except those arising under section 425(a) of the Congressional Budget Act of 1974) or demand for division of the question, shall be debatable for not more than 10 minutes equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit, which may include instructions only if offered by the Minority Leader or his designee.

Sec. 2. If, before March 30, 1996, the House has received a message informing it that the Senate has adopted the conference report accompanying the bill (S. 4) to grant the power to the President to reduce budget authority, and for other purposes, then—

(a) in the engrossment of H.R. 3136 the Clerk shall strike title II (unless it has been amended) and redesignate the subsequent titles accordingly; and

(b) the House shall be considered to have adopted the conference report.

Mr. Speaker, this rule provides for consideration in the House of H.R. 3136, as modified by the amendments designated in the Committee on Rules report on this resolution. This rule provides for two amendments. The first amendment is to title III of the bill relating to regulatory reform, and the second amendment is to title I of this bill relating to the Social Security earnings test limit. Both of these amendments address concerns of both houses of Congress and the administration that have been included in the bill in the spirit of bipartisan cooperation. It is hoped that the final product will meet the concerns of all parties involved.

The rule allows all points of order against consideration of the bill except those arising under section 425(a) of the Budget Act relating to unfunded mandates. The rule provides for 1 hour of debate equally divided between the chairman and ranking member of the Committee on Ways and Means, and of course we have just enacted an addendum to that, an amendment giving the gentleman from Pennsylvania [Mr. Clinger] and his committee an additional 30 minutes, equally divided between the chairman and the ranking member.

The rule further provides for the consideration of an amendment to be offered by the gentleman from Texas [Mr. Archer] or his designee, which is debatable for 10 minutes. This further amendment was provided to the manager of the bill in order to accommodate any further negotiations between Congress and the administration that occur prior to the Committee on Rules reported this bill. It is my understanding now, however, that the use of this authority will not be necessary. Upon completion of debate, the rule provides for one motion to recommit which, if containing instructions, may only be offered by the minority leader or his designee.

Finally, Mr. Speaker, the rule provides that if before March 30, 1996, the House has received a Senate message stating that it has adopted the conference report on S. 4, which is the Line-Item Veto Act, then following House passage and engrossment of H.R. 3136, the Clerk shall be instructed to strike title II unless amended from this bill. This title contains the exact text of the conference report of Senate bill 4.

Furthermore, upon the actions of the House, it will be deemed to have adopted the conference report which is the line-item veto conference report. This final procedure has been included in the rule as part of our continuing efforts to expedite the consideration of this terribly, terribly important piece of legislation.

Mr. Speaker, as to the text of H.R. 3136, let me express my strong support for these Contract With America measures. Title I, the Senior Citizens Right to Work Act of 1996, is crucial legislation which will lift the current impediments seniors throughout my district and yours and throughout this entire country face as they try to increase their income by working in their later years. It is the most ridiculous thing when you have paid into Social Security with your own money, over all of these years, 30, 40, 50, 60, whatever it might be, that money is yours. It is being paid back to you from a trust, and yet you are penalized if you earn more than $11,000. The idea is to give back one dollar for every three you earn over $11,000. That is about the most undemocratic thing that I have ever seen. This bill is going to correct that.

Title II also provides relief that was made in 1994 and is a promise that is going to be kept today. Title III, the Small Business Growth and Fairness Act of 1996, will provide needed regulatory relief and flexibility to millions of small business owners, to farmers and families across this country, enabling these job creators, and these kind of businesses create 75 percent of every new job in America every single year. It also provides relief that was made in 1994 and is a promise that is going to be kept today. Title IV is the line-item veto conference report.
The conference leaders, led by the gentleman from Pennsylvania, Chairman Clinger, sitting next to me over here, are to be commended for bringing the House such thorough and historic budget process reform and getting it through the Senate.

Mr. Speaker, as you well know, I have been an ardent supporter of the line-item veto all these years. Nevertheless, I believe the conference report language before us today will provide the President, any President, regardless of political party, with an even more effective, yet limited line-item veto authority that I ever thought could be possible. Without question, it will result in lower, more responsible Government spending. Under the bill, the President is delegated the constitutional authority to cancel dollar amounts of discretionary appropriations. He is granted the ability to limit tax benefits or increases in direct spending, and these cancellations must be transmitted by special message to the Congress within 5 days of signing the original bill into law.

With report to dollar amounts of discretionary appropriations, the President is permitted to cancel specific items in appropriations bills, any governing committee reports or joint explanatory statements to accompany a conference report. What that means is the bill will also allow the President to cancel any increase in direct spending, which includes entitlements and the Food Stamp Program. Believe me, that is going to make a difference, since this is something we have been fighting for years, the bill has established a block vote mechanism lowering the statutory spending caps, locking in any savings gained through the use of the line-item veto.

How many times have we offered amendments on this floor and we have cut out spending on a project only to find the money was reinstated for another project later on? That is going to stop right now when the President signs this bill.

The bill also provides for expedited procedures in both the House and the Senate for consideration of a bill to disapprove any cancellation by the President. That disapproval bill would then be subject to a veto by the President, which would then have to be overridden by a two-thirds vote of both houses in order for the money, intended to be canceled, to be spent or to take effect. I intend to discuss the specifics of these expedited procedures later on in the debate, as will my good friend, the gentleman from Pennsylvania [Mr. Clinger], the chairman of the conference on line-item veto. However, I will say now that these expedited procedures were intentionally drafted to allow any Member, majority or minority, who can muster sufficient support to receive a vote to cut out spending on the floor of this House any particular veto.

The bill also provides for expedited judicial review of any challenge to the constitutionality of the act. No severability or nonseverability provisions were included in the bill, but it is the intention of the conferees that any judicial determination regarding the constitutionality of the bill be applied severally to the legislation. This is consistent with the current rule of thumb regarding constitutional challenges to any law that is silent on the issue of severability.

Finally, the line-item veto authority becomes effective on the date of the earlier of these two: enactment of a 7-year balanced budget plan, or January 1, 1997. This authority would sunset on January 1, 2005.

Now, there has been some discussion whether the delay in the effective date has been motivated by partisan politics, but let us set the record straight here and now. As stated in the Committee on Rules yesterday, this effective date has been agreed to by the signers of the conference report found on both sides of the aisle, which were bipartisan. The Senate majority leader and Republican nominee for President, Bob Dole, and President Clinton himself, after a conversation between Majority Leader Dole and the President, both agreed to this effective date publicly in press conferences. Furthermore, the effective date was also chosen in part to take away any partisan games involving the line-item veto. Take it out of the picture during the presidential election year.

Mr. Speaker, with that discussion of the rule and the major provisions of the line-item veto, I urge support of the rule and the bill for this historic occasion.

I include the following material for the Record:

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THE AMENDMENT PROCESS UNDER SPECIAL RULES REPORTED BY THE RULES COMMITTEE; 103D CONGRESS V. 104TH CONGRESS

[As of March 27, 1996]

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1 This table applies only to rules which provide for the original consideration of bills, joint resolutions or budget resolutions and which provide for an amendment process. It does not apply to special rules which only waive points of order against appropriations bills which are already privileged and are considered under an open amendment process under House rules.

2 An open rule is one under which any Member may offer a germane amendment under the five-minute rule. A modified open rule is one under which any Member may offer a germane amendment under the five-minute rule subject only to an overall time limit on the amendment process and the requirement that the amendment be presented in the Congressional Record.

3 A modified closed rule is one under which the Rules Committee limits the amendments that may be offered only to those amendments designated in the special rule or the Rules Committee report accompanying it, or which preclude amendments to a particular portion of a bill, even though the rest of the bill may be completely open to amendment.

4 A closed rule is one under which no amendments may be offered (other than amendments recommended by the committee in reporting the bill).

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SPECIAL RULES REPORTED BY THE RULES COMMITTEE, 104TH CONGRESS

[As of March 27, 1996]

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

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

Mr. Speaker, I thank the gentleman from New York, my chairman and my good friend, for his kind words.

Mr. Speaker, we have very serious concerns about this rule and about the bill that makes in order the so-called Contract With America Advancement Act. This legislation provides for an increase in the public debt limit to $5.5 trillion, but it also includes three measures that are completely unrelated to the debt limit and will add to the deficit.
it would be. We hope it is a good amendment.

The rule also sets up a highly unusual procedure, which the gentleman from New York [Mr. Solomon] described a few minutes ago, for disposing of the bills of the Congress. The rule provides that if the other body approves the conference report on this bill before Saturday and the House passes H.R. 3136, the conference report shall be sent to the President as a free-standing bill.

Because the Senate approved the conference report last night, that part of this bill will in fact be separated upon passage of this legislation. We believe it is unnecessary and unwise to construct final action on the Line Item Veto Act in this convoluted manner. There is no good reason why this matter should not be considered in the same way other conference reports are normally considered; that is, as a free-standing legislation and without reference to the other body. For that matter, there is no good reason why any of the extraneous legislation included in this increase in the debt limit must be included.

While we understand that the inclusion of the three bills here reflects an agreement, reached between the President and the Republican leadership in both Houses, we regret that is the case. We think it would have been much more responsible and appropriate for us to consider a simple, straightforward debt limit increase.

The raising of the debt limit is an extremely urgent matter, as we all know. The fact this very necessary legislation is encumbered with unrelated controversial matters will cause, unfortunately, some of us who otherwise would support raising the debt limit to instead vote against it.

In the Committee on Rules last night, we offered an amendment to make in order a clean debt limit increase. Unfortunately, Mr. Speaker, our amendment was defeated on a party line vote, as were several other amendments we offered that would have given the House more choices in the outcome of this important legislation.

Mr. Speaker, the most troubling portion of this legislation, in my view, is the Line Item Veto Act conference report. While we all agree that reducing Federal budget deficits is one of the most important tasks facing us, many of us do not believe that providing the President with the extraordinary new authority contained in the Line Item Veto Act will do much, if anything, to help us achieve that goal.

What this legislation will do is transfer power to the President in a way that is not in any way constructive. The President’s cancellation of line items in appropriations, which includes not only items listed in bills but also in committee reports and joint statements of managers or direct spending or targeted tax benefits, would automatically take effect unless Congress specifically overrides the President’s action. This procedure would result in a dramatic and quite possibly unconstitutional shift in responsibility and power from the legislative branch to the executive branch. This broad shift of powers could easily lead to abuses. The President could target the rescissions against particular legislators or particular regions of the country or against the judicial branch. This power could be used to force Congress to pay for a pet Presidential project that a majority of legislators oppose or to agree to a policy that is completely unrelated to budgetary matters.

Furthermore, we would be transferring this unprecedented amount of power to the President with little reason to believe that it would have much of an effect on the Federal budget deficit. This new line item veto would be used primarily for annually appropriated discretionary spending. However, discretionary spending, as Members know, which accounts for less than one-third of the budget, is already the most tightly controlled type of spending, since it is subject to strict caps. It has been declining both as a percentage of the total Federal budget and as a percentage of GDP for the last several years and is unlikely to do so into the foreseeable future.

Additional controls in this area of the budget will not accomplish much, if anything, in the way of deficit reduction. In fact, discretionary spending is an area of the budget where Presidents have wanted more spending than Congress has approved. According to the Office of Management and Budget, from 1982 to 1993, Congress appropriated $39 billion less than the President had requested.

In addition, over the last 20 years, Congress has rescinded $20 billion more than the President has requested in rescissions. If those patterns continue and the President is given greater leverage in the appropriations process, it is likely that he will use this new line item veto authority as a threat to secure appropriations for programs he wants funded rather than to reduce total amount of spending.

I would also like to point out that the legislation is unlikely to accomplish what its advocates claim it will in the way of including special-interest targeted tax benefits under this new authority. That is because the bill allows the Joint Tax Committee, which is controlled by the House and Senate tax-writing committees, to determine what provisions in the bill constitute a targeted tax benefit before it is sent to the President. Thus it is highly unlikely that many special-interest tax benefits, if any at all, will be subject to the line item veto authority.

For all of these reasons, Mr. Speaker, if the House moves forward with approval of this line item veto authority, I believe even the measure’s most ardent supporter will in time come to regret it.

The other troubling piece of this package, at least in this Member’s view, is the increase in the Social Security earnings limits for recipients aged 65 to 69. While this legislation is extremely popular, I believe it moves in the wrong direction in terms of what we need to accomplish to control spending, and perhaps it is more than a little ironic that it is coupled with the line item veto in this piece of legislation. This part of the legislation would increase Social Security retirement benefits by an estimated $7 billion over the next 7 years alone. Most of that benefit increase also, most, would go to relatively well-off recipients while the spending cuts used to pay for those benefit increases would fall on those of more modest means.

In addition, the legislation would take a giant step toward turning Social Security retirement benefits into a reward for turning age 65 rather than insurance against the loss of income that comes with retirement, as the Social Security system was designed to provide. We should carefully whether that kind of change is wise, particularly when we know we are facing a huge shortfall in the funds that will be needed to pay existing levels of benefits when the large baby-boom generation reaches retirement age in the early part of the next century.

Finally, Mr. Speaker, although many of us on this side of the aisle would have greatly preferred a rule providing for a straightforward debt limit extension, we believe that if this legislation is going to be encumbered with extraneous matters that are a priority to our Republican Members, then the rule also ought to permit us to at least consider legislative changes on this side of the aisle as well. One of our highest priorities is increasing the minimum wage.

So, at the end of this debate, we shall move to the previous question so that we may amend the rule to provide for consideration of an amendment that would raise the minimum wage in two steps to $5.15 an hour.

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

Mr. SOLOMON. Mr. Speaker, I yield myself 30 seconds.
Mr. Speaker, I yield 3½ minutes to the gentleman from Sanibel, FL [Mr. Goss], one of the most respected and hardest-working Members of this body. He is a member of the Committee on Rules and also a tremendous help as a conferee on the line-item veto measure.

(Mr. GOSS asked and was given permission to revise and extend his remarks.)

Mr. Goss. Mr. Speaker, this is a fair rule, but an important hand that allows the House to approve necessary legislation to preserve the full faith and credit of the United States—while keeping important promises to the American people. I confess, I am extremely uncomfortable voting for an extension of the debt ceiling, to bring our spending under control. Finally, Mr. Speaker, I am delighted that this legislation includes the Senior Citizens' Right to Work Act, legislation to increase, to restore some fairness to our tax code for seniors. I take my hat off to the gentleman from Kentucky [Mr. Bunning] for the incredible work he has done on that, as well. The Social Security earnings limit is a dinosaur—and it discriminates mightily against those seniors who want to be productive. This is our first step toward the ultimate goal of repealing the unfair restriction altogether. Support this rule and the bill.

I take my hat off to the gentleman from New York [Mr. Solomon], the chairman, and the gentleman from Pennsylvania [Mr. Clinger], the chairman, and the gentleman from Massachusetts [Mr. Blute], for the extraordinary work they did in prevailing in the conference on this version we are passing today.

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes to the gentlewoman from California [Ms. Woolsey].

(Ms. Woolsey asked and was given permission to revise and extend her remarks.)

Ms. Woolsey. Mr. Speaker, I strongly urge my colleagues to reject this unfair rule. If we are going to attach unrelated items to this debt limit extension, then I believe the working people of America deserve to know why the Gingrich Republicans will not allow the House to vote on an amendment that would increase the minimum wage.

What is the majority so afraid of? Why are they in opposition to paying working parents enough, enough to support their families and enough to take care of their kids? Clearly, Mr. Speaker, the new majority is not about to do something good for the working families of this country and to make work pay.

To my colleagues who care about working people in this country, I urge you to reject this rule and show the new majority that it is high time for an increase in the minimum wage.

Yesterday the Committee on Rules rejected my request to offer an amendment to increase the minimum wage. They have left in the cold families who are working hard and playing by the rules and who are being left behind. Think about it, the minimum wage today is $4.25 an hour. That means the approximate annual salary for a full-time minimum wage worker is $8,500, barely half the official poverty line for a family of four and below what people make on welfare. They would deny a 90-cent-an-hour increase. Imagine 90 cents. This, from people who make over $130,000 a year.

Members of Congress earned more during the Government shutdown than a full-time minimum wage worker earns in a single year.

America needs a raise. Reject this rule. Help hard-working families by putting more money in their paychecks.

JERRY, if you can just give us some regulatory relief, in other words, so we don't have to spend so much of our money meeting these silly rules and who are being left behind. I yield 1 minute to the gentlewoman from Connecticut [Ms. Delauro].

Ms. Delauro. Mr. Speaker, I yield myself 30 seconds just to respond to the last two speakers, to say that yes, there is some merit in raising the minimum wage. I believe that it should be raised. But, just to give an example, I met with farmers from all over New York State yesterday, and we discussed that and how it would reflect on them. They said:

JERRY, if you can just give us some regulatory relief, in other words, so we don't have to spend so much of our money meeting these silly rules and who are being left behind.

Let the regulatory relief bills go through that we pushed for the last 2 years, and I think you would find some support.

Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania [Mr. Clinger], someone I have great respect for. The gentleman came to the body 18 years ago with the rule and the chairman of the Committee on Governmental Reform and Oversight. He was the chairman of our conference for over a year on the line-item veto. If you want to...
Mr. Speaker, this is one of those occasions when every Member of this body should be mindful of the undertaking that we make at the beginning of every Congress to protect and defend the Constitution of the United States, because the provision in this proposed bill runs absolutely in the face of that obligation.

The first words of the Constitution are, "All legislative powers herein granted shall be vested in a Congress of the United States." A few pages later, the Constitution states as follows: "If he approves, he shall sign it," — the bill — "but, if not, he shall return it with his objections."

These are the basic parameters of the legislative responsibilities that we have under the Constitution and that the President has under the Constitution, and it is not in our power to change them. It is our responsibility in fact to respect and preserve them.

While the friends that we have across the ocean in Britain are having second thoughts about their monarchy, this line-item veto provision and its effect will be to start the gradual accretion of power in an American monarchy.

What recalls those grand words of the Declaration of Independence in which we protested the usurpation of power by King George, then mark my words, we will lose regard the usurpation of power that we invite by future Presidents of the United States if this provision becomes law.

Thank God that the courts will be there to do the right thing and find it, as it is, contrary to the Constitution.

The court has spoken to this point many times, but most recently and on point I think in the Chada case, making it absolutely clear that the powers of neither branch with respect to the other are restricted, and responsibility on legislation can be eroded.

What is even more bizarre in this particular proposal is the provision for the 5-year "cancellation" period. Now, think about that. This is a metaphysical leap of Herculean proportions.

The enactment provisions of the Constitution say that once the President signs a bill, it shall be law. We propose that he then gets a 5-year cancellation right after signing a bill? That is absolutely ridiculous and no logical reading of the clear meaning of the Constitution with regard to these provisions.

But beyond the constitutional arguments, this proposal is fundamentally unwise, and it manifests a disrespect of our own responsibilities in this body under law and under the Constitution.

On the large issues, let us think back on the large issues, let us think back to what would have happened during the Reagan administration, with a President for his own reasons, sent budgets to this body zeroing out the most categories of education funding in the Federal budget. Presumably, if that President had this power, it would be exercised to eliminate most education funding by the U.S. Government, and 34 Senators representing 9 percent of the people of this country, in league with the President, could have brought about that outcome.

More pernicious, the invitation to usurpation that lies in this language can also be understood by going back to those days in the late eighties when we were still debating whether we would continue aid to the Contras. Now, if I happened to have been fortunate enough to have said, "I will sign a provision in an appropriations bill for a needed post office or a needed courthouse in my district, and it was down at the White House awaiting signature at the same time we were debating aid to the Contras," I would guarantee you I would have gotten a call from someone at the White House saying, "Congressman, I notice you had some success in dealing with this need in your district. We are pleased at that, but we need your support on aid to the Contras."

That is exactly the kind of absolutely evil excess of power that we are inviting future Presidents to use. Pick your issue. That is one that comes to mind.

It is clear that the Governors of the several States who have this power use it in exactly this way, to get their version of spending adopted in contradiction to the legislative judgment.

Mr. Speaker, I yield myself 30 seconds to just say to my good friend that I suspect he protests too much. From Thomas Jefferson to Richard Nixon, Presidents had the right of rescission. If they did not want to spend the money because it was not necessary, they did not have to do it. Unfortunately for America, this Congress took that President to the Supreme Court, and the Supreme Court made him spend the money. That is never happened, and that is why we are in the fiscal mess we are in today. We are attempting to turn around a little bit of that.

Mr. Speaker, I yield 3 minutes to the gentleman from Southgate, KY, Mr. JIM BUNNING, someone I used to worship when I was growing up. He was a hero of mine because of his baseball prowess, throwing no-hitters and pitching shutouts. He is no less a hero and was given permission to revise and extend his remarks.)

Mr. BUNNING of Kentucky. Mr. Speaker, I yield 5 minutes to the gentleman from Colorado (Mr. SKAGGS).

Mr. SKAGGS. Mr. Speaker, I thank the gentleman from California for the time.
Mr. Speaker, he who has chosen to load this bill with extraneous matters, including regulatory reform for small business, which is of questionable germaneness. The Republican leadership has deliberately decided not to allow this body to consider wage relief for the working poor.

Mr. Speaker, it is time for this House to give workers a raise, a raise that is long overdue. April 1 will mark the fifth anniversary of the last time the minimum wage was increased. The real wages of American workers have been declining for over two decades and the gap between rich and poor in this country continues to grow. In terms of distribution of wealth, the United States has become the most unequal industrialized nation in the world. Increasing the minimum wage is one modest step toward addressing this problem.

The Republican leadership of this House enjoys the distinction of destroying the spirit of bipartisanship on so many issues, including the minimum wage. In 1992, for example, the minimum wage increase passed this body by a vote of 392 to 37, with 135 Republicans voting for the bill, and 89 to 8 in the Senate, with the support of 36 Republicans. In fact, Speaker Gingrich, Senator Dole, and my committee chairman, Bill Goodling, voted for the last increase. Regrettably, Republicans now appear too embarrassed to even allow this body to vote on that issue.

We often talk about how important it is to get people off welfare. If we are serious about that, if we really want to get people off welfare as opposed to just talking about it, there is one simple way to do that—to make work pay. Recent studies suggest that 300,000 workers would be lifted out of poverty if the minimum wage were raised to $5.15 per hour. It is time to do something positive for the working poor.

Mr. Speaker, the vast majority of Americans support raising the minimum wage. It is unconscionable for the Republican leadership of this House to block the will of the American public. Defeat this rule, defeat the previous question, allow us to consider increasing the minimum wage.
which in fact placed, therefore, the fiscal stability of the international community at risk. Mr. Speaker, I will vote against this rule, and I will vote against it because it marries two issues, one which I very strongly support. KentUCKY. Finally, the Republican leadership has come to the extension of the debt until 1997, so that it will not be a political football but will be the recognition of fiscal responsibility. It is late but welcomed. However, they have married to that bill a line item veto. It is a line item veto which the gentleman from Colorado, one of the previous speakers, has characterized as contrary to the provisions of the Constitution of the United States. I agree with that premise. I am hopeful that the courts will find this provision unconstitutional, because I believe with Senator B r a d and I would hope with all of my colleagues that this is a radical shift of authority from the people of the United States and their representatives to the Executive of the United States.

Now, enhanced rescission. That is a device which would allow the President of the United States to take out of a piece of legislation and say to the American public, this item should not be passed but the bill should. But then the enhanced rescission would say, we have to bring it back to the House in the full light of the American public’s scrutiny in a democracy and pass it. But what it would not do is to give to the President the ability to take one-forward, one of a House say that I and I alone will top this from going into effect.

Mr. Speaker, that will be a radical shift of power. It is not surprising that we pass radical proposals in this Congress. The Budget Control Act of 1990, the Contract With America, the Brady Bill, and the Taxpayer Protection Act. The matter is it is bad policy. In my opinion, we will live to regret it.

It is ironic, indeed, that those who have waited 9 years, according to the gentleman from Kentucky [Mr. B U N N I N G], to see this legislation pass, propose today to have it delayed until January. If it is so important, why not now? Is it perhaps because President Clinton is a Democrat? I hope not.

Mr. SOLOMON. Mr. Speaker, I yield myself 45 seconds. I was proud to yield 15 to my good friend over there so he would have some time.

The President of the United States is a part of this agreement to make it January 1, 1997. That was what we call cooperation, bipartisanship. Let me just say to my good friends, as I listened to the speakers up here, one after another get up and oppose this line-item veto, I look at the National Taxpayers Union and say that every one of them appear as the biggest spenders in the Congress. They used to be a majority, and they are the ones that drove this debt through the ceiling, $5 trillion.

It is final time to have to stand up here today and vote to raise the debt ceiling by $500 billion when I voted for none of it, none of that debt.

Well, the reason I am going to vote for it is because we have a chance now to do something for the senior citizens, get rid of this heinous tax that is on Social Security now, on the earnings tax. We have a chance to do the line item to eliminate the crimp in every one of these big spenders. There are not many left around here. Most of them give up, but there are still a few and we are going to cut their spending off.

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

Mr. SOLOMON. I yield to the gentleman from Maryland.

Mr. HOYER. Mr. Speaker, the gentleman is not referring to me personally, I take it.

Mr. SOLOMON. No; absolutely not. I have great respect for my friend, although I will check the list to see if it is on it.

Mr. Speaker, I yield 3 minutes to the gentleman from Massachusetts [Mr. BL U T E], someone I have great respect for, from Shrewsbury, MA. He has only been here now for about 39 years. But I think the line-item veto has been a leader on this line item veto. With him and some of the others, like the gentleman from New York [Mr. QUINN] and the gentleman from Delaware [Mr. C A S T L E] and many others, the gentleman from Tennessee [Mr. D U N C A N ], who is not here on the floor yet, but because of them, we have this line-item veto here now. He is a great American.

Mr. BLUTE. Mr. Speaker, I thank the chairman for his kind words. This is, as my other has said, a very important day, a very exciting day because it means that this Government is going to make a break from the past and we are going to continue the process of turning the Federal ship of state away from deficits and debt and toward fiscal sanity and fiscal balance by giving the President of the United States the line-item veto authority. It is a major step forward in eliminating wasteful Federal spending.

In passing the conference report on S. 4, the line-item Veto Act, Congress is saying to the American people that we have listened to the call for fiscal responsibility. For more than a century, Presidents like Ronald Reagan, have called for the line-item veto, which is going to put a crimp in every one of these big spenders.

Mr. BLUTE. This line-item veto, Mr. Speaker, has been field tested in 43 States with very impressive results. This mechanism will guarantee that a cancellation or rescission in spending cannot be used in another account. Instead, any savings must be used toward deficit reduction.

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Mr. Speaker, on a personal note, I would like to commend and thank the gentleman from Pennsylvania [Mr. C L I N G E R], the gentleman from New York [Mr. SOLOMON], the gentleman from Florida [Mr. GOSS], and the gentleman from Kentucky [Mr. B U N N I N G], for allowing me the extraordinary opportunity to serve with them on this historic conference report.

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. D O G G E T T].

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

The Contract With America Advance- ment Act: what a true abuse of the English language. If this is an advancement of the Contract With America, the one thing it demonstrates is that some of our Republican colleagues cannot err backward from forward. Let us look at what is included in this great advancement of the Contract With America failed agenda.

Well, the first thing is an increase in the Social Security earnings limit. A laudable measure. So laudable that 411 Members of this body last year voted to approve it, and only four voted against it. Our senior citizens, this Social Security earnings limit adjusted already if our Republican colleagues had advanced it at the beginning of this Congress instead of at this point.
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What is the second item? Regulatory reform. Far different from the regulatory wreckage of the unilateral disarmament of our health and safety laws that they proposed last year. Again, if they had advanced this very modest regulatory reform of our small businesses across America would have had relief in 1995, not a promise in 1996. Finally and most important, it advances the contract through the line-item veto. What is the history of the line-item veto in this body?

We last February we took it up, and we considered it, and we approved it by a vote of 294 to 134. It is true that the version that is here before us today is improved, improved in part because at the time of that debate in February, my Republican colleagues rejected the sunset amendment that I proposed, and today they have incorporated that very amendment into this proposal.

The Speaker of the House came to the floor that night and he told us, and I quoted him: ‘I have a Republican majority giving to a Democratic President this year without any gimmicks an increased power over spending, which we think is important.’

Unfortunately, he did not think it was important enough to appoint conveyers for 6 months, or the President would have had this tool last year. What we have here is a Contract With America that is a flop, and this advancement act is a sop.

Mr. BEILENSON. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Michigan [Mr. BONIOR].

Mr. BONIOR. Mr. Speaker, the vote we are about to have on this rule, on the previous question on the rule, will be a vote on whether or not we as Members of this body want to raise the minimum wage, whether we want to raise the minimum wage.

Mr. Speaker, all over America people are working overtime. They are working second jobs. They are working third jobs to make ends meet. They deserve a break.

They deserve to have a government that is on their side, that will not stand in their way.

Now these are not kids we are talking about. We are talking about 60 percent of the people on the minimum wage are working with children, who work hard and deserve a raise. They do not come to this floor, do not come to this floor, I tell my colleagues, to tell us that it will cost jobs, because every study that has been done over the last few years, from California to Pennsylvania and New Jersey, have indicated that there would not be a loss of jobs. In fact, some of the studies say that there would be an increase in jobs in this country if we, in fact, raise the minimum wage.

Mr. Speaker, that is why over a hundred economists, three Nobel laureates, have said raise the minimum wage. When the minimum wage goes up, every benefit goes up. People who make a little bit more than the minimum wage will get a raise, people above them will get a raise, and what we will have is people circulating more money in the economy.

People will be buying more at the grocery store, they will be spending more at the hardware store. It will create a dynamic where people will have more money in their pockets, and they will be spending money, and they will help the economy.

Now over 12 million Americans would benefit right away from a 90-cent increase in the minimum wage, including about 42,000 people in my own State of Michigan alone.

Mr. Speaker, has been 5 years since we raised the minimum wage. Its value, as I said at the beginning of my remarks, it at its 40-year low, 40-year low. Seventy percent of the American people in a recent poll say they support an increase in the Minimum wage.

Now is the chance for my colleagues to stand up and face this issue head-on because here it is. This vote on the previous question on the rule is whether or not my colleagues are going to support the minimum wage, and if we vote for it.

I urge my colleagues to vote ‘no’ on the previous question, and put the opportunity to raise this issue, and I thank my colleague for having yielded me this time.

Mr. SOLOMON. Mr. Speaker, I yield 1½ minutes to the gentleman from Tennessee [Mr. DUNCAN], who asked the leader for as long as I can remember, ever since he succeeded his father as a Congressman, and he has been a real leader on this.
Mr. Speaker, with a national debt of over $5 trillion, we simply cannot afford to withhold this important tool from the President any longer.

Former Senator Paul Tsongas, writing in the Christian Science Monitor a few weeks ago, said that if past trends continue, the young people of today will face average lifetime tax rates of an incredible 82 percent.

We must do something about this to give a good economic future to our children and grandchildren.

I urge you to solve our problems by itself, but it will be a big step in the right direction. I urge passage of this very important legislation.

Mr. SOLOMON. Mr. Speaker, I yield 45 seconds to the gentleman from Harrisburg, PA [Mr. GEKAS].

(Mr. GEKAS asked and was given permission to revise and extend his remarks.)

Mr. GEKAS. I thank the gentleman for yielding to me.

Mr. Speaker, when I first ran for the House many years ago, I ran on a platform that included 10 separate items, much like the Contract With America. One of them, much like the Contract With America, was tax cuts which would reduce the cause of line-item veto. My own Commonwealth, Pennsylvania, had enjoyed since its constitutional existence long time ago that privilege on the part of the Governor, the chief executive. I wanted, as part of my campaign for election to the Congress, to try to transfer that responsibility to the Chief Executive of the United States.

We are at the threshold now of accomplishing one of my points of my own personal Contract With America. Second, another point, regulatory flexibility with judicial review is also at hand with this vote.

I urge support of the previous question.

Mr. BEILENSON. Mr. Speaker, I yield myself the balance of my time.

The SPEAKER pro tempore (Mr. GEKAS asked and was given permission to revise and extend his remarks.)

Mr. Speaker, I stand here today at the finish line of a race that has lasted 120 years, and I get so excited I can jump up and down. Today I stand with my Republican colleagues and a good number of Democrats. Wait and see, Mr. Speaker, and back on that side of the aisle will vote to deliver a promise to the American people.

As a conference on the line-item veto, I must submit that this historic moment is due in no small part to the efforts of our conference chairman, the gentleman from [Mr. CLINGER], sitting right next to me, and that of the Senate majority leader, Bob DOLE. If Bob DOLE had not put his weight behind this, we never would have got it by many of those Senators who do not want to give up that power. They want to spend, spend, spend, but they did, thanks to Bob DOLE.

Mr. Speaker, I ask unanimous consent to include in the Record further explanatory information regarding the expedited procedures of congressional consideration of a Presidential message.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

The statement referred to is as follows:

Mr. Speaker, in order to ensure that the provisions relating to the receipt and consideration of a cancellation message and a disapproval bill are clearly understood, I believe it is necessary to provide some further explanation.

Upon the cancellation of a dollar amount of discretionary budget authority, an item of direct spending or a limited tax benefit, the President must transmit to Congress a special message outlining the cancellation as required. When Congress receives this special message it shall be referred to the Committee on the Budget and the appropriate committee or committees of jurisdiction in each House. For example, the message pertaining to the cancellation of a dollar amount of discretionary budget authority from an appropriation law would be referred to the Committee on Appropriations of each House; a message pertaining to the cancellation of an item of direct spending would be referred to the authorizing committee or committees of each House from which the original authorization law derived. Any special message relating to more than one committee’s jurisdiction, i.e., a cancellation message from a large omnibus law such as a reconciliation bill, shall be referred to the authorizing committee or committees of each House with the appropriate jurisdiction.

Every special message is referred to the committees on the Budget of both the House and the Senate. This is due to the requirement in the bill that the President include in each special message certain calculations made by the Office of Management and Budget. These OMB calculations pertain to the adjustments made to the discretionary spending limits under sections 601 and the pay-as-you-go balances under section 252 of the Budget and Emergency Deficit Control Act of 1985, as a result of the cancellation to which the special message refers.
Upon receipt in the House, each special message shall be printed as a document of the House of Representatives.

In order to assist Congress in assuring a vote of disapproval on the President's cancellation message, a series of expedited procedures is provided for the consideration of a disapproval bill. A disapproval bill qualifies for these expedited procedures if it meets certain time requirements within an overall time period established for congressional consideration. However, if congressional consideration starts the first calendar day of session after the date on which the special message is received in the House and Senate, Congress has 30 calendar days of session in which to approve or disapprove under these expedited procedures the President's action. A calendar day of session is defined as only those days in which both Houses of Congress are in session.

During this 30-day time period, a disapproval bill may qualify for these expedited procedures if it meets certain time requirements. However, if the expiration of this 30 day period a disapproval bill may no longer qualify for these expedited procedures in the House of Representatives. A disapproval bill may qualify at any time for the expedited procedures in the Senate.

If Congress adjourns sine die prior to the expiration of the 30-calendar day of session time period and a disapproval bill relating to a special message was at that time pending before either House of Congress or any committee thereof or was pending before the President, a disapproval bill with respect to the same message may be reintroduced within the first 5 calendar days of session of the next Congress. This reintroduced disapproval bill qualifies for the expedited procedures and the 30-day period for congressional consideration begins over.

In order for a disapproval bill to qualify for the expedited procedures outlined in this section it must meet two requirements. First, a disapproval bill must meet the definition of a disapproval bill. Second, the disapproval bill must be introduced in later than the 5th calendar day of session following the receipt of the President's special message. Any disapproval bill introduced after the 5th calendar day of session is subject to the regular rules of the House of Representatives regarding consideration of a bill.

It should be noted that the expedited procedures provide strict time limitations at all stages of floor consideration of a disapproval bill. The conferences must provide both Houses of Congress with the means to expeditiously reach a resolution and to foreclose any and all delaying tactics—including, but clearly not limited to: extraneous amendments, repeated quorum calls, motions to recommit, or motions to instruct the committee. The conferences believe these expedited procedures provide ample time for Congress to consider the President's cancellations and work its will upon them.

Any disapproval bill introduced in the House of Representatives must disapprove all of the cancellations in the special message to which the disapproval bill relates. Any disapproval bill shall be referred to the appropriate committee or committees of jurisdiction. Any committee or committees of the House of Representatives to which such a disapproval bill has been referred shall report it without amendment, and with or without recommendation, not later than the seventh calendar day of session after the date of its introduction.

If any committee fails to report the disapproval bill within that period, it shall be in order for any Member of the House to move that the House discharge that committee from further consideration of the bill. However, such a motion is not in order after the committee has reported a disapproval bill with respect to the same special message. This motion shall only be made by a Member favoring the bill and only 1 day after the calendar day in which the Member offering the motion has announced to the House his intention to make such a motion and the form of which that motion takes. Furthermore, this motion to discharge the committee shall only be made at a time or place designated by the Speaker in the legislative schedule of the day after the calendar day in which the Member gives the House proper notice.

This motion to discharge shall be highly privileged. Debate on the motion shall be limited to not more than 1 hour and shall be equally divided between a proponent and an opponent. After completion of debate, the previous question shall be considered as ordered on the motion to its adoption without intervening motion. A further consideration of a disapproval bill by which the motion was agreed to or not agreed to shall not be in order. It shall not be in order to consider more than one such motion to discharge pertaining to a particular special message.

After a disapproval bill has been reported or a committee has been discharged from further consideration, it shall be in order to move that the House resolve into the Committee of the Whole House on the State of the Union for consideration of the disapproval bill. If the bill has been reported, the report on the bill must be available for at least one calendar day prior to consideration of the bill. All points of order, except that lying against the bill and its consideration shall be waived. The motion that the House resolve into the Committee of the Whole shall be highly privileged. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. During consideration of the bill in the Committee of the Whole the time required for the vote shall be dispensed with. General debate on the disapproval bill shall be confined to the bill and shall not exceed 1 hour equally divided between and controlled by a proponent and an opponent of the bill. After completion of the 1 hour of general debate, the bill shall be considered as ordered on the bill and amendments thereunto as ordered on the bill shall not be in order. Only one motion that the committee rise shall be in order unless that motion is offered by the manager of the bill.

No amendment shall be in order except any amendment striking the reference number or reference numbers of a cancellation or cancellations from the disapproval bill. This process allows Members the opportunity to narrow the focus of the disapproval bill striking references to cancellations they wish to overturn. A vote in favor of the disapproval bill is a vote to spend the money the President sought to cancel. A vote against the disapproval bill is a vote to agree with the President to cancel the spending.

No amendment shall be subject to further amendment, except pro forma amendments for the purposes of debate only. Consideration of the bill for amendment shall not exceed one hour excluding time for recorded votes and quorum calls. At the conclusion of consideration of the bill for amendment, the committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereon to final passage without any intervening motion. A motion to reconsider the vote on passage of the bill shall not be in order.

All appeals of decisions of the Chair relating to the application of the rules of the House of Representatives to this procedure for consideration of the disapproval bill shall be decided without debate.

It shall be in order to consider only one disapproval bill pertaining to each special message under these expedited messages except for consideration of a similar Senate bill. However, if the House has passed a disapproval bill with respect to the same special message as that to which the Senate bill refers, it shall not be in order to consider that bill.

A motion to reconsider the disapproval bill shall not be in order. It shall not be in order to reconsider the disapproval bill promptly convened.

Upon conclusion of such a committee of conference it shall be in order to consider the report of such a conference provided such report has been available to the House for 1 calendar day excluding Saturdays, Sundays, or legal holidays, unless the House is in session on such a day, and the accompanying statement has been filed in the House.

Directing the Committee of the Whole on the State of the Union to report the disapproval bills and the report on the disapproval bills shall report the committee's recommendation, not later than the seventh calendar day of the session following the receipt of the President's special message. A disapproval bill relating to a special message may be reintroduced within the time period and a disapproval bill relating to a special message may be reintroduced within the 30 day period for the expedited procedures.

Mr. SOLONOM. Mr. Speaker. In closing, I just would like to point out that President Ronald Reagan closed his autobiography entitled Ronald Reagan: In American Life with these following paragraphs, which I cited in my 1 minute earlier today. He said:

"And yet, as I reflected on what we accomplished, I had a sense of incompleteness, that there was still work to be done. We need a constitutional amendment to require a balanced budget," said Ronald Reagan, "and the President needs a line-item veto to cut unnecessary spending."

Come over here and give Ronald Reagan another birthday present. Let us pass this line-item veto. Give it to
the President who has guaranteed, "I will sign it."

Come over here and vote for it.

Mr. DINGELL. Mr. Speaker, I rise in opposition to this rule.

We have just been informed that this closed rule statement is done to this debatable bill, a completely unrelated Senate-passed bill that will promote fraud by rogue operators posing as small businesses. This bill has not been reviewed by the House committees of jurisdiction, and the SEC strongly opposes it as drafted.

While I strongly support initiatives to aid small business development, this legislation includes provisions that gives preferential treatment to small businesses that engage in securities fraud. One section would require the SEC to adopt a program to reduce, or in some circumstances to waive, civil penalties for violations of statutes or rules by small entities. This would have the obvious effect of encouraging rogues and knaves to conduct unlawful activities through small-business shells in order to get off with a slap on the wrist or a free fraud. Mr. Speaker, this is outrageously bad public policy.

I ask unanimous consent to include in the RECORD a copy of a letter from the Chairman bad public policy.

Mr. Chairman, this is outrageously bad public policy.

I urge my colleagues to defeat this rule.

DEAR CONGRESSIONAL DINGELL: I am writing to express the views of the Securities and Exchange Commission ("SEC" or "Commission") regarding S. 942, the "Small Business Regulatory Enforcement Fairness Act of 1996." S. 942 recently passed the Senate and we understand that it may soon be considered by the House. Although the Commission is very supportive of fostering small business endeavors, it has serious concerns that the bill could have an adverse impact on the Commission's enforcement program. The Commission's principal concerns are as follows:

The Commission is concerned about the provisions in S. 942 that suggest that preferential treatment should be afforded to small businesses that engage in violative conduct. Fraud is by no means confined to large entities: some of the most egregious securities frauds in recent years (e.g., involving penny stocks, prime bank notes, and wireless cable) have been perpetrated by shell companies and other entities that could qualify as "small entities" under S. 942. In fact, nearly three-quarters of the firms in the securities industry could be considered "small entities." As a general matter, the Commission believes that rules involving market integrity should apply and be enforced equally as to all firms, large as well as small.

Another troubling provision in S. 942 would shift attorneys fees and other expenses to the SEC if the Commission prevails in court, but where it fails to obtain the full relief it has sought. In order to protect investor funds from fraud and avoid the costs of lengthy litigation, the Commission often must act quickly, and swift, decisive enforcement action against fraud or other misconduct. The requirements of S. 942 could serve to hamper the Commission's enforcement efforts as such awards are appropriate relief from wrongdoers.

The Commission's enforcement program is well-recognized for its fairness. As a general practice, potential defendants are given the opportunity through "Wells" submissions to directly negotiate the terms of any SEC enforcement actions before they are instituted by the Commission. In addition, pursuant to The Securities Enforcement Remedies and Penalties Act of 1990, Congress already requires the Commission to weigh various factors before seeking or imposing civil penalties. These include mitigating factors—such as the ability of the respondent to pay a penalty as well as its ability to continue in business. The Commission is concerned, however, that the imposition of S. 942's additional requirements could "tilt" the enforcement balance in favor of small firms, regardless of the damage that may be done to public investors.

The Commission has a record on small business issues that is second to none. In recent years, the Commission has created a new, simpler registration and disclosure regime for small businesses that seek to raise capital in the securities markets. It has also sought to expand the category of small businesses that are exempt from the registration and disclosure requirements of the Exchange Act. Most recently, the Commission's internal Task Force on Disclosure Simplification released a report recommending the elimination of SEC regulations and forms, and proposing a variety of additional steps to ease the capital formation process for small businesses.

The Commission recognizes that still more can be done to reduce the regulatory burdens of small business, and we are committed to continuing our efforts in this area. However, while it is true that the SEC has requirements for small business issuers without impairing market fairness, there is much less room to dilute or alter the regulatory and enforcement work that applies to market professionals who handle investors' retirement funds and savings. In applying and enforcing rules relating to market integrity, the Commission believes that investor protection must come first.

The attached staff analysis discusses the issues raised by S. 942 in greater detail. We believe that the Commission's concerns can be easily met through appropriate exemptive provisions for the SEC. We ask your assistance in raising these issues on behalf of the Commission when S. 942 is considered by the House.

Sincerely,

Arthur Levitt
Chairman

attachment

STAFF ANALYSIS OF EFFECTS OF S. 942 ON SECURITIES AND EXCHANGE COMMISSION

The Securities and Exchange Commission ("SEC") has traditionally supported efforts to facilitate the capital formation process for small business. However, SEC staff is concerned that S. 942's provisions for small business regulatory reform may have the effect of sweep too broadly—that the bill could potentially impair regulatory and enforcement efforts that are crucial to the integrity of the securities markets, while imposing significant new costs upon the Commission. This analysis focuses on parts of the bill that the Commission staff believes are the most troublesome.

SMALL BUSINESS ENFORCEMENT VARIANCE

Section 202 of S. 942 would require each agency to adopt a policy or program "to provide for the reduction, and under appropriate circumstances to waive" civil penalties for violations of statutes or rules by small entities. This section appears to be premised on the assumption that violations by medium-sized or large businesses should be penalized, but that violations by small businesses should be tolerated. This approach does not seem appropriate for the regulation of the securities markets, which depend on the exercise of professional judgment by market participants, regardless of size.

As a threshold matter, it is important to recognize that serious fraud is not confined to large entities: some of the most egregious frauds in recent years (involving penny stocks, prime bank notes, and wireless cable) have involved firms described precisely as "small entities" under S. 942. In addition, this enforcement philosophy would also be applied to non-science based securities violations that are equally critical to the integrity of the securities market, for example, broker-dealer capital requirements. Notably, in crafting rules such as the capital requirements, the Commission already considers the size and the nature of a broker-dealer's business; if a firm violates the requirements applicable to them, there is no reason to consider these matters in the enforcement context.

This provision already exempts matters relating to environmental health and safety; on additional exemption relating to securities violations would appear equally tenable.

In any event, the language of the general regulatory exemption of Section 202 would permit the SEC to exempt small businesses from the reduction of civil penalties for violations by small businesses in mandatory; at a minimum, this language should be changed to clarify that the agency has discretion to consider "appropriate circumstances" in determining whether to reduce civil penalties.

AMENDMENTS TO EQUAL ACCESS TO JUSTICE ACT

The changes to EAJA made by S. 942 would increase the ability of all qualifying litigants (and not just small businesses) to recover fees from agencies under the Equal Access to Justice Act ("EAJA"). Currently, EAJA permits litigants to recover attorney's fees and other expenses from an agency if the agency's position was not "substantially justified." S. 942 would expand the opportunities for such recovery by permitting the award of fees and expenses if the judgment or decision of the court or adjudicative officer is "disproportionately less favorable" to the litigant than the relief requested by the SEC. In practical terms, this means that the SEC could "lose, even if it wins" in a lawsuit or other enforcement proceeding.

The changes to EAJA made by S. 942 would significantly increase the exposure of the Commission to fee awards, in at least two ways:

First, the SEC might have to pay EAJA fees even in cases that it wins, in the event that it does not obtain a fee award at initially sought. For example, in enforcement actions, the Commission frequently seeks to obtain an injunction against securities law violations. While the threat that a violation has occurred, it might not award an injunction for other reasons—for example, if the defendant is too old, working in a different type of business, or has expressed remorse for the violation. In such situations, the court's final judgment may be "disproportionately less favorable" to the Commission than the relief requested for reasons wholly unrelated to the merits of the Commission's case.

Second, the SEC would be vulnerable to fee awards in cases where it is unable to obtain a fee award at initially sought, but is successful to the extent it has obtained an enhancement for enforcement cases for insider trading fraud, for example, generally require the Commission to

Footnotes at end of article.
piece together documentary evidence such as telephone records and securities trading patterns. If a jury or judge disagrees with the Commission’s interpretation of the facts and exonerates a defendant, the Commission could be liable for EAJA fees, even if the Commission had reasonably interpreted the available evidence and sought relief that it believed was substantially justified by such evidence.

Similarly, adverse resolution of legal issues could subject the Commission to EAJA fee award. Even the most settled interpretation of the securities laws are subject to dissenting approaches of judicial or adjudicatory decisionmakers. In a recent case, for example, the Fourth Circuit refused to follow several other circuit courts that had long recognized a claim for fraudulent insider trading based on nonpublic information. United States v. Bryan, 58 F.3d 933 (4th Cir. 1995). In such situations of novel or unanticipated legal decisions, the adverse resolution of a central issue can remove any grounds for relief and subject the Commission to fee awards.

Finally, the Commission often must act with enforcement action against fraud, particularly in cases where money may be moved quickly outside of the jurisdiction of the SEC. Amendments of S. 942 would hamper the Commission’s enforcement efforts by requiring it to evaluate the risks to its own funds before seeing penalties or other appropriate relief from wrongdoing.

Because the Commission could be liable for EAJA awards even when it prevails in a lawsuit, when its position is reasonable, the Commission opposes the EAJA provisions of S. 942. 5

AMENDMENTS TO REGULATORY FLEXIBILITY ACT

S. 942 would amend the Regulatory Flexibility Act (“Reg. Flex. Act”) to permit court challenge of the Commission’s final regulatory flexibility analyses. Enacted in 1980, the Reg. Flex. Act currently requires the Commission to prepare flexibility analyses evaluating the economic impact of proposed SEC rules and rule changes on small businesses. The SEC takes seriously the Reg. Flex. Act requirements and carefully prepares the requisite analyses for every rulemaking action it takes. Nevertheless, the Act requires the Commission to predict market forces and behavior in advance.

The Reg. Flex. Act amendments in S. 942 would enable small businesses to challenge in court the SEC’s compliance with the Reg. Flex. Act. A small business might try to argue, for example, that the SEC did not adequately foresee the impact that a rule change would have on small businesses. As a result of such a challenge, a court could order the SEC to defer enforcement of the rule against small entities until the court completed its review of the challenge, unless the court were to find “good cause” for continuing the enforcement of the rule.

The amendments contained in S. 942 would thus make it possible for a party who opposes any Commission Rule proposal to use the Reg. Flex. analysis (regardless of the care and effort taken in its preparation) as a pretext for litigation. Conceivably, a provision that reduces burdens or provides exemp- tions for businesses—large or small—could be subject to attack under the Reg. Flex. Act amendments. The Commission did not foresee their potential impact on small businesses, even where the impact was shaped in large part by market shifts or economic forces. In any event, the Commission believes that, as a general matter, rules regulating market participants andadian enforcement issues should apply equally to all firms, large as well as small.

CONGRESSIONAL REVIEW OF COMMISSION REGULATIONS

Title V of S. 942 permits Congress to over- ride an agency’s adoption of any rules. This legislative veto authority does not extend, however, to rules that concern monetary policy proposed by the Board of Governors of the Federal Reserve System or the Federal Open Market Committee. Because the Commission’s rules directly concern the integrity and efficiency of the securi- ties markets, and are often closely tied to the stability of such markets, we believe that it is appropriate to accord the same ex- ception for SEC rules as is accorded to the Federal Reserve and the FOMC. 6

FOOTNOTES

1 Senator Bond has made notable efforts to narrow the scope of S. 942. However, the bill passed by the Senate includes significant issues with re- spect to the Commission’s enforcement and regu- latory programs. This analysis outlines those concerns for the Commission.

2 In fact, of the approximately 7600 broker-dealers registered with the Commission, over 5300 are small entities.

3 Although the proposed EAJA amendments pro- vide an exception for the Commission, if the “party or small entity has committed a willful violation of law or otherwise acted in bad faith, or special cir- cumstances made an award of attorney’s fees un- just,” a court or administrative law judge probably could not make a finding of “willful violation” or “bad faith” even if it determined that, even in a close case, its interpretation of the law or the facts did not permit the relief requested by the party.

4 “Under existing law, EAJA fees have not been im- posed on the SEC when the court has found that there was a reasonable basis for the Commission’s action. See, e.g., SEC v. Switzer, 590 F. Supp. 756 (W.D. Okla. 1984) (refusing to award EAJA fees, despite finding no securities law violation).”

5 Similarly concerns arise regarding H.R. 994, a sepa- rate regulatory reform bill that is currently under consideration.

6 A small entity has committed a willful violation of law or otherwise acted in bad faith, or special cir- cumstances made an award of attorney’s fees un- just.”

7 The vote was taken by electronic de- vice and there were—yeas 232, nays 180, indi- cating to the resolution, as amended. The vote was taken by electronic de- vice and there were—yeas 232, nays 180, indi- cating to the resolution, as amended.
The vote was taken by electronic device, and there were—aye's 232, noes 177, not voting 22, as follows:

[Vote list not transcribed in full.]

**NOT VOTING—29**

The Clerk announced the following pairs:

On this vote:
Mrs. Fowler, for Mrs. Collins of Illinois against.
Mr. Lazio of New York for, with Mr. Stokes against.
Mr. Gibbs and Mr. Deutch changed their vote from "aye" to "no."
Mr. Shays changed his vote from "no" to "aye."
So the previous question was ordered. The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

**PERSONAL EXPLANATION**
Mr. BLUETE. Mr. Speaker, on rollcall No. 98, I was attending a White House bill-signing ceremony on the Senior Citizens Housing Safety Act. Had I been present, I would have voted "aye."

[For text of conference report deemed adopted pursuant to Resolution 391, see proceedings of the House of March 21, 1996, at page H2640.]
CONTRIBUTION AMONG
ADVANCEMENT ACT OF 1996

Mr. ARCHER. Mr. Speaker, pursuant to House Resolution 391, I call up the bill—H.R. 3136—to provide for enactment of the Senior Citizens’ Right to Work Act of 1996, the Line-Item Veto Act, the Contract Independence and Program Improvement Act, the Deficit and Fairness Act of 1996, and to provide for a permanent increase in the public debt limit, and ask for its immediate consideration in the House.

The Clerk read the title of the bill. The SPEAKER pro tempore (Mr. HASTINGS of Washington). Pursuant to House Resolution 391, the amendments printed in House Report 104-500 are adopted.

The text of H.R. 3136, as amended pursuant to House Resolution 391, is as follows:

H.R. 3136

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE OF TITLE. This Act may be cited as the “Senior Citizens’ Right to Work Act of 1996.”

TITLE I—SOCIAL SECURITY EARNINGS LIMITATION AMENDMENTS

SEC. 101. INCREASES IN MONTHLY EXEMPT AMOUNT FOR PURPOSES OF THE SOCIAL SECURITY EARNINGS LIMIT.

(a) INCREASE IN MONTHLY EXEMPT AMOUNT FOR INDIVIDUALS WHO HAVE ATTAINED RETIREMENT AGE.—Section 203(f)(8)(D) of the Social Security Act (42 U.S.C. 403(f)(8)(D)) is amended to read as follows:

``(D) Notwithstanding any other provisions of law, an individual who has attained retirement age shall be entitled to an exempt amount for each semi-monthly period as follows:"

``(i) for fiscal year 1996, $752,000,000;

(ii) for fiscal year 1997, $790,000,000;

(iii) for fiscal year 1998, $825,000,000;

(iv) for fiscal year 1999, $860,000,000;

(v) for fiscal year 2000, $895,000,000;

(vi) for fiscal year 2001, $930,000,000;

(vii) for fiscal year 2002, $965,000,000.

(b) CONFORMING AMENDMENTS.—

(1) Section 203(f)(8)(B) of such Act (42 U.S.C. 403(f)(8)(B)) is amended to read as follows:

``(B) The term ‘continuing disability reviews’ means a review conducted pursuant to section 221(l) and a redetermination of the disability eligibility of a recipient conducted pursuant to section 221(n) of title 20, United States Code.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after 2001 and before 2003, $2,083.33 1/3, and

(d) USE OF FUNDS AND REPORTS.—
(1) IN GENERAL.—The Commissioner of Social Security shall ensure that funds made available for continuing disability reviews (as defined in section 201(g)(1)(A) of the Social Security Act, as amended) are used, to the extent practicable, to maximize the combined savings in the old-age, survivors, and disability insurance, supplemental security income, and medical programs.

(2) REPORT.—The Commissioner of Social Security shall provide annually (at the conclusion of each of the fiscal years 1996 through 2002) to the Congress a report on continuing disability reviews which includes—

(A) the amount spent on continuing disability reviews by the Social Security Administration and by the states and territories for the fiscal year covered by the report, and the number of reviews conducted, by category of review;

(B) the results of the continuing disability reviews in terms of cessations of benefits or determinations of continuing eligibility, by program; and

(C) the estimated savings over the short-, medium-, and long-term to the old-age, survivors, and disability insurance, supplemental security income, medicare, and medicaid programs from continuing disability reviews in terms of cessations for the fiscal year covered by the report and the estimated present value of such savings.

(c) OFFICE OF CHIEF ACTUARY IN THE SOCIAL SECURITY ADMINISTRATION.—

(1) IN GENERAL.—Section 702 of the Social Security Act (42 U.S.C. 902) is amended—

(A) by striking paragraph (G) and inserting—

``; or''

(B) by striking the period at the end of subparagraph (G) and inserting "; or''

(C) by inserting after subparagraph (G) the following new subparagraph:

``(H) if the benefits under this subsection are based on the wages and self-employment income of an individual who is subsequently divorced from such child's natural parent, the month after the month in which such divorce becomes final.''

(2) EFFECTIVE DATE.—Section 202(d) of such Act (42 U.S.C. 402(d)) is amended by adding the following new paragraph:

``(10) For purposes of paragraph (1)(H)—

(A) each individual described in subparagraph (A)(ii)(II) of paragraph (1)(H) and of the requirement described in subparagraph (A),''

(3) EFFECTIVE DATE.—

(A) The amendments made by paragraph (1) shall apply with respect to final divorces occurring after the third month following the month in which this Act is enacted.

(B) The amendment made by paragraph (2) shall take effect on the date of the enactment of this Act.

Sec. 105. DISABILITY BENEFITS TO DRUG ADDICTS AND ALCOHOLICS.

(a) AMENDMENTS RELATING TO TITLE II DISABILITY BENEFITS.—

(1) IN GENERAL.—Section 222 of such Act (42 U.S.C. 405) is amended to read as follows:

``(c)(1) There shall be in the Administration a Chief Actuary, who shall be appointed by, and in direct line of authority to, the Commissioner. The Chief Actuary shall be appointed from individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary shall serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing and controlling such individual's earnings and other resources with which the individual may reasonably be expected to support himself or herself.

(b) REPRESENTATIVE PAYEE REQUIREMENTS.—

(A) Section 205(1)(B) of such Act (42 U.S.C. 405(1)(B)) is amended to read as follows:

``(B) In the case of an individual entitled to benefits based on dependency, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing and controlling such individual's earnings and other resources with which the individual may reasonably be expected to support himself or herself.''

``(II) In the case of an individual entitled to benefits under title II of such Act (as amended by this Act) based on disability within 120 days after the date of the enactment of this Act, the Commissioner shall, not later than January 1, 1997, complete the entitlement determination (including a new medical determination) with respect to such individual pursuant to the procedures of such title.''

(b) AMENDMENTS RELATING TO SSI BENEFITS.—

(1) IN GENERAL.—Section 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)) is amended by adding at the end the following:

``(ii) Notwithstanding subparagraph (A), an individual shall not be considered to be disabled for purposes of this title if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the determination that the individual is disabled.''

(b) REPRESENTATIVE PAYEE REQUIREMENTS.—

(A) Section 1631(a)(2)(A)(ii)(I) of such Act (42 U.S.C. 1383(a)(2)(A)(ii)(I)) is amended by striking all that follows "15 years, or" and inserting "described in subparagraph (A)(ii)(II)".

(B) Section 1631(a)(2)(B)(vii) of such Act (42 U.S.C. 1383(a)(2)(B)(vii)) is amended by striking "disability" and inserting "described in paragraph (1)(B)".

(C) Section 1631(a)(2)(D)(ii) of such Act (42 U.S.C. 1383(a)(2)(D)(ii)) is amended by adding at the end the following:

``(III) In the case of a household eligible for benefits under this title by reason of disability, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing such benefits.''

(B) Section 1631(a)(2)(B)(vii) of such Act (42 U.S.C. 1383(a)(2)(B)(vii)) is amended by striking "eligible for benefits" and all that follows through "under a disability" and inserting "described in paragraph (1)(B)".

(C) Section 1631(a)(2)(D)(ii) of such Act (42 U.S.C. 1383(a)(2)(D)(ii)) is amended by adding at the end the following:

``(III) In the case of an individual entitled to benefits under title II of such Act (as amended by this Act) based on disability within 120 days after the date of the enactment of this Act, the Commissioner shall, not later than January 1, 1997, complete the entitlement determination (including a new medical determination) with respect to such individual pursuant to the procedures of such title.''

Sec. 106. ENTITLEMENT OF STEPCHILDREN TO CHILD'S INSURANCE BENEFITS BASED ON ACTUAL DEPENDENCY ON STEPPARENT SUPPORT.

(a) REQUIREMENT OF ACTUAL DEPENDENCY FOR FUTURE ENTITLEMENTS.—

(1) IN GENERAL.—Section 202(d)(4) of the Social Security Act (42 U.S.C. 402(d)(4)) is amended by striking "was living with".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to benefits of individuals who become entitled to such benefits for months after the third month following the month in which this Act is enacted.

(b) REQUIREMENT OF ACTUAL DEPENDENCY FOR PARENTAL SUPPORT.—

(1) IN GENERAL.—Section 202(d)(1) of the Social Security Act (42 U.S.C. 402(d)(1)) is amended by striking "or" at the end of subparagraph (A) and inserting "; or''

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to final divorces occurring after the third month following the month in which this Act is enacted.

(c) CONFORMING AMENDMENT.—Subsection (c) of section 225 of such Act (42 U.S.C. 422(c)) is repealed.

(d) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (4) shall apply to any individual who applies for, or whose claim is finally adjudicated by the Commissioner of Social Security based on disability for purposes of title II of the Social Security Act based on disability on or after the date of the enactment of this Act, and, in the case of any individual who applies for, or whose claim is finally adjudicated by the Commissioner with respect to, such benefits before such date of enactment, such amendments shall apply (A) to benefits based on disability occurring after the third month following the month in which such Act is enacted.

(e) CONFORMING AMENDMENT.—Subsection (c) of section 225 of such Act (42 U.S.C. 422(c)) is repealed.

(f) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (4) shall apply to any individual who applies for, or whose claim is finally adjudicated by the Commissioner of Social Security based on disability under title II of the Social Security Act, and, in the case of any individual who applies for, or whose claim is finally adjudicated by the Commissioner with respect to, such benefits before such date of enactment, such amendments shall apply (A) to benefits based on disability occurring after the third month following the month in which such Act is enacted.

(g) CONFORMING AMENDMENT.—Subsection (c) of section 225 of such Act (42 U.S.C. 422(c)) is repealed.

(h) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (4) shall apply to any individual who applies for, or whose claim is finally adjudicated by the Commissioner of Social Security based on disability under title II of the Social Security Act, and, in the case of any individual who applies for, or whose claim is finally adjudicated by the Commissioner with respect to, such benefits before such date of enactment, such amendments shall apply (A) to benefits based on disability occurring after the third month following the month in which such Act is enacted.

(i) CONFORMING AMENDMENT.—Subsection (c) of section 225 of such Act (42 U.S.C. 422(c)) is repealed.

(j) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (4) shall apply to any individual who applies for, or whose claim is finally adjudicated by the Commissioner of Social Security based on disability under title II of the Social Security Act, and, in the case of any individual who applies for, or whose claim is finally adjudicated by the Commissioner with respect to, such benefits before such date of enactment, such amendments shall apply (A) to benefits based on disability occurring after the third month following the month in which such Act is enacted.

(k) CONFORMING AMENDMENT.—Subsection (c) of section 225 of such Act (42 U.S.C. 422(c)) is repealed.

(l) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (4) shall apply to any individual who applies for, or whose claim is finally adjudicated by the Commissioner of Social Security based on disability under title II of the Social Security Act, and, in the case of any individual who applies for, or whose claim is finally adjudicated by the Commissioner with respect to, such benefits before such date of enactment, such amendments shall apply (A) to benefits based on disability occurring after the third month following the month in which such Act is enacted.

(m) CONFORMING AMENDMENT.—Subsection (c) of section 225 of such Act (42 U.S.C. 422(c)) is repealed.
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et seq.) is amended by adding at the end the following new section:
"TREATMENT REFERRALS FOR INDIVIDUALS WITH AN ALCOHOLISM OR DRUG ADDICTION CONDITION." Section 1621(a) of such Act (as amended by this Act) is amended in subpart I of part B of title XVIII of the Social Security Act (42 U.S.C. 300x-21) to read as follows:
(A) Section 1621(a) of such Act (42 U.S.C. 1396b) is amended by striking paragraph (3).

SEC. 136. In the case of any individual whose benefits under this title are paid to a representative payee pursuant to section 1631(a)(2)(A)(iii)(I), the Commissioner of Social Security shall notify such individual to the appropriate State agency administering the State plan for substance abuse treatment services approved under subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x-33) and shall be allocated pursuant to such section 1933.
(3) USE OF FUNDS.—A State or Tribal government receiving an allotment under this subsection shall consider as priorities, for purposes of expending funds allotted under this subsection, activities relating to the treatment of the abuse of alcohol and other drugs.

SEC. 106. PILOT STUDY OF EFFICACY OF PROVIDING INDIVIDUALIZED INFORMATION TO RECIPIENTS OF OLD-AGE AND SURVIVORS BENEFITS.
(1) IN GENERAL.—During a 2-year period beginning as soon as practicable in 1996, the Commissioner of Social Security shall conduct a pilot study of the efficacy of providing certain individualized information to recipients of monthly insurance benefits under section 202 of the Social Security Act, designed to promote better understanding of their contributions and benefits under the social security system. The study shall involve solely beneficiaries whose entitlement to such benefits first occurred on or after 1984 and who have remained entitled to such benefits for a continuous period of not less than 5 years.
(2) ANNUAL REPORTS.—During the course of the study, the Commissioner shall provide to each of the beneficiaries involved in the study one annualized statement, setting forth the following:
(A) an estimate of the aggregate aggregate wages and self-employment income earned by the individual on whose wages and self-employment income the benefit is based, as shown on the records of the Commissioner as of the end of the last calendar year ending prior to the beneficiary's first month of entitlement;
(B) the aggregate amount paid as benefits under section 202 of the Social Security Act based on such wages and self-employment income benefit as is based, as shown on the records of the Commissioner as of the end of the last calendar year preceding the issuance of the statement for which complete information is available.
(C) INCLUSION WITH MATTER OTHERWISE DISTRIBUTED TO BENEFICIARIES.—The Commissioner shall ensure that such statements are included, with other reports currently provided to beneficiaries on an annual basis.

SEC. 310. PROFESSIONAL STAFF FOR THE SOCIAL SECURITY ADVISORY BOARD.
"(1) the Federal Old-Age and Survivors Insurance Trust Fund;
(2) the Federal Disability Insurance Trust Fund;
(3) the Federal Hospital Insurance Trust Fund;
(4) the Federal Supplementary Medical Insurance Trust Fund;".

SEC. 201. SHORT TITLE.
This title may be cited as the “Line Item Veto Act”.

SEC. 202. LINE ITEM VETO AUTHORITY.
(a) IN GENERAL.—Title X of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 601 et seq.) is amended by adding at the end the following new part:
"PART C—LINE ITEM VETO
LINE ITEM VETO AUTHORITY.
"(1) any item of new direct spending; or
(2) any limited tax benefit; if the President—
(A) determines that such cancellation will—
(i) reduce the Federal budget deficit;
(ii) not impair any essential Government functions; and
(iii) not harm the national interest; and
(B) notifies the Congress of such cancellation by transmitting a special message, in accordance with section 1022, within five calendar days (excluding Sundays) after the enactment of the law providing the dollar amount of discretionary budget authority, item of new direct spending, or limited tax benefit that was canceled;

(2) IDENTIFICATION OF CANCELLATIONS.—In identifying dollar amounts of discretionary budget authority, items of new direct spending, and limited tax benefits for cancellation, the President shall—
(1) consider the legislative history, constitution, and purposes of the law which contains such dollar amounts, items, or benefits;
"(2) consider any specific sources of information referenced in such law or, in the absence of specific sources of information, the best available information; and

"(3) any limitations contained in section 1026 in applying this part to the specific provisions of such law.

"(c) EXCEPTION FOR DISAPPROVAL BILLS.—The authority granted by subsection (a) shall not apply to any dollar amount of discretionary budget authority, item of new direct spending, or limited tax benefit contained in any law that is a disapproval bill as defined in section 1026.

"SPECIAL MESSAGES

"SEC. 1022. (a) IN GENERAL.—For each law from which a disapproval bill has been made under this part, the President shall transmit to the House of Representatives a single special message to the Congress. (b) CONTENTS.—(1) The special message shall specify—

"(A) the dollar amount of discretionary budget authority, item of new direct spending, or limited tax benefit which has been canceled, and provide a corresponding reference number for each cancellation;

"(B) the determinations required under section 202(a), together with any supporting material;

"(C) the reasons for the cancellation;

"(D) to the maximum extent practicable, the estimated fiscal, economic, and budgetary effects of the cancellation;

"(E) all facts, circumstances and considerations relating to or bearing upon the cancellation, and to the maximum extent practicable, the estimated effect of the cancellation upon the objects, purposes and programs for which the canceled authority was provided; and

"(F) include the adjustments that will be made pursuant to section 1024 to the discretionary spending limits under section 601 and an evaluation of the effects of those adjustments on the discretionary spending limits.

"(c) EXCEPTION FOR DISAPPROVAL BILLS.—Upon the cancellation of a dollar amount of discretionary budget authority under subsection (a), the total amount of the item of new direct spending, or limited tax benefit shall be effective as of the date of approval of the law to which the cancellation applied.

"(b) CONTENTS IN DISCRETIONARY BUDGET AUTHORITY.—Upon the cancellation of a dollar amount of discretionary budget authority under subsection (a), the President shall transmit to the House of Representatives a special message containing a cancellation of discretionary budget authority and outlays in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985 for each applicable fiscal year set forth in paragraph (1) of subparagraph (B) and include such estimate as a separate entry in the report prepared pursuant to subparagraph (A).

"(2) DIRECTIONS TO SPENDING LIMITS AND LIMITED TAX BENEFITS.—(A) OMB shall, for each item of new direct spending or limited tax benefit canceled from a law under section 1022(a), estimate the deficit decrease caused by the cancellation of such item or benefit in that law and include such estimate as a separate entry in the report prepared pursuant to section 252(d) of the Balanced Budget and Emergency Deficit Control Act of 1985.

"(B) OMB shall not include any change in the deficit resulting from a cancellation of any item of new direct spending or limited tax benefit, or the enactment of a disapproval bill for any such cancellation, under this part in the estimates and reports required by sections 252(b) and 254 of the Balanced Budget and Emergency Deficit Control Act of 1985.

"(c) INTRODUCTION OF DISAPPROVAL BILLS.—(1) In general.—Any committee of the House of Representatives, to which a disapproval bill is referred shall report it without amendment, and with or without recommendation, not later than the seventh calendar day of the session following the date on which the bill is referred to the committee. If any committee fails to report the bill within that period, the bill shall be treated as a disapproval bill made only by a Member favoring the bill (but only at a time or place designated by the Speaker in the legislative schedule of the day). If a Member offers the motion to report an amendment, the motion shall be put to a vote not more than one hour, the time to be divided in the House equally between a proponent

"SEC. 1023. (a) IN GENERAL.—For each special message transmitted under this part shall be referred to the Committee on the Budget and the appropriate committee or committees of the Senate and the Committee on the Budget and the appropriate committee or committees of the House of Representatives. Each such message shall be printed as a document of the House of Representatives.

"(b) TIME PERIOD FOR EXPEDITED PROCEDURES.—(1) There shall be a congressional review period of 30 calendar days of session, beginning on the first calendar day of session after the date on which the special message is received in the House of Representatives and the Senate, during which the procedures contained in this section shall apply to both Houses of Congress.

"(2) In the House of Representatives, the procedures set forth in this section shall not apply after the end of the period described in paragraph (1).

"(3) If Congress adjourns prior to the end of a Congress or a committee thereof (including a conference committee of the two Houses of Congress), or was pending before the President, a disapproval bill for the same special message may be introduced within the first five calendar days of session of the next Congress and shall be treated as a disapproval bill under this part, and the time period described in paragraph (1) shall commence on the day of introduction of that disapproval bill.

"(c) CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—(1) Any committee of the House of Representatives to which a disapproval bill is referred shall report it without amendment, and with or without recommendation, not later than the seventh calendar day of the session following the date on which the bill is referred to the committee. If any committee fails to report the bill within that period, the bill shall be treated as a disapproval bill made only by a Member favoring the bill (but only at a time or place designated by the Speaker in the legislative schedule of the day). If a Member offers the motion to report an amendment, the motion shall be put to a vote not more than one hour, the time to be divided in the House equally between a proponent

"SEC. 1024. (a) IN GENERAL.—The cancellations of any dollar amount of discretionary budget authority, item of new direct spending, or limited tax benefit shall take effect upon receipt in the House of Representatives and the Senate of the special message notifying the Congress of the cancellation. If a disapproval bill of a cancellation is enacted into law, then all cancellations disapproved in that law shall be null and void and any such dollar amount of discretionary budget authority, item of new direct spending, or limited tax benefit shall be effective as of the original date provided in the law to which the cancellation applied.

"(b) CONTENTS OF DISAPPROVAL BILL.—Each special message transmitted under this part shall be referred to the Committee on the Budget and the appropriate committee or committees of the Senate and the Committee on the Budget and the appropriate committee or committees of the House of Representatives. Each such message shall be printed as a document of the House of Representatives.
and an opponent. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order.

"(2) After a disapproval bill is reported or a committee discharged to further consideration, it is in order to move that the House resolve into the Committee of the Whole House on the State of the Union for consideration of the bill, and if the report is available for at least one calendar day, all points of order against the bill and against consideration of the bill are waived. All points of order against the bill and against consideration of the bill are waived. The motion is highly privileged. A motion to reconsider the vote by which the motion to proceed to further consideration is agreed to or disagreed to shall not be in order. During consideration of the bill in the Committee of the Whole, the first reading of the bill shall be dispensed with. General debate shall proceed, shall be confined to the bill, and shall not exceed one hour equally divided and controlled by a proponent and an opponent of the bill. The motions that are considered as read for amendment under the five-minute rule. Only one motion to rise shall be in order, except if offered after debate. No amendment to the bill is in order, except any Member if supported by 49 other Members (a quorum being present) may offer an amendment striking out the whole of the bill and inserting another bill or resolution. A cancellation or cancellations from the bill. Consideration of the bill for amendment shall not exceed one hour excluding time for recorded votes and quorum calls. No amendment shall be subject to further amendment, except pro forma amendments for the purposes of debate only. At the conclusion of the consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments 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. A motion to reconsider the vote on passage of the bill shall not be in order.

"(3) Appeals from decisions of the Chair regarding application of the rules of the House of Representatives to the procedure relating to a disapproval bill shall be decided without debate.

"(4) It shall not be in order to consider under the main heading, "Disapproval bill" for the same special message except for consideration of a similar Senate bill (unless the House has already rejected a disapproval bill) in order to discharge the cancellation or cancellations described in paragraph (1) with respect to a disapproval bill for that special message.

"(5) REFTERRAL AND REPORTING.—Any disapproval bill introduced in the Senate shall be referred to the appropriate committee or committees of the Senate to which a similar disapproval bill has been referred shall report the bill not later than the seventh day of session following the date of introduction of that bill. If any committee fails to report the bill within that period, that committee shall be automatically discharged from further consideration of that bill, and the bill shall be placed on the Calendar.

"(6) DISAPPROVAL BILL FROM HOUSE.—When the Senate receives from the House of Representatives a disapproval bill, such bill shall be referred to the Senate committee and shall be placed on the Calendar.

"(7) CONSIDERATION OF DISAPPROVAL BILL.—After the Senate has proceeded to the consideration of the disapproval bill, if the Senate adopts the special message, then no other disapproval bill originating in that same House relating to that same message shall be subject to the procedures set forth in this subsection.

"(8) AMENDMENTS.—

"(9) DISPOSITION OF SENATE DISAPPROVAL BILL.—If the Senate has read for the third time a disapproval bill originating in the Senate, then it shall be in order at any time thereafter to move to proceed to the consideration of a disapproval bill for the same special message of the House of Representatives and placed on the Calendar pursuant to paragraph (2) strike all after the enacting clause, substitute the text of the Senate bill, agree to the Senate amendment, and vote on final disposition of the House disapproval bill, all without any intervening action or debate.

"(10) CONSIDERATION OF HOUSE MESSAGE.—Consideration in the Senate of all motions, amendments, or appeals necessary to dispose of a message from the House of Representatives that (i) is a substitute has been referred to a conference committee, the conferees shall report those cancellations upon which both Houses agree and may report any or all of those cancellations upon which the agreement is in disagreement, but shall not include any other matter.

"DEFINITIONS

"SEC. 1026. As used in this part:

"(1) APPROPRIATION LAW.—The term ‘appropriation law’ means an Act referred to in section 105 of title 1, United States Code, including any general or special appropriation Act, or any Act making supplemental, deficiency, or continuing appropriations, that has been signed into law pursuant to Article I, section 7, of the Constitution of the United States.

"(2) CALENDAR DAY.—The term ‘calendar day’ means a standard 24-hour period beginning at midnight.

"(3) CALENDAR DAYS OF SESSION.—The term ‘calendar days of session’ shall mean only those days on which both Houses of Congress are in session.

"(4) CANCEL.—The term ‘cancel’ or ‘cancellation’ means

"(i) that is budget authority provided by law and that is not an appropriation law, to prevent such budget authority from having legal force or effect;
"(ii) that is entitlement authority, to preclude the specific legal obligation of the United States from having legal force or effect.

"(iii) through the food stamp program, to prevent the specific provision of law that results in an increase in budget authority or outlays for that program from having legal force or effect.

"(C) with respect to a limited tax benefit, to prevent the specific provision of law that provides such benefit from having legal force or effect.

(5) DIRECT SPENDING.—The term 'direct spending' means—

(A) budget authority provided by law (other than an appropriation law);

(B) entitlement authority; and

(C) the food stamp program.

(6) DISAPPROVAL BILL.—The term 'disapproval bill' means a bill or joint resolution which only disapproves one or more cancellations of dollar amounts of discretionary budget authority, items of new direct spending, or limited tax benefits in a special message transmitted by the President under this part and—

"(A) the title of which is as follows: 'A bill disapproving the cancellations transmitted by the President requires that the blank space being filled in with the date of transmission of the relevant special message and the public law number of the cancellation is effective; or

"(B) which does not have a preamble and

"(C) which provides only the following after the enacting clause: 'That Congress disapproves of the cancellations—'

(7) DOLLAR AMOUNT OF DISCRETIONARY BUDGET AUTHORITY.—(A) Except as provided in subparagraph (B), the term 'dollar amount of discretionary budget authority' means the entire dollar amount of budget authority—

"(i) specified in an appropriation law, or the enactment, the amount of budget authority required to be allocated by a specific proviso in an appropriation law for which a specific dollar figure was not included;

"(ii) separately in any table, chart, or explanatory text included in the statement of managers or the governing committee report accompanying such law;

"(iii) represented by the product of the estimated procurement cost and the total quantity of items specified in an appropriation law or included in the statement of managers or the governing committee report accompanying such law; and

"(iv) represented by the product of the estimated procurement cost and the total quantity of items required to be provided in a law (other than an appropriation law) that authorizes the expenditure of budget authority from accounts, programs, projects, or activities for which budget authority is provided in an appropriation law;

"(B) The term 'dollar amount of discretionary budget authority' does not include—

"(i) direct spending;

"(ii) any existing budget authority rescinded or canceled in an appropriation law; or

"(iii) any existing budget authority allocated in an appropriation law; or

"(iv) any restriction, condition, or limitation on an appropriation law accompanying statement of managers or committee reports on the expenditure of budget authority for an account, program, project, or activity, or on activities involving such expenditure.

(8) ITEM OF NEW DIRECT SPENDING.—The term 'item of new direct spending' means an appropriation law that is estimated to result in an increase in budget authority or outlays for direct spending relative to the most recent levels calculated pursuant to section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

(9) LIMITED TAX BENEFIT.—(A) The term 'limited tax benefit' means—

"(i) any revenue-losing provision which provides a Federal tax deduction, credit, exclusion, or preference to 100 or fewer beneficiaries under the Internal Revenue Code of 1986 in any fiscal year for which the provision is in effect; and

"(ii) any Federal tax provision which provides temporary or permanent transitional relief from any fiscal year from a change to the Internal Revenue Code of 1986. A provision shall not be treated as described in subparagraph (A)(i) if the effect of that provision is that—

"(I) all persons in the same industry or engaged in the same type of activity receive the same treatment;

"(II) all persons owning the same type of property, or issuing the same type of investment, receive the same treatment; or

"(III) any difference in the treatment of persons is based solely on—

"(I) in the case of businesses and associations, the size of the business or association;

"(II) in the case of individuals, general demographic conditions, such as income, marital status, number of dependents, or tax return filing status;

"(III) the amount involved; or

"(IV) a generally-available election under the Internal Revenue Code of 1986.

"(B) A provision shall not be treated as described in subparagraph (A)(i) if—

"(i) it provides for the retention of prior law without any contracts or other legally enforceable obligations in existence on a date contemporaneous with congressional action specifying such date; or

"(ii) it is a correction to previously enacted legislation that is estimated to have no revenue effect.

"(D) For purposes of subparagraph (A)—

"(I) all businesses and associations which are related within the meaning of sections 707(b) and 1563(a) of the Internal Revenue Code of 1986 shall be treated as a single beneficiary;

"(II) all qualified plans of an employer shall be treated as a single beneficiary;

"(III) all holders of the same bond issue shall be treated as single beneficiaries; and

"(IV) if a corporation, partnership, association, trust or estate is the beneficiary of a provision, the shareholders of the corporation, the partners of the partnership, the members of the association, or the beneficiaries of the trust or estate shall not also be treated as beneficiaries of such provision.

(10) OMB.—The term 'OMB' means the Director of the Office of Management and Budget.
the Congressional Budget and Impoundment Control Act of 1974 may bring an action, in the United States District Court for the District of Columbia, for declaratory judgment and injunctive relief on the ground that any provision of this part violates the Constitution.

(2) A copy of any complaint in an action brought under paragraph (1) of subsection (a) shall be promptly delivered to the Secretary of the Senate and the Clerk of the House of Representatives, and each House of Congress shall have the right to intervene in such action.

(3) Nothing in this section or in any other law shall infringe upon the right of the House of Representatives to intervene in an action brought under paragraph (1) without the necessity of adopting a resolution to authorize such intervention.

(b) APPEAL TO SUPREME COURT.—Notwithstanding any other provision of law, any order of the United States District Court for the District of Columbia which is issued pursuant to an action brought under paragraph (1) of subsection (a) shall be reviewable by appeal directly to the Supreme Court of the United States. Any such appeal shall be taken by a notice of appeal filed within 30 calendar days after such order is entered, and the jurisdictional statement shall be filed within 30 calendar days after such order is entered. No stay of an order issued pursuant to an action brought under paragraph (1) of subsection (a) shall be issued by a single justice of the Supreme Court.

(c) EXPEDITED CONSIDERATION.—It shall be the duty of the District Court for the District of Columbia and the Supreme Court of the United States to advance on the docket and to expedite to the greatest possible extent the disposition of any matter brought under subsection (a).

SEC. 204. CONFORMING AMENDMENTS.

(a) SHORT TITLES.—Section 11(a) of the Congressional Budget and Impoundment Control Act of 1974 is amended by—

(1) striking "and" before "title X" and inserting a period; and

(2) inserting "Parts A and B of" before "title X";

and (3) inserting at the end the following new sentence: "Part C of title X may be cited as the "Small Business Regulatory Enforcement Fairness Act of 1996.""

(b) TABLE OF CONTENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding at the end the following:

"PART C—LINE ITEM VETO"

"Sec. 1021. Line item veto authority.

"Sec. 1022. Special messages.

"Sec. 1023. Cancellation effective unless disapproved.

"Sec. 1024. Deficit reduction.

"Sec. 1025. Expedited congressional consideration of disapproval bills.

"Sec. 1026. Definitions.

"Sec. 1027. Identification of limited tax benefits.

"(c) CIRCULARS; RETAINING AN EX-HOURLY SALARIED EMPLOYEE.;—Section 11(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking "and" and inserting ",

SEC. 205. EFFECTIVE DATES.

This Act and the amendments made by it shall take effect and apply to measures enacted on the earlier of—

(1) the day after the enactment into law, pursuant to Article I, section 7, of the Constitution of the United States, of an Act entitled "An Act to provide for a seven-year plan for deficit reduction and achieve a balanced Federal budget."); or

(2) January 1, 2005.

and have no force or effect on or after January 1, 2005.

TITLE III—SMALL BUSINESS REGULATORY FAIRNESS

SEC. 301. SHORT TITLE.

This title may be cited as the "Small Business Regulatory Enforcement Fairness Act of 1996.""
SEC. 315. COOPERATION ON GUIDANCE.

Agencies may, to the extent resources are available and where appropriate, in cooperation with the states, develop guidelines that fully implement the requirements of both Federal and state regulations where regulations within an agency’s area of interest at the Federal and state levels impact small entities. Where regulations vary among the states, separate guidelines may be created for separate states in cooperation with State agencies.

SEC. 316. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle shall take effect on the expiration of 90 days after the date of enactment of this subtitle.

Subtitle B—Regulatory Enforcement Reforms

SEC. 321. DEFINITIONS.

For purposes of this subtitle—

(1) the terms “rule” and “small entity” have the same meanings as in section 601 of title 5, United States Code;

(2) the term “agency” has the same meaning as in section 551 of title 5, United States Code; and

(3) the term “small entity compliance guide” means a document designated as such by an agency.

SEC. 322. SMALL BUSINESS AND AGRICULTURE ENFORCEMENT OMBUDSMAN.

The Small Business Act (15 U.S.C. 631 et seq.) is amended—

(1) by redesignating section 30 as section 31; and

(2) by inserting after section 29 the following new section—

SEC. 30. OVERSIGHT OF REGULATORY ENFORCEMENT.

(a) Definitions.—For purposes of this section—

(1) ‘Board’ means a Regional Small Business Regulatory Fairness Board established under section (b); and

(2) ‘Ombudsman’ means the Small Business and Agriculture Regulatory Enforcement Ombudsman designated under subsection (b).

(b) SBA ENFORCEMENT OMBUDSMAN.—

(1) Not later than 180 days after the date of enactment of this section, the Administrator shall designate a Small Business and Agriculture Regulatory Enforcement Ombudsman, who shall report directly to the Administrator, utilizing personnel of the Small Business Administration to the extent practicable. The Ombudsman shall act as intermediary between the Ombudsman and take actions as necessary to ensure compliance with the requirements of this section. Nothing in this section is intended to replace or diminish the activities of any Ombudsman or similar office in any other agency.

(2) The Ombudsman shall—

(A) work with each agency with regulatory authority over small businesses to ensure that small business concerns that receive or are subject to an audit, on-site inspection, or other enforcement related communication or contact by agency personnel are provided with a means to comment on the enforcement related communication or contact; and

(B) establish means to receive comments from small business concerns regarding actions by agency employees conducting compliance or enforcement activities with respect to the small business concern, means to refer comments to the Inspector General of the affected agency in the appropriate circumstance, and other feedback as necessary to maintain the identity of the person and small business concern making such comments on a confidential basis to the same extent as employee and contractor feedback protected under section 7 of the Inspector General Act of 1978 (5 U.S.C.App.);

(c) based on substantiated comments received from small business concerns and the Boards, annually report to Congress and affected agencies evaluating the enforcement activity and the responsiveness of the agency to comments received on draft reports prepared under subparagraph (A), and include a section of the final report in which the affected agency may make such comments as are not addressed by the Ombudsman in revisions to the draft.

(d) REGIONS SMALL BUSINESS REGULATORY FAIRNESS BOARDS.—

(1) Not later than 180 days after the date of enactment of this section, the Administrator shall establish a Regional Small Business Regulatory Fairness Board in each regional office of the Small Business Administration.

(2) Each Board established under paragraph (1) shall—

(A) meet at least annually to advise the Ombudsman on matters of concern to small businesses relating to the enforcement activities of agencies;

(B) report to the Ombudsman on substantiated instances of excessive enforcement actions of agencies against small business concerns including findings or recommendations of the Board as to agency enforcement policy or practice; and

(C) prior to publication, provide comment on the Board’s report on the Ombudsman prepared under subsection (b).

(3) Each Board shall consist of five members, who are owners, operators, or officers of small business concerns, appointed by the Administrator, after receiving the recommendations of the chair and ranking minority member of the Committees on Small Business of the House of Representatives and the Senate. Not less than three of the Board members shall be of the same political party. No member shall be an officer or employee of the Federal Government, in either the executive or legislative branch.

(4) Members of the Board shall serve at the pleasure of the Administrator for terms of three years or less.

(5) The Administrator shall select a chair from among the members of the Board who shall serve at the pleasure of the Administrator for not more than 3 years as chair.

(6) A majority of the members of the Board shall constitute a quorum for the conduct of business, but a lesser number may hold hearings.

(d) POWERS OF THE BOARDS.

(1) The Board may hold such hearings and collect such information as appropriate for carrying out this section.

(2) The Board may use the United States mails in the conduct under the same conditions as other departments and agencies of the Federal Government.

(3) The Board may accept donations of services necessary to conduct its business, provided that the donations and their sources are disclosed by the Board.

(4) Members of the Board shall serve without compensation, provided that, members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, unless their homes or regular places of business in the performance of services for the Board."

SEC. 323. RIGHTS OF SMALL ENTITIES IN ENFORCEMENT ACTIONS.

(a) IN GENERAL.—Each agency regulating the activities of small entities shall establish a policy or program within 1 year of enactment of this section to provide for the reduction, and under appropriate circumstances, the waiver of civil penalties for violations of a statutory or regulatory requirement by a small entity. Under appropriate circumstances, an agency may consider the ability to pay in determining penalty assessments on small entities.

(b) CONDITIONS AND EXCLUSIONS.—Subject to the requirement to pay for violations of other statutes, policies or programs established under this section shall contain conditions or exclusions which may include, but shall not be limited to—

(1) requiring the small entity to correct the violation within a reasonable correction period;

(2) limiting the applicability to violations discovered through participation by the small entity in a compliance assistance or audit program operated or supported by the agency or a state;

(3) excluding small entities that have been subject to multiple enforcement actions by the agency;

(4) excluding violations involving willful or criminal conduct;

(5) excluding violations that pose serious health, safety or environmental threats; and

(6) requiring a good faith effort to comply with the law.

(c) REPORTING.—Agencies shall report to the Committee on Small Business and Committee on Governmental Affairs of the Senate and the Committee on Small Business and Committee on Judiciary of the House of Representatives no later than 2 years after the date of enactment of this section on the scope of their program or policy, the number of enforcement actions against small entities that qualified for or were granted for the program or policy, and the total amount of penalty reductions and waivers.

SEC. 324. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle shall take effect on the expiration of 90 days after the date of enactment of this subtitle.

Subtitle C—Equal Access to Justice Act Amendments

SEC. 331. ADMINISTRATIVE PROCEEDINGS.

(a) Section 504(a) of title 5, United States Code, is amended by adding at the end the following new paragraph:

“(4) If, in an adversary adjudication arising from an agency action to enforce a party’s compliance with a statutory or regulatory requirement, the demand by the agency is substantially in excess of the decision of the adjudicative officer and is unreasonable when compared with such decision, under the facts and circumstances of the case, the adjudicative officer shall award to the party the fees and other expenses related to defending against the excessive demand, unless the party has committed a willful violation of law or otherwise acted in bad faith, or special circumstances make an award unjust.

(b) Section 504(b) of title 5, United States Code, is amended—

(1) in paragraph (1)(A), by striking “$5" and inserting “$125";

(2) at the end of paragraph (1)(B), by inserting “the expenditures referred to or the semiannual report required under subsection (a)(4), a small entity as defined in section 603;"

(3) at the end of paragraph (1)(D), by striking “; and"; and
(5) at the end of paragraph (1), by adding the following new subparagraph:

"‘(F) ‘demand’ means the express demand of the agency which led to the adversary adjudication, and shall include a recitation by the agency of the maximum statutory penalty (i) in the administrative complaint, or (ii) elsewhere when accompanied by an express demand for a lesser amount.”

SEC. 332. JUDICIAL PROCEEDINGS.

(a) Section 2412(d)(1) of title 28, United States Code, is amended by adding at the end of the paragraph:

“(D) If, in a civil action brought by the United States, or a proceeding for judicial review of an agency adjudication described in section 504(a)(4) of title 5 the demand by the United States is substantially in excess of the judgment finally obtained by the United States, the amount of judgment shall be reduced on comparison with such judgment, under the facts and circumstances of the case, the court shall award to the party the fees and other expenses related to defending against the excessive demand, unless the party has committed a willful violation of law or otherwise acted in bad faith, or special circumstances make an award unjust. Fees and expenses awarded under this subparagraph shall be paid only as a consequence of appropriate action, including a filing fee.".

(b) Section 2412(d) of title 28, United States Code, is amended—

(1) in paragraph (2)(A), by striking "$75" and inserting "$125";

(2) at the end of paragraph (2)(B), by inserting before the semicolon "or for purposes of subsection (d)(2)(A) as a small entity as defined in section 601 of title 5";

(3) at the end of paragraph (2)(G), by striking "and";

(4) at the end of paragraph (2)(H), by striking the period and inserting "; and"; and

(5) at the end of paragraph (2), by adding the following new subparagraph:

"(i) the express demand of the United States which led to the adversary adjudication, but shall not include a recitation of the maximum statutory penalty (i) in the complaint of the party; and (ii) elsewhere when accompanied by an express demand for a lesser amount.

SEC. 333. EFFECTIVE DATE.

The amendments made by sections 331 and 332 shall apply to civil actions and adversary adjudications commenced on or after the date of enactment of this subtitle.

Subtitle D—Regulatory Flexibility Act Amendments

SEC. 341. REGULATORY FLEXIBILITY ANALYSES.

(a) Initial Regulatory Flexibility Analysis.

(1) Section 601—Section 603(a) of title 5, United States Code, is amended—

(A) by inserting after "proposed rule", the phrase "; and if applicable, a certification under this section regarding the development of an alternative to a proposed rulemaking for an interpretative rule involving the internal revenue laws of the United States"; and

(B) by inserting before the semicolon "or for purposes of subsection (d)(2)(A) as a small entity as defined in section 601 of title 5";

(2) in subsection (b), by striking "at the time they are issued" and inserting "; and"

(3) at the end of subsection (b), by striking the period and inserting "; and"

(4) at the end of subsection (c), by striking "; and"

(5) at the end of subsection (d), by striking the period and inserting "; and"

(b) Final Regulatory Flexibility Analysis.

(1) in subsection (a)(1), by striking "such analysis or a summary thereof"; and

(2) in subsection (a)(2), by adding after "previous to the requirements of this section."

SEC. 342. JUDICIAL REVIEW.

Section 611 of title 5, United States Code, is amended to read as follows:

§ 611. Judicial review

(a) In general—

(1) A final rule made subject to this chapter, a small entity that is adversely affected or aggrieved by final agency action is entitled to judicial review of agency compliance with the small entity compliance provisions of this section, and of section 553(g)(1). In any such action, the court shall determine whether the agency has complied with the requirements of this section.

(2) Each court having jurisdiction to review such rule for compliance with this section and of section 553(g)(1) shall have jurisdiction to review such rule for compliance with this section.

(b) In the case where an agency delays the issuance of a final regulatory flexibility analysis pursuant to this chapter, an action for judicial review under this section shall be filed not later than—

(i) one year after the date the analysis is made available to the public, or

(ii) where a provision of law requires that an action challenging a final agency regulation be commenced before the expiration of the 3-year period, the number of days specified in such provision of law that is after the date the analysis is made available to the public.

(c) Nothing in this section stops the court from granting any relief in an action under this section, the court shall order the agency to take corrective action consistent with this chapter and chapter 7, including, but not limited to—

(A) remanding the rule to the agency, and

(B) deferring the enforcement of the rule against small entities until the court finds that the continued enforcement of the rule is in the public interest.

(d) Nothing in this section bars judicial review of any other provision or similar analysis required by any other law if judicial review of such section or analysis is otherwise permitted by law.

SEC. 343. TECHNICAL AND CORRECTING AMENDMENTS.

(a) Section 605(b) of title 5, United States Code, is amended—

(B) by inserting before "proposed rule", the phrase "; and if applicable, a certification under this section regarding the development of an alternative to a proposed rulemaking for an interpretative rule involving the internal revenue laws of the United States".

(b) Sections 603 and 604 of this title shall not apply to any proposed or final rule if the head of the agency certifies that the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities. If the head of the agency makes a certification under the preceding sentence, the agency shall notify the Committees on the Judiciary and Small Business of the Senate, the Committees on the Judiciary of the Senate and the House of Representatives, the Select Committee on Small Business of the Senate, and the Select Committee on Small Business of the House of Representatives and the Committees on the Judiciary and Small Business of the House of Representatives.
by including in the rulemaking record a written finding, with reasons therefor, that those requirements would not advance the effective participation of small entities in the rulemaking process. For purposes of this subsection, the factors to be considered in making such a finding are as follows:

(1) in developing a proposed rule, the extent to which the agency consulted with individuals representative of affected small entities with respect to the potential impacts of the rule and took such concerns into consideration;

(2) Special circumstances requiring prompt issuance of the rule.

(3) Whether the requirements of subsection (b)(2) were identified in subsection (b)(2) with a competitive advantage relative to other small entities.

(b) SMALL BUSINESS ADVOCACY PERSONS.—Not later than 30 days after the date of enactment of this Act, the head of each covered agency that has conducted a final regulatory flexibility analysis which a covered agency is required to conduct by this chapter—

(1) a covered agency shall notify the Chief Counsel for Advocacy of the Small Business Administration of the covered agency and the Chief Counsel with information on the potential impacts of the proposed rule on small entities and the type of small entities that might be affected;

(2) not later than 15 days after the date of receipt of the materials described in paragraph (1), the Chief Counsel shall identify individuals representative of affected small entities for the purpose of obtaining advice and recommendations from those individuals about the potential impacts of the proposed rule;

(3) the agency shall convene a review panel for such rule consisting wholly of full time Federal employees of the office within the agency that promulgates the rule to review the proposed rule, the Office of Information and Regulatory Affairs within the Office of Management and Budget, and the Chief Counsel; and

(4) the panel shall review any material the agency has prepared in connection with this chapter, including any draft proposed rule, collect advice and recommendations of each individual small entity representative identified by the agency after consultation with the Chief Counsel, on issues related to subsections 609(b), paragraphs (3), (4) and (5) and 603(c).

(5) not later than 60 days after the date a covered agency convenes a review panel pursuant to paragraph (3), the review panel shall report to the agency as to what steps the small entity representatives and its findings as to issues related to subsections 603(b), paragraphs (3), (4) and (5) and 603(c), provided that such report shall be made public as part of the rulemaking record; and

(6) where appropriate, the agency shall modify the proposed rule, the initial regulatory flexibility analysis or the decision on whether an initial regulatory flexibility analysis is required.

(6) A covering agency in its discretion apply subsection (b) to rules that the agency intends to certify under subsection 605(b), but the agency believes may have a greater than de minimis impact on a substantial number of small entities.

(7) For purposes of this section, the term covered agency means the Environmental Protection Agency, the Occupational Safety and Health Administration of the Department of Labor.

(b) In consultation with the individuals identified in subsection (b)(2), and with the Administrator of the Office of Information and Regulatory Affairs, the Office of Information and Budget, may waive the requirements of subsections (b)(3), (b)(4), and (b)(5)
in the case of the Senate, 60 session days, or in the case of the House of Representatives, 60 legislative days, before the date the Congress adjourns a session of Congress through the date on which the same or succeeding Congress first convenes its next session, section 802 shall apply to such rule in the succeeding session of Congress.

"(A) In applying section 802 for purposes of such additional review, a rule described under paragraph (1) shall be treated as though—

"(i) such rule were published in the Federal Register (as a rule that shall take effect) on—

"(I) in the case of the Senate, the 15th session day, or

"(II) in the case of the House of Representatives, the 15th legislative day, after the succeeding session of Congress first convenes; and

"(ii) no motion on such rule were submitted to Congress under subsection (a)(1) on such date.

"(B) Nothing in this paragraph shall be construed to affect the requirement under subsection (a)(1) that a report shall be submitted to Congress before a rule can take effect.

"(3) A rule described under paragraph (1) shall take effect as otherwise provided by law (including other subsections of this section).

"(e)(1) For purposes of this subsection, section 802 shall also apply to any major rule promulgated between March 1, 1996, and the date of the enactment of this chapter.

"(2) In applying section 802 for purposes of Congressional review, a rule described under paragraph (1) shall be treated as though—

"(A) such rule were published in the Federal Register on the date of enactment of this chapter; and

"(B) a report on such rule were submitted to Congress under subsection (a)(1) on such date.

"(3) The effectiveness of a rule described under paragraph (1) shall be as otherwise provided by law (including other subsections of this section).

"(f)(1) Any rule that takes effect and later is made of no force or effect by enactment of a joint resolution under section 802 shall be treated as though such rule had never taken effect.

"(2) If the Congress does not enact a joint resolution of disapproval under section 802 respecting a rule, no court or agency may have any effect on the Congress from any action of the Congress with regard to such rule, related statute, or joint resolution of disapproval.

§ 802. Congressional disapproval procedure

"(a) For purposes of this section, the term 'joint resolution' means only a joint resolution introduced in the period beginning on the date on which the report referred to in section 801(a)(1)(A) is received by Congress and continuing throughout the Congress whereupon enactment of such joint resolution would be the same if the period beginning on the date occurring—

"(A) in the case of the Senate, 60 session days, or

"(B) in the case of the House of Representatives, 60 legislative days, before the date the Congress adjourns a session of Congress through the date on which the same or succeeding Congress first convenes its next session, section 802 shall apply to such rule in the succeeding session of Congress.

"(2) If the report under section 801(a)(1)(A) was submitted during the period referred to in section 801(d)(1), after the expiration of the 60 session days beginning on the 15th session day after the succeeding session of Congress first convenes.

"(f)(1) If, before the passage by one House of the joint resolution described in subsection (a), that House receives from the other House a joint resolution described in subsection (a), then the following procedures shall apply.

"(1) The joint resolution of the other House shall not be referred to a committee.

"(2) With respect to a joint resolution described in subsection (a) of the House receiving the joint resolution—

"(A) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

"(B) the vote on final passage shall be on the joint resolution of the other House.

"(g) This section does not apply—

"(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of either House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a joint resolution described in subsection (a), and not to any other procedure or rule of either House in the extent that it is inconsistent with such rules; and

"(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

§ 803. Special rule on statutory, regulatory, and judicial deadlines

"(a) In the case of any deadline for, relating to, or involving any rule which does not operate to the same effect (or the effect which is terminated) because of enactment of a joint resolution under section 802, that deadline is extended until the date 1 year after the date of any change in or discontinuance of anything in that subsection shall be construed to affect a deadline merely by reason of the postponement of a rule's effective date under section 802(a).

"(b) The term 'deadline' means any date certain for fulfilling any obligation or exercising any authority established by or under any Federal statute or regulation, or by or under any court order implementing any Federal statute or regulation.

§ 804. Definitions

"For purposes of this chapter—

"(1) the term 'federal agency' means any agency as that term is defined in section 551(1).

"(2) The term "major rule" means any rule that the Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget finds has resulted in or is likely to result in—

"(A) an annual effect on the economy of $100,000,000 or more;

"(B) a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

"(C) significant adverse effects on competition, employment, investment, productivity, growth, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

The term does not include any rule promulgated under the Telecommunications Act of 1996 and the amendments made by that Act.

"(3) The term 'rule' has the meaning given in section 551, except that such term does not include—

"(A) any rule of particular applicability, including a rule that approves or prescribes for the future rates, wages, prices, services, or allowances therefor, corporate or financial structures, reorganizations, mergers, or acquisitions thereof, or accounting practices or disclosures bearing on any of the foregoing;

"(B) any rule relating to agency management or personnel; or

"(C) any rule of agency organization, procedure, or practice that does not substantially affect the rights or obligations of non-agency parties.
America Advancement Act of 1996. This legislation contains the Senior Citizens' Right to Work Act, the Line-Item-Veto Act, the Small Business Growth and Fairness Act of 1996, and provides for a permanent increase in the public debt ceiling.

Let me first compliment Chairmen Solomon, Clinger, and Bunning, and the rest of the line-item-veto conference for their hard work. As the original author of line-item-veto legislation at the request of the late President Reagan, I am a true believer in the line-item veto. I know that it will help control spending and therefore aid us in obtaining a balanced budget. Accordingly, I welcome its inclusion in H.R. 3136.

I am also proud that the Senior Citizens' Right to Work Act will be included in this legislation. It is another of my career-long projects—one which I began working on with former Senator Goldwater in the early 1970s. As you know, the House has already approved this measure by a large bipartisan vote of 412 to 4 last December 5. It would raise the earnings limit for seniors between the ages of 65 and 69 to $30,000 by the year 2000, while fully preserving the long-term financial integrity of the Social Security trust funds. In fact, according to the Social Security actuaries, this bill improves the long-range solvency of the trust funds by a significant amount.

This legislation is also strongly supported by a broad group of seniors' associations, including the AARP. We all know that the current earnings limit is too low and is nothing more than a tax on hard-working seniors.

In our Contract With America, we promised to raise the earnings limit which discourages older workers from remaining in the workforce and sharing their experience, knowledge, and skills with younger workers. Today, we take another important step in fulfilling that promise by providing relief from the onerous earnings limit to millions of Americans who want or need to work. Again, I want to compliment Social Security Subcommittee Chairman Jim Bunning and Whip Denny Hastert for their outstanding efforts on this legislation. They have been untiring in their work on this project.

Mr. Speaker, H.R. 3136 also includes another important element of our Contract With America, regulatory relief for small businesses. This is a vital element of the bill, and I believe Chairman Hyde will be speaking on it in more detail.

Finally, H.R. 3136 contains an increase in the permanent statutory debt ceiling from its current level of $4.9 trillion to $5.5 trillion. This amount should provide the Government with enough authority to operate through fiscal year 1997. This is the level included in the budget resolution signed by President Reagan.
people. I urge my colleagues on both sides of the aisle to support it today.

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

Mr. GIBBONS. Mr. Speaker, I yield 30 seconds to the gentlewoman from California [Ms. HARMAN].

PERSONAL EXPLANATION

Ms. HARMAN. Mr. Speaker, I was in my district yesterday on official business. Had I been present, I would have voted “no” on the rule and “no” on passage of H.R. 1833, the partial birth abortion bill; “yes” on the passage of House Resolution 378; and “yes” on the passage of House Concurrent Resolution 102.

Mr. GIBBONS. Mr. Speaker, I yield 1 minute to the gentleman from Indiana [Mr. JACOBS].

Mr. JACOBS. Mr. Speaker, this is a paradox day in the U.S. House of Representatives. We are going to raise the earnings limit under Social Security immediately from about $11,000 a year to $14,000 or so a year, I believe, and that will, on average, mean an income of about $20,000 for a Social Security retiree. That is a very good thing to do. The paradox is, at the same time we are not going to be doing anything about the minimum wage. So what are we saying in essence? We are saying that the person who is retired and might work part time needs $24,000 a year, but the young person who is working every day of the week and working hard, maybe digging ditches, and has children to support can get by just fine on $8,840 a year. So I want to congratulate my colleagues on a sense of humor, I suppose, and a wonderful paradox.

Mr. ARCHER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Idaho [Mrs. CHENOWETH].

(Mrs. CHENOWETH asked and was given permission to revise and extend her remarks.)

Mrs. CHENOWETH. Mr. Speaker, I rise in opposition to H.R. 3136.

Mr. Speaker, I strongly support increasing the Social Security earnings limit. The current earnings limit of $11,280 huts low-to-moderate-income seniors who work out of necessity, not choice.

Our Nation achieved unprecedented wealth and power because of the strong work ethic, self-reliance, and personal responsibility of today’s senior citizens. They are the generation that built this Nation. To punish these productive, industrious seniors, who are the ones that made America great is absolutely absurd. All Americans lose when the earnings limit prevents us from employing the teaching and experience of our Nation’s most precious resource.

Let me also say I support wholeheartedly empowering small businesses to challenge burdensome regulations. In fact, observation of the catastrophic effects of excessive regulations have on small businesses and property owners was a major motivation for my seeking office.

We should pass legislation to increase the Social Security earnings limit, and to empower small business, and I hope we do it soon. However, I must vote against this measure today because I simply cannot support what would be a monumental mistake that would be made by this Congress if we hand over legislative powers to the president in the form of a line-item veto.

Mr. Speaker, let me first say that I believe that a line item veto could be effective in eliminating wasteful port. However, I strongly believe that the consequences of shifting the delicate power balance of between the executive and legislative branches of government would far outweigh any advantages gained by this measure.

Let me remind you of Alexander Hamilton’s stern warning in Federalist No. 76 of why we must keep the powers given respectively to the legislature and executive branches of government separate.

Without the one or the other the former would be unable to defend himself against the depredations of that latter. (The Legislature) might gradually be stripped of his authorities by successive resolutions. And in one mode or the other, the legislative and executive powers might speedily come to be blended in the same hands.

Mr. Speaker, the Constitution specifically gives the powers of the purse to the people, which are represented in Congress. Let us not give that sacred responsibility away to the President because we as a Congress do not have the discipline to make necessary spending cuts. The more powers we give to the executive to control the spending of taxpayer dollars, the less we will have of a representative government our Founding Fathers envisioned.

Mr. Speaker, I strongly believe that the Congress will regret the day that we surrender this tremendous power to the executive. I urge my colleagues to stand back and take a hard look at what we are doing today, and whether it is really worth giving away power that rightfully belongs to this, the people’s House.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Illinois [Mr. HYDE], the highly respected chairman of the Committee on the Judiciary.

(Mr. HYDE asked and was given permission to revise and extend his remarks.)

Mr. HYDE. Mr. Speaker, I rise in support of H.R. 3136, and particularly title III of that bill, the Small Business Regulatory Enforcement Fairness Act of 1996.

Title III, as amended by the provision of S. 942, legislation I strongly support. Title III is an important aspect of the Regulatory Flexibility Act, allowing judicial review of certain aspects of that statute. The Regulatory Flexibility Act was first enacted in 1980. Under its terms, Federal agencies are directed to consider the special needs and concerns of small entities— that is, small businesses, local governments, and so forth, whenever they engage in a rulemaking subject to the Administrative Procedure Act. The agencies must then prepare and publish a regulatory flexibility analysis of the impact of the proposed rule on small entities, unless the agency certifies that the proposed rule will not “have a significant economic impact on a substantial number of small entities.”

From the beginning, the problem with this law has been the lack of availability of a judicial review mechanism to enforce the purposes of the law. Right now, if agencies do not actually conduct a regulatory flexibility analysis or fail to follow the other procedures set down in the act, there is no sanction. Thus, under current law, the small business community has no remedy.

Title III would cure this problem. In instances where an agency should have undertaken a regulatory flexibility analysis and did not, or where the agency needs to take corrective action with respect to a flexibility analysis that was performed, the agency is authorized to seek judicial review within 1 year after final agency action. A court will then review the agency’s action under the judicial review provisions of the Administrative Procedure Act. The remedies that a court may order include remanding the rule back to the agency and deferring enforcement of the rule against small entities, pending agency compliance with the Regulatory Flexibility Act.

Another important aspect of title III is the congressional review procedure. This will allow Congress to review all proposed rules to determine whether or not they should take effect. Specifically, title III would allow Congress to postpone for 60 days the implementation of any major rule, generally defined as having an annual effect on the economy of $100 million or more. The language to bypass the 60-day delay through the issuance of an Executive order, if the rule addresses an imminent threat to the public health or safety, or other emergency, or matters involving criminal law enforcement or national security.

This legislation was developed by Senator DON NICKLES and Senator HARRY REID. My Judiciary Committee staff has worked very closely with Senator NICKLES’ staff concerning the details of this provision.

I think it is important to emphasize that this approach means that Congress must be prepared to take on greater responsibility in the rulemaking process. If during the review period, Congress identifies problems in a proposed major rule prior to its promulgation, we must be prepared to take action. Each standing committee will have to carefully monitor the regulatory activities of those agencies falling within their jurisdiction.

Title III also includes a provision which will require Federal agencies to simplify forms and publish a plain English guide to help small businesses comply with Federal regulations. These compliance guides will not be subject to judicial review, but may be considered as evidence of the reasonableness of any proposed fines or penalties. Federal agencies would
also be directed to reduce or waive fines for small businesses in appropriate circumstances, if violations are corrected within a certain period. The proposal would also create an ombudsman within the Small Business Administration to guard against small businesses about compliance and enforcement practices, and to work with the various agencies so as to respond to the concerns of small businesses regarding those practices.

In addition, some important changes would be made in the Equal Access to Justice Act. The Equal Access to Justice Act (EAJA) currently provides that certain parties who prevail over the Federal Government in regulatory or court proceedings are entitled to an award in attorneys' fees and other expenses, unless the Government can demonstrate that its position was substantially justified or that special circumstances would make the award unjust. Eligible parties are individuals whose net worth does not exceed $2 million or businesses, organizations, associations, or units of local government with a net worth of no more than $7 million. The act covers both adversary administrative proceedings and civil court actions.

Title III proposes to change the Equal Access to Justice Act so as to make it easier for small businesses to recover their attorneys fees. The proposal is subjected to excessive fines and unsustainable proposed penalties. It would amend the EAJA to create a new avenue for small entities to recover their attorneys fees in situations where the Government has instituted an administrative or civil action against them for the purpose of enforcing a statutory or regulatory requirement. In these situations, the test for recovering attorneys fees would be whether the final demand of the United States, prior to the initiation of the adjudication or civil action, was substantially in excess of the decision or judgment ultimately obtained and is unreasonable when compared to such decision or judgment. The important point here is that this legislation will level the playing field and make it far more likely that the United States will not seek excessive fines or penalties. It does more than just put the small entities on a more equal footing.

Mr. Speaker, I have only described in very general terms today the substance of this important title. Because the language is the product of negotiation and compromise with important title. Because the language is the product of negotiation and compromise with important title. Because the language is the product of negotiation and compromise with important title. Because the language is the product of negotiation and compromise with important title. Because the language is the product of negotiation and compromise with important title. Because the language is the product of negotiation and compromise with important title. The important point here is that this legislation will level the playing field and make it far more likely that the United States will not seek excessive fines or penalties. It does more than just put the small entities on a more equal footing.

Mr. Speaker, I rise to speak against H.R. 3136. My opposition stems not from a desire to prevent the needed increase in the debt limit, nor do I oppose the increase in the Social Security earnings limit contained in section 3. The line-item veto is not about money as such. It is about power, specifically the balance of power between the executive and legislative branches of the Federal Government. This has nothing to do with Republicans and Democrats. It has nothing to do with the contract except the contract we should be keeping with history that provided for our constitutional democracy to be able to sustain a balance between the executive and the legislative. It assumes that the executive is compared to the legislative, is inherently inclined to restrain spending. In fact, however, congressional appropriations have been lower than the amounts requested by the past three Presidents, Democrat and Republican alike. In denying Congress the authority to single out proposed rescissions for individual consideration, H.R. 3136 denies to the Congress an authority it grants to the President.

If the President can unilaterally veto individual items in a single bill, why is Congress required to sustain or override those vetoes as an indivisible package? Why is Congress denied the authority, why are we denying ourselves the authority to judge each veto cast by the President? The upshot is more power for the executive branch, less for the legislature. By giving the President power to veto specific tax and appropriation items within a single bill, H.R. 3136 strips away a legislative branch of its share of its ability to strike a compromise with the executive.

Mr. Speaker, it upsets the carefully calibrated balance between the legislative and executive branches of Government. That balance is what inclines our political system to compromise. Look at what is happening in the rest of the world where the executive has exclusive authority. I know I am going to lose some of my friends that is what is going to be cast today. What I regret is, and this has happened before in our legislative history, there will be a few who will try to strike a balance to keep the power of the legislature against the executive, and one day there will be a Ph.D. writing a thesis about it, how we gave up our power, how we gave up the balance of power that exists in our democracy. Vote "no" on 3136.

Mr. ARCHER. Mr. Speaker, I yield 3 minutes to the gentleman from Kentucky [Mr. BUNNING], the respected chairman of the Subcommittee on Social Security of the Committee on Ways and Means.

Mr. BUNNING of Kentucky. Mr. Speaker, I thank the chairman for yielding me time. Mr. Speaker, I hope the third time around will be the charm and the Social Security earnings limit will be passed. I want to thank DENNIS HASTERT, the deputy whip, and all the Republican Members of the 104th Congress, but lack of Senate action has kept this measure off the President's desk.

I have a very good feeling that the tide has turned and our colleagues in the other body want to see this done as much as we do. I want to commend the House and Senate leadership for working with the Ways and Means Committee and the Finance Committee to make the earnings limit increase part of the debt limit legislation. We have worked out a fair bill which makes good policy while actually improving the financial integrity of the Social Security trust funds.

Increasing the earnings limit on working senior citizens, we are fulfilling the commitment we made in the Contract With America to bring economic relief to older workers. The earnings limit is a depression-era relic that has outlived its usefulness. Older workers have a great deal of knowledge and experience and our country needs the skills of experienced workers. The current limit is unrealistically low and sends the message that the Federal Government does not want seniors to continue working and contributing.

Today's older Americans are living longer and healthier. They want to contribute to society but they have to ask themselves if it is worth losing a good part of their Social Security benefits to do so.

In most cases, the answer is "No." By discouraging skilled older workers from working, we are forgoing one of society's greatest resources—experienced workers—a commodity every employer in the United States needs and values.

The earnings limit is particularly hard on lower to middle-income seniors who must work to supplement their Social Security benefits. Approximately 1 million working seniors have some or all of their benefits withheld because of the current earnings limit. These are not wealthy working seniors. These are seniors who do not have substantial pensions, investments or savings to supplement their Social Security checks.

The earnings limit is nothing less than a tax on work. Seniors need and deserve some tax relief. I urge my colleagues to join me in making this long
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overdue change to increase the earnings limit to $30,000.

Mr. GIBBONS. Mr. Speaker, I yield 3 minutes to the gentleman from Utah [Mr. Orton].

(Mr. ORTON asked and was given permission to revise and extend his remarks.)

Mr. ORTON. Mr. Speaker, I voted against the rule on this particular bill, not because I oppose the provisions of the bill in general but in specific, I have a problem with one provision on line-item veto.

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I am a long-time supporter of the line-item veto. That is an issue which has not been partisan. It is an issue that the administration has asked for. I have supported it, and many on both sides of the aisle have supported it. The concern I have is that the line-item veto, under this bill, will not go into effect until the end of the current term of this President. This President is a Democrat. This Congress is controlled by Republicans. That looks to the public like business as usual, like we are afraid to give a Democratic President the authority to veto specific items of pork.

It is not like we do not have a problem ongoing with pork-barrel spending. I have in my hand the Citizens Against Government Waste’s 1996 Congressional Pig Book. In that they identify $12.5 billion in just 8 appropriation bills that we passed in 1996. 8 of the 13, $12.5 billion of pork.

We passed in February 1995 through this House and in March through the other body a line-item veto bill. It took 6 months to even appoint conference. Now we finally have the line-item veto coming to passage as part of this bill. It is too late for 1996 and these billions of dollars. Under this bill, it is too late for 1997 as well.

Did they believe that, by passing line-item veto, there would only be Republican Presidents in the future? A Democratic President would not be eligible to use the line-item veto? Well, I am going to put into the RECORD statements by the majority leader of the House, majority leader in the Senate and majority whip in the Senate. I am also going to put into the RECORD statements by the Committee on Rules chair who works with people on both sides of this House, saying we are not afraid to give it to a Democrat President.

Here we are giving it, it is not just a Republican, we are giving it to him. No, you are not, not unless he wins re-election.

So I simply believe that we ought to change one provision in this bill. Let us make line-item veto effective immediately upon enactment. If the President does not appropriately use it, then Congress can challenge the Presidential. If the President does appropriately use it, we start cutting inappropriate spending today rather than waiting until after the 1997 fiscal year.

So I would urge my colleagues to re-visit this bill, and I hope that we will have a motion to recommit with instructions to do so.

Mr. CLINGER. Mr. Speaker, I yield myself 2 minutes.

As chairman of the Government Reform and Oversight Committee, I am very pleased to rise in strong support of this measure. Two of the provisions in this measure were initiated in the Government Reform and Oversight Committee, and we are very proud they are part of this debt ceiling increase, because the line-item veto goes directly to the question of trying to hold down the debt, which we are now going to be forced to increase today.

The previous speaker said that this was a provision that we should give the President right now. I would point out to the gentleman that this was a suggestion that the President himself made. Contrary to many of the Members on the other side of the aisle, this President, our President, supports the line-item veto and supports the date that has been selected.

I would also point out he does have within his own power the key to unlock this provision and make it effective today, and that would be if he would agree to a balanced budget agreement. That is, as I say, in his power.

We had a lot of trouble reconciling the many differences, frankly, that existed between the Senate and the House. Many in this room will remember how vast those differences were. But we were, in the final analysis, to come to agreement. It was a bipartisan bicameral agreement. There are Members on both sides who support strongly the provision of the line-item veto. There are Members on both sides, frankly, who disagree with the line-item veto.

The intent of the legislation, Mr. Speaker, is to provide the President a tool, only a tool, to approach this question of deficit reduction. We have provided it not just for the appropriations process, which would only get at about 30 percent of the spending, we have also provided it for entitlements. We have provided it for targeted tax preferences which have been so abused in the past.

The President is going to have a broad authority and broad ability to deal with the deficit and to deal with the debt, which has been spiraling out of control.

I would point out it is important to note, consistent with the demand of both Houses in the conference, the conference report does not allow the President to strike any restriction, condition, or limitation on how funds may be spent. It is limited to whole dollar amounts. No policy can be changed as a result of this.

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

Mr. GIBBONS. Mr. Speaker, I yield 30 seconds to the gentleman from Utah [Mr. Orton].

Mr. ORTON. Mr. Speaker, just in response to my friend who just mentioned that it was the President who asked for this, yes, the President asked for line-item veto. The President did not ask for line-item veto to be until after the new year of 1997. It was offered by the majority leader, Senator Dole, for the President to be able to accept litem veto. The President said he wanted line-item veto, he would be willing to accept it and would accept it under those terms.

It was not the President suggesting to delay line-item veto until 1997. The President did accept it, but he has apparently for it constitute effective immediately, and I have a letter so stating.

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

Mr. Speaker, let me explain to the Chair what I am about to do. I am going to yield to the gentlewoman from Connecticut [Mrs. KENNELLY], then I am going to get out of the way and let the gentlewoman from New York [Ms. Slaughter] have her 30 seconds.

I yield 2 minutes to the gentlewoman from Connecticut [Mrs. KENNELLY].

Mrs. KENNELLY. Mr. Speaker, I am delighted to stand here today, on March 28, 1996, because it is a good day for the United States of America, it is a good day for the economy of the United States of America, it is a good day for the financial markets of the United States of America, but most importantly it is a good day for the full faith and credit of the United States.

There is raising the debt limit. We should have done it 5 months ago, but we are doing it today, and I am pleased that that is happening.

There are those who say it did not matter if we did not raise it when we should have 5 months ago. I have to differ because I do not think there is any way of knowing if there were not interest rate increases or delaying schedules of auctions for securities, or, in fact, holding those actions for securities, or, in fact, holding those auctions when they should have.

Having said that, I am glad today has come. There is one disappointment I have, though, in this bill. For 19 years, for 19 years, the blind of this country have been joined with the elderly of this country, in being able to earn a certain amount of money over and above the Social Security earnings test. For some reason, the majority has decided to drop the blind from this joint relationship with those over 65. I do think it is too bad, because it really hurts the economic independence of the blind in this country.

I certainly hope the majority in another time will look at this piece of legislation. I know the gentleman from Texas [Mr. Archer] introduced it originally. I do hope once again we can couple the blind with those over 65 so economic independence can be theirs also.

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

Mr. Speaker, it is perhaps a good day but it certainly is a strange one. I would never have thought I would be
part of a Congress of the United States that would unilaterally hand over major parts of its power to the executive department. To me, the strength of the Government of the United States, as written by the Founding Fathers, is the separation of powers for each part of the legislative, the executive, and the judiciary, well defined.

With the action taken here in the House and in the Senate, we are unilaterally handing over to the President, whom he may be, the right to veto all the work that we do here in Congress. Members of the House who have served under Governors, who have the right of line-item veto, have told me that in many cases it is a genteel way to commit blackmail.

Will we save money with the line-item veto? Well, consider this scenario: Let us say there is a President who is finding it very difficult, perhaps, to get reelected, and to get support from the members of his party who serve in the House or Senate. He goes on a delegation, perhaps mine, New York, which is rather large, and says to us, you are not supporting me, but I do notice here that in the bills that have been sent to me, that there is a very critical item in New York that we have not so much money. We are then, Members, confronted with either determining whether we are going to stand pat, face the President of the United States and tell him to forget about it, or allow him to veto out what is necessary for the people that we represent.

It is possible, is it not, that under those circumstances, that a delegation, a legislator, anyone, a leader would decide not to spend less money, Mr. Speaker, but could be induced to spend more? Indeed, it may be that such a President wants more than that has been asked for; the line-item veto does not say that in all cases that they will be going for less; it is entirely possible that he will ask for more. I believe that this measure is unconstitutional, and I hope that it will be judged so. It is a tragedy to me that this has been added to on what is one of the most important pieces of legislation that we have to come before us. The threat of fiscal default hanging over the United States of America has left a cloud over us that should never have been there in the first place. No nation ever talked about defaulting by choice. To put aside, to sort of genteel from of blackmail, things that we normally would like to debate, strikes me as not the best way to do business.

We have heard this conference report being bipartisan and the great support that you have had on both sides of the aisle. I think it is important to point out, Mr. Speaker, that the conference that took place, took place only between House and Senate Republicans. No Democrat was in that conference. I am the only Democrat who saw the conference report after it was filed. Without any question, this side of the House had no impact whatever on that conference report.

But in addition, this conference report goes much further than either the House bill or the Contract With America went for. For example, it includes Medicare and Medicaid again up to the vagaries of the President, without the ability of the people here to make the determination for the people who sent us, the 500,000 and more in each district who depend upon us to make those decisions, now you want to turn those decisions over to the President.

But there is one other piece that I was particularly involved in myself during the 100 days of the Contract With America when line-item veto was brought up. We were concerned over on our side in the House about the abuse of the Federal Treasury, in many cases, just as much a breach of faith, to use tax policy. And we put forth an amendment on this side to make sure that no tax policy, the income that they can receive, certain persons in the United States, would be looked at and scrutinized if the line-item veto indeed became law. That has been narrowed to the point of nonrecognition. Your tax-broken freedom is being taken away.

What we are saying with this bill, this line-item veto today, is that the President may run through the bills in any way he or she likes, taking out anything or everything no matter the importance of it or what it may mean for the country. However, when it comes to tax benefits and tax policy, given to favorite constituents or constituent groups, nobody is going to be touching that. That is going to be sacrosanct.

Obviously, this bill is important for us to pass. Our fiscal responsibility and our fiscal reputation depend on it, and it is high time that the Social Security recipients receive some attention with the fact that they have been limited in the income that they can receive. Without jeopardizing their Social Security.

But, Mr. Speaker, adding line-item veto to this is an abrogation of our power. It is an abrogation of the Constitution of the United States to say, frankly, that putting it on this bill says to the Nation basically we cannot be trusted. It is going to have to be somebody at 1600 Pennsylvania Avenue to make these final decisions. That is a decision and a statement that I personally am not willing to make.

Mr. Speaker, I yield 3 minutes to the gentleman from Michigan [Mr. Smith].

Mr. SMITH of Michigan. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I would just like to briefly carry on the discussion of how much power has been transferred from Congress to the President. Article I, section 9 of the Constitution says that Congress shall control the purse strings. Article 1 of section VII of the Constitution says that Congress shall decide how deep we go into debt.

I will bring this chart to portray the authority and responsibility that Congress has now given away to the President of the United States. This pie chart represents the Federal budget for this coming year. The blue area represents the 52 percent of spending now in these welfare entitlement programs. The spending in those programs cannot be changed without the consent of the President.

It has been demonstrated now that the administration has the authority to go deeper in debt without the consent of Congress.

Transferring even greater power to the administrative branch, to the President, by saying that he will have the authority to line out to veto anything in an appropriation bill, is a tremendous transfer of power.

I served under three governors while in the State legislature in Michigan. Every one of those governors, liberal and conservative, used the leverage of the line-item veto to get spending they wanted. A lot of States have the line-item veto. Almost every one of those States also have a constitutional proviso that says they have to have a balanced budget.

In the State legislature, while the Governor says I want to shift priorities to what I think is important spending, either for political purposes or for philosophic goals. In the U.S. Government, where we do not have that kind of safeguard of a balanced budget, there is a danger of actually increasing spending and not decreasing spending as some presume.

During the last three decades, a lot of us wished that the President had authority to veto line-item spending and we did not like. But we now have a Congress that is becoming more frugal, is being more conscientious of a balanced budget, and is more interested in cutting. Now we are saying we are going to take away responsibility from this Chamber, from this body and give it to the President. This is inconsistent with what our Founding Fathers thought was an appropriate balance. I think this legislation could have different results than some expect. I hope we do not see the dangers that could result from further disrupting the balance of power.

Ms. SLAUGHTER. Mr. Speaker, I yield the balance of my time to the gentleman from Wisconsin [Mr. Barret].

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Wisconsin is recognized for 2½ minutes.

Mr. BARRETT of Wisconsin. Mr. Speaker, I thank the gentlewoman for yielding me the time.

Mr. Speaker, I support the line-item veto. It is a good measure, a measure...
that the American people want. Why? They want the line-item veto because they are concerned about two things. They are concerned about pork barrel spending, and they are concerned about special interest tax breaks.

We do not have the President's line-item veto. I believe we do need a line-item veto, and it is an essential element of our battle to bring the Federal budget under control. We have been very careful in this conference report to carefully define our terms and the limitations that Congress is placing on the President's use of the line-item veto. The purpose of the line-item veto is to add to our arsenal of weapons against low-priority or unnecessary Federal spending. The goal is deficit reduction and we have ensured that the authority applies only to money being spent. Just as 43 Governors do today, the President, under the line-item veto, will have the ability to cancel individual items of spending and tax legislation if he believes doing so will help reduce the deficit. The burden of proof will then be on the Congress to come up with a two-thirds major- ity. The President can spend the money over his objections. If the Congress is unable to muster that supermajority, then the funds are not spent and are applied to deficit reduction. The remarkable thing about this measure is that it fundamentally shifts the bias away from spending and toward saving the Treasury. After all, more than 70 percent of Americans have been asking for Americans know, entitlement programs are a major culprit in our current budget imbalance—and the line-item veto should help to curb the creation of new programs that we can't afford. The conference report also allows the President to cancel limited tax benefits—provisions that are slipped into the Tax Code to benefit 100 or fewer people at a cost to the taxpayers at large.

Mr. Speaker, our staff has spent countless hours refining the language of this measure to ensure that we understand the repercussions of this delegation of authority. While we recognize the possibility for gaming of the system—by the Congress and the executive—we have built in important safeguards, including an 8-year sunset to allow the President to assess the line-item veto's effectiveness. Finally, Mr. Speaker, I point out to my colleagues that the President and the House leadership have agreed that the effective date of this new authority will be January 1, 1997, or enactment of a 7-year balanced budget, whichever comes sooner—a result that ensures sufficient time for the Executive and Congress to consider the measure's provisions and impact. In addition, this specified effective date allows the line-item veto to rise above short-term political realities. I think it is a tremendously sensible decision and I applaud the President and our leaders for it.

Mr. Speaker, last night the other body adopted this conference report by a 69-to-31 vote. It's time for this House to deliver a similar result.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. DeLay], the distinguished major- ity whip and tireless leader in the battle to ensure a line-item veto.

Mr. DeLay. Mr. Speaker, I thank the gentleman for his words.

Mr. Speaker, I rise in strong support of the Contract With America Advance- ment Act, and I urge my colleagues to vote for it.

This bill proves the pundits wrong. The Contract With America is alive and well, and is working to better the lives of American families.

I am especially pleased by two provi- sions in this legislation.

The regulatory flexibility act is a small but significant step in the right direction for making commonsense changes to our regulatory system.

This bill will bring much needed con- trol on our leaders accountability to the regu- latory process. No process before this one has been willing to take responsibility for the way laws are imple- mented after they are signed.

I believe it is both appropriate and necessary for Congress to conduct over- site of agencies' promulgation of regulations, and I am very pleased that this, the first Republican Congress in 40 years, is the one to make it happen.

We also are finally enacting the line- item veto.

When I was first elected to the House, I made the line-item veto one of my top priorities. This may not be a good week for pork, but it is a great week for the American taxpayer.

Gone are the days, when Congresses inserted pork barrel projects to buy votes for their Members. With this line-item veto, we will make certain that those days of wasting taxpayer dollars are gone forever.

I applaud my colleagues for their work on this legislation, and I urge them to send this bill to the President.

Mr. Gibbons. Mr. Speaker, I yield 2 minutes to the gentleman from Mary- land [Mr. Cardin].

Mr. Cardin. Mr. Speaker, I rise in strong support of this legislation, but it is interesting how we got here. We got here today because the Republican leadership and the Democrat administra- tion worked together to bring this bill to a vote. We have Democrats and Republicans working together, and when we work together it is amazing what we can accomplish.

This bill is important. It does deal with the Social Security earning limi- tation. For too long senior citizens have been penalized for working with outrageously high tax rates. This bill corrects that.

The line-item veto is an important bill. It helps to spotlight individual ap- propriations. We give those omnibus bills too much time and we do not have an opportunity to study each and every provision in that legislation. The line- item veto will give us an opportunity
to look at these items individually and give the President a role as to whether they should become law.

Small business regulatory relief, there are problems with small business. The oversight function of Congress should have a look at what regulations impact on small business, and this bill does that.

Increasing the debt ceiling, we all know that we need to do that. We have already spent the money. We have got to hold the debt down.

But it is interesting, why have we delayed so long in bringing these bills forward? As I listened on the floor when we were considering other debt extension bills, the Republican leadership told us we could not consider it because we had to deal with deficit reduction. This bill does not deal with deficit reduction; it deals with extending the debt limit, as it should.

Perhaps the only lesson that we can take out of this bill on deficit reduction and balancing the budget if we use the process of Democrats and Republicans working together, then we can accomplish a balanced budget in this Congress. So I hope this legislation will spill over to other efforts between the two parties so that we can bring sound legislation to the floor, not in a vacuum by one party, but in cooperation by both parties, between the Congress and the President. If we do that, we will indeed serve our constituents well.

Mr. ARCHER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Kansas [Mrs. MEYERS], the chairwoman of the Committee on Small Business. (Mrs. MEYERS of Kansas asked and was given permission to revise and extend remarks.)

Mrs. MEYERS of Kansas. Mr. Speaker, I would like to thank the chairman very much for yielding me this time.

Mr. Speaker, I rise in strong support of H.R. 3136, the Small Business Regulatory Flexibility Act, and to support the increased personal income of the senior citizens earning threshold, I support the line-item veto, and particularly I support title III of this act, which is of enormous importance to this country's 21 million small businesses.

Subtitle A of title III provides that agencies will provide plain English guides on new regulations for small business. Subtitle B provides for a regulatory ombudsman to assist small businesses in disputes with the Federal Government. These two subtitles, along with subtitle D, the Regulatory Flexibility Act, were among the very top priorities listed by the White House Conference on Small Business.

I would like to focus for a moment on the Regulatory Flexibility Act, which those interested in small business have been working for for many years. The Regulatory Flexibility Act has been on the books since 1980, and it provides that agencies must review all new rules and regulations for their specific impact on small business and then help mitigate that impact if it is extreme. But there is no enforcement mechanism, and the agencies have largely ignored it.

This bill would provide for judicial review of the process, and thus put teeth in that Regulatory Flexibility Act. This judicial review of regulatory impact on small business has bipartisan support. It has passed this House by a vote of 415 to 15, and last week it passed the Senate by 100 to 0. There are many good reasons to support this bill, but its value and importance to small business is the best reason to me and to the Committee on Small Business.

I urge my colleagues to support H.R. 3136.

Mr. CLINGER. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Florida [Mr. MICA] who has been a champion for regulatory reform and also a leader in the line-item veto battle.

Mr. MICA. Mr. Speaker, I thank the chairman for yielding me this time.

Mr. Speaker, small business is really the largest employer in our country. Small business in fact is the cornerstone of free enterprise. Today small business in the United States is being choked to death on mindless regulations, excessive paperwork, and federally mandated compliance forms.

When they write the epitaph of American small business, let me read for you what the tombstone is going to say: "Here lies American small business, murdered by overregulation, murdered by taxation and litigation."

Today we cannot totally free the bondage of small business in America. What we can do today, however, is allow some regulatory flexibility, and that is what this legislation does.

Today, through this legislation, small business will have a small but a fighting chance to challenge this crazy Federal bureaucratic rulemaking process. Today we can let Congress place a small check on the bureaucrats who are jamming small businesses' ability to compete. Today we can let Congress place a small but fighting chance of pumping out mindless, costly, and ineffective regulations.

Today, if we are going to sink our Nation further into the rathole of debt, we can, through these regulatory reform measures, give small business, who employ our people, who pay our taxes, a small but fighting chance to dig us out of that rathole of debt.

Mr. CLINGER. Mr. Speaker, I am very pleased to yield 2 minutes to the gentleman from Indiana [Mr. McIntosh] who has been a leader in this Congress on regulatory reform and an active participant on our committee, and chairman of the Subcommittee on Regulatory Reform.

Mr. McIntosh. Mr. Speaker, I thank the chairman for yielding me this time, and thank him for his leadership on this bill.

Mr. Speaker, I rise in strong support of the line-item veto, the bureaucracy, the provision removing penalties from senior citizens, and title III, the Small Business Regulatory Enforcement Fairness Act of 1996.

What we have before us today is a small step toward reforming our regulatory process. It is time, Mr. Speaker, that we get Government off of our backs, and back on our side in this country.

Small businesses create 75 percent of the new jobs in this country, and I am particularly pleased to support the provisions of this bill that will allow small businesses to challenge agency decisions in court when they ignore the needs of small businesses and they ignore the new regulations and create red tape.

I am also very pleased with subtitle E that will bring agency regulations back to Congress for a vote. This part of the bill originated as a companion bill to my legislation, H.R. 450, the Regulatory Transition Act of 1995. And I was pleased to work with the gentleman from Pennsylvania, Chairman Clinger, the gentleman from New York, Chairman Solomons, and the gentleman from Illinois, Chairman Hyde, along with Senator Don Nickles, to craft provisions that will be acceptable to both bodies and provide for meaningful congressional review of agency rulemaking actions.

The Subcommittee on Regulatory Affairs has held field hearings around the country. We have heard from many people who are suffering because of Federal over-regulation. One person is Bruce Gohman, a small businessman in Minnesota, who says that he consciously limits his job creation to 50 employees. He will not hire more people because of the fear of being subjected to more red tape and more Government regulations.

I say we need this reform to allow Mr. Gohman to create more good jobs and to pay higher wages to his employees so that we can get this economy going again.

Mr. SPEAKER. Mr. Speaker, I strongly support title III of this bill, and say it is time we have regulations that are smarter, safer, and provide more environmental protection, and less red tape.

Mr. Speaker, this title is one of the most important pieces of legislation for small business growth and job creation that we will take up this year. In fact, it is the number one legislative priority for small business. Although this is not a comprehensive regulatory reform bill, this is an important first step in enacting needed reform for hard-working Americans in their quest to compete in the marketplace in Washington. Moreover, this title will hold the administration accountable for the impact of rules on all Americans.

As I have said, I am especially pleased with the reforms in subtitles D and E, which address issues that I have been concerned about for a number of years. Subtitle D will strengthen the Regulatory Flexibility Act by allowing affected small businesses, local governments, and other small entities to challenge certain agency action and inaction in court. Currently, the Regulatory Flexibility Act requires few rules to consider the impact the rules would have on small entities and prepare a regulatory flexibility analysis unless it certifies that the rule
would not have a significant economic impact on a substantial number of small entities. In my experience working with Vice President Quayle on the President's Council on Competitiveness, I discovered that the Federal agencies often ignored the mandate of the act and refused to perform a regulatory flexibility analysis. The limited judicial review provided in subtitle D will serve as a needed check on agency behavior and help enforce the mandate of the act.

Subtitle E will add a new chapter 8 to the Administrative Procedure Act, which will allow Congress to review agency rulemaking actions and determine whether Congress should pass joint resolutions under expedited procedures to overrule the rulemaking action. This subtitle originated almost one year ago as companion legislation to H.R. 450, the Regulatory Transi-
tion Act of 1995, which was reported out of my Subcommittee on National Economic Growth, Natural Resources, and Regulatory Affairs. Al-
though I would have liked this subtitle to go further, the bill we are going to pass today is a good start and can easily be amended in the future to provide for an expedited procedure to review and stop the most wrong-headed rule-
making proceedings before they waste more agency and private resources.

As the principal House sponsor of the Con-
gressional Review subtitle, I am very proud that this bill will soon be sent to the President again, and I hope signed by him this time. The House and Senate passed an earlier version of this subtitle as section 3006 of H.R. 2586, which was vetoed by the President last No-

vember. Before it became law, the bill will have been debated in Congress at least four times and passed the House at least twice. In dis-
cussions with the Senate and House co-spon-
sors this past week, we made several changes to the version of this subtitle that both bodies passed on November 9, 1995, and the version that the Senate passed last week. I will be happy to work with Chairman HYDE and Chairman CLINGER on a document that we can insert in the CONGRESSIONAL RECORD at a later time to serve as the equiva-

cent of a floor managers' statement. But be-
cause this bill will likely have a conference report or managers' statement prior to pas-
sage, I offer the following brief explanation for some of the changes in the subtitle:

**DEFINITION OF A "MAJOR RULE"**

The version of subtitle E that we will pass today takes the definition of a "major rule" from President Reagon's Executive Order 12291. Although President Clinton's Executive Order 12866 contains a definition of a signifi-
cant rule that is purportedly as broad, several of the administration's significant rule deter-
minations under Executive Order 12866 have been overturned. The administration's narrow

interpretation of "significant rulemaking action" under Executive Order 12866 helped convince me that Congress should not adopt that definition. We intend the term "major rule" to be broadly construed, particularly the non-
numerical factors contained in the new sub-
section 804(2) (B) and (C).

**AGENCY INTERPRETIVE RULES, GENERAL STATEMENTS OF POLICY, GUIDELINES, AND STATEMENTS OF AGENCY POLICY AND PROCEDURE ARE COVERED BY THE BILL**

All too often, agencies have attempted to circumvent the mandate and comment require-
ments of the Administrative Procedure Act by trying to give legal effect to general policy state-
ments, guidelines, and agency policy and procedure manuals. Although agency interpre-
tive rules, general statements of policy, guide-
line documents, and agency policy and proce-
dure manuals may not be subject to the notice and comment provisions of section 553(c) of title 5, United States Code, these types of documents are covered under the congres-
sional review provisions of the new chapter 8 of title 5.

Under section 801(a), covered rules, with very few exceptions, may not go into effect until the relevant agency submits a copy of the rule and an accompanying report to both Houses of Congress. Interpre-
tive rules, general statements of policy, and analogous agency policy guidelines are covered without qualification because they meet the definition of a "rule" borrowed from section 551 of title 5, and are not excluded from the definition of a rule.

Pursuant to section 801(3)(C), a rule of agency organization, procedure, or practice, is only excluded if it "does not substantially af-
fect the rights or obligations of nonagency par-
ties." The focus of the test is not on the type or rule but on its effect on the rights or obliga-
tions of nonagencies. A statement of agency procedure or practice with a truly minor, incidental effect on nonagency parties is excluded from the definition of a rule. Any other effect, whether direct or indirect, on the rights or obligations of nonagency parties is subject to the requirement that the rule have a nontrivial effect on their rights or obli-
gations.

**THE 60-DAY DELAY ON THE EFFECTIVENESS OF MAJOR RULES AND THE EMERGENCY AND GOOD CAUSE EXCEPTIONS**

Two of the three previous Senate versions of this subtitle would have delayed the effec-
tive date of a major rule until at least 45 days after the relevant agency submitted the major rule and an accompanying report to Congress. One of the Senate versions and both House versions opted for at least a 60-day delay on the effectiveness of a major rule. The 60-day period is meant to provide a more mean-

ingful time within which Congress could act to pass a joint resolution before a major rule went into effect. Even though the expended congressional procedures extend beyond this period—and some of the special House and Senate rules would never expire—it would be preferable for the Congress to act before out-
side parties are forced to comply with the rule.

The subtitle provides an emergency excep-
tion in section 801(c) and a limited good cause exception in section 808(2) from the 60-
day delay on the effectiveness of a major rule. The administration's narrow interpretation of "significant rulemaking action" under Executive Order 12866 helped convince me that Congress should not adopt that definition. We intend the term "major rule" to be broadly construed, particularly the non-
numerical factors contained in the new sub-
section 804(2) (B) and (C).

The objective is to cover each and every entity in the executive branch, whether it is a department, independent agen-
cy, independent establishment, or Government corporation, whether or not it conducts its rule-
making under section 553(c), and whether or not it is ever covered by other provisions of title 5, U.S. Code. This definition of "Federal agency" is also intended to cover entities and establishments within the executive branch, such as the U.S. Postal Service, that are sometimes excluded from the definition of an agency in other parts of the U.S. Code. This is because Congress is enacting the congres-
sional review legislation, in large part, as an exercise of its oversight and legislative re-
sponsibility over the executive branch. Regard-
less of the justification for excluding or granting independence for certain entities from the coverage of certain laws, that justification is because Congress is enacting the congres-
sional review legislation and is exercising its constitu-
tional oversight and legislative responsibility over all executive branch agencies and enti-
ties within its jurisdiction.

Examples too numerous to mention abound in which Federal entities and agencies issue regulations and rules that impact businesses, small and large, as well as major segments of the American public, yet are not subject to the traditional 5 U.S.C. 553(c) rulemaking process. It is essential that this regulatory reform measure include every agency, authority, or entity that establishes policies affecting all or any segment of the general public. Where it necessary, a few specific exceptions have been made, such as the exclusion for the monetary policy activities of the Board of Gov-
ernors of the Federal Reserve System, rules of particular applicability, and rules of agency management and personnel. Where it is necessary, no exemption is provided and the rule is that the entity in question is covered by this act. This is made clear by the provi-
sions of the new section 806 which states that the act applies notwithstanding any other pro-
vision of law.

Mr. CLINGER. Mr. Speaker, I yield 1 minute to the gentleman from California [Mr. Royce].

Mr. ROYCE. Mr. Speaker, I rise in support of this legislation which is ur-
gently needed to avoid financial chaos. This is a compromise bill. In exchange for extending the debt limit, it pro-
vides a much needed procedure for re-
ducing unnecessary pork barrel spending. That procedure is the line-item
White House. I was very new to this. I got a call from then-President Bush's White House. I was very new to this body. It said, can you do us a favor? Can you help us just one time temporarily raise the national debt? Just a temporary thing.

Mr. Speaker, I had only been here a couple of weeks, and, my goodness, the President of the United States called. I was flabbergasted and honored, and, of course, Mr. President, you made perfect sense. We have got to do that. So the debt was raised from $2.87 trillion to $3.1 trillion. That was not the end of it. In October 26, 1990, this House came up with a resolution. They raised the debt ceiling from $3.1 to $4.1 trillion, just a couple years later. And then again on August 5, 1993, the House raised the debt ceiling from 4.1 to 4.9.

It is like saying, I am going to pay off my Visa card but first I am going to raise my debt limit on my visa card from 5,000 to 10,000. You do not ever get there.

Today they are being asked to raise it from 6.7 to 9.5 trillion. Voting to raise the debt limit is a lot like an alcoholic saying, I am just going to have one more drink. A very good friend of mine from Mississippi, MS, just came out of alcoholic rehab. He said, I would wake up every morning and I could always find an excuse for just one more drink. It is Thanksgiving. It is the week before Christmas. It is Mardi Gras. It is spring break. There is always one more excuse, one more drink. But until he work up and said, I am not going to have any more excuses, no more drinks, did he cure his problem.

Mr. Speaker, America has to run out of excuses. We have got to quit borrowing. We cannot be for a balanced budget. The American people have consistently said that the biggest threat to this Nation is our horrible debt. It is a vulnerability greater than any other thing because it is eating up so much of our taxes. Just the interest on the national debt eats up more of our taxes than Medicare, than Medicaid, twice as much as Medicaid, the national defense, more than food stamps, and 12 times more than welfare.

In the 2 minutes that I have spoken to my colleagues, this Nation has spent $1 million on interest on the national debt, just in the past 2 minutes.

So what is their solution? We will borrow more money. We will pay more interest. That is crazy.

Mr. Speaker, what do they do? Do they come to the floor and be honest with the American people and say we want to borrow more money? No, they hide it. They hide it behind three bills that have already passed this body on their own merit, three bills that were just waiting for the U.S. Senate to agree to so they can become law.

There is only one purpose for this bill. It is to borrow more money and to waste more money on interest on the national debt. Instead of the balanced budget that the American people were promised, this is just more borrow and spend. But it is not the first time.

I have come to Congress that this has happened. Around November 7, 1989, I got a call from then-President Bush's White House. I was very new to this. I have come to Congress that this has happened. Around November 7, 1989, I got a call from then-President Bush's White House. I was very new to this.
because I do not think we can always count on the President of the United States, regardless of who he is, not to have some pettiness in his surroundings. But what I do not understand is there was a big push to do the line item veto, and I understand that this transaction will not go into place until 1997. Why not would the line item veto go and this President have the benefits of it for the next 7 months?

Mr. TRAFICANT. Mr. Speaker, I would like to respond by saying evidently the next President-elect will have the line item veto authority. It is amazing to me. I think it is unconstitutional, to start with, but I can remember a vote on a Btu tax, and the President wanted a Btu tax. I can remember that I happened to be the only Democrat in the Congress to speak out against that tax. With the line item veto it is not a very comfortable position. Maybe someone from that side might explain why.

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

Mr. TRAFICANT. I yield to the gentleman from Pennsylvania. We are going to miss him as well.

Mr. ARCHER. Just to briefly say, Mr. Speaker, the President has agreed to the date. Obviously he is confident that he is in fact going to be reelected. I do not share that confidence, but he believes that he will be. Therefore, he is going to have that ability on a January 1 in his view. The second thing is he has the key to provide the line-item veto to his use now upon signing a balanced budget agreement.

Mr. TRAFICANT. Reclaiming my time. I do not care if I am a Democrat or Republican, we are all Americans. We are expanding the power of the Presidency. That is not good for our country, Mr. Speaker.

Mr. ARCHER. Mr. Speaker, I yield 3 minutes. From the beauty whip, the gentleman from Illinois [Mr. HASTERT], a respected Member of the House. Mr. HASTERT. Mr. Speaker, I thank the gentleman for yielding time to me. This is the third time the House of Representatives has taken up legislation to raise the earnings limit for working seniors in the 104th Congress. I want to congratulate the gentleman from Texas [Mr. ARCHER], who think for 13 Congresses has worked to make this possible. I also want to congratulate the gentleman from Kentucky [Mr. BUNNING], who is the chairman of the Social Security Subcommittee, along with Members of the 104th class who have been working on this project for another 8 years. They have made this thing happen.

Mr. Speaker, every time this legislation has come to the floor, it has passed with nearly a huge bipartisan margin. It is clear the House understands the concern seniors, people who have to earn money by the sweat of their brow, usually people who have earned money by the sweat of their brow their whole life, who have not been able to accumulate huge savings or investments or those revenues or huge pensions, that today they have to go out and work to supplement their pension, to supplement their Social Security so that they can have a decent life, so that they can put their grandchildren through college, so that they can go on a vacation or somebody pay their property taxes or even by a new car. These people are affected by this bill.

I am proud to be able to stand here today and say those seniors will be able to make more money this year without paying a tax on work. Those seniors will be able to eventually realize and take the earnings test up to $30,000 so that they can share the benefits of work that all Americans can have without paying a penalty or a tax on it.

Mr. Speaker, I sincerely wish we were able to raise the limits faster, as in earlier versions of this bill, but I am happy to see that those seniors will be able to make more money this year without paying a tax on work. Those seniors will be able to eventually realize and take the earnings test up to $30,000 so that they can share the benefits of work that all Americans can have without paying a penalty or a tax on it.

Mr. Speaker, I sincerely wish we were able to raise the limits faster, as in earlier versions of this bill, but I am happy to see that those seniors will be able to make more money this year without paying a tax on work. Those seniors will be able to eventually realize and take the earnings test up to $30,000 so that they can share the benefits of work that all Americans can have without paying a penalty or a tax on it.

Mr. Speaker, I yield 1 minute to the gentleman from North Carolina [Mr. HEFNER]. Mr. HEFNER. Mr. Speaker, to my friend, the gentleman from Pennsylvania [Mr. CLINGER], who is leaving this august body and has been a friend for a long time, everything that is in this bill that we are debating here today, as soon as the President signs it, it will go into effect with the exception of the line-item veto; is that right?

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

Mr. HEFNER. Mr. Speaker, I yield to the gentleman from Pennsylvania.

Mr. CLINGER. Mr. Speaker, as I indicated, this would also go into effect if the President would agree to the balanced-budget agreement.

Mr. HEFNER. The balanced budget is not what we are voting on.

The Speaker pro tempore (Mr. HASTINGS of Washington). The time of the gentleman from North Carolina [Mr. HEFNER] has expired.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania [Mr. GEKAS]. Mr. GEKAS. Mr. Speaker, I thank the gentleman for yielding this time to me.

The American farmer and the owner of a small business will be, at the end of this day, applauding the action of Congress. What we do here today in reforming regulatory flexibility is for the first time give a disaffected regulator, if they sign such a word, the right to appeal a burdensome regulation that stifles business, it stifles the ability of the farmer to expand his operation and, thus, have created a situation in our country where entrepreneurs are afraid to hire new people, are afraid to embark on new enterprises.

What we do here today in reforming regulatory flexibility is for the first time give a disaffected regulator, if they sign such a word, the right to appeal a burdensome regulation that has been foisted upon them by administrative agencies. That is a tremendous advance. Instead of having to sit back until you make it effective as soon as the bill is signed?

Mr. Speaker, just as among friends here, we are just friends here, would it not have been possible to put into this legislation that as soon as the President signs it, he will have the line-item veto? It is just that simple.

Yes or no; could the gentleman have done it that way?

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

Mr. HEFNER. Mr. Speaker, I yield to the gentleman from Pennsylvania.

Mr. CLINGER. That could be done but would kill the conference agreement and prevent enactment of the bill. The President has in fact agreed that the date should be January 1.

Mr. HEFNER. That is not exactly true, Mr. CLINGER.

Mr. CLINGER. He did agree to that date; did he not?

Mr. HEFNER. That was the best he could get, but I think he would agree, if it were made possible, that the line-item veto would go into effect as soon as he—I do not think he would have any problem with that.

Mr. CLINGER. I would understand that, but if the gentleman would yield—

Mr. HEFNER. But it could be done.

Mr. CLINGER. There is recognition that this is an effort to try to—

Mr. HEFNER. Mr. Speaker, taking back my time, the gentleman is setting the legislative agenda here. He could have made it in order that everything would go into effect, the line-item veto, everything, would have gone into effect. It could have been done; am I right or not? Yes or no?

Mr. CLINGER. No. Not and pass the bill.

Mr. HEFNER. I reclaim my time.

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

Mr. HEFNER. No. Not and pass the bill.

Mr. HEFNER. I reclaim my time.

The Speaker pro tempore (Mr. HASTINGS of Washington). The time of the gentleman from North Carolina [Mr. HEFNER] has expired.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania [Mr. GEKAS]. Mr. GEKAS. Mr. Speaker, I thank the gentleman for yielding this time to me.

Mr. Speaker, just as among friends here, would it not have been possible to put into this legislation that as soon as the President signs it, he will have the line-item veto? It is just that simple.

Yes or no; could the gentleman have done it that way?
Mr. QUINN. Mr. Speaker, I yield ½ minutes to the gentleman from Delaware [Mr. CASTLE].

Mr. CASTLE. Mr. Speaker, I thank the distinguished gentleman for yielding this time to me, and let me just say I support this in every aspect of it. I think many, many good things are happening here.

I only have a minute and a half. I want to talk about the line-item veto. I think we need to look at the record first of all. Congress over the years, Republicans and Democrats, have spent a tremendous amount of money, more than, perhaps, we should have. I think this country really wants mechanisms in place which are going to help us reduce that burden of spending, and I believe strongly the line-item veto will do it.

I have listened to this whole argument today because I am interested in it. As a Governor of a State for 8 years, I had the line-item veto. We are one of the 43 States which has it just as easily as I can tell my colleagues it was beneficial in my State from both points of view. It caused us to get into a room together and to do our budgets, and to make absolutely sure we were in concert with each other and we were doing what was in the best interests of the State. It was beneficial, without a doubt, to the budget process of the State of Delaware and I am convinced it will be beneficial to the budget process of the United States of America.

We, in my judgment, are not yielding power to the President absolutely. We are allowing the President to become involved in the budget process. But we also retain the right to override vetoes in the process in which they arise, and, quite frankly, if we have a President who for political reasons, ideological reasons, political reasons, whatever it may be, decides to make an issue of all of this, we have the ability to just as easily point out that it is politics and that it is wrong.

What will really happen in this process is that we will be able to sit down together to negotiate things that are absolutely in the pork barrel category. They can be eliminated. So for the reasons of that and the rest of this very good bill I hope we will all support it here in a few minutes.

Mr. ARCHER. Mr. Speaker, I yield 30 seconds to the gentleman from Michigan [Mr. SMITH].

Mr. SMITH of Michigan. Mr. Speaker, I thank the gentleman from Texas for yielding time to a person that is here again with this opportunity to pass a historic measure. On a day when we are asking to support an increase in the debt limit to a record $5.5 billion, I think it is imperative and it is appropriate that we give the President the authority.

Mr. Speaker, I also want to take a moment at this time to commend our colleague, the gentleman from Pennsylvania [Mr. CLINGER], who is retiring after this session. We said yesterday at the Committee on Rules, I will say it again, his work on the line-item veto bill, as well as many other numerous reform problems and perspectives, has been truly remarkable. Without his effort it would still be stuck in committee and we would ask everybody to vote for the line-item veto.

Mr. ARCHER. Mr. Speaker, I yield 30 seconds to the gentleman from Michigan [Mr. SMITH].

Mr. ARCHER. Mr. Speaker, I yield 30 seconds to the gentleman from Michigan [Mr. SMITH].

Mr. ARCHER. Mr. Speaker, I yield 30 seconds to the gentleman from Michigan [Mr. SMITH].

Mr. SMITH of Michigan. Mr. Speaker, I thank the gentleman from Texas for yielding time to a person that wants to talk against the bill.

Mr. Speaker, what this bill does is increases the debt of the United States by $600 billion. At 5-percent interest, that is another $30 billion a year that taxpayers will have to pay.

I think it is unconscionable to continue to increase the debt without some specific legislative change, at the very least some direction, to cut the spending of this bloated Government. Borrowing has obscured the true siege of Government. Ultimately we must reach an open and fair process on the record, on the President's authority.

Mr. Speaker, what this bill does is brings the total cost of the American people to $600 billion. At 5-percent interest, that is another $30 billion a year that taxpayers will have to pay, and that is why I am voting against it.

Mr. GIBBONS. Mr. Speaker, I yield 3 minutes to the gentleman from California [Mr. BECERRA].

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

Mr. Speaker, let me rise in opposition to H.R. 3156 and mention that, along with some of the Members who have spoken earlier, I, too, believe that this bill will ultimately be found constitutional if it is signed into law. I also note with curiosity that we made the line-item veto effective after the advent of the current President, Bill Clinton, has expired, which is somewhat questionable as to why this Congress, under the new majority, has decided not to allow this particular President the opportunity to exercise a line-item veto if they are so adamantly for it.

But let me mention something that I find extremely disturbing in this particular bill, which I cannot understand why it is even in here, and that is the whole issue of regulatory reform. I do not think there is any Member of Congress who does not wish to see regulatory flexibility and decreasing the burden on small business so long as we provide protections to the environment, to workers, and to people, our consumers.

But, disturbingly, this bill commits an end run on the whole issue of regulatory reform because what it provides, in this particular piece of legislation, through an amendment which was attached to the budget bill, which amends the bill which came to us just 2 days ago, the whole structure used to regulate agencies and regulate businesses out there in this country. How someone is supposed to be able to tell someone that something got 2 days ago completely means and then now have to analyze something that they got last night, what that means is beyond me. But that is what we are being asked to swallow here through this end run.

I am not sure what is wrong with this particular bill, but why was it that the majority was unwilling to let sunshine on these provisions so we could decide if, in fact, this is the true regulatory reform we need?

Let me mention a couple of other things. This legislation creates, in the regulatory reform provisions, so-called regulatory fairness boards and advocacy panels. These are panels and boards that may be made up completely of a few favored small businesses that are trying to get themselves out of regulation, or can even include people who are exclusively major campaign contributors to particular Members of Congress or to particular parties. That I find very disturbing and very offensive.

What else does this legislation do? It allows for private ex parte communications. In other words, all the interested parties are normally under the customs practice allowed to sit on these boards or advocacy panels. Has this never been allowed to sit on these boards or advocacy panels? It is somewhat questionable as to why.

The legislation says no, we do not need to do that any more. Let us pass this law and let a few people who happen to sit on these boards or advocacy panels have the opportunity to privately, without the other interested parties,
sit down with some of these agencies that are actually going to create these particular regulations or remove certain regulations. That is unfair to those businesses that are trying to do this in a fair and evenhanded manner. If Congress is not going to do this in a fair and evenhanded manner, I would urge all the Members to, if they really have a chance, take a look at this. We are going to take out the penalties for environmental violations of law.

As I was saying, take a look at the provisions that deal with environmental regulations. What we see here are waivers of penalties that would otherwise apply to those businesses that would then have a violation of our clean water and safe drinking water standards. Any penalty for having violated those particular laws or regulations could be waived.

Not only that, but because we have not had enough time to examine it, it is going to be fairly clear from some of the cryptic language that is used that they are going to create a nest egg for attorneys, because they will be able to go in there and take this to court because so much of this is so difficult to understand. What they are doing though is putting the consumer at risk, they are putting the environment at risk, and I would urge Members to take a look at this for all the reasons I stated on what I thought would oppose H.R. 313.

Mr. ARCHER. Mr. Speaker, I yield myself such time as I may consume simply to very briefly respond to the gentleman who has just spoken.

Mr. Speaker, this legislation on small business regulatory reform should not come as a big surprise to him because it was debated thoroughly on the floor of this House last year. This was one of the elements of the Contract With America.

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

Mr. GIBBONS. Mr. Speaker, I yield 1½ minutes to the gentleman from Oklahoma [Mr. COBURN].

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

Mr. Speaker, I have voted on the three main components of this bill already, regulatory reform, Social Security earnings limit increase, and a line-item veto. I think it is very important that the American public knows what this bill is. This is adding things to increase the debt for our children. What is wrong with the scenario to say that we are in debt, we have no fiscal-out way, no agreed-to plan, to solve that debt, and we are going back to the bank to borrow more money?

Mr. Speaker, the Members of this Congress need to make sure they know what they are doing when they vote to extend the debt and jeopardize the future of our children by not doing the proper thing in terms of living with our means today.

Consider what it will be like when we are 70 or 80 years of age. They will not, our children or grandchildren, be able to buy a home, will not be able to own a car. Their living standard will be halved, because we did the wrong thing today. This is not about the Social Security earnings limit, this is not about the line-item veto, this is not about reg reform, this is about not living up to the very hard responsibility that this Congress has been entrusted with, and that is not to live beyond our means.

I would urge each Member of Congress to consider what the real issue is here today, to extend his debt limit until we have an agreement that gives us a plan on how we manage the finances of this country.

Mr. CLINGER. Mr. Speaker, I yield such time as she may consume to the gentlwoman from New Jersey [Mrs. ROUKEMA].

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks and include extraneous material.)

Mrs. ROUKEMA. Mr. Speaker, I rise in reluctant opposition to this legislation.

Mr. Speaker, I want my colleagues to know that I have absolutely no quarrel with the heart of this bill—the mechanism by which we enact a long-term increase to the Social Security earnings limit and believe the so-called reg flex provisions of this bill are an improvement on current law.

My opposition is prompted exclusively by the inclusion of the line-item veto in this must-pass legislation.

Mr. Speaker and my colleagues, enactment of the line-item veto is a serious error and a fundamental violation of the basic constitutional principal of the separation of powers. Every school child in America should have learned that. The separation of powers is a foundation of our democracy.

Mr. Speaker, Mr. David Samuels has it right in an Op-Ed piece in today’s New York Times—‘Line Item Lunacy.’ I include this article for the RECORD.

David Samuels writes:

The line-item veto would hand over unchecked power to a minority President with minority support in Congress, while opponents would have to muster two-thirds support to override the President’s veto.

By opening every line in the Federal budget to partisan attack, the likely result would be a chaotic legislature more susceptible than ever to obstructionists who could demand that the President use his line-item vetoing power to stop funding or sex education programs or aid to Israel as the price of their political support. And conservatives eager to cut Government waste would do well to consider what a liberal minority might do to their legislative hopes during a second Clinton term in office.

Nor would the line-item veto likely result in more responsible executive behavior. The ziggs and zags of Bill Clinton’s first term in office give us a clear picture of the post-partisan Presidency, in which the executive freelances across the airwaves in pursuit of poll numbers regardless of the political coherence of his message or the decaying ties of party. With the adoption of the line-item veto, the temptation for Presidents to strike out on their own would surely grow.

The specter of a President on horseback armed with coercive powers might seem far away to those who dismissed Ross Perot as a freak candidate in the last election. Yet no laser that powers lawmakers must be possessed of Mr. Perot’s peculiar blend of personal qualities and doomed to fail. Armed with the line-item veto, a future Ross Perrot—or Steve Forbes—would be equipped with the means to reward and punish members of the House and Senate by vetoing individual budget items. This would enable an independent President to build a coalition in Congress through a program of threats and horse-trading that would make our present sorely flawed system seem like a meal of Cicereon reeds.

President Clinton has promised to sign the line-item veto when it reaches his desk. Between now and then, the historic breach of our constitutional and arent not that the measure proposes should be subject to a vigorous public debate. At the very least, we might reflect on how we intend to govern at a time when the dynamics of two-party politics are dissolving before our eyes.

He’s absolutely right: the line-item veto, the version included in the bill is fairly pure—would give the President of the United States new dramatic, unilateral powers. It would mean that any President, operating in league with just 34 Senators, could strip any...
spending proposal or tax cut, no matter their merit, from any bill. The consolidation of power in the executive branch is undeniable. As Mr. Samuels writes, “By opening every line in the Federal budget to partisan attack, the likely result would be a chaotic legislative process more susceptible than ever to obstructionism.”

This line-item veto could easily take legislative horse-trading to a new level. While many President’s have held out the prospect of a pork in order to enlist votes for legislation they wanted—that is, the vote trading that occurred during the NARADA debate—the line-item veto will allow a President to threaten specific programs and projects proposed by Members in order to compel their cooperation on other votes.

This is a dramatic shift in the balance of power is an open invitation to any President to engage in legislative blackmail. For example, what if President Clinton decided to remove only Republican initiatives from a measure? If 34 Democratic Senators uphold his action, the President wins. We must recognize the genius of the framers of our U.S. Constitution. They did not want a king or a dictator or an oligarchy—a small group running the Nation. So they wrote the Constitution based on a delicate system of checks and balances and the separation of powers—on a system that would suggest, on the contrary, this provides the President with a refined tool to attack the deficit problem that looms over us. It merely gives him an effort to be more selective in the way that he goes about deficit reduction.

Congress retains the power to override any Presidential veto. We have not given that power away. I am sure that we will exercise that power. We also limit his ability to do this to whole dollar amounts. He cannot single out projects unless they are congressional earmarks. He has to take out the entire amount if he is going to do anything, so that was, I think, an important addition that we got in conference.

Mr. Speaker, there are the dire results that have been indicated by some of the Members who have spoken against this measure, if, in fact, that turns out to be true; there is a sunset provision in this legislation that provides that there will be an opportunity to review this matter at a time within 8 years. Mr. Speaker, I think this is a reasonable, a reasoned, and a sensible measure that should be enacted.

I want to discuss just one other brief area that needs clarification in this legislation. We created small business and agriculture enforcement ombudsmen who would be appointed by the Administrator in the SBA. Concerns have arisen in the inspector general community that those ombudsmen would have new enforcement powers that would conflict with those currently held by the inspectors general. I want to make it very clear that nothing in this act is intended to supersede the Inspector General Act of 1978, or to other- wise restrict or interfere with the activities of any office of the inspector general but, rather, be used to help our small business and work with the inspection general.

Mr. Speaker, I urge a strong bipartisan support for the increase in the debt limit and the line-item veto and regulatory reform.

Mr. Speaker, I include for the RECORD a letter from the Joint Committee on Taxation containing examples of how the tax provisions of this measure would work.

The material referred to is as follows:


Hon. Peter Blute, House of Representatives, Longworth House Office Building, Washington, DC.

DEAR MR. BLUTE: This is in response to your letter of March 24, 1996, in which you requested the staff of the Joint Committee on Taxation to prepare some examples of how the provisions of S. 4, the “Line Item Veto Act,” would apply to tax legislation.

The Line Item Veto Act provides that each “limited tax benefit” is subject to the President’s line-item veto authority. In general, the Line Item Veto Act defines a “limited tax benefit” as any provision of special and temporary tax consequences under the Internal Revenue Code that is either (1) a revenue-losing provision that provides a Federal tax deduction, exclusion, or credit, (2) a Federal tax provision that benefits fewer beneficiaries in any fiscal year for which the provision is in effect (subject to certain exceptions described below); or (2) a Federal tax provision that provides temporary or permanent transitional relief to 10 or fewer beneficiaries in any fiscal year, except to the extent that the provision provides for the retention of prior law for all binding contracts (or other legally-enforceable obligations) in existence on a date contemporaneous with Congressional action specifying such a date.

A provision is defined as “revenue-losing” if it results in a reduction in Federal tax revenues either for the first year in which the provision is effective or for the 5-year period beginning with the fiscal year in which the provision is effective. A revenue-losing provision that affects 100 or fewer beneficiaries in a fiscal year is not a limited tax benefit if any of certain enumerated conditions is satisfied. First, if a provision has the effect of providing all persons in the same industry or engaged in the same activity with the same treatment to all persons owning the same type of property or issuing the same property, it is a limited tax benefit even if there are 100 or fewer persons in the affected industry. For this purpose, the staff of the Joint Committee on Taxation believes that a broad definition of “activity” is intended to be applied, e.g. for purposes of determining whether a proposal related to drug testing is a limited tax benefit, all persons engaged in drug testing would be considered to be engaged in the same activity or the same industry rather than all persons engaged in clinical testing of drugs for certain diseases. A second exception for provisions that have the effect of providing the same treatment to all persons owning the same type of property or issuing the same property is for proposals that are temporary and have a reasonable duration, or that have a reasonable duration and do not substantially affect the economic behavior of individuals, such as their income level, marital status, number of dependents, or return filing status. Finally, there are a number of reasons why we should not enact this legislation. It has been suggested that there are a number of reasons why we should not enact this legislation. It has been suggested that it is unconstitutional. It is not really our job to determine what is constitutional or what is not unconstitutional, but the fact is that we do provide severability in this measure. If a provision, any provision of the matter is considered unconstitutional, it can be stricken and the rest of the matter can stand.

It has also been suggested, Mr. Speaker, that we have engaged in a reckless spending proposal that would suggest, on the contrary, this provides the President with a refined tool to attack the deficit problem that looms over us. It merely gives him an effort to be more selective in the way that he goes about deficit reduction.

The Line Item Veto Act provides that each “limited tax benefit” is subject to the President’s line-item veto authority. In general, the Line Item Veto Act defines a “limited tax benefit” as any provision of special and temporary tax consequences under the Internal Revenue Code that is either (1) a revenue-losing provision that provides a Federal tax deduction, exclusion, or credit, (2) a Federal tax provision that benefits fewer beneficiaries in any fiscal year for which the provision is in effect (subject to certain exceptions described below); or (2) a Federal tax provision that provides temporary or permanent transitional relief to 10 or fewer beneficiaries in any fiscal year, except to the extent that the provision provides for the retention of prior law for all binding contracts (or other legally-enforceable obligations) in existence on a date contemporaneous with Congressional action specifying such a date.
We have made a preliminary review of the Balanced Budget Act of 1995 (the "BBA"), as passed by the Congress, and have also provided examples of items from earlier legislation that would constitute limited tax benefits if the Line Item Veto Act were in effect at the time such provisions were enacted. (The Line Item Veto Act is scheduled to go into effect on July 4, 1997, or the day after a seven-year balanced budget act has been enacted, whichever is earlier.) The attached list is not intended to be dispositive of exhaustive. The Joint Committee staff continued to analyze the provisions in the BBA and other tax legislation and it is possible that additional provisions will be identified as limited tax benefits.

I hope that this information is helpful to you. If we can be of further assistance, please let me know.

Sincerely,
KENNETH J. KIES,
Chief of Staff.

EXAMPLES OF LIMITED TAX BENEFITS WITHIN THE MEANING OF S. 4, THE LINE-ITEM VETO ACT

THE BALANCED BUDGET ACT ("BBA") OF 1995

1. Exemption from the generation-skipping transfer tax for transfers to individuals with deceased parents (sec. 11074).

Under present law, a generation-skipping transfer tax generally is imposed on transfers to an individual who is more than one generation younger than the transferor. Any transfer of a terminal facility (from a grandparent to a grandson or other grandchild) is subject to the generation-skipping transfer tax. The BBA provision would expand the present-law exception to apply also in other limited circumstances, e.g., to transfers to grandnieces and grandnephews whose parents are deceased.

This provision is a "limited tax benefit" because it loses revenue, it is expected to benefit fewer than 100 beneficiaries in at least one fiscal year in which the provision would be in effect, and it does not fall within any of the stated exceptions. It does not provide the same treatment to all persons engaged in the same activity—making generation-skipping transfers—because transfers to individuals with deceased parents would be treated differently than transfers to individuals whose parents are still alive.

2. Extension of the orphan drug tax credit (sec. 1115).

Prior to January 1, 1995, a 50-percent tax credit was allowed for qualified clinical testing expenses incurred in the testing of certain drugs for rare diseases or conditions. The BBA provision would extend the credit through December 31, 1997.

This provision is a "limited tax benefit" because it loses revenue, it is expected to benefit fewer than 100 drug companies in at least one fiscal year in which the provision would be in effect, and it does not fall within any of the stated exceptions. It does not provide the same treatment to all persons engaged in the activity of drug testing, because the drug companies that benefit from these transition rules would allow corporations with business operations in the local furnishing of electricity or gas if the business's service area does not exceed either two contiguous counties or a city and one contiguous county. If, after such bonds are issued, bonds are expanded beyond the permitted geographic area, interest on the bonds becomes taxable, and interest paid by the private parties on borrowed money becomes deductible. The BBA provision would allow private businesses engaged in the furnishing of electricity or gas to expand their service areas beyond the geographic bounds allowed under present law without penalty under certain specified circumstances.

This provision is a "limited tax benefit" because it loses revenue, it is expected to benefit fewer than 100 importers in at least one fiscal year in which the provision would be in effect, and it does not fall within any of the stated exceptions. Although anyone who imports recycled halons would receive the same treatment under the provision, otherwise engaged in the manufacture and import of ozone-depleting chemicals would not qualify for the exemption.

6. Transition relief from repeal of section 936 credit (sec. 11305).

Under present law, certain domestic corporations with business operations in the U.S. possessing assets on December 31, 1995, of $5 billion or more, and stock or securities, would not receive the credit which significantly reduces the U.S. tax on certain income related to their operations in the possessions. The BBA provision would repeal the section 936 credit which would be in effect, and it does not fall within any of the stated exceptions. The provision does not treat all persons engaged in the same activity, i.e., collectively investing funds in stocks and securities, would not receive the benefit of the provision.

7. Modification to tax-exempt bond penalties for local furnishing of electric energy or gas (sec. 11333).

Under present law, tax-exempt bonds may be issued to benefit private businesses engaged in the furnishing of electric energy or gas if the business’s service area does not exceed either two contiguous counties or a city and one contiguous county. If, after such bonds are issued, the service area is expanded beyond the permitted geographic area, interest on the bonds becomes taxable, and interest paid by the private parties on borrowed money becomes deductible. The BBA provision would allow private businesses engaged in the furnishing of electricity or gas to expand their service areas beyond the geographic bounds allowed under present law without penalty under certain specified circumstances.

This provision is a "limited tax benefit" because it loses revenue, it is expected to benefit fewer than 100 importers in at least one fiscal year in which the provision would be in effect, and it does not fall within any of the stated exceptions. Although anyone who imports recycled halons would receive the same treatment under the provision, otherwise engaged in the manufacture and import of ozone-depleting chemicals would not qualify for the exemption.

8. Modification to tax-exempt bond penalties for local furnishing of electric energy or gas (sec. 11333).

Under present law, tax-exempt bonds may be issued to benefit private businesses engaged in the furnishing of electric energy or gas if the business’s service area does not exceed either two contiguous counties or a city and one contiguous county. If, after such bonds are issued, the service area is expanded beyond the permitted geographic area, interest on the bonds becomes taxable, and interest paid by the private parties on borrowed money becomes deductible. The BBA provision would allow private businesses engaged in the furnishing of electricity or gas to expand their service areas beyond the geographic bounds allowed under present law without penalty under certain specified circumstances.

This provision is a "limited tax benefit" because it loses revenue, it is expected to benefit fewer than 100 importers in at least one fiscal year in which the provision would be in effect, and it does not fall within any of the stated exceptions. Although anyone who imports recycled halons would receive the same treatment under the provision, otherwise engaged in the manufacture and import of ozone-depleting chemicals would not qualify for the exemption.

9. The BBA provision would grant tax-exempt status to any cooperative service organization comprised solely of members that are electric cooperatives and community foundations, if the organization meets certain requirements and is organized and operated solely to hold, condense, and collect from the members in stocks and securities, and to collect income from such investments and turn over such income, less expenses, to the members.

This provision is a "limited tax benefit" because it loses revenue, it is expected to benefit fewer than 100 beneficiaries in at least one fiscal year in which the provision would be in effect, and it does not fall within any of the stated exceptions. Although anyone who imports recycled halons would receive the same treatment under the provision, otherwise engaged in the manufacture and import of ozone-depleting chemicals would not qualify for the exemption.

10. Transitional relief under section 2056A (sec. 11614).

Under present law, an excise tax is imposed on any person who makes a taxable dispositive transfer of property to a non-U.S.-citizen spouse outside a qualified domestic trust. The marital deduction is not available for property passing to a non-U.S.-citizen spouse outside a qualified domestic trust.
The requirements for a qualified domestic trust were modified in the Omnibus Budget Reconciliation Act of 1990 ("OBRA 1990"). The BBA provision would allow trusts created prior to enactment of OBRA 1990 to qualify as QDTs if they satisfy the requirements that were in effect before the enactment of OBRA 1990. This provision was termed a "limited tax benefit" because it loses revenue, it is expected to benefit fewer than 100 beneficiaries in at least one fiscal year in which the provision would be in effect, and it does not treat any of the stated exceptions. The provision would benefit a closed group of taxpayers. Trusts created before the enactment of OBRA 1990 might be expected to provide a benefit to 10 or fewer beneficiaries in at least one fiscal year in which the provision would be in effect. In retrospect, it is believed that 10 or fewer beneficiaries in at least one fiscal year in which the provision would be in effect, and all persons engaged in the same activity would not be entitled to the benefit of this provision. All persons who engage in the activity of making contributions to CDCs are not treated the same, and the benefit is based upon size, filing status, or any of the other enumerated factors.

4. Exemptions from cutbacks in meal and entertainment expenses

Prior to 1986, a 100-percent deduction was provided for certain meal and entertainment expenses. In 1986, the deduction was reduced to 80-percent. In 1993, the deduction was again reduced to a 50-percent deduction. In both 1986 and 1993, an exemption was provided for food and beverages provided on an offshore oil or gas platform or vessel if the food and beverages were provided for support camps in proximity to and integral to such a platform or rig, if the platform or rig is located in the United States north of 34 degrees north latitude (i.e., in Alaska).

These exemptions both were limited to "limited tax benefits" in 1986 if they were expected to be expected to provide a benefit to 100 or fewer beneficiaries in at least one fiscal year in which the provision would be in effect. In retrospect, it is believed that 10 or fewer beneficiaries in at least one fiscal year in which the provision would be in effect, and all persons engaged in the same activity would not be entitled to the benefit of this provision. They are subject to a State's annual private activity volume limitation. However, specific transition relief was provided for "bonds issued—(A) after October 13, 1987, by an authority created by a statute—(i) approved by the State Governor on July 24, 1996 and (ii) sections 1 through 10 of which became effective on January 15, 1987, and (B) to provide facilities serving the area specified in such statute on the date of its enactment."

This provision is a "limited tax benefit" because it loses revenue, it is expected to benefit only on issuer of tax-exempt bonds, and it does not fall within any of the stated exceptions. No other issuers of tax-exempt bonds would benefit from the provision.

5. Transition relief from private activity bond requirements

The Omnibus Budget Reconciliation Act of 1990 created a new category of private activity bond for bonds issued by a governmental unit to acquire certain nongovernmental output property, e.g., electrical generation facilities. Such bonds generally are subject to a limit on the amount of volume limitation. However, specific transition relief was provided for "bonds issued—(A) after October 13, 1987, by an authority created by a statute—(ii) after the effective date of such statute on the date of its enactment."

This provision is a "limited tax benefit" because it loses revenue, it is expected to benefit only on issuer of tax-exempt bonds, and it does not fall within any of the stated exceptions. No other issuers of tax-exempt bonds would benefit from the provision.

The Omnibus Budget Reconciliation Act of 1990 included a provision that created an income tax credit for entities that make qualified cash contributions to one of 20 "community development corporations" ("CDCs") to be selected by the Secretary of HUD using certain selection criteria. Each CDC could designate which contributions (up to $2 million per CDC) would be eligible for the credit.

This provision would have constituted a "limited tax benefit" because it loses revenue, it is expected to benefit only 10 or fewer beneficiaries in at least one fiscal year in which the provision would be in effect. In retrospect, it is believed that 10 or fewer beneficiaries in at least one fiscal year in which the provision would be in effect, and all persons engaged in the same activity would not be entitled to the benefit of this provision. All persons who engage in the activity of making contributions to CDCs are not treated the same, and the benefit is based upon size, filing status, or any of the other enumerated factors.

A facility if "(i) such facility is to be used by both a National Hockey League team and a National Basketball Association team, (ii) such facility is to be constructed on a platform using air rights over land acquired by a State authority and identified as site B in a contract dated May 30, 1984, between the State of Utah and the Federal Government for a State urban development corporation, and (iii) such facility is eligible for real property tax (and power and energy) benefits pursuant to a particular statute."
of the United States. They were unwilling to give this authority to any President, Republican or Democrat, because they claimed it for themselves, in defiance of the will of the American people. Today we will pass it, Mr. Speaker.

We are doing that today, regulatory reform to give relief to the small business men and women of this country who create the majority of our new good jobs. Again, we are trying to roll back the regulatory steamroller that has been running over small America and hand back to the hallmark of initiatives of the past Democrat majorities.

In this landmark piece of legislation, we are increasing the limitation on earnings available to our senior citizens before they see a reduction of their Social Security benefits, benefits that were bought and paid for with after-tax dollars throughout all their working years, a simple justice for senior Americans, denied to them for all these decades by the Democrat majorities in the past.

They say we are late in getting this done. In the first few months of the second session of our first term in the majority in 40 years, they say we are late. We have done what it is there never would or never could even try to do. We will stand on our promptness. These contract items that will go forward today, I expect the President will sign. Unhappily, he has vetoed others. The President has already vetoed lower taxes for the working men and women of this country. Welfare reform, much needed and much called for by the people of this country, the President has vetoed twice. A balanced budget the President has vetoed; significant spending reductions and reform, the President has vetoed. The President has not been an agent of change for the American people, Mr. Speaker. The President has been a veto for the American people.

When the President vetoed these bills, he shut down the Government, and yes, he won a short-term public relations battle. Many were counting us out in our new majority by the end of last year, but we came back in March, and we are back. We have just completed the most productive month of this Congress. During this month of March we have passed a farm bill that is truly revolutionary, taking agriculture in the direction of freedom for all Americans.

As I have observed the move of farm policy in the past, I have found myself observing that when the American farmers bit on it and joined a partnership with the Federal Government, they became the junior partners, not free on their own land. We are fixing that this month.

We are passing this month a job that we began in 1990, that we had prepared in 1991, that was forced to come to this floor by the Democrat majority in 1991, that would move health legislation to end job lock, and would make insurance more affordable for all Americans. That will be done before we leave this week.

We will pass this week product liability reforms. The gentleman from Illinois, Henry Hyde, our distinguished chairman of the Committee on the Judiciary, again that committee for 22 years, 22 years of time when the American people cried for relief from the product liability laws that were choking off job creation in America, and the gentleman from Illinois never got to see even a single hearing on the subject under the Democratic Congress. We will pass that on to the President this week. He says he will veto it on behalf of the trial lawyers.

We have passed already in March the most effective death penalty ever. We have passed an immigration reform that one, protects our borders; and two, reflects the true openness and compassion to lovers of freedom that this country has demonstrated through its foundation and through its entire history.

Today in Roll Call, Mr. Speaker, this legislation was called landmark and nontraditional. It is landmark and it is nontraditional, nontraditional in the sense that for the past 40 years we had a major party that only chose to build on the status quo, never chose to dare to take a chance on freedom, never chose to dare to innovate, never chose to keep faith and be responsive to the demands of the American people. We are doing that today, and we will do that through the rest of this term, and we will do that in the next Congress, because, Mr. Speaker, the American people deserve a Congress that has the ability to know their goodness and the decency to respect it. That is what they will have.

Mr. SKAGGS. Mr. Speaker, this is one of those occasions when everyone Member should be mindful of the undertaking that we make at the beginning of every Congress to protect the good jobs of the United States, because adopting the line-item veto provision in this proposed bill would run absolutely counter to that obligation. The first words of Article I, sec. 1 of the Constitution are, “All legislative powers herein granted shall be vested in a Congress of the United States.” Later in Article I, sec. 7 dealing with the President’s responsibility with regard to legislation, the Constitution states as follows: “If he approve, he shall sign it.”—the bill—“but, if not, he shall return it with his objections.”

Those are the basic parameters of the legislative responsibilities that we have under the Constitution and that the President has under the Constitution, and it is not in our power to change them. It is our responsibility in fact to respect and preserve them.

While our friends across the ocean in Britain are having second thoughts these days about their monarchy, this line-item veto provision will effectively start the accretion of monarchial power in the American presidency. The Founders would surely be appalled.

Incredibly, unfathomably, after an appropriation bill has been passed by the Congress and signed into law, the President can repeal, the authors of this bill say “cancel,” those parts of that law he opposes by the mere act of writing them down on paper and sending the list to Congress. This “repeal” power may be suitable for Royalty but it is an unconstitutional insult to the principle of representative democracy.

We cherish the words of the Declaration of Independence in which we protested the usurpation of power by King George, and mark my words, we will live to regret the usurpation of power that we invite on the part of future Presidents of the United States if this provision becomes law.

I respectfully suggest the Members stand ready to do the right thing and to find this provision, as it is, contrary to the Constitution.

The Supreme Court has spoken to this issue most recently and on point in the Chadha case, there making it absolutely clear that the powers of neither branch with respect to the division of responsibility on legislation can be legislatively eroded.

What is even more bizarre in this particular proposal is the provision for the 5 day cancellation period. Now think about that. This is a metaphysical leap of situations.

The enactment provisions of the Constitution say that once the President signs a bill, it shall be law. We propose that he then has a 5 day cancellation right, after signing a bill? That is absolutely absurd. This defies any logical reading of the Constitution.

The enactment provisions of the Constitution delineate the roles and powers of Congress and the President with respect to legislation.

But beyond the constitutional arguments, this proposal is fundamentally unwise. And, it manifests a shameful disrespect by us of our own responsibilities and the Constitution.

On the large issues, let us think back to what would have happened during the Reagan administration, with a President who, for his own reasons, sent budgets to this body zeroing most categories of education funding in the Federal budget. Presumably, if that President had this power, it would be exercised to eliminate most education funding by the United States Government, and 34 Senators representing 9 percent of the people of this country, in league with the President, could have brought about the outcome.

The invitation to usurpation that lies in this language is even more pernicious and can also be understood by going back to the late eighties, when we were still debating whether we would continue aid to the Contras. Now, let’s say I happened to have been fortunate enough to have gotten a provision in an appropriations bill for a needed post office or a needed courthouse in my district, and the bill went down at the White House awaiting signature at the same time we were debating aid to the Contras. I would guarantee you I would have gotten a call from someone at the White House saying “Congressman, I notice you had some success in dealing with this need in your district. We are pleased at that, but we need your support on aid to the Contras.” The not so subtle message: your vote on what we want, or you lose the post office.

That is the kind of extortionate excess of power that we are inviting future presidents to apply. Pick your issue. That is one that comes to my mind.

It is clear that the Governors of the several States who have this power use it in exactly
I, section 7 on its head. What the President
repeal or "cancel" appropriations and some
their sense, however, that "the negative would
cludes that of preventing good ones." It was
power "the power of preventing bad laws in-
the Framers acknowledged that with the veto
straints are also imposed, such as require-
more conducive to preventit under different terms and districts. And it af-
bicameral legislature, with each body elected
also recognized the need for some checks on
the view that the legislature would be the most
papers, Hamilton and Madison both expressed
bicameral legislation is the key to this approach to this issue, requiring each Member of
power merely fails to identify it as such.
Why? I think the answer is obvious. Many
members of the majority party are fond of
handing out tax breaks to their friends in par-
industries. So, under this bill, a member
members of the majority party are fond of
handing out tax breaks to their friends in par-
 ticulard industries. So, under this bill, a member
who wants to include funding in an appropri-
tions bill for a national park in her Congres-
sional District must worry about the President
canceling a benefit to her District, but a mem-
tions bill for a national park in her Congres-
sional District must worry about the President
canceling a benefit to her District, but a mem-
member who wants to provide funding to his favor-
ante industry or business by including a tax
break in a larger tax bill doesn't need to be
concerned.
Mr. Chairman, this proposal goes too far in
fuzzing the separation of powers set forth in
the Constitution. It subjects members of
Congress to a new, extreme form of executive
branch pressure. It unfairly targets appropri-
a tion expenditures more than tax ex-
penditures. I urge my colleagues to reject it
before it is rejected by the courts. Regrettably,
this provision so taints this entire bill, other-
wise needed to extend the debt limit, that the
bill itself should be defeated.
Mr. STEARNS. Mr. Speaker, I rise in sup-
port of this legislation to raise the debt ceiling
because I do not believe we can allow our
Government to go into default. To do oth-
erwise would wreak havoc on our Nation's
good standing and would result in Social Security
and Veterans benefits from being sent out.
It is difficult to take this action but I can tell
you that because of this Congress' vigilance
we have already saved approximately $23 bil-
lion in spending over the past year. This is
a very good start on the road to achieving a bal-
anced budget.
There are two provisions in particular that
are included in this measure that allow me to
tax in favor of H.R. 3136.
We provide the means to give the President
the line-item veto. President Reagan asked
Congress over and over again—"Give me the
line-item veto." If only Congress had given
him this mechanism for fiscal discipline, we
might have been able to deal with the huge debts which, if not
reduced, threaten to crush the next generation
with huge taxes and a diminished quality of life.
The President's veto power, as a check on
Congress, is recognized to be a blunt instru-
mament. As Hamilton explained in Federalist 73,
the Framers acknowledged that with the veto
power "the power of preventing bad laws in-
cludes that of preventing good ones." It was
their sense, however, that "the negative would
be employed with great caution."
Mr. Speaker, if the line-item veto were consid-
red today, by providing those Members with the authority
to repeal or "cancel" appropriations and some
tax laws, turns the framework defined in article
I, section 7 on its head. What the President
might decide to "cancel" under this provision
is simply repealed, unless the Congress goes
through an entire repetition of the article I leg-
sislative process, including a two-thirds vote of
both houses. This would allow the President
and a minority in only one house of Congress
to frustrate the will of the majority—an out-
come that is clearly contrary to the constitutional principle of
majority rule.
Finally, Mr. Speaker, I must comment on a
very deceptive provision of this line-item veto
bill. The authors of the bill claim it doesn't
focus unfairly on appropriations bills—which
traditionally includes education, environ-
mental, health, and other governmental
programs—because it also includes tax provi-
sions among the items the President can
"cancel."
But, the only tax provisions that can be can-
celled are "limited tax benefits," defined as
income-losing provisions that provide a bene-
fit to "100 or fewer beneficiaries under the In-
ternal Revenue Code of 1986." A tax break for
a particular industry that takes millions of dol-
ars out of the Federal treasury can't be can-
celled by the President. And even a so-called
limited tax benefit that is limited to a few hundred people
that is, immunized from veto—if the conference re-
port merely fails to identify it as such.
Mr. VENTO. Mr. Speaker, I reluctantly sup-
port this measure, H.R. 3136, the debt limit
package. First, we need to honor the debt
which our Nation has incurred. The U.S. credit
rating must not be in question, nor should the
United States be placed on the receiving end of
funding for education, environ-
mental, health, and other governmental
programs. That's a marginal tax rate of 33 percent.
That's a high price for merely wanting to work.
The earnings test limit won't work. It treats So-
cial Security benefits in kind and
more like welfare. It represents a Social Secu-
ry bias in favor of unequal earned income over
earned income.
The Republicans have today sold symbolism,
which are included in this measure that allow me to
include funding for education, environ-
mental, health, and other governmental
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ry bias in favor of unequal earned income over
earned income.
The Republicans have today sold symbolism,
Mr. CONYERS. Mr. Speaker, I am opposed to the present tax provisions of the bill for the following reasons.

On process: This bill has never been considered by the Judiciary Committee or by any other committee in the House. It’s stealth process—we only saw the final draft late last night—raises the Republican record of disfavor for the committees and for proper democratic process. This bill was created by a secret process in the House, and will allow special interests to secretly influence regulations in the executive branch.

The secret influences of the few: Under the bill, so-called Regulatory Fairness Boards and Advocacy Panels are to be established to directly influence the content of regulations and the regulatory process. These boards are to be made up solely of a few favored small businesses, and can include exclusively campaign contributors.

Ex parte contacts in reg writing: The boards and advocacy panels will provide an avenue for private business interests and the OIRA Administrator to influence regulations and enforcement—a departure from the commonly accepted principle that the regulation writing process should be open and on the record. They provide an ex parte and secret forum for these favored businesses to complain about how statutorily mandated regulations are written and enforced.

Yet another attack on the environment: While we all support the concept of regulatory flexibility—that is helping small businesses comply with a vast array of Federal regulations—it is a small price to pay for the extreme. For it allows the waiver of some of our most important environmental regulations relating to safe drinking water and clean air. If, for example, it happens to be a small business that is operating a chemical manufacturing operation or a small business that is a water supplier, laws protecting citizens from drinking water hazards like cryptosporidium or other chemical contamination could simply be waived (section 323). Our environmental safety and health is at risk from these hazards regardless of the size of the business.

Still more litigation for the lawyers: Section 611 allows for environmental regulations that protect our air, water, food, and workplaces to be suspended or even overturned by the courts if these and other ill-defined provisions are not strictly adhered to. This judicial review is different from what the House has voted on in the past—for past regulatory flexibility bills that we’ve voted on allow for judicial review of the reg flex analysis only. This bill, however, could permit hundreds of environmental rules at risk, the subject of litigation in the courts for merely procedural reasons that are only marginally related to the fundamental issues surrounding the promulgation of the rule.

Mrs. MALONEY. Mr. Speaker, I intend to vote for this bill. It contains measures which I strongly support. Most importantly, raising the debt ceiling is absolutely essential to ensuring the continued full faith and credit of the United States. Without passage of this bill, the economic security of our country would be gravely imperiled. The legislation also contains provisions to relieve regulations burden on our Nation’s small businesses and a measure, which I strongly support, to increase the earnings limit for Social Security recipients.

This measure also contains a line-item veto provision about which I have very serious concerns. First, this conference report grants to the President the significant power to item veto new entitlement spending. Spending on Medicare, Medicaid, Social Security, and food stamps help out most vulnerable citizens, the elderly, and infirm. The original House bill, and the Republican line-item veto on a contract on America, did not grant this authority.

The line-item veto provision before us today also would not become effective until January 1, 1997. This time conveniently exempts the fiscal year 1997 appropriations cycle from Presidential item-vetoes. Cynics might conclude that the Republican majority wants one last chance to tuck the pet projects into this year’s appropriations bills.

Finally and most egregiously Mr. Chairman, this line-item veto measure expands a loophole included in the House-passed bill and expanded it into a black hole for special interests. The House bill included a provision on allowing the President to item veto targeted tax breaks. Unfortunately, the majority of this bill is much broader than tax law. In the bill’s term very narrowly to mean only those tax give-aways that affect 100 or fewer people. This artificial number can easily be fudged by a smart tax lawyer—you simply have to help out 101 or 102 people.

This conference report includes this loophole and expands it into a black hole for special interests by allowing the President to item veto only those targeted tax benefits identified by the Joint Committee on Taxation, a committee controlled by the tax writing committees of Congress. So if they say it isn’t a special interest tax break, the President can never veto it. Mr. Chairman, this is a sham.

The Republican Party was committed to the much broader definition right up to the moment they gained the majority, then they had a sudden change of heart. With this bill the Republicans claim they will end special interest tax breaks, but if you read the fine print you’ll see they expect nothing of the kind.

Mr. BEREUTER. Mr. Speaker, This Member rises in support of H.R. 3136, the Contract With America Advancement Act.

This Member is particularly pleased that, as reported on the House floor, H.R. 3136 included the Line-Item Veto Act. An important tool in the battle to reduce spending would be to give the President line-item veto authority.

A line-item veto would enable the President to veto individual items in an appropriations bill without vetoing the entire bill. With a line-item veto the executive could strike a pen to the pork-barrel projects that too often find their way into appropriations bills.

This power is currently given to 43 of the Nation’s Governors, where it has been a successful tool that discourages unnecessary expenditures at the State level. It is appropriate that the President have this authority as well.

This Member has cosponsored legislation to institute a line-item veto since 1985, and is pleased that this initiative may soon be enacted into law. Legislation to provide for a line-item veto has been introduced in Congress for over 100 years. The time has come to recognize the need for more stringent and binding budget mechanisms.

This Member is also pleased that H.R. 3136 raises the limit on income senior citizens may earn and still receive full Social Security benefits. In the last three Congresses, this Member cosponsored related legislation, and has consistently supported efforts to reduce or eliminate the Social Security earnings limit on senior citizens who must work to make ends meet. Seniors of modest means who have to work to supplement their Social Security check should be allowed to pay an effective marginal tax rate higher than that of millionaires.

In addition, this legislation includes much-needed regulatory relief provisions that...
would inject some common sense into the current regulatory and bureaucratic framework which now exists.

Federal regulations cost the economy hundreds of billions of dollars each year. Too often, these regulations were not based on sound science and resulted in little or no benefit to society. This is an issue which must be addressed to provide relief from the plethora of Federal regulations.

This Member urges his colleagues to support H.R. 3136 as reported to the House floor, in order to advance important initiatives to establish a line-item veto, provide regulatory relief, and tax on senior citizens.

Mr. FRANKS of Connecticut. Mr. Speaker, I rise today in strong support of H.R. 3136, the Contract With America Advancement Act, a measure to provide for a line-item veto, for Social Security benefits relief for our senior citizens and for small business regulatory reform.

Mr. Speaker, during my tenure in the Congress, I have been a solid and steady advocate of a platform that recognizes we need to bring real change to this Federal Government of ours. For example, during my freshman and sophomore years, I had sponsored legislation providing for the implementation of a Presidential line-item veto, which is the foundation of America’s economic base. I support regulatory flexibility for small business and having clear guidelines so that the small entity is not penalized for trying to do the right thing.
March 28, 1996

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legislation this Congress is actually doing something about it. We are living up to our campaign promises to make the Government less intrusive, less burdensome on the private sector. We will make Government regulations more sensible, more responsive to those who must comply with them. And we will do it without jeopardizing the environment, or public health and safety.

Many of these issues we debate in Congress have become polarized by partisanship and deep philosophical differences. But this issue, providing judicial review of the RFA, is a fine example of how both parties can identify a problem which the American people want us to fix, and how we can work together, both Republicans and Democrats, to solve a problem and help the American people. I am proud to have worked in a bipartisan fashion with Jan Meyers, Ike Skelton, and John LaFalce for 4 years to pass judicial review of the RFA.

Working together, we convinced over 250 Members of the last Congress to cosponsor our legislation, and have passed RFA judicial review with overwhelming majorities in the House. We have put aside our partisan differences to pass this commonsense legislation.

The Republican Congress and President Clinton, who have disagreed on so many issues, have been strong supporters of including judicial review of the RFA. Vice President Gore's Reinventing Government Commission recommended providing RFA judicial review as its top priority for the Small Business Administration. RFA judicial review was again a top recommendation of the White House Conference on Small Business conducted last year. We have received letters pledging strong support for RFA judicial review from the President, Chief of Staff Leon Panetta, and SBA Administrator Philip Lader. I would like to request consent to include those letters in the Record. Mr. Jere Glover, the administration's chief advocate for small business, has been a strong supporter of judicial review and his influence has been very important.

Virtually every national small business organization has been strongly supportive of judicial review, but a handful of groups have been active participants of the Regulatory Flexibility Act coalition for the past 4 years, and have made this issue a top priority for their members. I would like to recognize these organizations for their outstanding work and commitment to passing this legislation. Jim Morrison, Benson Goldstein and Becky Anderson of the National Association for the Self Employed have provided invaluable institutional knowledge about how the RFA can and should work. David Voight of the U.S. Chamber of Commerce has provided great assistance in continued efforts to pass legislation for such judicial review. Thank you for your leadership in this important issue to small business.

Sincerely,

PHILIP LADER,
Administrator-Designate.

THE WHITE HOUSE,

Hon. Malcolm Wallop,
U.S. Senate,
Washington, DC.

DEAR SENATOR WALLOP: Your particular question about the Administration's position on judicial review of actions taken under the Regulatory Flexibility Act has come to my attention. As you have discussed with Senator Bumpers, the Administration supports such judicial review of "Reg Flex."

The Administration supports a strong judicial review provision that will permit small businesses to challenge agencies and receive meaningful redress when they choose to ignore the protections afforded by this important statute.

In fact, the National Performance Review endorsed this policy to ensure that the Act's intent is achieved and the regulatory and paperwork burdens on small businesses, states, and other entities are reduced.

As Chairman of the Policy Committee of the National Performance Review, under Vice President Gore's leadership I vigorously advocate this position. I have continued to champion this policy within the Administration.

If confirmed as Administrator of the U.S. Small Business Administration, I will join the Congress and the small business community in continued efforts to pass legislation for such judicial review.

Sincerely,

AL Gore,
THE WHITE HOUSE,

Hon. Malcolm Wallop,
U.S. Senate,
Washington, DC.

DEAR SENATOR WALLOP: My Administration strongly supports judicial review of agency determinations under the Regulatory Flexibility Act, and I appreciate your leadership over the past years in fighting for this reform on behalf of small business owners.

Although legislation establishing such review was not enacted during the 103rd Congress, Administration remains committed to securing this very important reform. Toward that end, my Administration will continue to work with the Congress and the small business community for enactment of a strong judicial review that will permit small businesses to challenge agencies and receive meaningful redress when agencies ignore the protections afforded by this statute.

As you know, the National Performance Review endorsed this policy to ensure that the Act's intent is achieved and the regulatory and paperwork burdens on small businesses, states, and other entities are reduced.

Again, thank you for your continued leadership in this area.

Sincerely,

Bill Clinton,
Mr. SHAW. Mr. Chairman, I rise today in support of H.R. 3136, the Contract With America Advancement Act, which includes language to raise the amount of money a senior citizen may earn before losing Social Security benefits. Twice before I have supported this legislation; in the Senior Citizens' Equity Act, Mr. Chairman, and in H.R. 1, the Senior Citizens' Equity Act. But I have made this issue a top priority from the very beginning, and in fact was the first small business organization to bring this issue to my attention. Marcel Dubois and the American Trucking Associations have been extremely active in mobilizing small businesses in support of RFA judicial review. Finally, Tom Halkic of the National Association of Towns and Townships has played a critical role in bringing to the attention of Congress the importance of judicial review not only to small businesses, but to small governmental bodies as well.

Finally, I want to thank Representatives Meyers, LaFalce, and Skelton and their staff, particularly Harry Katrich of the Small Business Committee, and Eric Nicoll of my staff for their persistent dedication to passing this legislation over the past 4 years.

Small Business Administration, October 8, 1994.

Hon. Malcolm Wallop,
U.S. Senate,
Washington, DC.

DEAR SENATOR WALLOP: The Administration supports strong judicial review of agency determinations under the Regulatory Flexibility Act that will permit small businesses to challenge agencies and receive meaningful redress when agencies do not comply with the protections afforded by this important statute.

In fact, the National Performance Review publicly endorsed this policy to ensure that the Act's intent is achieved and the regulatory and paperwork burdens on small businesses, states, and other entities are reduced.

As Chairman of the Policy Committee of the National Performance Review, under Vice President Gore's leadership I vigorously advocate this position. I have continued to champion this policy within the Administration.

If confirmed as Administrator of the U.S. Small Business Administration, I will join the Congress and the small business community in continued efforts to pass legislation for such judicial review.

Sincerely,

E LON E P A N E T T A,
Chief of Staff.

THE VICE PRESIDENT,
House, November 1, 1994.

Hon. Thomas W. Ewing,
Washington, DC.

DEAR REPRESENTATIVE EWING: Thank you for contracting me regarding the Regulatory Flexibility Act. As the President and I have made clear, we strongly support judicial review of agency determinations rendered under the Regulatory Flexibility Act. We remain committed to securing this important reform during the next Congress and will work with Congress for the enactment of strong judicial review for small businesses.

We also understand that it will be important to continue our work with small businesses to ensure that such an amendment provides a sensible, reasonable, and rational approach to judicial review, as recommended by the National Performance Review. As you know, the National Performance Review recommended that which was (or is now to be) sought by the small business community—i.e., an amendment that furthers the intent of the Act and reduces the paperwork burden on small businesses.

The President and I look forward to working with Congress on this matter and appreciate your leadership in this area.

Sincerely,

AL GORE,
THE WHITE HOUSE,

Hon. Malcolm Wallop,
U.S. Senate,
Washington, DC.

DEAR SENATOR WALLOP: My Administration strongly supports judicial review of agency determinations under the Regulatory Flexibility Act, and I appreciate your leadership over the past years in fighting for this reform on behalf of small business owners.

Although legislation establishing such review was not enacted during the 103rd Congress, Administration remains committed to securing this very important reform. Toward that end, my Administration will continue to work with the Congress and the small business community for enactment of a strong judicial review that will permit small businesses to challenge agencies and receive meaningful redress when agencies ignore the protections afforded by this statute.

As you know, the National Performance Review endorsed this policy to ensure that the Act's intent is achieved and the regulatory and paperwork burdens on small businesses, states, and other entities are reduced.

Again, thank you for your continued leadership in this area.

Sincerely,

Bill Clinton,
Increasing the Social Security earnings limit from $11,520 to $30,000 will significantly improve benefits for moderate- and middle-income beneficiaries who work out of necessity, not choice. It will also remove the penalty on those with income from work, but not from other sources such as dividends and interest. I urge my colleagues to help our Nation’s seniors by voting for this bill.

Mr. DAVIS. Mr. Chairman, I rise to speak in favor of the Senior Citizens’ Right to Work Act which has been included in H.R. 3136. This bill will help manage the costs between the ages of 65 to 69 by working to eliminate financial penalties on hardworking seniors who want to supplement meager Social Security benefits. I strongly urge all of my colleagues to support H.R. 3136 and our senior citizens by increasing the Social Security earnings limit.

The Senior Citizens’ Right to Work Act also contains a provision which will eliminate Social Security disability benefits to drug addicts and alcoholics. While I adamantly support this provision, I would like to voice my concern about the fraud and abuse that will occur as a result. Given that the SSI and SSD programs, we must be alert to the likelihood that many of these drug addicts and alcoholics currently on Federal disability rolls will attempt to qualify for Social Security benefits under other disability categories. I believe that more can and should be done to ensure accountability in these programs, eliminate fraud and abuse, and save Federal dollars.

Mr. Chairman, we should support referral and monitoring agency programs that currently use national case tracking systems to identify drug addicts and alcoholics, who are improperly receiving Federal checks. These types of programs have already saved the Federal taxpayers millions of dollars that would have been spent as a result of the fraudulent practices of drug addicts and alcoholics. Unfortunately, this legislation, in eliminating the drug addiction and alcoholism benefit category, will also eliminate these types of tracking programs. I hope that we can correct this blow to current fraud and abuse monitoring practices in order to ensure that drug addicts and alcoholics do not receive Federal funds.

Mr. BROWN of California. Mr. Speaker, small manufacturing businesses striving to meet Federal regulatory requirements must have access to the technological information they need to comply with Federal and State laws and regulations. Therefore, I am pleased that the Regulatory Flexibility Act title of this conference report makes it clear that any Federal agency with the requisite expertise is empowered to help in this effort. I am especially pleased that the Manufacturing Extension Program (MEP) of the National Institute of Standards and Technology will continue to provide its full menu of services in southern California and throughout the Nation.

Those of us who have worked to promote the concept of technology extension over the years are well aware of the unique roles played by the Small Business Development Centers (SBDC), the Agricultural Extension Service, and other specialized programs in helping small business. Each of these programs, however, has limited funding; and when they are given further funding, they may not have enough resources to go around. If small business people are required to take time away from production to comply with environmental and other standards, we want them to locate the help to do so as readily as possible, whether that help comes from the Small Business Administration, the Department of Commerce, or the Department of Agriculture.

Given that SBDC’s have a broad mission to serve all small business, specialized programs like the MEP are often best situated to meet the regulatory compliance needs of small manufacturers. In my native southern California, for example, there are many excellent examples of small businesses that no SBDC could have been expected to provide. Our region is blessed by a large number of small manufacturers, including defense subcontractors, who need very specialized assistance to meet California’s air and water quality standards. This led the MEP to set up the Los Angeles Pollution Prevention Center, which provides the specialized environmental engineering expertise both to companies and also to other manufacturing extension centers.

Let me give some specific examples. Without this center, it would have been extremely difficult for Nelson Name Plate, a small manufacturer of metal and plastic nameplates, to survive the mandated phase-out of chemicals it was using for cleaning its brass stock. The center helped engineer a closed-loop, customized cleaning system which required no modification of its sanitation permits. The Pollution Prevention Center also permitted Art-Craft, a 20-person firm in the Santa Barbara area, to identify a waterborne primer for painting aircraft which met the exacting standards of both Boeing and the Clean Air Act and to develop the monitoring system it needed to show compliance. It helped CUI, a medical products company, to develop the monitoring system it needed to prove compliance. It helped CUI, a medical products company, to develop the monitoring system it needed to prove compliance. It helped CUI, a medical products company, to develop the monitoring system it needed to prove compliance. It helped CUI, a medical products company, to develop the monitoring system it needed to prove compliance.

Mr. Speaker, clearly it is in the Nation’s interest to write our laws so that small businesses can provide good jobs and high-quality products while meeting envior-mental and other important regulations. I thank the American Chemical Society, which is vital to our Nation’s defense and is involved in the deliberative legislative process. We ought to review these provisions in committee and work on a bipartisan basis to evaluate and improve upon them instead of slipping them in to must-pass legislation.

If my colleagues are not concerned with some of the provisions of the regulatory reform language in H.R. 3136, I would urge them to consider the consequences of the line-item veto section of this bill.

I am concerned with wasteful spending, and I have voted to cut a multitude of unneeded programs like the superconducting supercollider and the advanced liquid rocket motors.

However, I am opposed to the line-item veto because it would disrupt the checks and balances of the Constitution. Currently, the President has the power to veto any legislation and Congress can attempt to override this veto. A line-item veto would severely inhibit the legislative branch’s say in the spending priorities of this Nation.

The line-item veto sounds innocuous enough, but the people of a small State like Rhode Island know full well what giving the President the authority to pick and choose budget items means.

Indeed, Rhode Island has experienced a Presidential effort through existing executive branch authority to eliminate an essential program.

In 1992, President Bush tried to rescind funding for the Seawolf submarine program which is vital to our Nation’s defense and is the livelihood of thousands of working Rhode Islanders.

Fortunately, Democrats beat back this attempt, but I am concerned that the line-item provision before us would make future battles closer to a Sisyphean battle than a fair fight. For example, a President—of any political party—could use the line-item veto to eliminate other programs that are important to Rhode Island without fear because a small State like mine only has four votes in Congress.
I would argue that it was this fear of retribution which motivated the Founding Fathers to give the legislative branch the power of the purse and restrict the President's veto powers. Regrettably, the line-item veto before us today, would grossly distort the Constitution's delicate balance of power and tilt it to the President's side. I cannot support such a shift with the interests of my State in mind.

Mr. Speaker, as I stated earlier, I will support this bill because it is imperative that we prevent the Government from defaulting on obligations made many years ago. In addition, I will also vote for this legislation because it contains provisions that would increase the amount of income that Social Security recipients can earn without losing any benefits.

Under current law, Social Security recipients between the ages of 65 and 69 can earn up to $11,520 in 1996 without having their benefits reduced. Each $3 in wages earned in excess of this limit results in a deduction of $1 in Social Security benefits.

This legislation gradually increases the amount seniors under age 70 can earn without losing any benefits to $30,000 by the year 2002.

I support increasing the Social Security earnings test and voted in favor of the Senior Citizens' Right to Work Act, which included this increase. The House overwhelmingly passed this bill on December 5, 1995 by a vote of 411 to 4.

Approximately 1 million of the 42 million Social Security recipients are expected to benefit from this increase in the earnings limit.

Increasing the earnings test will help improve the overall economic situation of low and middle income seniors in Rhode Island who work out of necessity, not by choice. For example, a Rhode Island senior currently making $12,500 loses almost $330 in Social Security benefits. With the increase included in the legislation before us, that senior would not lose any benefits.

Our seniors have the skills, expertise, and enthusiasm that employers value, and they should be encouraged to work and contribute, not penalized for it.

Mr. Speaker, in closing, I believe I have a duty to prevent the default of the U.S. Government and I will support H.R. 3136, but I would urge my Republican colleagues to stop using important budget legislation as a vehicle for pet causes. Thank you, Mr. Speaker.

The SPEAKER pro tempore. Pursuant to House Resolution 391, the previous question is ordered on the bill, as amended.

Mr. BONIOR. I do, Mr. Speaker.

Mr. BONIOR. I am in its present form, Mr. Speaker.

Mr. ARCHER. Mr. Speaker, I reserve a point of order against the motion to recommit. The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. BONIOR moves to recommit the bill to the Committee on Ways and Means with an instruction to report the bill back to the House forthwith with the following amendment: Add at the end of section 333(b) the following:

"The amendment made by subsection (a) shall only apply during periods when the minimum wage is at least $4.70 an hour during the year beginning on July 4, 1996 and not less than $5.15 an hour after July 3, 1997."

Mr. BONIOR. I move a point of order.

The SPEAKER pro tempore. Mr. Speaker, I make a point of order.

The SPEAKER pro tempore. Mr. Speaker, I state his point of order.

Mr. ARCHER. Mr. Speaker, I make, actually, two points of order: a point of order that the motion to recommit with instructions is not germane to the bill; and, second, that the motion to recommit with instructions constitutes an unfunded entitlement governmental mandate under section 424 of the Congressional Budget Act.

I would ask that a ruling first be made on the point of order against germaneness, on the basis of germaneness. The SPEAKER pro tempore (Mr. BONIOR) to speak on the point of order.

Mr. BONIOR. I do, Mr. Speaker.

Mr. BONIOR. I offer a motion to recommit. The Chair recognizes the gentleman from Michigan [Mr. BONIOR] to speak on the point of order.

Mr. BONIOR. Mr. Speaker, this bill is very broad in its scope. This bill provides that the President be given a line-item veto authority. This bill provides for an increase in the amount Social Security recipients could earn before their Social Security benefits are reduced. Third, it allows small businesses to seek judicial review of regulations.

Mr. Speaker, this bill has to do with taxpayers. There is nothing more important to taxpayers and citizens in this country than to be able to have revenues in their pockets. What we are offering and what we are suggesting under this motion to recommit is that we be given the chance to vote on the increase in the minimum wage, which has not been raised for the past 5 years. The minimum wage is a very important part of a variety of laws in this country. There is a deal with ability of people to make ends meet. People today have incomes—

The SPEAKER pro tempore. The Chair would advise the gentleman from Michigan [Mr. BONIOR] to speak on the point of order, and keep his remarks confined to that point.

Mr. BONIOR. I would say to the Speaker that the minimum wage is directly related to the interest of small business in our country today.

The third piece of this bill that was added in the Committee on Rules allows small business to seek judicial review of regulations. In that sense, Mr. Speaker, it seems to me that those people who are affiliated with small business on the employment side ought to have redress to getting a decent wage in this country. You cannot live and raise a family on $9,000 a year or less. We are asking millions of Americans to do that. This bill will provide an opportunity.

Mr. ARCHER. Mr. Speaker, may we have regular order on the debate on the point of order?

The SPEAKER pro tempore. The gentleman is correct. The gentleman from Michigan is reminded that his remarks are germane to the point of order as raised by the gentleman from Texas [Mr. ARCHER].

Mr. BONIOR. Let me just add another point to my argument, Mr. Speaker, on a more technical ground, because I am not able, under the admonition of the Speaker, and the proper admission, I would say, to talk about the substance, which deals with giving people a fair wage in this country. So I will talk about subtitle c of the bill that requires that the Department of Labor certify whether any of its rules, including rules governing the minimum wage, where a small business could go to court seeking a stay of the Department of Labor's rules governing the minimum wage.

It seems to me that, because of the addition of that subsection and the broadening of the bill, the minimum wage indeed is in order as a discussion point in a motion to recommit.

I would further add, Mr. Speaker, that my recommittal motion is logically relevant to the bill and establishes a condition that is logically relevant to subtitle c. Under the House precedent, my motion, I think, meets this test. If we are meeting the test for employers, if we are meeting the test for seniors, it seems to me we ought to be meeting the test for those women, primarily, millions of them raising kids on their own making less than $8,000 a year. They ought to be given the chance to have this debated and voted on by the House of Representatives.

Mr. Speaker, wages are important, they are stagnant in this country.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman will suspend.

Mr. ARCHER. Mr. Speaker, I regret again that I must ask for regular order. The gentleman wants to wander afield and to debate the substance of the motion to recommit, which is improper at this moment in the House.

The SPEAKER pro tempore. The Chair has observed that the gentleman is to confine his remarks to the point of order, and not the substance. Mr. BONIOR. Mr. Speaker, I apologize to my friend from Texas and to the Speaker for wandering. I have difficulty not talking emotionally about this issue because of what I see in the country. But I will confine my remarks to subsection c of the bill that requires...
Mr. ARCHER. Mr. Speaker, the motion to recommit is not germane because it seeks to introduce material within the jurisdiction of a committee that is not dealt with in this bill. That is, the subject of the amendment, the minimum wage falls within the jurisdiction of the Committee on Economic and Educational Opportunities, while the subject matter of the bill falls only within the jurisdiction of the Committee on Ways and Means, the Committee on the Budget, the Committee on Rules, the Committee on the Judiciary, the Committee on Small Business, and the Committee on Government Reform and Oversight.

In addition, the motion to recommit seeks to amend the Fair Labor Standards Act, which is not amended by this bill.

Finally, there is the gentleman’s argument about rulemaking. The rulemaking authority under this bill is general and not agency specific. Therefore, the motion to recommit is not germane to the bill and should be ruled out of order on that basis.

Mr. ENGEL. Point of order, Mr. Speaker.

The SPEAKER pro tempore. Does the gentleman from New York [Mr. ENGEL] wish to be heard on the point of order raised by the gentleman from Texas [Mr. ARCHER]?

Mr. ENGEL. Yes; I would.

The SPEAKER pro tempore. The gentleman from Texas is recognized.

Mr. ENGEL. Mr. Speaker, I must say that I think it is disingenuous and outrageous to say that the majority leader’s point of order is not in order here.

The SPEAKER pro tempore. The gentleman will suspend.

Mr. ARCHER. Mr. Speaker, the gentleman on the other side of the aisle can debate substance at another point in time. This debate now is on the point of order, and they should be told to restrain their comments on the point of order.

The SPEAKER pro tempore. The gentleman from Texas is correct. The Chair would remind the gentleman from New York, as he reminded the minority whip, that he is to confine his remarks to the question of germaneness as raised on the point of order by the gentleman from Texas.

Mr. ARCHER. Mr. Speaker, I would seem to me, if we are debating this bill on raising the debt ceiling limit, that something to do with the minimum wage, to raise the debt ceiling limit lifting as the line-item veto is and as allowing seniors to make more money for Social Security purposes, I cannot see why one would not be germane and why these other things are germane. In fact, we should have a clean lifting of the debt ceiling and then we would not have to worry about germaneness after all.

So it would seem to me that we cannot on the one hand attach all kinds of extraneous things to the lifting of the debt ceiling and then on the other hand claim that the minimum wage is not at least as relevant to the lifting of the debt ceiling as the line-item veto and senior citizens are. I just do not think it is fair if we are going to talk about in the case of Wisconsin, it ought to be fair. While they may want to stifle free speech on the other side of the aisle, I think we have a right to ask for equity here.

The SPEAKER pro tempore. The Chair is prepared to rule on the point of order raised by the gentleman from Texas on germaneness. The gentleman from Texas makes a point of order that the motion violates section 425 of the congressional budget act of 1974. In accordance with section 426(b)(2) of the Act, the gentleman has the floor for the purposes of reporting the specific language in question is the text of the instructions that amends the Fair Labor Standards Act to increase the minimum wage.

According to the congressional budget office, an increase in the minimum wage from $4.25 to $5.15 would exceed the threshold amount under the rule of $50 million. In fact, CBO estimates that it would impose an unfunded mandate burden of over $1 billion over 5 years. Let me also point out that CBO estimates that this proviso would result in a 0.5- to 2-percent reduction in the employment level of teenagers and a smaller percentage reduction for young adults. These would produce employment losses of roughly 100,000 to 500,000 jobs. Therefore, I urge the Chair to sustain this point of order, and I urge my colleagues to vote against the consideration of this unfunded mandate on State and local governments.

The SPEAKER pro tempore. The gentleman from Texas makes a point of order that the motion violates section 425 of the Congressional Budget Act of 1974. In accordance with section 426(b)(2) of the Act, the gentleman has the floor for the purposes of reporting the specific language of the motion. Under section 426(b)(4) of the Act, the gentleman from Texas [Mr. ARCHER] and a Member opposed will each control 10 minutes of debate on the point of order.

Pursuant to section 426(b)(3) of the Act, after debate on the point of order, the Chair will put the question of consideration, to wit: Will the House now consider the motion? Mr. BONIOR. Mr. Speaker, I seek time in opposition to the point of order.

The SPEAKER pro tempore. The gentleman from Michigan [Mr. BONIOR] will control 10 minutes.

The Chair recognizes the gentleman from Texas [Mr. ARCHER].

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

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

Mr. ARCHER. I would like to set the record straight that a point of order would be made on this particular motion on the basis that this provides an additional burden on small businesses in this country. That is from our perspective not accurate, not fair. Let me take the accuracy argument first.

Every study recently done in New Jersey, in Pennsylvania, in California, has come to the conclusion that an increase in the minimum wage has not been increased in 5 years, which is at $4.25 an hour, which is at its lowest level in 40 years, would not only, Mr. Speaker, would not only not cost business, would not cost jobs, it would
Mr. Speaker, this clearly is an unfunded mandate on State and local government. It is the very thing that this Congress, and I am urging a "no" vote on this particular motion. I hope Members are watching this debate because this is the first time that we have had this kind of vote in the 104th Congress, and I am urging a "no" vote on this particular motion.

I hope Members will really take a look at what is happening here. This is blatant politics and blatant hypocrisy.
Mr. Bonior. Mr. Speaker, I demand a recorded vote.

The vote was taken by electronic device, and there were—ayes 232, noes 185, not voting 14, as follows:

[Roll No. 99]

AYES—232

...Talent

NOES—185

...Zimmer

The SPEAKER pro tempore. The question was; and the Speaker pro tempore announced that they ayes appeared to have it.
Mr. VOLKMER. Mr. Speaker, do we have the balanced budget before us to speak on? What is the issue which the speakers in the well should address?  

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The House is debating whether to consider the motion to recommit; the question that the House is debating right now is whether the pending recommittal motion should be considered.  

Mr. VOLKMER. A recommittal motion.  

The SPEAKER pro tempore. Whether to consider a recommittal motion.  

Mr. VOLKMER. Whether to consider a recommittal motion.  

The SPEAKER pro tempore. That is correct.  

The gentleman from Pennsylvania [Mr. GOODLING] is recognized for 1½ minutes.  

Mr. GOODLING. Mr. Speaker, our balanced budget provides an instant raise for workers in the form of lower taxes, reduced interest costs, and greater economic opportunity which will lead to higher wages for America's workers.  

Let me assure Members that the committee of jurisdiction will look at the overall picture as to why in the last 3 years we have had a very stagnant economy, which has resulted in a very stagnant growth in relationship to wages and benefits. We will look at the overall picture. We will see whether it is unfunded mandates, such as one that was proposed today. We will look to see whether it is regulatory reform that is needed. But we will not look at a single issue because the issue is all-encompassing and we have to look at every piece of that and we will do it in a conference. We will do it in committee. We will do it in hearings. But we will not be rushed to do something that will, in fact, hurt the economy even more. We cannot afford to grow at 1 percent or less, or we will never get out of this stagnant economy that we are presently in.  

Mr. BONIOR. Mr. Speaker, I yield 1 minute to the gentleman from New York [Mr. HINCHHEY].  

Mr. HINCHHEY. Mr. Speaker, I am surprised that the leadership of this House would suggest that requesting an increase in the minimum wage for American workers is an unfunded mandate. If we follow that logic, adhere to it, then this body would not be able to do anything to protect the health and welfare of the American people. We just heard it said that the so-called balanced budget contains provisions that will be beneficial to the American workers, tax cuts. In fact the opposite is true. We are chopping away at the earned income tax credit. We are going to raise taxes for minimum wage people. That is what my colleagues are going to do.  

Mr. Speaker, the American people need an increase in their wages. They need an increase in wage. They have come to this Congress and asked for it. The last time this Congress authorized an increase in their salary was 1969. They are falling way behind. At the rate of this minimum wage, a person working full time makes only $8,500 a year. That is below the poverty level. The American people need an increase in their wage. They have asked for it. We have a responsibility to give it to them. Let us give them an increase.  

Mr. ARCHER. Mr. Speaker, I yield myself such time as I may consume, simply to respond that the Parliamentarian and the Speaker have decided that there are adequate grounds, that there is an unfunded mandate in this bill, or we would not have been having this procedural vote. Let me make that very clear. This is a procedural vote. There are adequate grounds to establish that there is an unfunded mandate in this bill.  

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

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

Let me correct the gentleman from Texas by suggesting that he is a motion to proceed in order to have a debate on the minimum wage. That is what we are discussing. That is the issue that is before us. The question is will we even proceed to discuss this basic, fundamental, economic justice issue of whether people can earn a decent living and whether they should move to work as opposed to welfare in this country. That is what this is about.  

My friend, and he is my friend, from Texas said that there are not enough hearings. That is not a vote. They blocked it here again in the legislative calendar. My colleagues do not want a vote. They are blocking it again.  

Mr. Speaker, the distinguished gentleman from Pennsylvania [Mr. GOODLING], who is also my friend, says we need to study this. We are not going to be rushed. We need to go slow. It is at its 40-year low, 40-year low, the minimum wage. No hearings have been held in this Congress.  

We have got about 30-some days left in the legislative calendar. My colleagues do not want a vote. They are blocking a vote. They blocked the vote on the minimum wage in the Senate. They are blocking it in the House. Wages are important to people. We want to put money in people's pockets by raising their wages. That is what this issue is all about.  

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Connecticut [Ms. DELAURO].  

Ms. DELAURO. Mr. Speaker, the Republican majority will find any excuse to hurt hard-working middle-class families in this country. Today the Republican majority would deny and block a vote to increase the minimum wage. Mothers and fathers are working harder, longer hours, two and three jobs,
and have seen their wages not rise but decrease. They scramble to pay their bills, to make ends meet at the end of every week. More than two-thirds of minimum wage workers are 20 years and older, they are not teenagers.

The approximate annual average salary of a minimum wage worker is $8,500 a year. It is below the poverty level. It is below the welfare level.

Imagine, this Republican majority says no to a 90 cents increase an hour for working families in this country. Shame. Stop the excuses. Let us vote on a minimum wage in this country. Shame. Stop the excuses. Let us vote on a minimum wage in this country.

Mr. VOLKMER. Without listening to the Congressional Budget Office.

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

Mr. VOLKMER. The gentleman will state it.

Mr. FRANK of Massachusetts. Mr. Speaker, it has to do with the nature of the question.

As I understand it, we are talking about the new rule adopted at the beginning of this Congress dealing with what to do when there is an unfunded mandate. Would this vote, and this would help, I believe, us clarify it, because we have dealt with this once before in my recollection, would a vote now to proceed with the minimum wage vote be the equivalent of what the House did when we adopted the rule on the agriculture bill which waived the unfunded mandate point of order?

When the House adopted the majority's proposed rule on the agriculture bill, it waived the point of order with regard to unfunded mandates and allowed us then to proceed on the bill which CBO said had unfunded mandates. Are we now being asked to do the same thing; namely, take up the bill although CBO does not say there are unfunded mandates in there, as we did when we adopted the majority's rule on the agriculture bill?

The SPEAKER pro tempore. The Chair can only respond that the reason the House is having this debate is so the House can make the judgment on whether there shall be a vote on the motion to recommit.

Mr. ENGEL. Mr. Speaker, I have a parliamentary inquiry.

Mr. VOLKMER. That is the point of order.

Mr. ENGEL. Mr. Speaker, the previous gentleman mentioned that the rule on the agriculture bill waived a point of order with regard to unfunded mandates. Is this the blatant politics and blatant hypocrisy that the majority whip was referring to?

Mr. BONIOR. Mr. Speaker, I demand 30 seconds.

Mr. ARCHER. Mr. Speaker, I yield 30 seconds to the gentleman from Vermont [Mr. SANDERS].

(Mr. SANDERS asked and was given permission to revise and extend his remarks.)

Mr. VOLKMER. That is a parliamentary inquiry.

Mr. BONIOR. Mr. Speaker, I demand a recorded vote.

Mr. SANDERS. Mr. Speaker, the leadership of this Congress has passed huge tax breaks for the rich and for the largest corporations in America.

But somehow, when some of us want to raise the minimum wage for millions of American workers, we are told that we are not even allowed to have a vote.

People today are working longer hours for lower wages, and they are entitled to a raise. Mr. Speaker, let us raise the minimum wage; more importantly, let us have the guts to vote on the issue.

Mr. ARCHER. Mr. Speaker, I yield the balance of my time to the gentleman from Texas [Mr. ARMYE], the majority leader.

Mr. ARMYE. Mr. Speaker, after years of frustration and months of hard work we are here today to do three good things for the American people: to give the President of the United States the long-sought line-item veto authority the American people wish for him to have, to give the senior citizens of America a chance to work in their senior years and still retain their Social Security benefits with less prejudice from the Government's desire to take their earnings away, their benefits away, if they earn money, and to create job opportunities by lessening the red tape burden on small business. We are here to do these things that the minority, when they were in the majority, would not do, and we can complete that work.

Now we are being asked, and I might say it has been a very colorful and entertaining show; we are being asked to go back on the work that we did earlier on unfunded mandates and pose an unfunded mandate on the communities in our country in order to raise the minimum wage. Is this an effort to stop three good things from happening or to do one bad thing?

I was just asked by one of my colleagues a moment ago why is it the minority did not raise the minimum wage last year when they had the majority in the House, they had the majority in the Senate and they had the White House?

Mr. Speaker, I suspect the reason is that they read page 27 of Time magazine on February 6, 1995, where the President was quoted as saying that raising the minimum wage is, and I quote, "the wrong way to raise the incomes of low wage earners." Perhaps they did not.

We have had an interesting show. I have been much entertained by it, I am sure the Nation has been entertained. But this body belongs to the people for serious work.

I propose that we vote down this motion, get on with our work, and do some good things for America rather than punish the working poor.

The SPEAKER pro tempore. The question is, will the House now consider the motion to recommit?

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

RECORDED VOTE

Mr. BONIOR. Mr. Speaker, I demand a recorded vote.
CONGRESSIONAL RECORD — HOUSE

Mr. GILMAN changed his vote from "no" to "aye." So the question of consideration was decided in the negative.

The result of the vote was announced as above recorded.

Mr. MOAKLEY. Mr. Speaker, I would like to clarify for the Record inaccurate claims made by those on the Republican side of the aisle that this motion contains an unfunded intergovernmental mandate. The fact of the matter is, Mr. Speaker, it does not. They suggested that the Congressional Budget Office has determined that this motion regarding the minimum wage contained an unfunded mandate. CBO did not make any such determination. In fact, CBO has determined just the opposite, that this motion does not contain any unfunded mandates. The document to which the Republicans referred did not cite this language at all but rather referred to a letter written by CBO last year to the Member from Texas, that this motion does not contain any unfunded mandates. The document to which the Republicans referred did not cite this language at all but rather referred to a letter written by CBO last year to the Member from Texas.

The motion and the new section would not increase the minimum wage, but would make other provisions conditional on such an increase. Implementation of the Federal requirements on the public and private sector.

DEAR CONGRESSMAN: As you requested, we would be pleased to provide them. The motion and the new section would not increase the minimum wage, but would make other provisions conditional on such an increase. Implementation of the Federal requirements on the public and private sector.

It is very important that the membership of the House of Representatives, during this first formal raising of the unfunded mandate point-of-order, be aware of this attempt by the Republican majority to misuse, confuse, and distort the once laudable intention of this law. The unfunded mandates legislation enjoyed widespread bi-partisan support, passing the House by vote of 394 to 28. I was a member of the conference committee and a supporter of this measure. Members on both sides of the aisle supported this initiative because of growing concern over the imposition of unfunded Federal requirements on the public and private sector.

I am deeply concerned that the unfunded mandates law is being used not to curtail the past practice of imposing financial burdens on State and local government entities and the private sector, but instead to stifle debate on certain legislative items.

During the consideration on the unfunded mandates legislation in January 1995, I expressed my concern on the section of the bill implementing this new point-of-order. The legislation specifically prevents the Rules Committee from waiving the point-of-order that is triggered when there is an unfunded mandate—as defined by Public Law 104-4—in any bill, joint resolution, motion, conference report, or amendment. Among the mandates rules in the history of the House of Representatives have been given this special protection. If a member raises an unfunded mandates point-of-order, all he or she need do is to cite the provision in the measure under debate. There is an automatic 20 minutes of debate followed by a vote. There is no parliamentary or budgetary ruling and there is no burden of proof on the
Mr. ORTON. Mr. Speaker, before being recognized to speak on my motion to recommit, I have a parliamentary inquiry which is important to resolve, so people can understand the motion to recommit and how it fits into what we have been voting on.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. ORTON. Mr. Speaker, is it correct that the rule which was adopted providing for debate on this bill did automatically adopt the conference report on the line-item veto as a separate bill and authorize that to be sent to the Senate for their consideration?

The SPEAKER pro tempore. In response to the gentleman, if title II were amended as a result of a motion to recommit, then it would not be stricken from the engrossed bill. But the operation of section 2(b) of the House Resolution 391 would not be affected. The conference report on S. 4 would stand as adopted.

Mr. ORTON. Therefore, Mr. Speaker, the conference report, standing as adopted, would go to the President for his signature, regardless of whether this motion to recommit is adopted and the title is amended. The only effect of amending the title would be to keep title II in the bill as amended for Senate consideration of the title II as amended, is that correct?

The SPEAKER pro tempore. That is correct.

Mr. ORTON. So if we adopt the motion to recommit and amend this title II, the President would have the original conference bill under the rule for his signature, and assuming the Senate adopted this bill with the amendment, would also have title II as amended, under this bill for his signature, is that correct?

The SPEAKER pro tempore. That would be possible.

Mr. ORTON. I thank the Speaker.

The SPEAKER pro tempore. The gentleman from Utah [Mr. ORTON] is recognized for 5 minutes on the motion to recommit.

Mr. ORTON. Mr. Speaker, I will be as clear and concise as I can. This motion to recommit does one thing and one thing only to the bill we are considering. It simply says that the line-item veto provisions of the bill would become effective immediately upon enactment, rather than waiting until the next calendar year to become effective.

Therefore, the President will already get the opportunity to sign the conference report making line-item veto effective the beginning of next year.

Mr. Speaker, I yield to the gentleman from Indiana [Mr. ROEMER].
Mr. ROEMER. Mr. Speaker, I thank the gentleman from Utah for yielding.

I would say this is a very simple motion. I voted for a line-item veto for President Bush. I voted for the rule to give the line-item veto immediately to the President 2 hours ago. This motion will say, do not wait until 1997, do not play politics, do not do what the American people do not want us to do. Let the President cut $25 billion out of spending now.

Mr. Speaker, it would be interesting to see and explain to our constituents why we did not extend the line-item veto to the President of the United States tomorrow.

Mr. ORTON. Mr. Speaker, in closing let me just say we do not want to make this a partisan fight. This motion to recommit is not partisan. This motion to recommit does nothing to the bill which we are adopting except one thing: making the line-item veto effective immediately upon enactment so that the President can veto the order of the aisle and if it sticks, that means that if any President vetoes an item and it sticks, that means that we have that satisfaction.

Mr. ARCHER. Mr. Speaker, I yield to the gentleman from Pennsylvania [Mr. CLINGER], the chairman of the Committee on Government Reform and Oversight.

Mr. CLINGER. Mr. Speaker, I served as chairman of the conference on the line-item veto. It was a difficult, contentious, hotly contested conference. We argued and debated over the issues long and hard. It took us a year, yes, it took us longer than any of us would have wanted.

It was not a partisan matter; in fact, there are those who support line-item veto, the gentleman from Utah being one of the staunchest supporters of the President who is on the other side of the aisle and in both Chambers, so this is not a partisan issue. But what we finally arrived at, I think, is the best that we can get. One of the items that was agreed to was an effective date. That's not a very difficult resolution because there was an agreement reached between the President of the United States and the majority leader of the Senate to depoliticize the issue.

Mr. Speaker, I would point out that to change the effective date now would really put this right square in the middle of the Presidential debate. I think it would clearly distort what we are trying to do here. By putting it on an annual, 1 obviously, the gentleman from Utah [Mr. ORTON] and Members on the other side of the aisle feel very strongly that they will, in fact, reelect our President, their party leader. We, on the other hand, feel very strongly that we will elect our nominee, Mr. Dole. This is a fight that I think we can win. It's a fight that I think we will win.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Texas [Mr. ARCHER] is recognized for 5 minutes in opposition to the motion to recommit.

Mr. ARCHER. Mr. Speaker, I yield to the gentleman from New York [Mr. SOLOMON], the chairman of the Committee on Rules.

Mr. SOLOMON. Mr. Speaker, I am a little concerned with what I am hearing here today because Senate Majority Leader DOLE and President Clinton chose the effective dates that are in this bill today. If we want to kill line-item veto, we will unbalance this very, very delicate document we have here today.

Mr. Speaker, our conference has spent a year now working together with people who did not want a line-item veto over in the other body. There were a lot of them. But finally, with the leadership of Bob DOLE we got them to move, and they conceded to us on almost everything, almost everything. We have a real, true line-item veto today. Something we have always wanted.

Now, there are things in here I do not like. There is a sunset provision for 8 years. I wanted it to be permanent. Know what we did? We traded that off to get something that my colleagues and I want, and that is a lockbox provision, so that if any President vetoes an item and it sticks, that means that money cannot be reprogrammed. It means it is cut out of the budget and we have that satisfaction.

Mr. Speaker, Ronald Reagan told me once, JERRY, the art of compromise means success in politics; people have other views. We have worked diligently with Senator EXON and other good Democrats on the other side of the aisle in the Senate to put this together. We better vote down this motion to recommit and vote for this, and let us give the President a true line-item veto. That is what the American people want.

Mr. ARCHER. Mr. Speaker, I yield to the gentleman from Pennsylvania [Mr. CLINGER], the chairman of the Committee on Government Reform and Oversight.

Mr. CLINGER. Mr. Speaker, I served as chairman of the conference on the line-item veto. It was a difficult, contentious, hotly contested conference. We argued and debated over the issues long and hard. It took us a year, yes, it took us longer than any of us would have wanted.

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Mrs. MYRICK, Ms. J. JACKSON-LEE of Texas, Mrs. CLAYTON, Mr. WATT of North Carolina, and Mr. NADLER changed their vote from “yea” to “nay.”

Messrs. PAYNE of New Jersey, SHADE, and SALMON changed their vote from “nay” to “yea.”

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The question is on the passage of the bill.

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

RECORDED VOTE

Mr. CLINGER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—a yeses 328, noes 91, not voting 12, as follows:

[Roll No. 102]

AYES—328

In full: Ayes 328; noes 91; not voting 12.

Not Voting—16

Mr. CLINGER. The Clerk announced the following pair:

Mrs. Collins of Illinois for, with Mrs. Fowler against.

On this vote:

Mrs. Collins of Illinois for, with Mrs. Fowler against.

Mr. Chairman, I would like to announce that the Clerk will announce the following pair:

Mr. Collins (IL) for, with Mr. Stupak against.

Mrs. Smith of Washington for, with Mr. Stokes against.

On this vote:

Mr. Mrs. Fowler for, with Mrs. Collins of Illinois against.

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes had it to have it.
Mr. CRAPO and Mr. BARTLETT of Maryland changed their vote from "aye" to "no."
Mr. FOGLIETTA changed his vote from "no" to "aye."
So the bill was passed. The motion to reconsider was announced as above recorded.
A motion to reconsider was laid on the table.

MESSAGE FROM THE PRESIDENT
A message in writing from the President of the United States was communicated to the House by Mr. Edwin Thomas, one of his secretaries.

ANNUAL REPORT OF NATIONAL ENDOWMENT FOR THE ARTS, FISCAL YEAR 1994—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES
The SPEAKER pro tempore (Mr. KoLec) laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, without objection, referred to the Committee on Economic and Educational Opportunities:

To the Congress of the United States:
It is my special pleasure to transmit herewith the Annual Report of the National Endowment for the Arts for the fiscal year 1994.

Over the course of its history, the National Endowment for the Arts has awarded grants for arts projects that reach into every community in the Nation. The agency's mission is public service through the arts, and it fulfills this mandate through support of artistic excellence, our cultural heritage and traditions, individual creativity, education, and public and private partnerships for the arts. Perhaps most importantly, the Arts Endowment encourages arts organizations to reach out to the American people, to bring in new audiences for the performing, literary, and visual arts.

The results over the past 30 years can be measured by the increased presence of the arts in the lives of our fellow citizens. More children have contact with working artists in the classroom, at children's museums and festivals, and in the curricula. More older Americans now have access to museums, concert halls, and other venues. The arts reach into the smallest and most isolated communities, and in our inner cities, arts programs are often a haven for the most disadvantaged, a place where youth can rediscover the power of imagination, creativity, and hope.

We can measure this progress as well in our re-designed communities, in the buildings and sculpture that grace our cities and towns, and in the vitality of the local economy, wherever the arts arrive. The National Endowment for the Arts works the way a Government agency should work—in partnership with the private sector, in cooperation with State and local government, and in service to all Americans. We enjoy a rich and diverse culture in the United States, open to every citizen, and supported by the Federal Government for our common good.

WILLIAM J. CLINTON.

HEALTH COVERAGE AVAILABILITY AND AFFORDABILITY ACT OF 1996
Mr. GOSS, Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 392 and ask for its immediate consideration.
The Clerk read the resolution, as follows:
H. Res. 392
Resolved, That upon the adoption of this resolution it shall be in order to consider in the House the bill (H.R. 3103) to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to expand access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes. An amendment in the nature of a substitute, consisting of the text of H.R. 3160, modified by the amendment specified in part 1 of the report of the Committee on Rules accompanying this resolution, shall be considered as read, and any further amendment thereto to final passage without intervening motion except: (1) two hours of debate on the bill, as amended, with 45 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means, 45 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce, and 30 minutes equally divided between the chairman and ranking member of the Committee on Ways and Means, 45 minutes equally divided between the chairman and ranking member of the Committee on Commerce, and 30 minutes equally divided between the chairman and ranking member of the Committee on Economic and Educational Opportunities; (2) by the minority leader or his designee, which shall have 45 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means, 45 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce, and 30 minutes equally divided and controlled by the minority leader or his designee; (3) on any conference report thereon, a conference report thereto to final passage without intervening motion except: (1) one motion to recommit without instructions, but instructions may be offered by the minority leader or a designee; (2) one motion to recommit, with or without instructions, but instructions may be offered by the minority leader or a designee; (3) one motion to recommit with instructions; and (4) one motion to recommit, with or without instructions, but instructions may be offered by the minority leader or a designee.

Finally, this rule provides that the yeas and nays are ordered on final passage and that the provisions of clause 5(c) of rule XXI shall not apply to votes on the bill, amendments thereto or conference reports thereon. The purpose of this last provision, Mr. Speaker, is one of an abundance of caution with respect to the requirement of a supermajority vote for any amendment or measure containing a Federal income tax rate increase. The provision in question in the bill is a popular one with Members on both sides of the aisle, the rephrasing that currently allows people to renounce their citizenship to avoid paying U.S. taxes.
Although most people might agree that bringing a currently exempt group of people under an existing income tax rate is not an increase in Federal income tax rates, and thus would not be subject to the new House rule, we have been advised that some might disagree. And possibly the MSA withdrawal penalty could be construed by some as a tax rate increase but I do not believe that was what the rule was aiming at.

And so, to ensure that this important provision does not jeopardize passage of this bill, we are providing this protection from the rule.

Mr. Speaker, I am pleased to support this cooperative product, to provide genuine health insurance reform for working Americans. The constituents of this House have taken the bill from the other body and built upon it, achieving a better product without overloading it to the point of failure. This bill improves on the other body’s bill by addressing and fixing the problem of affordability. This bill ensures that individuals will not be denied health insurance if they change jobs. It ensures that individuals who move to another job that doesn’t offer coverage can buy an individual policy without a penalty, and that they are not subject to preexisting condition restrictions. These portability provisions are the cornerstone, but we have done more because we recognize that if we provide access to the uninsured without making it affordable, we have accomplished nothing.

Today, 85 percent of the uninsured work for small businesses. We respond by allowing small employers to join together to provide health insurance. This bill allows self-employed individuals to deduct 50 percent of their health insurance premiums, giving them the same advantage larger companies already enjoy. By establishing medical savings accounts, this bill offers individuals more control over their own health care costs. We propose to limit lawsuit abuse—which drives up health care costs and makes insurance more expensive for everyone—and attack medical malpractice, with stiff penalties on those who cheat the system. It’s a solid package of real reform.

Mr. Speaker, this bill had not even been produced before opponents began tearing it apart.

The same folks who in the last Congress tried to engineer socialized medicine, Government-run medicine that tells you when you are sick, what doctors you must see and what pills you must take. Those folks have joined together again to deride our plan which they said would ruin the prospect for health care reform. I believe their goal is to have Government run all of your lives. But this bill is a positive proposal for meaningful and doable health care reform now.

Support the rule; support the bill.

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

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

Mr. Speaker, I would like to point out today’s rule is one more closed rule in a year of 100 percent restrictive rules. I just want to remind Members of this because of the orations we used to hear from the other side on closed rules.

This year, every rule that has come out of the Committee on Rules so far has been restricted in some form. It also waives the three-fifths vote required for tax increases, which my Republican colleagues like so much, so they wanted to make it an amendment to the Constitution. If the three-fifths vote for tax increases is that important, Mr. Speaker, why are Republicans waiving it on this bill? In fact, this is the second time the three-fifths vote has come up and it is the second time that they have waived it.

Mr. Speaker, today we have a great opportunity. We have the chance to make a huge difference in the lives of millions of Americans. We have the chance to pass a bipartisan health bill that will do two things that will affect every single American. Today, if Republicans will join with the Democrats, we could pass a bill that would enable more people to take their health care with them when they leave a job, and limit preexisting conditions so that people are not denied health care just because they have been ill.

But, Mr. Speaker, even though this opportunity is right at our fingertips in the form of the Kennedy-Kassebaum-Roukema bill, it is about to slip away. It is because my Republican colleagues have loaded up a very excellent bill with a lot of goodies for special interests. My Republican colleagues, Mr. Speaker, have also added medical savings accounts which will take over $2 billion from Medicare and spend it on tax breaks for younger and wealthier people, and they have added controversial malpractice provisions which will virtually ensure the bill’s veto.

Mr. Speaker, over the last year I have had a first-hand experience with the American health care system, and I know how important good health care is, and I know how important good health insurance is. I can tell my colleagues there is not a single person in this country that does not worry that they may lose their health care if they change jobs, or even worse, they would be denied their health care coverage just because they have had a previous illness.

But this Republican-controlled House is once again about to put the good of special interests before the good of the Nation.

Mr. Speaker, this is a time of great uncertainty in our country. Today many workers wake up each morning wondering whether they will have a job at the end of the day and even whether they will be able to provide their family health care. Today health care costs are skyrocketing, and the Republican Party has looked the other eye to the needs of working men and women.

But we have heard over and over again our Republican colleagues talk about providing opportunity for America’s middle class. Mr. Speaker, if ever there was a chance to do that, this is the bill. This is our chance to do something for the people of this country, and we should take it.

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

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

Mr. Speaker, I think there are a couple of points that need to be made here.

Technically of course, at the very onset of this rule debate, this is not a closed rule which we are debating. This is a modified closed rule. What is the difference? The difference in the importance of a modified closed rule is that the modified closed rule allows their side the opportunity to offer a complete substitute. In addition to that, it allows them to make a motion to recommit. There is certainly plenty of room for them to maneuver over there, to offer the kind of amendments or changes that they feel are important.

Mr. Speaker, a few words should be said in response to the comments made about the waiver of clause 5(c) of rule XXI in this rule against the bill and the amendments thereto. As my colleagues are aware, clause 5(c) requires a three-fifths vote on the adoption or passage of any bill, joint resolution, amendment or conference report carrying, quote, a Federal income tax rate increase, unquote.

We do not feel there is any provision in this bill that raises Federal income tax rates as construed by the legislative history on this rule. As the section-by-section analysis of this rule explained when the rule was adopted on January 4 of 1995, and I quote, "purposes of the term ‘Federal income tax rate increase’ is, for example, an increase in the individual income tax rates established in section 1 and the corporate income tax rates established in section 11, respectfully, of the Internal Revenue Code of 1986.

Those are commonly understood marginal tax rates, or income bracket tax rates, applicable to various minimum and maximum income dollar amounts for individuals and corporations."

In response to the letter from the ranking minority member of the Committee on Rules to the chairman last year, investigating a clarification of this rule, the Committee on Rules published such a clarification in the report on the rule for the reconciliation bill. The bottom line of that clarification reads as follows, and again I quote:

"It is the intent of this committee that the term ‘Federal income tax rate increase’ should be narrowly construed and confined to the rate specified in those two sections, that is sections 1 and 11 of the Internal Revenue Code respectfully, of marginal rates for individuals and corporations."

Nothing in the bill before us increases either the individual income
tax rates contained in section 1 of the Code or the corporate income tax rates contained in section 11 of the Code. Thus, according to the Committee on Rules clarification, as requested by the ranking minority member, this bill does not trigger three-fifths vote on either the majority substitute or on the bill itself. However, as was mentioned in the opening statement on the rule, the waiver was provided out of an abundance of caution to avoid unnecessary points of order that might otherwise arise.

**EXPLANATION AND DISCUSSION OF CLAUSE 5(c), RULE XXI WAIVER**

(Excerpted From the Rules Committee's Report on H. Res. 245, the Reconciliation Rule)

As indicated in the preceding paragraph, the Committee has provided in this rule that the provisions of clause 5(c) of House Rule XXI, which require a three-fifths vote on any bill, joint resolution, amendment, or conference report "carrying a Federal income tax rate increase," shall not apply to the votes on H.R. 2401, or to any changes any amendment thereto or conference report thereon.

The suspension of clause 5(c) of rule XXI is not because there are any Federal income tax rate increases contained in the reconciliation substitute being made in order as base text by this rule. As the Committee on Ways and Means has pointed out in its portion of the report on the reconciliation bill—

"The Committee has carefully reviewed the provisions of Title XIII and XIV of the revenue reconciliation provisions approved by the Committee to determine whether any of these provisions constitutes a Federal income tax increase within the meaning of the House Rules. It is the opinion of the Committee that there is no provision of Titles XIII and XIV of the revenue reconciliation provisions that constitutes a Federal income tax rate increase within the meaning of House Rule XXI, 5(c) of (d)."

Nevertheless, the Committee on Rules has suspended the application of clause 5(c) as a precautionary measure to avoid unnecessary points of order that might otherwise arise over confusion or misinterpretations of what is meant by an income tax rate increase.

Such point of order was raised and overruled on the final passage vote of H.R. 1215, the omnibus tax bill, on April 13, 1995. The ranking minority member of the Rules Committee subsequently wrote to the chairman of this Committee requesting a clarification of the rule. An exchange of correspondence with the Parliamentarian and the Counsel of the Joint Tax Committee was subsequently released by the chairman of this Committee on June 15, 1995. During the ruling and the provision of the bill which gave rise to the point of order.

The Committee would simply conclude this discussion by citing from the section-by-section analysis of H. Res. 6, adopting House Rules for the 104th Congress, placed in the Congressional Record, at the time these were adopted on January 4, 1995. With respect to clauses 5(c) and (d) which require a three-fifths vote on any income tax rate increase in a proportionate consideration of any retroactive income tax rate increase, respectively:

"For purposes of these rules, the term "federal income tax rate increase" is, for example, an increase in the individual income tax rates established in section 1, and the corporate income tax rates established in section 11, of the Internal Revenue Code of 1986, (Congressional Record, Jan 4, 1995, p. H–34)."

The rates established by those sections are the commonly understood "marginal" tax rates or income "bracket" tax rates applicable to various minimum and maximum income dollar amounts for individuals and corporations. It is the intent of this committee that the term "Federal income tax rate increase" should be narrowly construed and should not be interpreted to include those two sections. As indicated in the Ways and Means Committee's report, those rates have not been increased by any provision contained in H.R. 2401 as made in order as base text by this resolution.

Mr. Speaker, I yield 6 minutes to the gentleman from Illinois (Mr. Hastert). Mr. HASTERT. I think the gentleman from Colorado for yielding me this time.

Mr. Speaker, I think we need to talk about how this bill came about and what is in it and what is not in it. The bill is an amalgam of ideas that have been tested around this House for the last 5 or 6 years, that make eminent good sense.

Now this year of course the House has been working on Medicare and Medicaid reform and those discussions have been on the back burner, but we have always tried to use the issue and work the issue of portability so that we could have people move from group to group and group to individual.

Now, in the Senate bill there was some controversy with the group to individual because people who were basically healthy, when they lose their jobs, many times do not go out and buy a very expensive insurance policy. People who are sick, or if they are 15 years of age, and three kids, and a wife who is going to deliver, or if they are 55 years of age and have a preexisting condition, and then go to into immediate health insurance coverage, they are going to go out and buy that insurance policy, probably at whatever cost.

So we thought that it was very, very important that we design and change the group to individual policy so that only sick people would not buy individual insurance and hold down the cost so that insurance can be available and affordable to everybody.

So, the way that we structure group to individual allows for that, but it is the central theme of what this bill does.

Health care availability is something that we all strive for. We know that there are a lot of Mercedes and Rolls Royces out there that are not available. The problem is people do not drive those because they cannot afford them. Well, my colleagues, that is the same way in health care. If someone cannot afford the health care, if they cannot afford that insurance policy, then they do not buy it, and those folks riding around in Mercedes and Rolls Royces certainly have a lot of money to spend, and they can probably afford anything. But most of those people are those who do not have jobs.

So that is the issue. How do we take people who have a health care bill and they do not have a job?

Our approach to that is an approach of a type of policy that they can buy that is a low-cost policy, maybe a deductible, but something that is affordable, not for just people who are sick, but people who are well. So the theme of affordability and availability is central to everything that we have put in this package, and my colleagues from the Senate and from the House get it beyond the Senate package, but it is because we think that the Senate package was lacking.

We have had four committees that have worked on this bill. And the committees that went out and structured things that were within their jurisdiction and moved legislation through their committees, had hearings, subcommittee hearings, full committee hearings, took amendments, listened to amendments, went through the debate and moved out a package; each bill within the jurisdiction of that committee. The Committee on Rules then put those three bills together, plus some information or piece of legislation that the Committee of the Whole has juked and jived and put it together with the Rules Committee yesterday.

Now what is the difference between this bill, the House Republican bill sponsored by the chairman of the four committees and supported by the chairman, and the Senate bill? For one thing, we have medical savings accounts, and my colleagues will hear people over here saying, "Boy, medical savings accounts are only for rich people, that is just a fraud." Medical savings accounts are for everybody. The average employer cost per employee family in this country is about $4,500 a year. If my colleagues had a $4,500 savings or $4,500 a year insurance policy, Medisave, a policy, probably my colleagues would take a $2,000 deductible and buy a high deductible policy; my colleagues would take that other $2,500 and put it in their medical savings accounts.

Now is that for rich people? No, that is for the average worker. That is for the guy who carries a lunch bucket to work. But a fellow or a person or a family that wants to control his own choice in health care, that does not want an HMO or an insurance company telling him what doctor to go to, or what hospital to go to, or what type of treatment to get, somebody that wants to control their own health care choice, and with a medical savings account, you do just that. If my colleagues do not spend that money, then they get to keep it, and that is real portability, because if my colleagues had this insurance policy for a couple of years and they have $10,000 or $15,000 or $20,000 in their medical savings account, that gives them real portability. My colleagues can move that and take it wherever they want, or buy insurance with it, pay for health care costs with it.

Also, this bill has long-term care experience so that people, seniors, can take their assets and move it into long-term care, or if they have a fatal disease, they can take their life insurance, cash it in,
and buy long-term care or health care with it.

We also have small group employer, so the 85 percent of the people who do not have insurance today that live in families that work for small businesses, that they can go to the market, and get the same break that big businesses get.

Now this is commonsense reform, my colleagues. It is something that everybody can work with, it makes health care not just available, but affordable. I hope that my colleagues would vote for this rule.

Mr. MOAKLEY. Mr. Speaker, I yield 3 minutes to the gentleman from Rhode Island [Mr. REED].

Mr. REED. Mr. Speaker, I rise in opposition to the Republican effort to sabotage realistic and meaningful health care reform this year. Senators KENNEDY and KASSEBAUM have sponsored health insurance reform legislation that is a positive first step to removing the barriers for coverage for thousands of Rhode Islanders and millions of Americans.

I am cosponsor of the Kennedy-Kassebaum bill. It will be offered as a Democratic substitute, and this bill would prohibit insurance companies from dropping coverage when a person changes jobs or preventing coverage if a person has a preexisting condition. In addition, this bill would increase the tax deduction for the self-employed from 30 percent to 80 percent by the year 2002. It is also estimated that this bill would help 25 million Americans each year, with minimal impact on individual premiums or the federal budget. In Rhode Island this would be terribly helpful for thousands of Almacs workers who were recently laid off when the store closed, a supermarket chain.

These are individuals that need this type of coverage. Regrettably, House Republicans decided against taking up this bipartisan bill. House Republicans chose instead to cater to special interests and consider a bill with controversial, and costly provisions. This Republican plan will doom the prospect of meaningful health care reform this year in the Congress.

Mr. Speaker, I urge rejection of this measure. Our constituents need a bill that will make health care more affordable for all Americans.

Mr. KENNEDY of Massachusetts. Mr. Speaker, will the gentleman yield?

Mr. REED. I yield to the gentleman from Massachusetts.

Mr. KENNEDY of Massachusetts. Mr. Speaker, I appreciate the gentleman's comments.

Mr. Speaker, this bill is very simple. There was a deal cut in the U.S. Senate, the Kennedy-Kassebaum bill. President Clinton agreed to Kennedy-Kassebaum. All the Republicans in the Senate, agreed to Kennedy-Kassebaum. The Kennedy-Kassebaum bill does three things. It says to the ordinary citizens of this country that if they are willing to pay their health care premium if they change their jobs, they are going to continue to get health care. If they lose their job, they are going to continue to get health care. If they get sick, they will continue to get health care.

With the Republican substitute, the Republicans have taken a stake and thrown it into the heart of health care reform. This notion of supporting MSA's, this notion of including caps on damages so if you lose your leg you are only going to pay people $250,000, ending the pain in this case, does the job of throwing off the track the ability of the American people, once and for all, to get needed health care coverage.

All we are trying to do is enrich the pockets of the doctors, enrich the pockets of the lawyers, and take away from the serious effort of getting the people that do not have health insurance or that lose health insurance simply because they get sick, simply because they lose their job, taking that hope away.

We have the opportunity to get the job done. Let us come together, and let us support the Democratic substitute which will once again put health reform back on track.

Mr. CARDIN. Mr. Speaker, I yield 1½ minutes to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Speaker, thank you my friend, the gentleman from Massachusetts, for yielding me this time.

Mr. Speaker, I reject the bad Mr. Speaker's rule. I thought we were going to get a rule and a bill before us that will let us deal with health insurance portability and preexisting conditions, that will let us deal with the problems that our constituents are facing of losing their jobs and losing their health benefits, and being unable to get health insurance without preexisting condition restrictions. Democrats and Republicans agreed to deal with that issue.

Yet this rule is likely we will get to that day. This rule does not permit any amendments to be offered. Many amendments were suggested in the Committee on Rules, that would help improve the bill that has been brought forward.

Let me just mention a couple of the areas that troubled me. The bill preempts State laws in many, many ways. I thought we were supposed to be returning power to our States. This bill makes sure that our States respond to health insurance problems. In my own State, we have adopted small group market reform. Yet the provisions in the underlying bill would seriously jeopardize Maryland's ability to continue that small market reform. I am offered an amendment in the Committee on Rules for fraud and abuse. There are new provisions in this bill that make it more difficult for the Justice Department to bring fraud cases against providers that are cheating. Yet the Committee on Rules did not make that amendment in order.

The group-to-individual provisions need to be improved. They are too restrictive to a person who loses their health insurance and must provide an individual plan. This rule does not allow us the opportunity to go forward with the type of portability that we need. The only option before us is to support the Democratic substitute that if we want portability and eliminating preexisting conditions.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentlewoman from California [Ms. ESHOO].

Ms. ESHOO. Mr. Speaker, I rise in opposition to this rule. I had hoped to have an amendment made in order which would raise the lifetime benefit cap on health insurance from $1 million to $10 million. My amendment would have benefited the 1,500 Americans a year who exceed the current cap, and some 10,000 Americans between now and the year 2000. It would save Medicaid $7 billion over 5 years, and the cost justifiable. The American Academy of Actuaries estimates a 1-percent to 2-percent increase in premiums.

Mr. Speaker, a medical catastrophe could befall any one of us here in this Chamber, and in this body, any one of our children, our parents, our loved ones, at any time. Many times I say to myself, "There but for the grace of God go I." Not being able to have sufficient health insurance coverage severely compounds the catastrophe. A point that needs to be made is the plight of the distinguished actor Christopher Reeve, who is well known to all of us. In honor of his courage, I introduced legislation upon which the amendment was based, name the Christopher Reeve Health Insurance Reform Act.

Mr. Speaker, every day we see inflation adjustments for other needed services: for consumer products, for education. In some of these cases, the adjustment reflects the reality of current costs. In others, they offer protection to the American people. My amendment would have done both. I am disappointed not for myself, but for the people of this Nation that my amendment was not allowed a rule.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Connecticut [Ms. D'ELAUR].

Ms. D'ELAUR. Mr. Speaker, I rise today on behalf of the hardworking families in my district, families who struggle to pay their bills, work hard, and they play by the rules. They live in fear of losing their health insurance if they change jobs. They cannot get health care coverage because of a preexisting condition. These families are a pink slip away from disaster.

I went to visit the Tomaso Construction Co. in my district. I met with workers there, and a worker said to me that he is frightened to death that he may lose his job. He has a child with a terminal illness. He stays up nights worrying that he will lose his job and will not be able to have the health insurance he needs for his child. Today Congress has the chance to prove to that we are here to help working families.

The bipartisan Kennedy-Kassebaum-Roukema bill expands access to health care...
Mr. Speaker, I urge my colleagues to reject this special interest payoff and support the Democratic substitute. It will provide real health care security to the hardworking families of this country.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentleman from North Dakota [Mr. POMEROY].

Mr. POMEROY. Mr. Speaker, the bill reported out under this rule preempts states' rights and eliminates the ability of employees, who are insured through associations or multiple employer arrangements known as MEWAs. This preemption of State law is a horrible idea, and deserves separate consideration and debate while the bill is on the House floor.

The consequence of allowing insurance entities to operate without effective State oversight creates a situation where small businesses will be ripped off. Folks who believe they are insured by their company's plan will find out they are not, often after they have racked up ruinous health bills.

Mr. Speaker, I am the only Member of this Chamber to have served since 1987 as a State insurance commissioner. I know full well what will be hit with fraudulent insurance practices if this bill is enacted. I have seen it happen. In the home State of the gentleman from Florida [Mr. Goss], a fraudulent entity collected nearly $35 million in premiums from 7,000 employers. It collapsed, leaving 40,000 employees without coverage, and $29 million in unpaid claims.

Why in the world would the majority want to wipe out the State laws developed to keep this from happening again? Why in the world would the Committee on Rules not allow separate consideration on this issue? Time and time again we have heard the new majority hail the role of State government, yet today's bill washes out the efforts of States to protect small businesses and the workers they ensure. Vote “no” on this bad bill.

Mr. Goss. Mr. Speaker, I yield 30 seconds to the gentleman from Illinois [Mr. FAWELL].

Mr. FAWELL. I thank the gentleman for yielding time to me.

Mr. Speaker, the gentleman has made the statement that it is a terrible thing to preempt State law, but the gentleman must be aware that under the ERISA statute, most of private health care in this Nation is indeed a situation where State law has been preempted, and employer-provided health care is basically self-insured or, in some cases, with fully insured plans. So this is not the evil thing that one would think.

All we are suggesting is that small employers might have the same advantages as large employers have. That is all.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Georgia [Ms. MCKINNEY].

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

Mr. Speaker, this Congress has a historic opportunity to pass limited, but meaningful health insurance reform. Just an hour from now, however, we'll begin to debate a bill specifically constructed by the Republican leadership to sabotage any meaningful reform this Congress.

Rather than supporting the bipartisan Kennedy-Kassebaum-Roukema bill, the G.O.P. House leaders insist on pushing their own bill which contains controversial provisions like medical savings accounts.

And what medical savings accounts? Just follow the money. The Golden Rule Insurance Co. has given more than $1.4 million to the G.O.P. and, coincidentally, Golden Rule just happens to be the premier company peddling medical savings accounts.

Mr. Speaker, the sad saying is true: He who has the gold, rules. And while the American people want serious health insurance reform, all they are getting from the G.O.P. is cash-and-carry government.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentleman from New York [Mr. ENGEL].

Mr. ENGEL. Mr. Speaker, I thank the gentleman from Massachusetts for yielding time to me.

Mr. Speaker, for the whole day today the Republican leadership blocked consideration of a raise in the minimum wage. Then the majority whip, in relation to my speech that I made, said, "This is blatant politics and blatant hypocrisy." His words clearly should have been taken down, but the Speaker disallowed it.

Now the Republican leadership shamefully is not allowing us to consider a clean version of the Kennedy-Kassebaum-Roukema health reform bill, even though the American people want it. The American people want to know that if they lose their jobs, they can continue their coverage. The American people want to know that if there is a preexisting condition used as an excuse not to give them or a loved one health insurance, that that cannot be used as an excuse anymore. It has been reported in the newspapers and is supported by the President. It represents the minimum that can be done to provide additional health security to the American people.

Again, the Republican leadership is blocking it, taking this bill and weighing it down with all kinds of strange things that do not belong in this bill. They know it is going to kill the bill. That is their real motive, to kill this bill. They can pretend they are concerned with the health care reform, but in reality what they are doing to this bill kills the bill, and the American people ought to know that.

Republicans have been talking a lot about how they want to reconnect with average working people. Is this the way they do it? By blocking the Roukema bill, this demonstrates that the Republican leadership are more interested in political gain than in passing legislation that helps the American worker. This is really shameful.

Mr. MOAKLEY. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York [Ms. SLAUGHTER].

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

Mr. Speaker, as we debate the merits of health insurance reform, it is crucial that we keep in mind one of the most important and very important aspect of health insurance reform, that is genetic information and the potential for insurance discrimination. Last December, I introduced H.R. 2749, the Genetic Information Nondiscrimination in Health Insurance Act—a bill to prevent the potentially devastating consequences of discrimination based on genetic information.

I am very pleased to learn that both the Republican version of health insurance reform and the Democratic substitute contain some of the protections I introduced in my bill last fall.

While the provision included in both versions of the legislation on the floor today is not as comprehensive as those outlined in my bill, it represents a crucial first step in providing protection for people for predisposition to genetic disease.

As chair of the Women's Health Task Force, I closely followed the reports last year indicating that increased funding for breast cancer research had resulted in the discovery of the BRCA-1 gene-link to breast cancer. While the obvious benefits of the discovery include potential lifesaving early detection and intervention, the inherent dangers of the improper use of genetic information are just becoming evident.

We must learn from the lessons of the past. We must remember the disastrous results of discriminating against those genetically predisposed to sickle cell anemia. And, we must guard against history repeating itself. There are recent reports of people with a familial history of cancer, who are afraid of getting tested for fear of losing access to insurance. We must assure our citizens that advances in our understanding of human genetics will be used to promote health and not promote discrimination. Both the lessons of the past and the recent discoveries point to the need for comprehensive Federal regulations.
The bill I introduced last December would prevent discrimination by prohibiting insurance providers from: denying or canceling health insurance coverage, or varying the terms and conditions of health insurance coverage, on the basis of genetic information; and requesting or requiring an individual to disclose genetic information, and disclosing genetic information without prior written consent.

Mr. Speaker, the provisions contained in the legislation being considered today prohibit the use of genetic information as a preexisting condition. I applaud the inclusion of that aspect of my legislation in the insurance reform packages. However, the provisions are limited in two major respects. One, the pool of people covered by this legislation is restricted to those in the employment market. Two, the legislation does not address the important issue of privacy protection.

I hope that my colleagues and I can continue to work together to apply the prohibitions on genetic discrimination across the board to cover all packages. However, the provisions are limited to those who are covered by a particular health insurance policy.

Mr. Speaker, I urge a "no" vote on this rule.

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

Mr. Speaker, for those who are distressed about the opportunity they might have or might not have a chance to get at the bill known as the Kassebaum-Kennedy-Roukema, I believe it is the substitute that is going to be made in order, and they should take it up with the leadership on the other side of the aisle.

Mr. Speaker, I yield 2 minutes to my friend and colleague, the distinguished gentleman from Florida [Mr. BILIRAKIS].

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

Mr. Speaker, as the chairman of the Subcommittee on Health and Environment of the Committee on Commerce, I truly believe that reforming our Nation's health care system is one of the most important issues before Congress today.

Mr. Speaker, who does not support insurance portability? Who does not believe that people with preexisting conditions have a right to purchase health insurance at a reasonable price, just like everyone else?

And who can argue that fraud in our health care system has to be controlled or that unnecessary paperwork should be eliminated? The legislation before us today would address these and other important issues so that they could be enacted into law this year.

Mr. Speaker, our legislation is a starting point for reform, a reasonable step in resolving our Nation's health care problems. The bill in the Senate is also a reasonable beginning, and I commend Chairwoman Kassebaum for her work, but it does not go far enough. Even the President's bill in the last Congress addressed administrative simplicity and medical malpractice reform. These, along with the problems of waste, fraud, and abuse, are consensus items.

If we enact into law, Mr. Speaker, these important consensus items, then many Americans will certainly benefit. I urge my colleagues to show the American people that we truly want change by supporting this rule and acting now on health reform.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentlewoman from California [Ms. WOOLSEY].

(Ms. WOOLSEY asked and was given permission to revise and extend her remarks.)

Ms. WOOLSEY. Mr. Speaker, how often do we get a clear shot at helping 25 million people get covered for a preexisting condition? Today, we have that chance. We can help them stay healthy. We can help them achieve their dreams. Unfortunately, however, some Members of this body do not want us to have a clear shot with a clean bill. They want to gum up the works with proposals we do not need, proposals that doom this entire bill.

Why would they do this? Two words, Mr. Speaker: Special interests. Mr. Speaker, many Democrats agree. In fact, they do not want to give individuals the protection against genetic discrimination.

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

Mr. SALMON. Mr. Speaker, I rise to strongly endorse this rule.

I would like to talk about one particular component of the piece of legislation that is exposed in the rule, and that is medical savings accounts. It truly is an idea whose time has come.

Let us face the facts. Those on the other side have had more confidence in bureaucracy and the heavy-handed government than they do in individuals. In fact, they do not want to give individuals these kinds of choices because they believe that Washington knows better what their needs are than they know what their own needs are for themselves. Medical savings accounts are being demanded by people out there. In fact, there are some 3,000 companies who are already offering medical savings accounts.

Mr. Speaker, the only problem is our tax policy is discriminatory. It does not give the same kind of tax advantage to people wanting to establish medical savings accounts as it does to those companies providing premium coverage for traditional health care. Despite the charges of the opponents, MSA's are great for sick people and for the less well off. Why? Because you get first-dollar coverage, and sick people would want it as well as healthy people.

Finally, I would just like to say that they will work, by cutting out the bureaucracy, the red tape and the paper work and replacing it with a free market. Individuals will be able to shop around and get the best deal that they can. When my last child was born, we had a traditional health care policy that paid $3,900 for the delivery. Two months later my wife had a baby at the same hospital, same doctor, yet they negotiated a cash payment of $1,500. They work.

Let us talk about special interests, let us talk about the fact that the biggest interest group against this is managed care. Why? Because they would rather see the savings go into the managed care, the HMO programs, than they would back in the individual's pockets. We let us get rid of the heavy-handed government and let us really think about special interests and who is in whose pocket.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Texas [Ms. JACKSON-LEE].

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE. Mr. Speaker, for those who are disheartened about the opportunity they might have or might not have a chance to get at the bill known as the Kassebaum-Kennedy-Roukema, I believe it is the substitute that is going to be made in order, and they should take it up with the leadership on the other side of the aisle.

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And who can argue that fraud in our health care system has to be controlled or that unnecessary paperwork should be eliminated? The legislation before us today would address these and other important issues so that they could be enacted into law this year.

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Why would they do this? Two words, Mr. Speaker: Special interests. Mr. Speaker, many Democrats agree. In fact, they do not want to give individuals the protection against genetic discrimination.
Likewise, let us not take the State administrators out of determining whether the rates are too high when you have to pay for an insurance plan. It is time to support a bill that the Senate will support.

The New York Times said, health reform now. But the Republican plan will kill it. Let us be bipartisan. Support the Kennedy-Kassebaum-Roukema bill, which is a Democratic substitute, and make sure that we do not collapse on the American people. Provide them with good health reform, good insurance, portability, and the coverage of preexisting disease.

Mr. Speaker, I rise today in support of the Democratic substitute to the Health Coverage Availability Act. This bill contains the portability provisions found in the Kassebaum-Kennedy-Roukema proposal, and it also increases the tax deduction for the self-employed health insurance costs, which is 30 to 80 percent in 2002, instead of the 50 percent offered in the Republican bill. I believe that this promise of portability, the ability to pool together to purchase health insurance reform, is enjoyed by many employees. This Democratic substitute has the provisions that hold bipartisan support. I believe that we should work together to pass some meaningful health care reform this year, and we should not attach controversial provisions that would endanger the bill. Contrary to what some of our colleagues argue, I believe the bill should be passed by the Senate. These provisions would allow employees who get laid off to keep their health insurance, and gives individuals the freedom to make career decisions based on the best interests of the individual. The American people would have to cost containment, as studies have shown. Soaring health costs are a large reason for an increasing anxiety among cash-strapped working Americans, and MSA’s are proven to lower costs to employees and employers without sacrificing service and care.

Mr. Speaker, I support the bipartisan political for 1 day and include MSA’s in health insurance reform so Americans can worry less about their health care and more about their career and family. Mr. MOAKLEY. Mr. Speaker, I yield 12 minutes to the gentleman from New Jersey [Mr. PALLONE].

Mr. PALLONE. Mr. Speaker, when I talk to my constituents about health insurance reform, basically they say, look, the quality of health care is good in this country, but 1 out of 3 people do not have health care coverage. But on the issue of affordability, essentially by adding these medical savings accounts to this bill, which I think is a big mistake and will essentially kill the bill, what we are doing is making health insurance less affordable, going against the goal and what most people want.

The reason is very simple, and that is why I do not understand some of the comments on the other side. Essentially what this bill would do is allow people who are going to take advantage of MSA’s are people who have a lot of money, or people who are healthy who figure that they can put this money aside and have it collect, and they only need catastrophic health care coverage. Few people have the ability to start their own business based on what is best for their career and family without worrying about his or her family’s health insurance.

In addition to portability, exclusion of pre-existing conditions, tax deductions, and the health insurance reform bill would also include provisions that allow small employers to pool together to purchase health insurance. These small businesses should be allowed the same exemptions from State regulations that big businesses enjoy. But, I do not believe that medical malpractice provisions that put a price on pain and suffering as low as $250,000 should be included in any health insurance bill that we pass today.

In any case, MSA’s should be added to health insurance reform because they will lower costs while still giving individuals the freedom to make career decisions based on the best interests of the individual. The American people would have to cost containment, as studies have shown. Soaring health costs are a large reason for an increasing anxiety among cash-strapped working Americans, and MSA’s are proven to lower costs to employees and employers without sacrificing service and care.

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split. The healthy and the wealthy are going to get out of the risk pool and have the MSAs. The people who are sicker or do not have as much money, probably who will be the majority, they will see their premiums go up; and in essence health insurance will be less affordable.

Vote against the rule and vote against this Republican leadership bill.

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

Mr. PAUL. Mr. Speaker, I thank the gentleman from the opportunity to address the question of MSA's and also follow the gentleman from New Jersey [Mr. Pallone].

I serve as chairman of the Subcommittee on Civil Service of the Committee on Government Reform and Oversight and actually had the opportunity to conduct hearings on MSA's. We have heard the other side of the aisle and the gentleman from New Jersey [Mr. MORAN].

Let me say what Mayor Schundler testified to, the mayor of Jersey City, N.J., who came before our subcommittee. He said MSA's were offered and 60 percent of eligible employees chose MSA's under their previous plan. What were the results? And this is a city facing financial disaster and not being able to provide health care for their employees. The results reduced the out-of-pocket costs to employees and still saved the city about $275 per employee, but they do not want to deal with the facts on the other side.

Let us take another area, a small county, Ada County, ID, testified that under their county's MSA plan, the taxpayer saved money and the employees saved out-of-pocket costs which were reduced.

Then the private sector was at our hearing. At the hearing the subcommittee heard of reported cost savings ranging from 17 to 40 percent by more than 1,100 private businesses that have adopted MSA's.

Finally, how about the AFL-CIO? Let us see what one of their affiliates said. They called MSA's an option offered to their employees a win-win situation.

So if we went to provide health care cost effectively, these are the facts, this is the result, and this is how we can do it. It just happens to be a new idea whose time has arrived.

Mr. MOAKLEY. Mr. Speaker, I yield ½ minutes to the gentleman from Virginia [Mr. Moran].

Mr. MORAN. Mr. Speaker, there is a lot that could and should be said about MSA's. I am going to save that for another time. Right now I would like to spend maybe a minute and a half and talk about the subject of hypocrisy.

Tomorrow the Committee on Rules is going to bring up a rule for a constitutional amendment that would require a two-thirds vote to raise income taxes, and then, the very next legislative day, April 15, when we get back from vacation, we are going to bring that bill up on the floor to require a two-thirds vote.

Now on the first day of this legislative term back in January 1995, we passed a law that was supposed to go into effect in 1997. It required that we require a three-fifths vote to raise taxes, and do you know, every single time it has applied, it has been waived, and here is the third time that the Committee on Rules again waives the three-fifths requirement.

We had a chance with that Contract With America, Tax Relief Act that was a big issue. Remember I raised a point of order. It turns out that, sure enough, it did include a tax increase. So the Parliamentarian recognized we had to waive it.

The second time we had the budget resolution, we had the Committee on Rules had to waive it, and now the third time we have got tax increases here. We are going to waive the rule because let us just apply this to this bill, but is it not unbelievable that tomorrow the Committee on Rules—just for pure expedience, political gain—is going to bring up this rule saying that you need a two-thirds vote, you need a two-thirds vote and then are expecting us to vote on it April 15. Unbelievable. I think some of the members of the Committee on Rules ought to be embarrassed about this one.

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

Mr. ROYCE. Mr. Speaker, I rise in support of the rule and this legislation because this legislation gives individuals greater control over their own health care through the introduction of medical savings accounts.

These medical savings accounts put individuals in charge of their own health care. It gives them greater freedom and more choices, and it will drive down costs. At the same time, they help resolve the portability issue.

One problem with the current health insurance system in this country is that coverage for working people is usually tied to the job rather than the individual. Medical savings accounts, which would be owned by the individual for life, move with the individual. It is the ultimate in portability.

Medical savings accounts are becoming increasingly common in the public sector. This popularity in the private sector is even more significant considering the fact that they are handcapped by tax laws which give deductions to employers who pay their workers' insurance premiums but not to the employers who are paying into the medical savings accounts. This inequitable tax treatment penalizes individuals who want to select their own health providers and plans as well as individuals without health plans at work.

The legislation before us today removes this handicap and allows individuals and employers to make tax-deductible contributions to the accounts when employees are covered by a high deductible health insurance policy.

Further, in allowing for a tax-free buildup of these accounts, this bill makes the choice of medical savings accounts available to many more Americans, and everyone owning an MSA could have the ability to spend their money wisely. That is a marked contrast to the use-it-or-lose-it approach fostered by third-party plans. The savings would be theirs, and so would the choice.

The competition would also put pressure on providers to reduce costs so everyone would benefit, and while MSA options may not solve every problem, it would certainly help consumers giving them more choices, more control, lifetime security, and lower costs.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentleman from Michigan [Mr. Dingell], the former chairman of the Committee on Commerce.

Mr. DINGELL asked and was given permission to revise and extend his remarks.

Mr. DINGELL. Mr. Speaker, I rise in opposition to this closed rule. I want to acknowledge the gracious reception I received at the Committee on Rules hearing yesterday from Chairman Solomon and the other members of the Rules Committee. And I appreciate that the rule makes in order a substitute, which I will offer together with my colleagues (Mr. Spratt and Mr. Bentsen), that will enable us to pare this bill down to two simple and uncontroversial provisions: a clean Kassebaum-Roukema bill, and tax deductibility of health insurance for the self-employed.

But what we asked for was an open rule, and we have not gotten one. Thus, while the Republican leadership has loaded this bill down with a fine assortment of goodies for their friends in the health insurance industry, the medical profession, the HMO's, and other special pleaders, Democrats will not have a fair opportunity out here on the floor to make changes in those special-interest provisions.

For example, I had hoped to offer an amendment to strike a provision in the Republican bill that contains a sneak attack on the pocketbooks of America's seniors. This sneaky provision would put millions of our senior citizens at the mercy of health insurance scam artists who want to sell policy after policy to the same frightened and infirm people, whether they need it or not. The Republican bill would repeal existing protections in the Medicare law that regulate the sale of duplicative policies that had seniors paying premiums over and over again for coverage they didn't need.

But my amendment was not made in order. It seems that my Republican colleagues care more about helping their friends in the health insurance business than about protecting seniors from rip-offs. Oppose this rule.
Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentleman from Virginia [Mr. SCOTT].

Mr. SCOTT. Mr. Speaker, the original bill had broad bipartisan support that guaranteed that those who lose their jobs and cannot find a reason can still get health insurance coverage.

This bill is loaded up with so many special interest provisions that for the consumer, the poor and the sick, it does more harm than good. The medical savings accounts will allow a few healthy people to take money out of the Medicare Program, leaving behind a group that are, on average, sicker and, therefore, will have higher health care costs.

Mr. Speaker, we should reject the special-interest wrongdoer protections and instead pass the original bipartisan consumer protection health care bill.

Mr. MOAKLEY. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Missouri [Mr. VOLKMER].

MR. VOLKMER. Mr. Speaker, I am sure that the Members are watching and listening to this debate on the rule for the so-called Health Care Availability and Affordability Act.

I hope Members will really take a look at what is happened here. This is blatant politics and blatant hypocrisy. The bill’s title speaks of laudatory goals, while the provisions of the bill for medical savings accounts will ultimately have adverse effects on health insurance policies of all persons in this country who are wealthy and cannot afford a medical savings account. The Golden Rule Insurance Co. is being repaid by the Gingrich majority for Golden Rules contribution to GOPAC and the Republican’s campaign coffers. It’s more than 30 pieces of silver. It is millions from taxpayers’ pockets to put into the pockets of Golden Rule. Blatant politics and blatant hypocrisy.

Mr. GOSS. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Florida [Mr. SCARBOROUGH].

Mr. SCARBOROUGH. Mr. Speaker, I have been really intrigued by this debate. We hear actually some of the architects of the Clinton health care plan, that would socialize the health care system and one-seventh of our economy, lecturing us on how we need to now fix health care in America. Very intriguing.

The fact of the matter is that what it shows is we have two different views of America. Who do we believe in empowering Americans, and those Americans who believe that we must socialize government, socialize health care, and do everything we can to take the decision out of the hands of the consumers and the doctors. Who could not like medical savings accounts? Who could not? They take the middle man out. They give power to patients and doctors, family doctors, to sit down and decide what the best course of treatment is to cure people who are ill that come to their office without having to call an insurance company first and then decide how to use the money.

Somebody said it helps special interests and actually drives up costs. Let me tell my colleagues, that is a novel approach. I wonder what economics class has ever been taught that shows that free enterprise and empowering consumers drives up the cost of medical care. It is absolutely nonsensical. So let’s look at the two different views of America. With Democrats in control, they wanted to socialize; with the Republicans in control, we want to privatize. We want to drive down costs, and we want to empower doctors and patients to sit down together and decide what is best for their medical future. That makes sense to me.

I support the rule and the bill.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. STEARNS].

(MR. STEARNS asked and was given permission to revise and extend his remarks.)

Mr. STEARNS. Mr. Speaker, I thank my colleague for yielding this time to me.

Mr. Speaker, I rise in support of this rule. The legislation we will vote on today addressed the most fundamental and important issues that currently prevent a large majority of the uninsured from accessing the health care system.

What do Americans want from Health Care Reform? They want health care reform that ensures portability, controls costs, and expands access to care.

If we are to have true health care reform, we must include malpractice reforms, medical savings accounts, increases in tax deduction for health insurance for self-employed individuals, provisions to prevent waste, fraud, and abuse, and administrative reforms. Without providing such necessary relief, we will not succeed in bringing down the costs associated with delivering health care.

Passage of this bill will benefit all Americans, especially the 39 million who lack any type of health coverage. These individuals must live in constant fear of becoming sick and not having the necessary insurance to meet their medical needs.

Lastly, I am particularly pleased that my suggestion to include “genetic information” in the definition of health status was agreed to and made part of the final package. I believe by doing so we have enhanced and made it an even better piece of legislation. I will have more to say about this in the next period of debate.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the gentleman from Georgia [Mr. KINGSTON].

Mr. KINGSTON. Mr. Speaker, I find it amazing that last year the group that wanted to nationalize health care has taken exception with the Republican Party because we want to go beyond the portability issue. What is it that we want to do that we disagree? Medical savings accounts, giving consumers choices rather than command-and-control Washington Bureaucrats. We want to stop waste, fraud, and abuse.

I realize the Democratic Party is partial to waste, and I can understand that. We want to stop medical malpractice, and we have tort reform. The Hill newspaper, though, explains the Democrats’ position on that with $2.2 million in campaign contributions last year going to political candidates, 94 percent Democrats.

I will put this in the Record, Mr. Speaker.
TRIAL ATTORNEYS SEEK MORE HILL CLOUT

(By Craig Karmin)

In a move that would increase the political power of trial lawyers and benefit Democratic congressional candidates, the Association of Trial Lawyers of America is planning a new program to encourage its members to contribute to ATLA-endorsed candidates.

These individual contributions would supplement ATLA's political action committee, which was the sixth largest contributor during the last election cycle. According to a letter the association sent to the Federal Election Commission, ATLA would "obtain advance commitments from its members to contribute a specified amount" to certain candidates. It would first "recommend the size of contributions that members should send to particular candidates" and "suggest when members should mail their contributions."

The FEC met last week on the subject and is expected to approve ATLA's request to engage in these activities in the near future. But this could be prohibited under bipartisan campaign finance reform bills pending in both the House and Senate. ATLA contends that these contributions are constitutionally protected by the First Amendment.

The association's plan to strongly urge its 60,000 members to contribute to congressional campaigns would expand the power and influence of an already formidable special interest on Capitol Hill and in the White House.

"We are going to set in place a collection mechanism from all the patients in this country in this bill. We have overridden all States, all insurance commissioners, everybody else in one provision, stuck in a 300-page bill that most people on this floor have never read," Pam Liapakis, president of ATLA, said at a news conference yesterday. "When I asked in the Committee on Ways and Means about this section, they said it has been cleared with all the groups. So I called some of the groups and it has cleared with the groups. They understand that this is an invasion of privacy."

Mr. Speaker, I urge a "no" vote on the previous question. If the previous question is defeated, I shall offer an amendment to the rule which will make in order the amendment by the gentleman from Wisconsin [Mr. Gunderson], the gentleman from Illinois [Mr. Poshard], the gentleman from Kansas [Mr. Roberts], the gentleman from Texas [Mr. Stenholm], the gentleman from Minnesota [Mr. Gutknecht], and other members of the Rural Health Coalition.

"We want long-term health care. Businesses are in favor of that, as are large corporations. My small businesses are in favor of that, as are small businesses all over America. Then again, the Democratic Party has never been partial to small businesses. What is it on long-term health care? We want long-term health care."

Mr. Speaker, I support the rule and strongly urge a "yes" vote on the bill. The article referred to follows:

Mr. MOAKLEY. Mr. Speaker, I yield myself the balance of my time.

The SPEAKER pro tempore (Mr. Kolbe). The gentleman from Massachusetts is recognized for 1½ minutes.

Mr. MOAKLEY. Mr. Speaker, I urge a "no" vote on the previous question. If the previous question is defeated, I shall offer an amendment to the rule which will make in order the amendment by the gentleman from Wisconsin [Mr. Gunderson], the gentleman from Illinois [Mr. Poshard], the gentleman from Kansas [Mr. Roberts], the gentleman from Texas [Mr. Stenholm], the gentleman from Minnesota [Mr. Gutknecht], and other members of the Rural Health Coalition.

"We want long-term health care. Businesses are in favor of that, as are large corporations. My small businesses are in favor of that, as are small businesses all over America. Then again, the Democratic Party has never been partial to small businesses. What is it on long-term health care? We want long-term health care."

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"We want long-term health care. Businesses are in favor of that, as are large corporations. My small businesses are in favor of that, as are small businesses all over America. Then again, the Democratic Party has never been partial to small businesses. What is it on long-term health care? We want long-term health care."

Mr. Speaker, the text of my proposed amendment is as follows:

PREVIOUS QUESTION AMENDMENT TEXT (H.R. 3103±H. RES. 392)

On page 3, line 11 of House Resolution 392, immediately after "opponent;" strike "and" and insert the following: ("(3) the amendment printed in Section 2 of the resolution by Representatives Gunderson, Poshard, Roberts and Gutknecht or their designees, which shall be in order without intervention of any point of order (except those arising under section 425(a) of the Congressional Budget Act of 1974) demand for division of the question, shall be considered as read, and shall be separately debatable for 30 minutes equally divided and controlled by the proponent and opponent; and (4)

"At the end of the resolution, add the following new section:"

"(1) The amendment printed in Section 2 of the resolution by Representatives Gunderson, Poshard, Roberts and Gutknecht or their designees, which shall be in order without intervention of any point of order (except those arising under section 425(a) of the Congressional Budget Act of 1974) demand for division of the question, shall be considered as read, and shall be separately debatable for 30 minutes equally divided and controlled by the proponent and opponent; and (4)"

"At the end of the resolution, add the following new section:"
ACCESS HOSPITAL .—A State may designate a rural health network (as defined in subsection (b)) as a critical access hospital if the facility—

(A) has developed, or is in the process of developing, a State rural health care plan that—

(i) provides for the creation of one or more rural health networks (as defined in subsection (b)) in the State;

(ii) promotes regionalization of rural health services in the State, and

(iii) improves access to hospital and other health services for rural residents of the State;

(B) has developed the rural health care plan described in paragraph (A) in consultation with the State rural health association, rural hospitals located in the State, and the State Office of Rural Health (or, in the State, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

(C) makes available 24-hour emergency care services in each area served by a critical access hospital, and

(D) meets such other criteria as the Secretary may require.

(2) The term `inpatient rural primary care hospital services' means items and services, furnished to an inpatient of a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agreement between the facility and the Secretary under section 1883 of such Act (42 U.S.C. 1395e(b)(3)(A)) is amended by striking "inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.''.

(3) The term `inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.''.

RULES RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) Definitions.—Section 1812(a)(1) of such Act (42 U.S.C. 1395x(bb)(1)) is amended by striking "inpatient rural primary care hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.''.

(2) Waiver of conflicting part A provisions.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to carry out this section.
costs of the critical access hospital in providing such services.

(3) TREATMENT OF CRITICAL ACCESS HOSPITALS AS PROVIDERS OF SERVICES.—(A) Section 1128A(a)(4) of such Act (42 U.S.C. 1395aa(a)) is amended by striking “a rural primary care hospital” and inserting “a critical access hospital”.

(B) The first sentence of section 1128A(a)(4) of such Act (42 U.S.C. 1395aa(a)) is amended by striking “critical access hospital” and inserting “a rural primary care hospital”.

(C) Section 1128B(c) of such Act (42 U.S.C. 1395cc(c)) is amended by striking “outpatient critical access hospital services” and inserting “critical access hospital services”.

(D) Section 1134 of such Act (42 U.S.C. 1395h(c)(2)(C)) is amended by striking “rural primary care hospital services” and inserting “critical access hospital services”.

(E) Section 1138(a)(1) of such Act (42 U.S.C. 1395w(a)(1)) is amended—

(i) by inserting “critical access hospitals” each place it appears in subparagraphs (A) and (B) and inserting “critical access hospital”; and

(ii) in the matter preceding clause (ii), by striking “rural primary care hospital” and inserting “critical access hospital”.

(F) Section 1831(c)(2)(C) of such Act (42 U.S.C. 1395ww(d)(2)) is amended by striking “rural primary care hospital” and inserting “critical access hospital”.

(G) Section 1833 of such Act (42 U.S.C. 1395ww(d)(3)) is amended—

(i) by striking “critical access hospital” and inserting “critical access hospitals”; and

(ii) by striking “rural primary care hospital” and inserting “critical access hospital”.

(H) Section 1836(c)(2)(C) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by striking “rural primary care hospital services” and inserting “critical access hospital services”.

(I) Section 1837(e)(5) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by striking “critical access hospital services” and inserting “critical access hospital services”.

(J) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking “critical access hospital” each place it appears and inserting “critical access hospital”.

(K) Section 1864(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended—

(i) in subparagraph (F)(i), by striking “critical access hospitals” and inserting “critical access hospital”;

(ii) in subparagraph (H), in the matter preceding clause (i), by striking “primary care hospitals” and “critical access hospitals” and inserting “critical access hospital services” and “critical access hospital services”, respectively;

(iii) in subparagraph (I), in the matter preceding clause (i), by striking “primary care hospitals” and inserting “critical access hospital” and inserting “critical access hospital”; and

(iv) in subparagraph (N), (I) in the matter preceding clause (i), by striking “primary care hospitals” and inserting “critical access hospital” and inserting “critical access hospital”.

(L) Section 1866(a)(3) of such Act (42 U.S.C. 1395cc(a)(3)) is amended—

(i) by striking “rural primary care hospital” each place it appears in subparagraphs (A) and (B) and inserting “critical access hospital”; and

(ii) by striking “rural primary care hospitals” each place it appears in subparagraphs (A) and (B) and inserting “critical access hospitals”.

(M) Section 1867(e)(5) of such Act (42 U.S.C. 1395x(u)) is amended by striking “rural primary care hospital” and inserting “critical access hospital”.

(N) Section 1886(c)(1) of such Act (42 U.S.C. 1395x(mm)) is amended—

(i) by striking “rural primary care hospital services” and inserting “critical access hospital services”; and

(ii) by striking “rural primary care hospital services” and inserting “critical access hospital services”.

(P) Section 1888(b)(D)(i) of such Act (42 U.S.C. 1395mm(d)(3)(D)) is amended by striking “outpatient critical access hospital services” and inserting “critical access hospital services”.

(Q) Section 1891(b)(2)(C) of such Act (42 U.S.C. 1395mm(d)(3)(D)) is amended—

(i) in clause (i), by striking “as in effect on September 30, 1995” before the period at the end; and

(ii) in clause (v), by inserting “as in effect on September 30, 1995” after “1820 (i)(1)”; and

(R) by striking “1820(g)” and inserting “1820(e)

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PART B AMENDMENTS RELATING TO CRITICAL ACCESS HOSPITALS.—

(C) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395w(d)(5)(D)) is amended to read as follows:

“(D) During a period beginning on the date of the enactment of this subsection and ending on October 1, 1996, the amount of payment for outpatient critical access hospital services furnished on or after October 1, 1996.

“G) The facility meets such staffing requirements as would apply under section 1864(a)(1), is amended by adding at the end the following new section:

SEC. 502. ESTABLISHMENT OF RURAL EMERGENCY ACCESS HOSPITALS TO MEET HOSPITAL ANTI-DUMPING ACT REQUIREMENTS.

(a) IN GENERAL.—Section 1863 of the Social Security Act (42 U.S.C. 1395cc) is amended by adding at the end the following new section:

“Rural Emergency Access Care Hospital; Rural Emergency Access Hospital Services

“(oo) The term ‘rural emergency access care hospital’, means, for a fiscal year, a facility with respect to which the Secretary finds the following:

“(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

“(B) The facility was a hospital under this Act for the fiscal year ending on the date of the enactment of this subsection (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

“(C) A physician is available on-call to provide emergency medical services on a 24-hour basis.

“(D) The facility meets such staffing requirements as would apply under section 1886(e), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

“(E) There is a practitioner who is qualified to provide advanced cardiac life support services as determined by the State (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

“(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

“(G) The facility meets such staffing requirements as would apply under section 1886(e), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

“(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1886(aa) and of clauses (ii) and (iv) and (v) of section 1886(bb) and of clause (iii) of section 1886(cc) and of paragraphs (C) through (J) of paragraph (2) of section 1886(dd) and of paragraphs (E) and (F) of section 1886(EE).

“(I) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1886(aa) and of clauses (ii) and (iv) and (v) of section 1886(bb) and of clause (iii) of section 1886(cc) and of paragraphs (C) through (J) of paragraph (2) of section 1886(dd) and of paragraphs (E) and (F) of section 1886(EE) as applicable to the facility and the State under the requirements applicable to such facilities under section 1886(e)(2).
Section 1834(g) of such Act (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(a) by redesignating clause (iii) as clause (iv); and

(b) inserting after clause (iii) the following new clause:

``(iv) Under the guidelines published by the Secretary, in the case of a hospital which is identified by the Secretary as a rural referral center under paragraph (5)(C) of the Social Security Act for fiscal year 1997 and each subsequent fiscal year.

Subtitle B—Small Rural Hospital Antitrust Fairness

SEC. 511. ANTITRUST EXEMPTION.

The antitrust laws shall not apply with respect to—

(a) the merger of, or the attempt to merge, 2 or more hospitals,

(b) a contract entered into solely by 2 or more hospitals to allocate hospital services, or

(c) the attempt by only 2 or more hospitals to enter into a contract to allocate hospital services, if each of such hospitals satisfies all of the requirements referred to in section 512 at the time such hospitals engage in the conduct described in paragraph (1), (2), or (3), as the case may be.

SEC. 512. REQUIREMENTS.

The requirements referred to in section 511 are as follows:

(1) The hospital is located outside of a city, or in a city that has less than 150,000 inhabitants, as determined in accordance with the most recent data available from the Bureau of the Census.

(2) The most recently concluded calendar year, the hospital received more than 40 percent of its gross revenue from payments made under Federal programs.

(3) There is in effect with respect to the hospital a certificate issued by the Health Care Financing Administration specifying that such Administration has determined that Federal expenditures would be reduced, consumer costs would not increase, and access to health care services would not be reduced, if the hospital and the other hospitals that requested such certificate merge, or locate the hospital services specified in such request, as the case may be.

SEC. 521. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

(a) General Rule—Gross income shall not include any qualified loan repayment.

(b) Qualified Loan Repayment—For purposes of this section, the term ‘‘qualified loan repayment’’ means any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338(b) of the Public Health Service Act.

(c) Conforming Amendment—Paragraph (3) of section 338(b) of the Public Health Service Act is amended by striking ‘‘Federal, State, or local’’ and inserting ‘‘State or local’’.

(d) Effective Date—The amendments made by this section shall apply to payments made under section 338(g) of the Public Health Service Act after the date of the enactment of this Act.

Mr. Speaker, every single rule the House has adopted this session has been restrictive in the way it was written, but correctly. The Republican House has so far adopted 100 percent restrictive rules in this session. If it is adopted, the rule before us will leave that 100 percent purely restrictive rules record intact.

This is the 65th restrictive rule reported out of the Committee on Rules in this Congress. In addition, 71 percent of the legislation considered this session has not been reported from committee. Ten out of 14 measures brought up this session have been reported. Mr. Speaker, I include the following material for the Record:

FLOOR PROCEDURE IN THE 104TH CONGRESS: COMPILED BY THE RULES COMMITTEE DEMOCRATS

<table>
<thead>
<tr>
<th>Bill No.</th>
<th>Title</th>
<th>Resolution No.</th>
<th>Process used for floor consideration</th>
<th>Amendments in order</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.R. 1*</td>
<td>Compliance with Paperwork Reduction Act</td>
<td>R. Res. 6</td>
<td>Closed</td>
<td>None</td>
</tr>
<tr>
<td>H. Res. 6</td>
<td>Open Print Day Resolution Package</td>
<td>R. Res. 38</td>
<td>Closed contained a closed rule on H.R. 1 within the closed rule</td>
<td>Restrictive: Motion adopted over Democratic objection in the Committee of the Whole to close rule</td>
</tr>
<tr>
<td>H.R. 5*</td>
<td>Unfunded Mandates</td>
<td>R. Res. 36</td>
<td>Closed</td>
<td>Restrictive: Motion adopted over Democratic objection in the Committee of the Whole to close rule</td>
</tr>
<tr>
<td>H. Res. 2*</td>
<td>Balanced Budget</td>
<td>R. Res. 44</td>
<td>Closed</td>
<td>Restrictive: Motion adopted over Democratic objection in the Committee of the Whole to close rule</td>
</tr>
<tr>
<td>H. Res. 3</td>
<td>Committee印ings Scheduling Resolution</td>
<td>R. Res. 10</td>
<td>Restricted only certain subtitles</td>
<td>N/A</td>
</tr>
<tr>
<td>H. Res. 24</td>
<td>To transfer the property of the land to the Taos Pueblo Indians of New Mexico</td>
<td>R. Res. 51</td>
<td>Restricted only in House amendments</td>
<td>N/A</td>
</tr>
<tr>
<td>H. Res. 10</td>
<td>To provide for the exchange of lands within Gates of the Arctic National Wildlife Refuge</td>
<td>R. Res. 47</td>
<td>Restricted in House amendments</td>
<td>2r-40</td>
</tr>
<tr>
<td>H. Res. 43</td>
<td>To provide for the conveyance of lands to certain individuals in Butte County, California</td>
<td>R. Res. 53</td>
<td>Restricted in House amendments</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 2*</td>
<td>Line Item Veto</td>
<td>R. Res. 60</td>
<td>Restricted in House amendments</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 663</td>
<td>Victim Restitution Act of 1995</td>
<td>R. Res. 55</td>
<td>Open</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 666</td>
<td>Executive Reorganization Act of 1995</td>
<td>R. Res. 63</td>
<td>Open</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 667</td>
<td>Violent Crime Incarceration Act of 1995</td>
<td>R. Res. 63</td>
<td>Open</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Subtitle C—Miscellaneous Provisions

SEC. 522. TELEMEDICINE SERVICES.

The Secretary of Health and Human Services shall establish a methodology for making payments under part B of the Medicare program for telemedicine services furnished on an emergency basis to individuals residing in an area designated as a health profession shortage area (under section 332(a)(1) of the Public Health Service Act).

Mr. Speaker, every single rule the House has adopted this session has been restrictive in the way it was written, but correctly. The Republican House has so far adopted 100 percent restrictive rules in this session. If it is adopted, the rule before us will leave that 100 percent purely restrictive rules record intact.
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</thead>
<tbody>
<tr>
<td>H.R. 669</td>
<td>The Criminal Alien Deportation Improvement Act</td>
<td>H. Res. 69</td>
<td>Open; Pre-printing gets preference; Contains self-executing provision</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 728</td>
<td>Local Government Law Enforcement Block Grants</td>
<td>H. Res. 72</td>
<td>Restrictive; 10 hr. Time Cap on amendments; Pre-printing gets preference</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 739</td>
<td>National Security Revitalization Act</td>
<td>H. Res. 83</td>
<td>Restrictive; 10 hr. Time Cap on amendments; Pre-printing gets preference</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 740</td>
<td>Senate Compliance</td>
<td>N/A</td>
<td>Restricted; 8 hr. Time Cap on amendments; Pre-printing gets preference</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 833</td>
<td>To Permanently Extend the Health Insurance Deduction for the Self-Employed</td>
<td>H. Res. 88</td>
<td>Closed; On Suspension Calendar Over Democratic objection</td>
<td>None</td>
</tr>
<tr>
<td>H.R. 839</td>
<td>The Paperwork Reduction Act</td>
<td>H. Res. 91</td>
<td>Restricted; makes in only the Goliath amendment; Waives all points of order; Contains self-executing provision</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 889</td>
<td>Emergency Supplemental/Rescinding Certain Budget Authority</td>
<td>H. Res. 92</td>
<td>Restricted; makes in only the Obey substitute;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 459</td>
<td>Regulatory Moratorium</td>
<td>H. Res. 93</td>
<td>Restrictive; 10 hr. Time Cap on amendments; Pre-printing gets preference</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 926</td>
<td>Regulatory Flexibility</td>
<td>H. Res. 96</td>
<td>Restricted; 10 hr. Time Cap on amendments; Pre-printing gets preference</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 925</td>
<td>Private Property Protection Act</td>
<td>H. Res. 100</td>
<td>Restricted; 12 hr. time cap on amendments; Requires Members to pre-print their amendments in the Record prior to the bill's consideration for amendment, waive germane and budget act points of order as well as points of order concerning appropriating on a legislative bill against the committee substitute submitted as base text.</td>
<td>1D</td>
</tr>
<tr>
<td>H.R. 1058</td>
<td>Securities Litigation Reform Act</td>
<td>H. Res. 104</td>
<td>Restricted; 7 hr. time cap on amendments; Pre-printing gets preference</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1059</td>
<td>Regulatory Flexibility</td>
<td>H. Res. 106</td>
<td>Restricted; makes in only the 12 germane amendments and denies 64 germane amendments from being considered.</td>
<td>8D, TR</td>
</tr>
<tr>
<td>H.R. 1150</td>
<td>Making Emergency Supplemental Appropriations and Rescissions</td>
<td>H. Res. 115</td>
<td>Restricted; Makes in order only 4 amendments considered under a &quot;Queen of the Hill&quot; procedure and denies 21 germane amendments from being considered; The substitutes are to be considered under a &quot;Queen of the Hill&quot; procedure; All points of order are waived against the amendments.</td>
<td>N/A</td>
</tr>
<tr>
<td>H. Res. 73</td>
<td>Term Limits</td>
<td>H. Res. 119</td>
<td>Open;</td>
<td>N/A</td>
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<tr>
<td>H.R. 4</td>
<td>Welfare Reform</td>
<td>H. Res. 123</td>
<td>Open;</td>
<td>N/A</td>
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<td>H.R. 177</td>
<td>Family Privacy Act</td>
<td>H. Res. 125</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 660</td>
<td>Housing for Older Persons Act</td>
<td>H. Res. 126</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1215</td>
<td>The Contract With America Tax Relief Act of 1995</td>
<td>H. Res. 129</td>
<td>Restricted; Self Executes language that makes tax cuts contingent on the adoption of a balanced budget plan and strikes sections 3006. Makes in order only one substitute; Waives all points of order against the bill; substitute made in order as original text.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 483</td>
<td>Medicare Select Extension</td>
<td>H. Res. 130</td>
<td>Restricted; Makes in only 31 perfecting amendments and two substitutes; Denies 130 germane amendments from being considered; The substitutes are to be considered under a &quot;Queen of the Hill&quot; procedure; All points of order are waived against the amendments.</td>
<td>1D, 3R</td>
</tr>
<tr>
<td>H.R. 655</td>
<td>Hydrogen Future Act</td>
<td>H. Res. 136</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1368</td>
<td>Coast Guard Authorization</td>
<td>H. Res. 139</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 961</td>
<td>Clean Water Act</td>
<td>H. Res. 140</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 535</td>
<td>Coming National Fish Hatchery Conveyance Act</td>
<td>H. Res. 144</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 584</td>
<td>Conveyance of the Fairport National Fish Hatchery to the State of Iowa</td>
<td>H. Res. 147</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 614</td>
<td>Conveyance of the New London National Fish Hatchery Production Facility</td>
<td>H. Res. 148</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H. Con. Res. 67</td>
<td>Budget Resolution</td>
<td>H. Res. 149</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1561</td>
<td>American Overseas Interns Act of 1995</td>
<td>H. Res. 155</td>
<td>Open;</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1530</td>
<td>National Defense Authorization Act FY 1996</td>
<td>H. Res. 164</td>
<td>Restricted; Makes in order only the amendments printed in the report; waive all points of order against the substitute; substitute and amendments printed in the report. Gives the Chairman and the floor executives a provision which strikes section 807 of the bill provides for an additional 30 min. of debate on Nunn-Lugar section; Allows Mr. Clinger to offer a modification of his amendment and substitute the committee substitute.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1817</td>
<td>Military Construction Appropriations; FY 1996</td>
<td>H. Res. 167</td>
<td>Open; waives clauses 2 and 6 of rule XXII against the bill; 1 hr. general debate; House passed budget numbers for the fiscal years 1995-96; Waives all points of order against the amendments; Makes in order only 11 amendments; waives sections 302(f) and 508(a) of the Budget Act against the bill and cl. 2 and 6 of rule XXII against the bill. All points of order are waived against the amendments.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1854</td>
<td>Legislative Branch Appropriations</td>
<td>H. Res. 169</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1868</td>
<td>Foreign Operations Appropriations</td>
<td>H. Res. 170</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1905</td>
<td>Energy &amp; Water Appropriations</td>
<td>H. Res. 171</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1869</td>
<td>Foreign Operations Appropriations</td>
<td>H. Res. 172</td>
<td>Open; waive the amendments in the report; waive all points of order against the substitute; make NEA funding subject to House passed authorization; waive clauses 2, 6, 7, and 8 of rule XXII against the bill; amendments printed in order in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1944</td>
<td>Revisions Bill</td>
<td>H. Res. 175</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1866</td>
<td>(2nd rule) Foreign Operations Appropriations</td>
<td>H. Res. 177</td>
<td>Open; waive the amendments in the report; waive all points of order against the substitute; make NEA funding subject to House passed authorization; waive clauses 2, 6, 7, and 8 of rule XXII against the bill; amendments printed in order in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1977</td>
<td><em>Rule Deferred</em> Interior Appropriations</td>
<td>H. Res. 185</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 177</td>
<td>Interior Appropriations</td>
<td>H. Res. 187</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1976</td>
<td>Agriculture Appropriations</td>
<td>H. Res. 188</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 1977</td>
<td>(3rd rule) Interior Appropriations</td>
<td>H. Res. 189</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 2020</td>
<td>Treasury Postal Appropriations</td>
<td>H. Res. 190</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>H.R. 96</td>
<td>Disapproving MPH for China</td>
<td>H. Res. 191</td>
<td>Open; waives clauses 2, 6, 7, and 8 of rule XXII against the bill; makes in order the Gilman amendments; substitute and amendments printed in the report.</td>
<td>N/A</td>
</tr>
<tr>
<td>Bill No.</td>
<td>Title</td>
<td>Resolution No.</td>
<td>Process used for floor consideration</td>
<td>Amendments in order</td>
</tr>
<tr>
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</tr>
<tr>
<td>H.R. 202</td>
<td>Transportation Appropriations</td>
<td>H. Res. 194</td>
<td>Open; waives cl. 3 of rule XII and section 402 (d) of the CBA against consideration of the bill; waives cl. 6 and cl. 2 of rule XXII against provisions in the bill; makes in order the Cline/Solomon amendment waives all points of order against the amendment (Line Item Veto); waives the bill be read by title; Pre-printing gets priority. <strong>RULE MODIFIED</strong></td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 70</td>
<td>Exports of Alaskan North Slope Oil</td>
<td>H. Res. 197</td>
<td>Open; waives all points of order against provisions in the bill; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2076</td>
<td>Commerce, Justice Appropriations</td>
<td>H. Res. 198</td>
<td>Open; waives cl. 2 and cl. 6 of rule XIII against provisions in the bill; Pre-printing gets priority; Provides the bill be read by title.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2099</td>
<td>VA/HUD Appropriations</td>
<td>H. Res. 201</td>
<td>Open; waives cl. 2 and cl. 6 of rule XXII against provisions in the bill; Provides that the amendment in part 1 of the report is the first business, if adopted it will be considered as base text (30 min.); waives all points of order against the King and Davis amendments; Pre-printing gets priority; Provides that the bill be read by title.</td>
<td>N/A.</td>
</tr>
<tr>
<td>S. 21</td>
<td>Termination of U.S. Arms Embargo on Bosnia</td>
<td>H. Res. 204</td>
<td>Restrictive; 3 hours of general debate; Makes in an amendment to be offered by the Minority Leader or a designee (1 hr). If motion to recommit has instructions it can only be offered by the Minority Leader or designee. <strong>RULE MODIFIED</strong></td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2126</td>
<td>Defense Appropriations</td>
<td>H. Res. 205</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; Provides a Senate hook-up w. S. 652.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2127</td>
<td>Labor/HHS Appropriations Act</td>
<td>H. Res. 208</td>
<td>Open; Provides that the first order of business will be the managers amendments (10 min.), if adopted they will be considered as base text; waives cl. 2 and cl. 6 of rule XXII against provisions in the bill; waives all points of order against certain amendments printed in the report; Pre-printing gets priority; Provides the bill be read by title.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2154</td>
<td>Economically Targeted Investments</td>
<td>H. Res. 210</td>
<td>Open; 2 hr of gen. debate; Makes in order the committee substitute as original text. <strong>RULE MODIFIED</strong></td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2155</td>
<td>Intelligence Authorization</td>
<td>H. Res. 212</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2162</td>
<td>Deficit Reduction Lock Box</td>
<td>H. Res. 218</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2167</td>
<td>Federal Acquisition Reform Act of 1995</td>
<td>H. Res. 221</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2245</td>
<td>National Highway System Designation Act of 1995</td>
<td>H. Res. 224</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2274</td>
<td>Reform.</td>
<td>H. Res. 225</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2405</td>
<td>Omnibus Civilian Science Authorization Act of 1995</td>
<td>H. Res. 227</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2425</td>
<td>Medicare Preservation Act</td>
<td>H. Res. 228</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2492</td>
<td>Legislative Branch Appropriations Bill</td>
<td>H. Res. 229</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2493</td>
<td>7 Year Balanced Budget Reconciliation Social Security Taxation Act.</td>
<td>H. Res. 245</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H. Con. Res. 120</td>
<td>7 Year Balanced Budget Reconciliation Social Security Taxation Act.</td>
<td>H. Res. 246</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2345</td>
<td>To Consolidate and Reform Workforce Development and Literacy Programs Act (WCFERS).</td>
<td>H. Res. 222</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2535</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 230</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2586</td>
<td>Temporary Increase in the Statutory Limit on the Public Debt</td>
<td>H. Res. 258</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2595</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 267</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2606</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 273</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2621</td>
<td>Maritime Security Act of 1995</td>
<td>H. Res. 287</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2642</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 233</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2644</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 234</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2645</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 235</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2646</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 236</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2647</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 237</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2648</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 238</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2649</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 239</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2650</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 240</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2651</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 241</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2652</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 242</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2653</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 243</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2654</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 244</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2655</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 245</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
<tr>
<td>H.R. 2656</td>
<td>To Protect Federal Trust Funds</td>
<td>H. Res. 246</td>
<td>Open; waives all points of order against provisions in the bill; waives all points of order against the amendment; waives the bill be read by title; Pre-printing gets priority.</td>
<td>N/A.</td>
</tr>
</tbody>
</table>

**Additional Information:**

- **March 28, 1996**
- **CONGRESSIONAL RECORD — HOUSE**
- **FLOOR PROCEDURE IN THE 104TH CONGRESS; COMPILED BY THE RULES COMMITTEE DEMOCRATS—Continued**
<table>
<thead>
<tr>
<th>Bill No.</th>
<th>Title</th>
<th>Resolution No.</th>
<th>Amendments in order</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.R. 1749</td>
<td>Utah Public Lands Management Act of 1995</td>
<td>H.Res. 303</td>
<td>Open; waives cl 2(10) of rule XI and sections 302(1) and 313(1) of the Budget Act against the bill's consideration. Makes in order the Resources substitute as base text and waives cl 7 of rule XI and sections 302(2) and 306(a) of the Budget Act.</td>
</tr>
<tr>
<td>H.R. 804</td>
<td>Providing for Debate and Consideration of Three Measures Relating to U.S. Troop Deployments in Bosnia.</td>
<td>N/A</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 309</td>
<td>Revised Budget Resolution</td>
<td>H.Res. 309</td>
<td>Closed; in order the House the motion printed in the Rules Committee report; 1 hr. of general debate for minority; if adopted it is considered base text.</td>
</tr>
<tr>
<td>H.R. 558</td>
<td>Texas Low-Level Radiactive Waste Disposal Compact Consent Act</td>
<td>H.Res. 313</td>
<td>Open; pre-printing gets priority.</td>
</tr>
<tr>
<td>H.R. 1643</td>
<td>To authorize the extension of non-discretionary treatment (MN) to the products of Bulgaria.</td>
<td>N/A</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 558</td>
<td>Making continuing appropriations/establishing procedures making</td>
<td>H.Res. 336</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 1358</td>
<td>Convergence of National Marine Fisheries Service Laboratory</td>
<td>H.Res. 338</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 2854</td>
<td>The Agricultural Market Transition Program</td>
<td>H.Res. 366</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 3021</td>
<td>To Guarantee the Continuing Full Investment of Social security and Other Federal Funds in Obligations of the United States.</td>
<td>H.Res. 371</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 3010</td>
<td>A Further Downpayment Toward a Balanced Budget</td>
<td>H.Res. 372</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 2200</td>
<td>The Immigration and National Interest Act of 1995</td>
<td>H.Res. 384</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 165</td>
<td>Making further continuing appropriations for FY 1996</td>
<td>H.Res. 386</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 125</td>
<td>The Gun Crime Enforcement and Second Amendment Restoration Act of 1996</td>
<td>H.Res. 388</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 3136</td>
<td>The Contract With America Advancement Act of 1996</td>
<td>H.Res. 391</td>
<td>NA</td>
</tr>
<tr>
<td>H.R. 3103</td>
<td>The Health Coverage Availability and Affordability Act of 1996</td>
<td>H.Res. 392</td>
<td>NA</td>
</tr>
</tbody>
</table>

| * Contract Bills, 67% restrictive; 33% open. ** All legislation 1st Session, 53% restrictive; 47% open. *** All legislation 2nd Session, 94% restrictive; 6% open. **** All legislation 104th Congress, 65% restrictive; 35% open. ***** NR indicates that the legislation being considered by the House for amendment has not been reported from committee. *****) Restrictive rules are those which limit the number of amendments which can be offered, and include calls of modified open and modified closed rules as well as completely closed rules and rules providing for consideration of the bills in question as opposed to the Committee of the Whole. This definition of restrictive rule is taken from the Republican chart of resolutions reported from the Rules Committee in the 103rd Congress. N/A means not available. |

Mr. GOSS. Mr. Speaker, I yield myself the balance of my time.

The SPEAKER pro tempore. The gentleman from Florida is recognized for 1 minute.

Mr. GOSS. Mr. Speaker, first of all I would like to say that we have considered many amendments in this process and it is quite clear there are many good ideas.

This does not pretend to be comprehensive health care reform. This is very special, and it is meant to be doable and accomplished now, to take a subject we think we can do to make improvement for access and affordability for a great many Americans, to take the bill the Senate has worked on and to make it better here and to send it to the American people. We think that is doable.

We have given the other side two bites at this. We have given them their own substitute and the right to reconmit, of course.

Some have said, "Oh, my gosh; what we need to do here is get back on the health care track." Let me remind you, the health care track of the last 40 years was derailed in a monumental train wreck under the Clinton administration. They cannot even find the evidence for that.

We now have something that is doable today, and all we need to do is get this rule on the floor, have the debate, vote this health care reform, and we come out with more health care opportunities for more Americans than we have today. It is worth doing.

Mr. Speaker, I urge support of the rule.

Mr. Speaker, I move the previous question on the resolution. The SPEAKER pro tempore. The question is on ordering the previous question.

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

Mr. GOSS. 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.

Pursuant to the provisions of clause 5 of rule XV, the chair announces that he will reduce to a minimum of 5 minutes the period of time within which a vote by electronic device, if ordered, will be
taken on the question of agreeing to the resolution.

The vote was taken by electronic device, and there were—yeas 299, nays 186, not voting 16, as follows:

Ms. FURSE and Mr. BALDACCI, Mr. COBURN and Mr. THOMAS of California changed their vote from "yea" to "nay."

So the previous question was ordered. The result of the vote was announced as above recorded.

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

The resolution was agreed to. A motion to reconsider was laid on the table.

A message from the Senate by Mr. Lundenregan, one of its clerks, announced that the Senate has passed without amendment a bill and joint resolution of the House of the following titles:

H.R. 336. An act to provide for enactment of the Senior Citizens' Right to Work Act of 1996, the Line-Item Veto Act, and the Small Business Growth and Fairness Act of 1996, and to provide for a permanent increase in the public debt limit; and

H.J. Res. 108. A joint resolution waiving certain enrollment requirements with respect to two bills of the One Hundred Fourth Congress.

The message also announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two House on the amendment of the Senate to the bill (H.R. 2854) "An act to modify the operation of certain agricultural programs."

HEALTH COVERAGE AVAILABILITY AND AFFORDABILITY ACT OF 1996

Mr. ARCHER. Mr. Speaker, pursuant to House Resolution 392, I call up the bill (H.R. 3103), to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. COMBEST). Pursuant to House Resolution 392, the amendment in the nature of a substitute consisting of the text of H.R. 3106 modified by the amendment specified in part 1 of House Report 104-501 is adopted.

The text of H.R. 3103 consisting of the text of H.R. 3160, as modified, is as follows:

H.R. 3160

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 CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Coverage Availability and Affordability Act of 1996."

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

Sec. 101. Portability of coverage for previously covered individuals.

Sec. 102. Limitation on preexisting condition exclusions; no application to certain newborns, adopted children, and transplants.

Sec. 103. Prohibiting exclusions based on health status and providing for limited coverage periods.

Sec. 104. Enforcement.

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and Individual Markets

PART I—AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

Sec. 131. Guaranteed availability of general coverage in the small group market.

Sec. 132. Guaranteed renewability of group coverage.
PART II—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

Sec. 141. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

Sec. 142. Guaranteed renewability of individual health insurance coverage.

PART III—ENFORCEMENT

Sec. 151. Incorporation of provisions for State enforcement with Federal fallback authority.

Subtitle C—Affordable and Available Health Coverage Through Multiple Employer Pooling Arrangements

Sec. 161. Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions and solvency standards for multiple employer health plans.

PART 7—RULES GOVERNING REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS

Sec. 701. Definitions.

Sec. 702. Clarification of duty of the Secretary to implement provisions of current law providing for exemptions and solvency standards for multiple employer health plans.

Sec. 703. Requirements relating to sponsors, boards of trustees, plan operations.

Sec. 704. Other requirements for exemption.

Sec. 705. Maintenance of reserves.

Sec. 706. Notice requirements for voluntary termination.

Sec. 707. Corrective actions and mandatory termination.

Sec. 708. Additional rules regarding State authority.

Sec. 162. Affordable and available fully insured health coverage through voluntary health insurance associations.

Sec. 163. State authority fully applicable to self-insured multiple employer welfare arrangements providing medical care which are not exempted under new part 7.

Sec. 164. Clarification of treatment of single employer arrangements.

Sec. 165. Clarification of treatment of certain collectively bargained arrangements.

Sec. 166. Treatment of church plans.

Sec. 167. Enforcement provisions relating to multiple employer welfare arrangements.

Sec. 168. Cooperation between Federal and State authorities.

Sec. 169. Filing and disclosure requirements for multiple employer welfare arrangements offering health benefits.

Sec. 170. Single annual filing for all participating employers.

Sec. 171. Effective date; transitional rule.

Subtitle D—Definitions; General Provisions

Sec. 191. Definitions; scope of coverage.

Sec. 192. State flexibility to provide greater protection.

Sec. 193. Effective date.

Sec. 194. Rule of construction.

Sec. 195. Filing requirements to exercise of commerce clause authority.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION; MEDICAL LIABILITY REFORM

Sec. 200. References in title.

Subtitle A—Fraud and Abuse Control Program

Sec. 201. Fraud and abuse control program.

Sec. 202. Medicare integrity program.

Sec. 203. Beneficiary incentive programs.

Sec. 204. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against Federal health care programs.

Sec. 205. Guidance regarding application of health care fraud and abuse sanctions.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

Sec. 211. Mandatory exclusion from participation in Medicare and State health care programs.

Sec. 212. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from Medicare and State health care programs.

Sec. 213. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.

Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.

Sec. 215. Intermediate sanctions for Medicare health maintenance organizations.

Sec. 216. Additional exception to anti-kickback penalties for discounting and managed care arrangements.

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Sec. 611. Long-term care services and insurance.

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TITLE VI—FINANCIAL ASSISTANCE FOR STATES
TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

SEC. 101. PORTABILITY OF COVERAGE FOR PREEXISTING CONDITIONS.

(a) CREDITING PERIODS OF PREVIOUS COVERAGE TOWARD PREEXISTING CONDITION RESTRICTIONS.—The period during which such a person was continuously covered under a group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in subsection (b)(2)) is reduced by the length of the aggregate period of coverage if any defined in subsection (b)(3) applicable to the participant or beneficiary as of the date of commencement of coverage under the plan.

(b) DEFINITIONS AND OTHER PROVISIONS RELATING TO PREEXISTING CONDITIONS.—

(1) PREEXISTING CONDITION.—

(A) IN GENERAL.—For purposes of this subtitle, subject to subparagraph (B), the term “preexisting condition” means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was first received within the 6-month period ending on the day before—

(i) the effective date of the coverage of such participant or beneficiary, or

(ii) the earliest date upon which such coverage could have been effective if there were no waiting period applicable, whichever is earlier.

(B) TREATMENT OF GENETIC INFORMATION.—For purposes of this section, genetic information referred to in a preexisting condition, so long as treatment of the condition to which the information is applicable has not been sought during the 6-month period described in subparagraph (A).

(2) PREEXISTING CONDITION LIMITATION PERIOD.—

For purposes of this subtitle, the term “preexisting condition limitation period” means, with respect to coverage of an individual under a group health plan or health insurance coverage, the period during which benefits with respect to treatment of a condition exist, and are not provided based on the fact that the condition is a preexisting condition.

(3) AGGREGATE PERIOD OF QUALIFIED PRIOR COVERAGE.—

(A) IN GENERAL.—For purposes of this section, the term “aggregate period of qualified prior coverage” means, with respect to coverage of an individual under a group health plan or health insurance coverage offered in connection with a group health plan, the aggregate of the qualified prior coverage periods (as defined in subparagraph (B)) of such individual occurring before the date of such commencement. Such period shall be treated as zero if there is more than a 60-day break in coverage under a group health plan or health insurance coverage offered in connection with such a plan) between the date the most recent qualified coverage period ends and the date of such commencement.

(B) QUALIFIED COVERAGE PERIOD.—

(i) IN GENERAL.—For purposes of this paragraph, subject to subparagraph (c), the term “qualified coverage period” means, with respect to an individual, any period of coverage of the individual under a group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, and includes coverage under a health plan offered under chapter 89 of title 5, United States Code.

(ii) DISREGARDING PERIODS BEFORE BREAKS IN COVERAGE.—Such term does not include any period of a 60-day break in coverage described in subparagraph (A).

(iii) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraphs (A) and (B), a 60-day break in coverage described in subparagraph (A) shall not be considered to be a preexisting condition limitation period that is in a waiting period for any coverage under a group health plan (or for health insurance coverage offered in connection with a group health plan) to be treated as a break in coverage described in subparagraph (B).

(d) ESTABLISHMENT OF PERIOD.—A qualified coverage period with respect to an individual shall be established through presentation of certifications described in subsection (c) or in such other manner as may be specified in regulations to carry out this title.

(2) CERTIFICATIONS OF COVERAGE; CONFORMING COVERAGE.

(A) IN GENERAL.—The plan administrator of a group health plan, or the insurer or HMO offering health insurance coverage in connection with a group health plan, shall, on request made on behalf of an individual covered under the plan and insurer or HMO the plan statement of the effect of this election; and make such election and shall include a description of the effect of this election.

(B) ALTERNATIVE METHOD.—Such a plan, insurer, or HMO may elect to make such determination on a benefit-specific basis for all participants and beneficiaries and not to include as a qualified coverage period with respect to a specific benefit coverage during a previous period unless such previous coverage for that benefit was included at the end of the most recent period of coverage. In the case of such an election—

(i) the plan, insurer, or HMO shall prominently state in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment under the plan (or at the time of renewal of such insurance coverage is offered for sale in the group health market) that the plan or coverage has made such election and shall include a description of the effect of this election; and

(ii) upon the request of the plan, insurer, or HMO, the entity providing a certification under section 103(e), the term “aggregate period of qualified prior coverage” means, with respect to an individual, any period of coverage under a group health plan or health insurance coverage that is in connection with a group health plan, or insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, and an insurer or HMO of otherwise becomes covered under health insurance coverage or (covered for medical assistance under title XIX of the Social Security Act).

(2) LOSS OF BREAK IN COVERAGE.—A period for which a participant or beneficiary first becomes eligible for coverage under the plan and shall run concurrently

(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—

(a) IN GENERAL.—Subject to paragraph (2), a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, and an insurer or HMO of otherwise becomes covered under health insurance coverage (or covered for medical assistance under title XIX of the Social Security Act).

(b) LOSS OF BREAK IN COVERAGE.—A period for which a participant or beneficiary first becomes eligible for coverage under the plan and shall run concurrently

(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—For purposes of this section, pregnancy shall not be treated as a preexisting condition.

(d) ELIGIBILITY PERIOD IMPOSED BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION LIMITATION.—A health maintenance organization (as defined in section 1851) offering health insurance coverage in connection with a group health plan and which does not use the preexisting condition limitations allowed under this section and which provides health insurance coverage under such a plan shall not impose an eligibility period for such coverage option, but only if such period does not exceed—

(1) 90 days, in the case of a participant or beneficiary whose initial coverage commenced on or before the date of adoption beginning at the time of adoption or placement if the individual, within the 30-day period beginning on the date of adoption or placement.

(2) Such term means such a person terminates upon the term of such an election—

(i) shall provide to disclose to the requesting plan, insurer, or HMO the plan statement (insofar as it relates to health benefits under the plan) or any other detailed benefit information on the benefits under the plan that is otherwise covered under the plan, and

(ii) may charge for the reasonable cost of providing such information.

SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLUSIONS; NO APPLICATION TO CERTAIN NEWBORNS, ADOPTED OFFSPRING, AND PREGNANCY.

(a) LIMITATION OF PERIOD.—

(i) IN GENERAL.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as described in subsection (b)(2)) does not exceed 12 months, counting from the effective date of coverage.
with any other applicable waiting period under the plan.

SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH STATUS AND PROVIDING FOR ENROLLMENT PERIODS.

(a) Prohibition of Exclusion of Participants or Beneficiaries Based on Health Status—

(1) In general.—A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not require a participant or beneficiary under the terms of such plan or coverage based on health status (as defined in section 191(c)(6)).

(2) Construction.—Nothing in this subsection shall be construed as preventing the establishment of preexisting condition limitations and restrictions to the extent consistent with the provisions of this subtitle.

(b) Prohibition of Discrimination in Premium Contributions of Individual Participants or Beneficiaries Based on Health Status.—

(1) In general.—A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not require a participant or beneficiary under the terms of such plan or coverage based on health status (as defined in section 191(c)(6)).

(2) Construction.—Nothing in this subsection shall be construed as preventing the establishment of preexisting condition limitations and restrictions to the extent consistent with the provisions of this subtitle.

(c) Enrollment of Eligible Individuals Who Lose Other Coverage.—A group health plan shall permit an uncovered employee who is otherwise eligible for coverage under the terms of the plan (or an uncovered dependent, as defined under the terms of the plan, of such an employee, if family coverage is available) to enroll for coverage under the plan during a period of at least one benefit option if each of the following conditions is met:

(1) The employee or dependent was covered under a group health plan or health insurance coverage offered in connection with such a plan from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, or

(2) To prevent such a plan, insurer, or HMO from varying the premiums or contributions required of participants or beneficiaries based on factors (such as scope of benefits, geographic location, age, or wage levels) that are not directly related to health status.

(d) Enrollment of Eligible Individuals Who Lose Other Coverage.—A group health plan shall permit an uncovered employee who is otherwise eligible for coverage under the terms of the plan (or an uncovered dependent, as defined under the terms of the plan, of such an employee, if family coverage is available) to enroll for coverage under the plan during a period of at least one benefit option if each of the following conditions is met:

(1) The employee or dependent was covered under a group health plan or health insurance coverage offered in connection with such a plan from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, or

(2) To prevent such a plan, insurer, or HMO from varying the premiums or contributions required of participants or beneficiaries based on factors (such as scope of benefits, geographic location, age, or wage levels) that are not directly related to health status.

(3) The employee or dependent lost other coverage under a group health plan or health insurance coverage (as a result of loss of eligibility for the coverage, termination of employment, or reduction in the number of hours worked), or

(4) The employee requests such enrollment within 30 days after the date of termination of such coverage.

(4) Family Coverage and Group Health Plans.—

(A) In general.—If a group health plan makes family coverage available, the plan may not require, as a condition of coverage of an individual as a dependent (as defined under the terms of the plan) of a participant in the plan, a waiting period applicable to the coverage of such dependent who—

(A) is a newborn,

(B) is an adopted child or child placed for adoption (within the meaning of section 102(b)(3)), at the time of adoption or placement, or

(C) is a spouse, at the time of marriage, if the participant has met any waiting period applicable to the coverage of such spouse.

(B) Timely enrollment.—(A) In general.—Enrollment of a participant’s beneficiary described in paragraph (1) shall be timely if a request for enrollment is made within 30 days of the date family coverage is first made available or, in the case described in—

(i) paragraph (1)(A), within 30 days of the date of the birth,

(ii) paragraph (1)(B), within 30 days of the date of the adoption or placement for adoption, or

(iii) paragraph (1)(C), within 30 days of the date of the marriage with such a beneficiary who is the spouse of the participant, if family coverage is available as of such date.

(C) Coverage.—If available coverage includes family coverage and enrollment is made under such timely basis under subparagraph (A), the coverage shall become effective not later than the first day of the first month beginning 15 days after the date the completed request for enrollment is received.

(e) Multiemployer Plans, Multiple Employer Health Plans, and Multiple Employer Welfare Arrangements.—

(A) Employer Welfare Arrangements.—A group health plan which is a multi-employer plan, a multiple employer health plan (as defined in section 701(b) of the Employee Retirement Income Security Act of 1974), or a multiple employer welfare arrangement (to the extent to which benefits under the arrangement consist of medical care) may not deny an employee whose employers are covered under such a plan or arrangement continued access to the same or different coverage under the terms of such a plan or arrangement, other than—

(1) for nonpayment of contributions,

(2) for fraud or other intentional misrepresentation of material fact by the employer, or

(3) for noncompliance with material plan or arrangement provisions,

(b) Employer Welfare Arrangements.—A group health plan which is a multi-employer plan, a multiple employer health plan (as defined in section 701(b) of the Employee Retirement Income Security Act of 1974), or a multiple employer welfare arrangement (to the extent to which benefits under the arrangement consist of medical care) may not deny an employee whose employers are covered under such a plan or arrangement continued access to the same or different coverage under the terms of such a plan or arrangement, other than—

(1) for nonpayment of contributions,

(2) for fraud or other intentional misrepresentation of material fact by the employer, or

(3) for noncompliance with material plan or arrangement provisions.

(c) Employer Welfare Arrangements.—A group health plan which is a multi-employer plan, a multiple employer health plan (as defined in section 701(b) of the Employee Retirement Income Security Act of 1974), or a multiple employer welfare arrangement (to the extent to which benefits under the arrangement consist of medical care) may not deny an employee whose employers are covered under such a plan or arrangement continued access to the same or different coverage under the terms of such a plan or arrangement, other than—

(1) for nonpayment of contributions,

(2) for fraud or other intentional misrepresentation of material fact by the employer, or

(3) for noncompliance with material plan or arrangement provisions.

(d) Disability Benefits.—

(E) Liability for Tax.—Paragraph (2) of subsection (e) shall not apply.

(2) Deferred to State Regulation.—No tax shall be imposed on a failure to meet the requirements of such section on any failure to meet the requirements of such section on any failure to meet the requirements of such section on any failure to meet the requirements of such section on any failure to meet the requirements of such section on any failure to meet such requirement if the failure is solely because of the product offered by the insurer or organization under such contract.

(3) Limitation on Imposition of Tax.—In no case shall a tax be imposed by this section on a failure to meet such a requirement if—

(A) a civil money penalty has been imposed by the Secretary of Labor under part 5 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 with respect to such failure, or

(B) a civil money penalty has been imposed by the Secretary of Health and Human Services, or the Secretary of the Treasury, with respect to any individual.''

(2) Notice Requirement.—Section 4980B(f)(6)(A) of such Code is amended by inserting before the period at the end thereof—"and subject to the requirements of—".
Act of 1974 for purposes of applying such title.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—The Secretary of Labor shall enforce each subsection referred to in paragraph (1) with respect to any entity which is an insurer or health maintenance organization regulated by a State only if the Secretary of Labor determines that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

(3) LIMITATIONS ON LIABILITY.—

(A) GENERAL.—No liability shall be imposed under this subsection on the basis of any failure during any period for which it is established to the satisfaction of the Secretary of Labor that none of the persons against whom the liability would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(B) NO APPLICATION WHERE FAILURE CORRECTED WITHIN 30 DAYS.—No liability shall be imposed on the basis of any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the liability would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(4) AVOIDING DUPLICATION OF CERTAIN PENALTIES.—In no case shall a civil money penalty be imposed under the authority provided for in paragraph (1) for a violation of this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or a civil money penalty imposed under the authority provided under subsection (c).

(c) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPOSITION.—Subject to the succeeding provisions of this subsection, any group health plan, insurer, or organization that fails to meet a requirement of this subtitle (other than section 103(e)) is subject to a civil money penalty under this section.

(B) LIABILITY FOR PENALTY.—Rules similar to the rules described in section 4980B(e) of the Internal Revenue Code of 1986 shall apply to civil money penalties for a tax imposed under section 4980B(a) of such Code as apply to liability for a penalty imposed under subparagraph (A).

(2) PAYMENT OF PENALTY.

(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary of Health and Human Services shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this subtitle, the gravity of the violation, and the overall limitations for unintentional failures provided under section 4980B(c)(4) of the Internal Revenue Code of 1986.

(3) LIMITATIONS.

(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed on any failure to apply for coverage under section 4980B(c)(4) of the Internal Revenue Code of 1986 if the person being assessed with the penalty would not have known, or exercising reasonable diligence would have known, that such failure existed.

(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(4) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 755 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of modification or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of such judge. A final order imposing the penalty shall be subject to review only as provided under subparagraph (D).

(E) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any person against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such person is located or the United States District Court for the district in which such person resides, if a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary.

(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(iv) APPEAL.—Any final decision, order, or assessment of a civil money penalty concerning such review shall be subject to appeal as provided in chapter 13 of title 28 of such Code.

(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION FOR REVIEW.—

(i) FAILURE TO PAY ASSESSMENT.—If any person fails to pay an assessment after it has become a final and unappealable order, the Secretary shall take such action as shall be determined.

(ii) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(G) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—Paragraph (1) shall not have the force and effect of law unless the provisions of section 101, 102, or 103 (other than section 103(e)) with respect to any entity which offers health insurance coverage and which is an insurer or HMO regulated by a State only if the Secretary of Health and Human Services has determined that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

(3) NONDUPlication OF SANCTIONS.—In no case shall a civil money penalty be imposed under this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or for which a civil money penalty has been imposed under the authority provided under subsection (b).

(d) COORDINATION IN ADMINISTRATION.—The Secretary of the Treasury, Labor, and Health and Human Services shall issue regulations that are nonduplicative to carry out this subtitle. Such regulations shall be issued in a manner that assures coordination and nonduplication in their activities under this subtitle.

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and Individual Markets

PART 1—Availability of Group Health Insurance Coverage

SEC. 131. GUARANTEED AVAILABILITY OF GENERAL COVERAGE IN THE SMALL GROUP MARKET.

(a) ISSUANCE OF COVERAGE.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, each insurer or HMO that offers health insurance coverage in the small group market in a State—

(A) must accept every small employer in the State that applies for such coverage; and

(B) must accept every small employer that applies for enrollment during the initial period in which the individual is in the service area for such plan or HMO; and

(C) may not restrict the eligibility of individuals.

(2) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term "eligible individual" means, with respect to an insurer or HMO that offers health insurance coverage to any small employer in the small group market, any individual who is an employee of the employer as shall be determined—

(A) in accordance with the terms of such plan;

(B) as provided by the insurer or HMO under rules of the insurer or HMO which are uniformly applicable, and

(C) in accordance with all applicable State laws governing such insurer or HMO.

(b) SPECIAL RULES FOR NETWORK PLANS AND HMOs.—

(1) IN GENERAL.—In the case of an insurer that offers health insurance coverage in the small group market through a network plan and in the case of an HMO that offers health insurance coverage in such a manner, the insurer or HMO may—

(A) limit the employers that may apply for such coverage to those with eligible individuals whose place of employment is in the service area for such plan or HMO; and

(B) limit the individuals who may be enrolled under such coverage to those whose place of residence or employment is in the service area for such plan or HMO.

(2) WITHIN THE SERVICE AREA OF SUCH PLAN OR HMO, DENY SUCH COVERAGE TO SUCH EMPLOYERS OR INDIVIDUALS—

(A) WHERE THE INSURER OR HMO MAKES SUCH DETERMINATION; and

(B) TO SUCH EMPLOYERS OR INDIVIDUALS IN SUCH CIRCUMSTANCES.
existing group contract holders and enrollees, and
(ii) it is applying this paragraph uniformly to all employers and to the claims experience of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(1) 30-DAY SUSPENSION UPON DENIAL OF COVERAGE. — An insurer or HMO upon denying health insurance coverage in any service area in accordance with paragraph (1)(C), may deny coverage in the small group market within such service area for a period of 30 days after such coverage is denied.

(c) Special Rule for Financial Capacity Limitations.

(1) IN GENERAL.—An insurer or HMO may deny health insurance coverage in the small group market if the insurer or HMO demonstrates to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage, and

(B) it is applying this paragraph uniformly to all employers without regard to the claims experience or duration of coverage of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(2) 30-Day Suspension upon Denial of Coverage. — An insurer or HMO upon denying health insurance coverage in connection with group health plans in any service area in accordance with paragraph (1) may not offer coverage in connection with group health plans in the small group market within such service area for a period of 30 days after such coverage is denied.

(3) Exception to Requirement for Issuance of Coverage by Reason of Failure by Plan to Meet Certain Minimum Participation or Contribution Rules.

(A) In General.—Paragraph (a) shall not apply in the case of any group health plan with respect to which—

(i) participation rules of an insurer or HMO which are described in paragraph (2) are not met, or

(ii) contribution rules of an insurer or HMO which are described in paragraph (3) are not met.

(B) Participation Rules.—For purposes of paragraph (1)(A), participation rules (if any) of an insurer or HMO shall be treated as met with respect to the group health plan if—

(i) such rules are uniformly applicable and in accordance with applicable State law and the number or percentage of eligible individuals with respect to whom participation rules are applicable equals or exceeds a level which is determined in accordance with such rules.

(C) Contribution Rules.—For purposes of paragraph (1)(B), contribution rules (if any) of an insurer or HMO shall be treated as met with respect to a group health plan only if such rules are in accordance with applicable State law.

SEC. 132. GUARANTEED RENEWABILITY OF GROUP COVERAGE.

(a) In General.—Except as provided in this section, an insurer or health maintenance organization offers health insurance coverage in the small or large group market, the insurer or organization must renew or continue in force such coverage at the option of the employer.

(b) General Exceptions.—An insurer or organization may nonrenew or discontinue health insurance coverage only—

(i) if the insurer or organization acts uniformly without regard to the claims experience of employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(C) in exercising the option to discontinue coverage of this type and in offering one or more other types of health insurance coverage to the employees and beneficiaries covered under such coverage within a period of at least 60 days prior to the date of the discontinuation of such coverage;

(b) the insurer or organization offers to each employer in the small employer or large employer market provided coverage of this type, the option to purchase any other health insurance coverage currently being offered by the insurer or organization for employers in such market; and

(c) in exercising the option to discontinue coverage of this type and in offering one or more other types of health insurance coverage to the employees and beneficiaries covered under such coverage within a period of at least 60 days prior to the date of the discontinuation of such coverage.

(2) Discontinuance of All Coverage.

(A) In General.—Subject to subparagraph (C), in any case in which an insurer or HMO elects to discontinue all health insurance coverage in the small group market or the large group market, or both markets, in a State, the insurer or organization may be deemed by the applicable State authority to have discontinued by the insurer or organization only if—

(i) the insurer or organization provides notice to the applicable State authority and to each employer (and participants and beneficiaries covered under such coverage) of such discontinuation at least 60 days prior to the date of the discontinuation of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market (or any successor program), including such coverage toward the new coverage's preexisting condition exclusion period (if any) in a manner consistent with subsection (b)(3).

(B) Exception for Uniform Modification of Coverage.—At the time of coverage renewal, an insurer or HMO may modify the coverage offered to a group health plan in the group health market so long as such modification is effective on a uniform basis in all group health plans with the same type of coverage.

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

SEC. 134. GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE.

(a) Goals.—The goals of this section are—

(1) to guarantee that any qualifying individual (as defined in subsection (b)(1)) is able to obtain qualifying coverage (as defined in subsection (b)(2)); and

(2) to assure that qualifying individuals obtaining such coverage receive credit for their prior coverage toward the new coverage's preexisting condition exclusion period (if any) in any plan consistent with subsection (b)(3).

(b) Qualifying Individual and Health Insurance Coverage Defined.—In this section—

(1) Qualifying Individual.—The term "qualifying individual" means an individual—

(A)(i) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the qualified coverage periods (as defined in section 101(b)(3)(B)) is 18 or more months and (ii) whose most recent prior coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with such plan);

(2) Qualifying Coverage.—The term "qualifying coverage" means, with respect to an insurer or HMO in the State during the previous year (not including coverage issued under this section), or

(A) the health insurance coverage in connection with such employer or HMO in the State during the previous year (not including coverage issued under this section)

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as elected by the plan or by the State under subsection (c)(1).

(b) Assumptions.—For purposes of subparagraph (A), the actuarial value of benefits provided or underwritten by the coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(3) PREVIOUS COVERAGE.—Credit is consistent with this paragraph only if any preexisting condition exclusion period is reduced at least to the extent such a period would be reduced if the coverage under this section were under a group health plan to which section 101(a) applies. In carrying out provisions similar to the provisions of section 101(c) shall apply.

(c) Optional State Establishment of Mechanisms to Achieve Goals of Guaranteeing Availability of Coverage.—

(1) IN GENERAL.—Any State may establish, to the extent of the State’s authority, public or private mechanisms reasonably designed to meet the goals specified in subsection (a), that a State implements such a mechanism by the deadline specified in paragraph (4), the State may elect to have such mechanisms apply instead of having subsection (d)(3) apply in the State. An election under this paragraph shall be by notice from the chief executive officer of the State to the Secretary of Health and Human Services on a timely basis consistent with the deadlines specified in paragraph (4). In establishing what constitutes such a mechanism under this subsection, a State may exercise the election described in subsection (b)(2)(A) with respect to each insurer or HMO in the State (or on a collective basis after exercising such election for each such insurer or HMO).

(2) TYPES OF MECHANISMS.—State mechanisms under this subsection may include one or more (or a combination) of the following:

(A) Health insurance coverage pools or programs authorized or established by the State.

(B) Mandatory group conversion policies.

(C) Guaranteed issue of one or more plans providing individual health insurance coverage to qualifying individuals.

(D) Open enrollment by one or more insurers or HMOs.

The mechanisms described in the previous sentence are not an exclusive list of the mechanisms (or combinations of mechanisms) that may be used under this subsection.

(3) SAFE HARBOR FOR BENEFITS UNDER CURRENT RISK POOLS.—In the case of a State that has a health insurance coverage pool or risk pool in effect on March 12, 1996, and that implements the mechanism described in paragraph (2)(A), the benefits under such mechanism (or benefits the actuarial value of which is not less than the actuarial value of such current benefits, using the assumptions described in subsection (b)(2)(B)) are deemed, for purposes of this section, to constitute qualified individual health insurance.

(4) DEADLINE FOR STATE IMPLEMENTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the deadline under this paragraph is July 1, 1997.

(B) EXTENSION TO PERMIT LEGISLATION.—The deadline under this paragraph is July 1, 1998, in the case of a State whose legislature has not enacted any mechanism for the protection of individuals with preexisting condition exclusion at any time between January 1, 1997, and June 30, 1997.

(3) Construction.—Nothing in this section shall be construed as preventing a State from—

(i) implementing guaranteed availability mechanisms before the deadline.

(ii) implementing such mechanisms that are in effect before the date of the enactment of this Act,

(iii) offering guaranteed availability of coverage that is not qualifying coverage, or

(iv) offering guaranteed availability of coverage to individuals who are not qualifying individuals.

(d) Fallback Provisions.—

(1) No State Election.—If a State has not provided notice to the Secretary of an election under paragraph (c), the Secretary shall notify the State that paragraph (3) will be applied in the State.

(2) Preliminary Determination After State Election.—

(A) A State has provided notice of an election on a timely basis under subsection (c), and

(B) The Secretary finds, after consultation with the chief executive officer of the State and the insurance commissioner or chief insurance regulatory official of the State, that such a mechanism (for which notice was provided) is not reasonably designed to meet the goals specified in subsection (a), the Secretary shall notify the State of such preliminary determination, and the consequences under paragraph (3) of a failure to implement such a mechanism, and permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) designed to meet the goals specified in subsection (a). The Secretary shall not make such a determination unless the mechanism is not reasonably designed to meet the goals specified in subsection (a). The Secretary shall not make such a determination unless the mechanism is not reasonably designed to meet the goals specified in subsection (a). The Secretary shall not make such a determination unless the mechanism is not reasonably designed to meet the goals specified in subsection (a).

(3) Description of Fallback Mechanism.—As provided under subsection (c) and subject to paragraph (5), each insurer or HMO in the State involved that issues individual health insurance coverage—

(A) shall offer health insurance coverage, in which qualifying individuals obtaining such coverage receive credit for their prior coverage toward the new coverage’s preexisting condition exclusion period if any in a manner consistent with subsection (b)(3), to each qualifying individual in the State, and

(B) may not decline to issue such coverage to such an individual based on health status (except as permitted under paragraph (4)).

(4) Application of Network and Capacity Limitations.—Under provisions of subsections (b) and (c) of section 131 shall apply to an individual in the individual health insurance market under this subsection in this provision, they apply under section 131 to an employer in the small group market.

(5) Termination of Fallback Mechanism.—The provisions of this subsection shall cease to apply to a State if the Secretary finds that a State has implemented a mechanism that is reasonably designed to meet the goals specified in paragraph (3) and, until the Secretary finds that such mechanism is no longer being implemented.

(c) Guaranteeing Renewability of Individual Health Insurance Coverage.—

(1) Guaranteed Renewability.—Subject to the succeeding provisions of this section, an insurer or HMO that provides individual health insurance coverage to an individual shall renew or continue such coverage at the option of the individual.

(2) Nonrenewal Permitted in Certain Cases.—An insurer or HMO may nonrenew or discontinue individual health insurance coverage only on the grounds that the insurer or organization has not failed to receive timely premium payments.

(3) Fraud.—The individual has made an intentional misrepresentation of material fact under the terms of the coverage.

(4) Termination of Coverage.—Subject to subsection (c), the insurer or HMO is ceasing to offer health insurance coverage in the individual market in a State (or, in the case of a network plan or HMO, in a geographic area).

(5) Movement Outside Service Area.—The individual has changed residence and resides outside the service area of the insurer or organization or outside the area for which the insurer or organization is authorized to do business.

(6) Premium Payments.—Nothing in this section shall apply to an insurer or HMO only if it is applied uniformly without regard to the claims experience of employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(7) Termination of Individual Coverage.—The provisions of section 132(c) shall apply to this section in the same manner as they apply under section 132, except that any reference to an employer or market is deemed a reference to the covered individual or the individual market region.

(d) Exception for Uniform Modification of Coverage.—The provisions of section 131(c) shall not apply to a State with respect to insurers offering health insurance coverage in the individual market in any section in the same manner as they apply to health insurance coverage offered in connection with a group health plan in the group market under such section.

PART 3—Enforcement


The provisions of paragraphs (1) and (2) of section 101(c) shall apply to enforcement of the requirements in each of part 1 or part 2 with respect to insurers and HMOs regulated by a State in the same manner as such provisions apply to enforcement of the requirements in section 101, 102, or 103 with respect to insurers and HMOs regulated by a State.
SUBTITLE C—AFFORDABLE AND AVAILABLE HEALTH
COVERAGE THROUGH MULTIPLE EMPLOYER POOLING
ARRANGEMENTS

SEC. 161. CLARIFICATION OF DUTY OF THE SEC-
RETARY TO IMPLEMENT PROVISIONS OF CURRENT LAW
PROVIDING FOR EXEMPTIONS AND SOL-
VENCY STANDARDS FOR MULTIPLE EMPLOYER
HEALTH PLANS.

(a) RULES GOVERNING REGULATION OF MULT-
IPLE EMPLOYER ARRANGEMENTS.—The
Secretary, by regulation, may prescribe reg-
ulations for the purpose of implementing sec-
tion 514(b)(6) of title I of the Employee Retire-
ment Income Security Act of 1974 (as amended
by the preceding provisions of this title), that
are in addition to the regulations prescribed
pursuant to paragraph (1), a multiple em-
ployer welfare arrangement described in
section 514(b)(6)(B) of title I of the Employee

(2) IN GENERAL.—The term ‘insurer’ means an
insurer, an insurance company, an insurance
organization, or a plan that establishes or
maintains the arrangement.

(b) TREATMENT UNDER PREEMPTION RULES.

(1) IN GENERAL.—The term ‘employee benefit
plan’ means a multiple employer welfare
arrangement described in section 514(b)(6)(B) of
title I of the Employee Retirement Income

(2) TREATMENT OF MULTIPLE EMPLOYER
HEALTH PLAN.

(a) TREATED AS EMPLOYEE WELFARE
BENEFIT PLAN WHICH IS A GROUP HEALTH
PLAN.—

(1) IN GENERAL.—A multiple employer
welfare arrangement—

(A) under which the benefits consist sole-
lly of medical care (disregarding such inci-
dental benefits as the Secretary shall specify
by regulation), and

(B) under which some or all benefits are
not fully insured,

shall be treated for purposes of subtitle A
and the other parts of this title as an em-
ployee welfare benefit plan which is a group
health plan if the arrangement is exempt
under section 514(b)(6)(B) of title I of the
Employee Retirement Income Security Act of
1974 (as amended by the provisions of this
part).

(2) EXCEPTION.—In the case of a multiple
employer welfare arrangement which would be
described in clause (i) of paragraph (1) and
had not been denied an exemption, the Secret-
ary shall provide written notice to the
arrangement and contract administrators
and other service providers of the reason
for denying the exemption.

(3) TREATMENT OF MULTIPLE EMPLOYER
HEALTH ARRANGEMENTS.

(a) TREATED AS EMPLOYEE WELFARE
BENEFIT PLAN WHICH IS A GROUP HEALTH
PLAN.—

(1) IN GENERAL.—A multiple employer
welfare arrangement—

(A) under which the benefits consist sole-
lly of medical care (disregarding such inci-
dental benefits as the Secretary shall specify
by regulation), and

(B) under which some or all benefits are
not fully insured,

shall be treated for purposes of subtitle A
and the other parts of this title as an em-
ployee welfare benefit plan which is a group
health plan if the arrangement is exempt
under section 514(b)(6)(B) of title I of the
Employee Retirement Income Security Act of
1974 (as amended by the provisions of this
part).

(2) EXCEPTION.—In the case of a multiple
employer welfare arrangement which would be
described in clause (i) of paragraph (1) and
had not been denied an exemption, the Secret-
ary shall provide written notice to the
arrangement and contract administrators
and other service providers of the reason
for denying the exemption.
The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, an annual report.

"SEC. 703. REQUIREMENTS RELATING TO SPONSORS, BOARDS OF TRUSTEES, AND PLAN OPERATIONS."

"(a) In General.—A complete application for a exemption under section 514(b)(6)(B) shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

(1) The sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years before the date of the application for exemption, a continuing and substantial entity which has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such person, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement may be a member of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(2) Governing instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B), the joint board of trustees shall be the sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(3) The board of trustees or the single employer or the group of employers described in paragraph (2) has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such person, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement may be a member of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(4) Governing instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B), the joint board of trustees shall be the sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(5) The board of trustees or the single employer or the group of employers described in paragraph (2) has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such person, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement may be a member of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(6) Governing instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B), the joint board of trustees shall be the sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(7) The board of trustees or the single employer or the group of employers described in paragraph (2) has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such person, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement may be a member of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(8) Governing instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B), the joint board of trustees shall be the sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(9) The board of trustees or the single employer or the group of employers described in paragraph (2) has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such person, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement may be a member of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(10) Governing instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B), the joint board of trustees shall be the sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(11) The board of trustees or the single employer or the group of employers described in paragraph (2) has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such person, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement may be a member of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(12) Governing instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B), the joint board of trustees shall be the sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(13) The board of trustees or the single employer or the group of employers described in paragraph (2) has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such person, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement may be a member of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(14) Governing instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B), the joint board of trustees shall be the sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.

(15) The board of trustees or the single employer or the group of employers described in paragraph (2) has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such person, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement may be a member of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for exemption under section 514(b)(6)(B) and to contract with a service provider to administer the day-to-day affairs of the arrangement.
"(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to as "the Plan Administrator"), and

"(B) provides that the sponsor of the arrangement is to serve as plan sponsor (referred to in section 3(16)(B)), and

"(C) incorporates the requirements of section 705.

"(2) CONTRIBUTIONS.—The contribution rates referred to in section 702(b)(3)(B) are described as

"(3) REGULATORY REQUIREMENTS.—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the provisions of this part.

"SEC. 705. MAINTENANCE OF RESERVES.

"(a) IN GENERAL.—Each multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) and under which benefits are not fully insured shall establish and maintain reserves, consisting of—

"(1) a reserve sufficient for unearned contributions;

"(2) a reserve sufficient for benefit liabilities which have been incurred, which have not been determined, or which a State provides that the arrangement has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

"(3) a reserve, in an amount recommended by the qualified actuary, for any other obligations of the arrangement.

"(b) DEFICIENCY AS TO CERTAIN RESERVES.—The total of the reserves described in subsection (a)(2) shall not be less than an amount equal to the greater of—

"(1) one percent of expected incurred claims and expenses for the plan year, or

"(2) $400,000.

"(c) REQUIRED MARGIN.—In determining the amounts of reserves required under this section in connection with any multiple employer welfare arrangement, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such arrangement.

"(d) ADDITIONAL REQUIREMENTS.—The Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary considers appropriate, and in any case may provide, by regulation or otherwise, with respect to any arrangement or any class of arrangements.

"(e) REQUIREMENTS FOR EXCESS/STOP LOSS COVERAGE.—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such arrangement or arrangements.

"(f) ALTERNATIVE MEANS OF COMPLIANCE.—The Secretary may permit an arrangement to substitute, for all or part of the requirements of this section, such security, guaranty, hold-harmless arrangement, or other financial arrangement as the Secretary determines, if the committee or arrangement or arrangement committee to fully meet all its financial obligations on a timely basis. The Secretary may take into account, for purposes of this subsection, evidence provided by the arrangement or sponsor which demonstrates an assumption of liability with respect to the arrangement. Such evidence may include, but are not limited to, guaranteed issue of insurance, bonding, insurance, letter of credit, recourse under applicable terms of the arrangement in the case of self-funding participants of participating employers, security, or other financial arrangements.

"SEC. 706. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

"Except as provided in section 707(b), a multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) may terminate only if the board of trustees—

"(1) not less than 60 days before the proposed termination date, provides to the participating and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date.

"(2) develops a plan for winding up the affairs of the arrangement in connection with such termination in a manner which will result in the resolution of benefits for which the arrangement is obligated, and

"(3) submits such plan in writing to the Secretary.

"Actions required under this paragraph shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

"SEC. 707. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—A multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) shall continue to meet the requirements of section 705, irrespective of whether such exemption continues in effect. The board of trustees of such arrangement shall determine quarterly whether the requirements of section 705 are being met. If the committee determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination, the committee shall—

"(i) promptly report to the Secretary, in such form and manner as the Secretary may prescribe by regulation, such determination to the committee; and

"(ii) upon such determination, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 705.

"(b) MANDATORY TERMINATION.—In any case in which—

"(1) the Secretary has been notified under subsection (a) of a failure of a multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) to meet the requirements of section 705 and has not been notified by the board of trustees of the arrangement that corrective action has been restored, the committee shall—

"(i) promptly report to the Secretary, in such form and manner as the Secretary may prescribe by regulation, such determination to the committee; and

"(ii) upon such determination, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with such requirements, and

"(2) the Secretary determines that the continuing failure to meet the requirements of section 705 can be reasonably expected to result in a continuing failure to pay benefits for which the arrangement is obligated, the board of trustees of the arrangement shall—

"(i) upon such determination, and in the course of the termination, take such actions as the Secretary may require, including recovering contributions through the application of the provisions of this part referred to in section 705(f), as necessary to ensure that the affairs of the arrangement will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the arrangement is obligated.

"SEC. 708. ADDITIONAL RULES REGARDING STATE AUTHORITY.

"(a) EXCLUSION OF ARRANGEMENTS FROM THE SMALL GROUP MARKET IN ANY STATE UNLESS THE STATE HAS CERTIFIED THE ARRANGEMENT TO HAVE ACCESS TO HEALTH INSURANCE COVERAGE IN SUCH STATE.

"(1) In general.—If a State certifies to the Secretary that such a plan is required to make health insurance coverage provided in the small group market in such State (or prohibit the provision of such coverage) by a multiple employer welfare arrangement which is otherwise exempt under section 514(b)(6)(B) and whose sponsor is described in section 703(a)(1), notwithstanding such exemption. Any such certification shall be in effect for such period, not greater than 3 years, as is designated in such certification. Such certification shall apply with respect to such arrangements as are identified, individually or by class, in the certification.

"(2) GUARANTEED ACCESS.—For purposes of paragraph (1), any arrangement that would otherwise provide health insurance coverage offered by a group health plan or otherwise provide guaranteed access to health insurance coverage to the residents of such State means—

"(A) a certification that the number of residents of such State who are members of the arrangement, or who are potential members of the arrangement, is or will be at least 50 percent of the total number of the residents of such State, or

"(B) certification that—

"(i) the small group market in such State provides guaranteed issue of insurance coverage more affordable.

"(ii) such sponsor operates in the majority of the 50 States and in at least 2 of the regions of the United States, and

"(iii) the arrangement covers, or is to cover, in the case of a newly established arrangement, at least 7,500 participants and beneficiaries, and

"(B) at the time of such application, the sponsor is operating in any State if—

"(A) provided guaranteed issue of individual health insurance coverage for the small group market in any State which are designed to make health insurance coverage more affordable.

"(iii) the State has implemented rating reforms in the small group market in such State which are designed to make health insurance coverage more affordable.

"(B) at the time of such application, the sponsor is operating in any State if—

"(A) the small group market in such State provides guaranteed issue of insurance coverage more affordable.

"(B) at the time of such application, the sponsor is operating in any State if—

"(A) the small group market in such State provides guaranteed issue of insurance coverage more affordable.

"(B) at the time of such application, the sponsor is operating in any State if—

"(A) the small group market in such State provides guaranteed issue of insurance coverage more affordable.

"(B) at the time of such application, the sponsor is operating in any State if—

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"(B) at the time of such application, the sponsor is operating in any State if—

"(A) the small group market in such State provides guaranteed issue of insurance coverage more affordable.
in the individual market using pure community rating and did not provide for any transfer of payments (after the effective date of the guaranteed issue requirement) in the implementation of community rating.

"(B) required insurers offering health insurance coverage in connection with group health plans to reimburse insurers offering individual health insurance coverage for losses resulting from those insurers offering individual health insurance coverage on an open enrollment basis. Regulations under this part may provide for an exemption from the applicability of paragraph (1) in the case of certain arrangements that affect a single insurer.

"(C) ASSIGNMENT AUTHORITY WITH RESPECT TO NEW ARRANGEMENTS.—

"(1) IN GENERAL.—Notwithstanding section 314, a State may impose by law a premium tax on multiple employer welfare arrangements which are otherwise exempt under section 314(b)(6)(B) and the sponsor of which is described in section 702(a)(1).

"(A) in the case of an arrangement established after March 6, 1996, and

"(B) in the case of an arrangement in existence as of March 6, 1996, if the arrangement commenced operations in such State after March 6, 1996.

"(2) PREMIUM.—For purposes of this subsection, the term 'premium tax' imposed by a State on a multiple employer welfare arrangement means any tax imposed by such State if

"(A) such tax is computed by applying a rate to the amount of premiums or contributions received by the arrangement from participating employers located in such State with respect to individuals covered under the arrangement who are residents of such State,

"(B) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

"(C) such tax is otherwise nondiscriminatory, and

"(D) the amount of any such tax assessed on the arrangement is reduced by the amount of any tax or assessment imposed by the State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage (or other insurance related to the provision of medical care) in the arrangement (as defined in regulations) provided by such insurers or health maintenance organizations in such State to such arrangement.

"(3) REGION.—The term 'region' means any of the following regions:


"(B) the Southeast Region, consisting of the States of Texas, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, and Tennessee.

"(C) the Midwest Region, consisting of the States of Montana, South Dakota, North Dakota, Nebraska, Kansas, Oklahoma, Minnesota, Iowa, Missouri, Wisconsin, Michigan, Illinois, and Indiana.


"(4) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

"(A) Section 314(b)(6)(A)(ii) of such Act (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by striking "is fully insured" and inserting "under which all benefits are fully insured", and by inserting "and which is not described in section 702(a)(1)" after "paragraph (B)"

"(B) Section 314(b)(6)(B) of such Act (29 U.S.C. 1144(b)(6)(B)) is amended—

"(A) by inserting "(ii)" after "(B)";

"(B) by striking "which are not fully insured" and inserting "which under any benefit is not fully insured"; and

"(C) by striking "Any such exemption" and inserting

"(i) Subject to part 7, any exemption under clause (i)"

"(ii) Conforming Amendments to Definition of Plan Sponsor.—Section 316(b) of such Act (29 U.S.C. 1146(b)) is amended by adding at the end the following sentence:

"Such term also includes the sponsor (as defined in section 702(b)(6)) of a multiple employer welfare arrangement which is or has been a multiple employer welfare arrangement (as defined in section 701(b))."

"(C) Definition.—

"(1) Group Health Plan.—Section 3 of such Act (29 U.S.C. 1100) is amended by adding at the end the following new paragraph:

"(4) Except as otherwise provided in this title, the term 'group health plan' means an employee welfare benefit plan to the extent that the plan provides medical care (within the meaning of section 607(1)) to employees or their dependents as defined in the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"(2) Inclusion of Certain Partners and Self-Employed Sponsors in Definition of Participant.—Section 37 of such Act (29 U.S.C. 1102(7)) is amended—

"(A) by inserting "(i)" after "(7)"; and

"(B) by adding at the end the following new paragraph:

"(B) In the case of a group health plan, such term includes

"(i) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership;

"(ii) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual; and

"(iii) such individuals as described in paragraph (1)(B) or (C) of this section who become eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

"(3) Health Insurance Coverage.—Section 3 of such Act (as amended by paragraph (1)) is amended further by adding at the end the following new paragraph:

"(43A) Except as provided in subparagraph (B), the term 'health insurance coverage' means benefits consisting of medical care (within the meaning of section 1395w(g)(1)) and similar supplemental coverage provided under a group health plan.

"(4) Coverage Issued as a Supplement to Liability Insurance.—

"(v) Liability insurance, including general liability insurance and automobile liability insurance.

"(v) Workers' compensation or similar insurance.

"(v) Automobile medical-payment insurance.

"(vii) Coverage for a specified disease or illness.

"(viii) Hospital or fixed indemnity insurance.

"(ix) Short-term limited duration insurance.

"(x) Such other coverage, comparable to that described in previous clauses, as may be specified in regulations.

"(4) Medical Care.—Section 607(1) of such Act (29 U.S.C. 1167(1)) is amended—

"(A) by striking "The term" and inserting the following:

"(A) In general.——The term;

"(B) by striking "as defined" and all that follows through "1992"; and

"(C) by adding at the end the following new subparagraph:

"(5) Medical Care.—For purposes of this paragraph, the term 'medical care' means

"(i) amounts paid for, or items or services in the form of, the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for, or items or services provided for, the purpose of affecting any structure or function of the body;

"(ii) amounts paid for, or services in the form of, transportation primarily for and essential to medical care referred to in clause (i), and

"(iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii)."

"(5) OTHER DEFINITIONS.—Section 314 of such Act is further amended by adding at the end the following new subsection:

"(e) For purposes of this section, the terms 'fully insured', 'health maintenance organization', 'insurer' have the meanings given such terms in section 701.

"(f) Clerical Amendment.—The table of contents in section 3 of the Employee Retire ment Income Security Act of 1974 (as amended by section 102(g)) is amended by inserting after the item relating to section 609 the following new item:

"(g) Part 7—Rules Governing Regulation of Multiple Employer Health Plans

"(Sec. 701. Definitions.

"(Sec. 702. Clarification of duty of the Secretary to implement provisions of current law providing for exemptions and solvency standards for multiple employer health plans.

"(Sec. 703. Requirements relating to sponsors, boards of trustees, and plan operations.

"(Sec. 704. Other requirements for exemption.
"Sec. 705. Maintenance of reserves.

"Sec. 705. Maintenance of reserves.

"Sec. 706. Notice requirements for voluntary termination.

"Sec. 706. Notice requirements for voluntary termination.

"Sec. 707. Corrective actions and mandatory termination.

"Sec. 707. Corrective actions and mandatory termination.

"Sec. 708. Additional rules regarding State authority.

SEC. 162. AFFORDABLE AND AVAILABLE FULLY INSURED HEALTH COVERAGE THROUGH VOLUNTARY HEALTH INSURANCE ASSOCIATIONS.

Section 534 of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating subsections (d) as subsections (a) and (b); and

(2) by inserting after subsection (c) the following new subsection:

(d)(1) The provisions of this title shall supersede any and all State laws which regulate health insurance insofar as they may now or hereafter—

(A) preclude an insurer or health maintenance organization from offering health insurance coverage under voluntary health insurance associations,

(B) preclude an insurer or health maintenance organization from setting premium rates under a voluntary health insurance association based on the claims experience of the voluntary health insurance association (within the meaning of section 607(1)) or, without the claims experience of any particular employer or the basis of the claims experience of such employer alone, or

(C) require—

(i) health insurance coverage in connection with a voluntary health insurance association to include specific items or services consisting of medical care, or

(ii) an insurer or health maintenance organization offering health insurance coverage in connection with a voluntary health insurance association to include in such health insurance coverage specific items or services consisting of medical care, except to the extent that such law prohibits an exclusion for a specific disease in such health insurance coverage. Subparagraph (C) shall apply only with respect to items and services which shall be specified in a list which shall be prescribed in regulations of the Secretary.

(2)(A) If a State certifies to the Secretary that such State provides to its residents guarantees that are substantially similar to the requirements of section 534 of the Employee Retirement Income Security Act of 1974, such State may regulate any health insurance coverage provided in the small group market in such State (or prohibit the provision of such coverage) by voluntary health insurance associations, as defined in the preceding provision of this clause.

(B) The term `voluntary health insurance association' means a multiple employer welfare arrangement in connection with a group health plan with respect to a calendar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year for purposes of this paragraph for more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group (within the meaning of section 3(40)(B)(ii)).

"(E) The term `region' means any of the following regions:


(iii) The Midwest Region, consisting of the States of Montana, South Dakota, North Dakota, Nebraska, Kansas, Oklahoma, Minnesota, Iowa, Missouri, Wisconsin, Michigan, Illinois, and Indiana.


SEC. 163. STATE AUTHORITY FULLY APPLICABLE TO SELF-INSURED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS PROVIDING MEDICAL CARE WHICH ARE NOT EXEMPTED UNDER NEW PART 7.

(a) In General.—Section 514(b)(6)(A)(i) of the Employee Retirement Income Security Act of 1974 is amended by inserting before the period the following: "Save to the extent that, in any such case, if the arrangement provides medical care (within the meaning of section 607(1)), such a law of any State may apply without limitation under this title".

(b) Cross-Reference.—Section 514(b)(6) (as amended by section 3(40)(B)(ii)) is amended by adding at the end the following new subparagraph:
164. Clarification of treatment of certain collectively bargained arrangements. Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraph only if the following requirements are met:

"(i) all of the benefits provided under the plan or arrangement are fully insured (as defined in section (b));

(ii) the plan or arrangement is a multi-employer plan, and

(iii) the requirements of clause (B) of the proviso to clause (5) of section 301(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

(b) A plan or arrangement is established or maintained in accordance with this subparagraph only if—

"(i) all of the benefits provided under the plan or arrangement are fully insured (as defined in section (b));

(ii) the plan or arrangement is a multi-employer plan, and

(iii) the requirements of clause (B) of the proviso to clause (5) of section 301(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

(c) A plan or arrangement is deemed to be established or maintained in accordance with this subparagraph only if—

"(i) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(ii) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(iii) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(iv) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(v) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(vi) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(vii) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

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"(xlii) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

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"(v) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(w) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(x) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(y) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

"(z) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or
terms governing such fund, be used for, or diverted to, any purpose other than for the exclusive benefit of the participants and beneficiaries of the church plan whose assets are pooled in such fund.

(f) Inapplicability of Certain Provisions.—

(1) Prohibited Transactions.—Section 406 shall not apply to a church plan by reason of an election under subsection (a).

(2) Continuation Coverage.—Section 601 shall not apply to a church plan by reason of an election under subsection (a).

(b) Conforming Amendments.—

(1) Section 4(b)(2) of such Act (29 U.S.C. 1003(b)) is amended by inserting before the semicolon the following: "except with respect to provisions made applicable under any election made under section 704(a) of this Act.''

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (a), by inserting "(including a church plan which is not exempt under section 4(b)(2) by reason of an election under section 704)'' before the period in the first sentence; and

(B) in subsection (b)(2)(B), by inserting "and including a church plan which is not exempt under section 4(b)(2) by reason of an election under section 704) after "death benefits".

(c) Clerical Amendment.—The table of contents in section 1 of such Act (as amended by section 3(a)) is further amended by inserting after the item relating to section 703 the following new item:

"Sec. 707. Special rules for church plans.''

SEC. 167. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

(a) Enforcement of Filing Requirements.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by sections 102(c)) is further amended—

(1) in subsection (a)(6), by striking "paragraph (2) or (5)" and inserting "paragraph (2), (5), or (6)''; and

(2) by adding at the end of subsection (c) the following new paragraph:

"(6) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of such person's failure or refusal to file the information required to be filed with the Secretary under section 101(g).''

(b) Actions by States in Federal Court.—Section 502(a) of such Act (29 U.S.C. 1132) is amended—

(1) in paragraph (8), by striking "or" at the end;

(2) in paragraph (9), by striking the period and inserting "; and"; and

(3) by adding at the end the following: "(10) by a State official having authority under the law of such State to enforce the laws of such State regulating insurance, to enjoin any act or practice which violates any requirement under subsection (i) for an exemption under section 4(b)(6) with which such State has the power to enforce pursuant to section 502(c)(1).''

(c) Criminal Penalties for Certain Willful Violations of This Title.—Section 501 of such Act (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" after "SEC. 501;" and

(2) by adding at the end the following new subsection:

"(b) Any person who, either willfully or with willful blindness, falsely represents, to any official, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefits described in section 3(1) to employees or their beneficiaries as—

"(1) being a multiple employer welfare arrangement to which an exemption has been granted under section 514(b)(6),

"(2) having been established or maintained under one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158), or in paragraph fourth of section 2 of the Railway Labor Act (45 U.S.C. 152), paragraph fourth or which are reached pursuant to labor-management negotiations described in the provisions of State public employee relations laws, or

"(3) being a plan or arrangement with respect to which the requirements of subsection (c)(1), (D), or (E) of section 3(4)(a) are met, shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''

(d) Cessation of Activities in Absence of Effective State Regulation Unless Standards Are Met.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(nn) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of a multiple employer welfare arrangement providing benefits consisting of medical care (within the meaning of section 607(1)) that—

"(A) is not licensed, registered, or otherwise approved or supervised by the States in which the arrangement offers or provides benefits, and

"(B) if there is in effect with respect to such arrangement an exemption under section 514(b)(6)(B), is not operating in accordance with the requirements under part 7 for such an exemption,

"(1) the Secretary may enter into an agreement with the Secretary of the United States Department of Labor to enforce the provisions of this title.

"(2) Each registration statement—

"(A) required to be filed under section 4(b)(6), shall be filed or maintained with respect to which the requirements of subsection (c)(1) are met.

"(B) shall be filed under this paragraph if the arrangement offers or provides benefits, and

"(C) is amendable by inserting after the period the following: "and this Act, including, but not limited to, coordinating Federal and State efforts through the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,''

"(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act.

"(C) make readily available to the States timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

"(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.''

SEC. 168. FILING AND DISCLOSURE REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS OFFERING HEALTH BENEFITS.—

(a) In General.—Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (g) as subsection (i); and

(2) by inserting after subsection (f) the following new subsections:

"(g) Registration of Multiple Employer Welfare Arrangements.—(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement describing in paragraph 2 within 60 days before commencing operations in the case of an arrangement commencing operations on or after January 1, 1977 and no later than February 15 of each year (in the case of an arrangement in operation since the beginning of such year), unless, as of the date by which filing otherwise must be made, such arrangement provides no benefits consisting of medical care (within the meaning of section 607(1)).

"(2) Each registration statement—

"(A) shall be filed in such form, and contain such information, concerning the multiple employer welfare arrangement and any persons involved in its operation (including
whether coverage under the arrangement is fully insured, as shall be provided in regulations which shall be prescribed by the Secretary, and

(2) Multiemployer benefits under the arrangement consisting of medical care (within the meaning of section 607(1)) are not fully insured, shall contain a certification that copies of such certificates have been transmitted by certified mail to—

(i) in the case of an arrangement which is a multiple employer health plan (as defined in section 171), the State insurance commissioner of the State in which the arrangement is located, or

(ii) in the case of an arrangement which is a multiple employer welfare arrangement, the State insurance commissioner of each State in which the arrangement is located.

(3) The person or persons responsible for filing the annual registration statement are—

(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

(B) in the case of a multiple employer welfare arrangement, the person or persons for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually exercising control over the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or exercised directly by such person or persons or through an agent designated by such person or persons.

(4) Any agreement entered into under section 191(c) of this Act, or any contract entered into under section 192 of such Act, and any agreement entered into under any Act requiring filings under this section (or any regulations necessary to carry out the requirements of such Act) shall be effective only if such agreement or contract is filed with the Secretary of Labor, and the filing is certified pursuant to subsection (c)(9).

(5) For purposes of this title, the term `domicile State' means, in connection with a multiemployer welfare arrangement, the State in which, according to the application for an exemption under this section, the arrangement is located, except that, in any case in which information contained in the annual report of the arrangement filed under this paragraph indicates that most individuals covered under the arrangement are located, except in the case of a multiemployer welfare arrangement established in accordance with the State insurance commissioner of such State.

(6) The Secretary may exempt from the requirements of this subsection such class of multiple employer welfare arrangements as the Secretary deems appropriate.

(h) Filing Requirements for Multiple Employer Welfare Arrangements—

(1) IN GENERAL—A multiple employer welfare arrangement which provides benefits consisting of medical care (within the meaning of section 607(1)) and is fully insured, shall contain a certification that copies of such certificates have been transmitted by certified mail to—

(i) in the case of an arrangement which is a multiple employer health plan (as defined in section 171), the State insurance commissioner of the State in which the arrangement is located, or

(ii) in the case of an arrangement which is a multiple employer welfare arrangement, the State insurance commissioner of each State in which the arrangement is located.

(2) Time for Disclosure.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.

(b) EFFECTIVE DATES.—Section 101(g) of the Employee Retirement Income Security Act of 1974 (added by subsection (a)) shall take effect on the date of the enactment of this Act. Section 101(h) of such Act (added by subsection (a)) shall take effect as provided in section 171.

SEC. 170. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS.

(a) IN GENERAL.—The amendments made by section 101(b)(3)(B)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003), as added by amendment made by this Act, shall apply to any single annual report which is filed after the amendment becomes effective.

(b) EFFECTIVE DATES.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(c) TRANSITIONAL RULE.—(1) IN GENERAL.—Subject to the succeeding provisions of this subsection and subsection (d), the terms `employee welfare benefit plan' and `employee welfare arrangement', as defined in subsection (c)(9) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise, and includes a group health plan (within the meaning of section 5000(b)(1) of the Internal Revenue Code).

(2) LIMITATION OF REQUIREMENTS TO PLANS WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The requirements of subsection (a) and paragraph (1) of this subsection shall apply to a group health plan for any plan year, for health insurance coverage offered in connection with a group health plan for a year, only if the group health plan is a multiemployer welfare arrangement for such year that includes at least two participating employers as defined in such subsection.

(3) EXCLUSION OF PLANS WITH LIMITED COVERAGE.—If any benefits under a plan are not fully insured, whether the arrangement is a multiemployer welfare arrangement which provides benefits consisting of medical care (within the meaning of section 607(1)), or is a multiemployer welfare arrangement established in accordance with the State insurance commissioner of each State in which the arrangement is located, or

(i) in the case of an arrangement which is a multiple employer health plan (as defined in section 171), the State insurance commissioner of the State in which the arrangement is located, or

(ii) in the case of an arrangement which is a multiple employer welfare arrangement, the State insurance commissioner of each State in which the arrangement is located.

(3) Time for Disclosure.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.

(b) EFFECTIVE DATES.—Section 101(g) of the Employee Retirement Income Security Act of 1974 (added by subsection (a)) shall take effect on the date of the enactment of this Act. Section 101(h) of such Act (added by subsection (a)) shall take effect as provided in section 171.

SEC. 171. TRANSITIONAL PROVISIONS.

(a) IN GENERAL.—Subject to the succeeding provisions of this subsection and subsection (d), the term `employee welfare benefit plan' and `employee welfare arrangement', as defined in subsection (c)(9) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise, and includes a group health plan (within the meaning of section 5000(b)(1) of the Internal Revenue Code).

(b) LIMITATION OF REQUIREMENTS TO PLANS WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The requirements of subsection (a) and paragraph (1) of this subsection shall apply to a group health plan for any plan year, for health insurance coverage offered in connection with a group health plan for a year, only if the group health plan is a multiemployer welfare arrangement for such year that includes at least two participating employers as defined in such subsection.

(c) EXCLUSION OF PLANS WITH LIMITED COVERAGE.—If any benefits under a plan are not fully insured, whether the arrangement is a multiemployer welfare arrangement which provides benefits consisting of medical care (within the meaning of section 607(1)), or is a multiemployer welfare arrangement established in accordance with the State insurance commissioner of each State in which the arrangement is located, or

(i) in the case of an arrangement which is a multiple employer health plan (as defined in section 171), the State insurance commissioner of the State in which the arrangement is located, or

(ii) in the case of an arrangement which is a multiple employer welfare arrangement, the State insurance commissioner of each State in which the arrangement is located.

(3) Time for Disclosure.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.

(b) EFFECTIVE DATES.—Section 101(g) of the Employee Retirement Income Security Act of 1974 (added by subsection (a)) shall take effect on the date of the enactment of this Act. Section 101(h) of such Act (added by subsection (a)) shall take effect as provided in section 171.
designated by the State to enforce the requirements of this title for the State involved with respect to such insurer or organization.

(2) "BONA FIDE ASSOCIATION."—The term "bona fide association" means an association which—
   (A) has been actively in existence for at least three years,
   (B) has been formed and maintained in good faith for purposes other than obtaining insurance,
   (C) is not condition membership in the association on health status,
   (D) makes health insurance coverage offered through the association available to all members regardless of health status,
   (E) does not make health insurance coverage offered through the association available to any individual who is not a member (or dependent of a member) of the association at the time the coverage is initially issued,
   (F) does not impose preexisting condition exclusions except in a manner consistent with the requirements of sections 101 and 102 as they relate to group health plans, and
   (G) provides for renewal and continuation of health insurance coverage in a manner consistent with the requirements of section 132 as they relate to renewal and continuation of insurance coverage in a group market.

(3) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:
   (A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric coverage.
   (C) Title XXII of the Public Health Service Act.

(4) HEALTH INSURANCE COVERAGE.—
   (A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance coverage" means benefits consisting of medical care (provided directly, through inpatient or outpatient care, or through health maintenance organization) or policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or health maintenance organization.
   (B) EXCEPTION.—Such term does not include medical care available only on the basis of affiliation with a bona fide association.

(5) HEALTH MAINTENANCE ORGANIZATION; HMO.—The terms "health maintenance organization" and "HMO" mean—
   (A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a)),
   (B) an organization recognized under State law as a health maintenance organization,
   (C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization, or
   (D) an organization maintained by a partnership, to the extent that such organization is eligible to be considered to be in a partnership an individual who is a partner in relation to the partnership, or
   (ii) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual, if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

(6) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—As used in this title:
   (1) INDIVIDUAL MARKET.—The term "individual market" means the market for health insurance coverage offered to individuals and not to employers or in connection with a group health plan.
   (2) LARGE GROUP MARKET.—The term "large group market" means the market for health insurance coverage offered to employers (other than small employers) on behalf of their employees (and their dependents) and does not include health insurance coverage available solely in connection with a bona fide association.

(3) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a calendar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year. All persons 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 for purposes of this title.

(4) SMALL GROUP MARKET.—The term "small group market" means the health insurance market under which individuals eligible to be considered to be in a partnership an individual, participant, or beneficiary experience a lapse in coverage that is greater than the applicable period provided for under such subtitle; or
   (B) to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition that is shorter than the applicable period provided for under such subtitle;
   (C) the term "participant" includes—
   (i) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual, if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

(5) TREATMENT OF PARTNERSHIPS AND PARTICIPANTS.—In the case of a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership:
   (1) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership.

SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.

(a) STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.—Subject to subsection (b), nothing in this subtitle or subtitle A or B shall be construed to preempt State laws—
   (1) that relate to matters not specifically addressed in such subtitles; or
   (2) that require insurers or HMOs—
      (A) to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition that is shorter than the applicable period provided for under such subtitle; or
      (B) to allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the period provided for under sections 101(b)(3)(A), 101(b)(3)(B)(ii), and 102(b)(2); or

SEC. 193. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this title, the provisions of this title shall apply on the effective dates specified in subsection (b).

(b) SPECIFIED EFFECTIVE DATES.—

(1) Group health plans, and health insurance coverage offered in connection with group health plans, beginning on or after January 1, 1998.

(2) Individual health insurance coverage issued, renewed, or effectuated on or after July 1, 1998.

(c) CONSIDERATION OF PREVIOUS COVERAGE.—The provisions of this title shall not be construed to apply with respect to health plan coverage offered in connection with group health plans, and health insurance coverage, prior to the date of enactment of this Act.

(d) CONSTRUCTION.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Rehabilitation Act of 1973.

SEC. 194. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to diminish the authority of any Inspector General established under this Act.

SEC. 200. REFERENCES IN TITLE.

(a) REFEREE.—The term `referred' shall mean referred to an Inspector General in an investigation under section 1128A(b) of this title, for purposes of facilitating the use of information obtained in conducting an investigation under this Act.

(b) RELATION TO OTHER REFERENCES.—Nothing in this Act shall be construed to affect the meaning of the term `refer' as defined in section 1128A(b) of this title.

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI of the Social Security Act,Subtitle A—FRAUD AND ABUSE CONTROL PROGRAM—

(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—In addition to the Inspector General's powers under section 1128(c), the Inspector General is authorized to use the materials and services of an appropriate Federal, State, or local law enforcement or regulatory agency, or private entity, in the course of conducting their own investigations, to the extent that such use would not interfere with the exclusive jurisdiction of such agency or entity with respect to any investigation or proceeding.

(c) INVESTIGATIVE ACTIVITIES.—In carrying out investigations, the Inspector General is authorized to use the materials and services of other Federal, State, or local law enforcement or regulatory agencies, or private entities, or the services of any other appropriate persons, to the extent that such use would not interfere with the exclusive jurisdiction of such agency or entity with respect to any investigation or proceeding.
"(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

"(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, and to be available without further appropriation to the Account from the Trust Fund for fiscal year 2003, $304,000,000.

"(ii) For each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

"(iii) For each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

"(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated to the Account from the General fund of the United States Treasury and hereby appropriated to the Account for Medicare and Medicaid programs—

"(i) for fiscal year 1997, not less than $30,000,000 and not more than $40,000,000;

"(ii) for fiscal year 1998, not more than $40,000,000 and not more than $50,000,000;

"(iii) for fiscal year 1999, such amount shall be not less than $50,000,000 and not more than $60,000,000;

"(iv) for fiscal year 2000, such amount shall be not less than $60,000,000 and not more than $70,000,000;

"(v) for fiscal year 2001, such amount shall be not less than $70,000,000 and not more than $80,000,000;

"(vi) for fiscal year 2002, such amount shall be not less than $80,000,000 and not more than $90,000,000;

"(vii) for each fiscal year after fiscal year 2002, such amount shall be not less than $90,000,000 and not more than $100,000,000;

"(viii) for each fiscal year after fiscal year 2007, such amount shall be not less than $100,000,000 and not more than $120,000,000.

"(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

"(i) for fiscal year 1997, not less than $50,000,000 and not more than $70,000,000;

"(ii) for fiscal year 1998, not less than $70,000,000 and not more than $90,000,000;

"(iii) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

"(iv) for fiscal year 2000, not less than $100,000,000 and not more than $120,000,000;

"(v) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

"(vi) for fiscal year 2002, not less than $130,000,000 and not more than $140,000,000;

"(vii) for fiscal year 2003, $140,000,000 and not more than $150,000,000; and

"(viii) for each fiscal year after fiscal year 2003, not less than $150,000,000 and not more than $160,000,000.

"(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

"(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

"(ii) investigations;

"(iii) financial and performance audits of health care programs and operations;

"(iv) inspections and other evaluations; and

"(v) provider and consumer education regarding compliance with the provisions of title XI.

"(A) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

"(i) For fiscal year 1997, such amount shall be not less than $20,000,000 and not more than $30,000,000.

"(ii) For fiscal year 1998, such amount shall be not less than $30,000,000 and not more than $40,000,000.

"(iii) For fiscal year 1999, such amount shall be not less than $40,000,000 and not more than $50,000,000.

"(iv) For fiscal year 2000, such amount shall be not less than $50,000,000 and not more than $60,000,000.

"(v) For fiscal year 2001, such amount shall be not less than $60,000,000 and not more than $70,000,000.

"(vi) For fiscal year 2002, such amount shall be not less than $70,000,000 and not more than $80,000,000.

"(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $80,000,000 and not more than $90,000,000.

"(B) AMOUNTS SPECIFIED.—The amount appropriated to the Medicare Integrity Program under section 1893(c) is hereby specified as follows:

"SEC. 202. MEDICARE INTEGRITY PROGRAM.—

"(A) ESTABLISHMENT OF INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

"MEDICARE INTEGRITY PROGRAM. Ð There is hereby established the Medicare Integrity Program under section 1893. The Secretary shall by regulation promulgate such regulations as are necessary to carry out the purposes of this section.

"SEC. 1893. (a) ESTABLISHMENT OF PROGRAM. Ð Title XVIII is amended by adding at the end the following new section:

"MEDICARE INTEGRITY PROGRAM.

"MEDICARE INTEGRITY PROGRAM. Ð There is hereby established the Medicare Integrity Program under section 1893. The Secretary shall by regulation promulgate such regulations as are necessary to carry out the purposes of this section.

"SEC. 1893. (a) ESTABLISHMENT OF PROGRAM. Ð Title XVIII is amended by adding at the end the following new section:

"MEDICARE INTEGRITY PROGRAM.

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"MEDICARE INTEGRITY PROGRAM.
Secretary of Health and Human Services (in this section referred to as the "Secretary") shall provide an explanation of benefits under the medicare program under title XVIII for the item or service with respect to which a payment was made under the program which is furnished to the individual, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code). (2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion as provided in this subsection, the Secretary shall make a payment to the individual of such amount as the Secretary considers appropriate.

(3) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under title 1128, section 1129A, or section 1129B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourse provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for a sanction by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH CARE PROGRAMS.—(a) In General.—Section 1128B (42 U.S.C. 1320a–7b) is amended as follows:

(1) In the heading, by striking "MEDI-CARE OR STATE HEALTH CARE PROGRAMS" and inserting "FEDERAL HEALTH CARE PROGRAMS".

(2) In subsection (a)(1), by striking "a program under title XVIII or a State health care program (as defined in section 1128B)" and inserting "a Federal health care program".

(3) In subsection (a)(5), by striking "a program under title XVIII or a State health care program (as defined in section 1128B)" and inserting "a Federal health care program".

(4) In the second sentence of subsection (a), by striking "a State plan approved under title XIX and inserting "a Federal health care program", and

(b) by striking "the State may at its option (notwithstanding any other provision of that title or of such plan)" and inserting "the administrator of such program may at its option (not notwithstanding any other provision of such program)".

(5) In subsection (b), by striking "title XVIII or a State health care program each place it appears and inserting a Federal health care program".

(6) In subsection (c), by inserting "as defined in section 1128B(h)" after "a State health care program".

(7) By adding at the end the following new subsection:

"(f) For purposes of this section, the term 'Federal health care program' means—

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

(2) any State health care program, as defined in section 1128B(h)."

(8) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS.—(a) Solicitation and Publication of Modifications to Existing Safe Harbors and New Safe Harbors.—

"(1) In general.—

(A) Solicitation of Proposals for Safe Harbors.—The Secretary shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), solicitation for the modification or establishment of new safe harbors and proposed additional safe harbors, including safe harbors, if appropriate, with a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Programs and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

(iii) advisory opinions to be issued pursuant to section 1320a–7b(f);

(iv) special fraud alerts to be issued pursuant to subsection (c);

(B) Publication of Proposed Modifications and Proposed Safe Harbors.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, in the Federal Register published proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day period, after receiving comments from the public during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the 'Inspector General') shall submit annual reports to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.)—

(i) describing any solicitation described in subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which public was intended to be the basis for the publication, and the reasons for the rejection of the proposals that were not included.

(2) Criteria for Modifying and Establishing Safe Harbors.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary shall consider—

(A) an increase or decrease in access to health care services;

(B) an increase or decrease in the quality of health care services.

(3) An increase or decrease in patient population of choice among health care providers.

(4) An increase or decrease in competition among health care providers.

(5) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(6) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

(7) An increase or decrease in the potential overutilization of health care services.

(8) The existence or nonexistence of any potential financial benefit to a health care provider, hospital, or practice which may vary based on their decisions of—

(i) whether to order a health care item or service;

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider;

(iii) whether the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

(8) Advisory Opinions.—

(1) Issuance of Advisory Opinions.—The Secretary shall issue written advisory opinions, as provided in this subsection.

(2) Matters Subject to Advisory Opinions.—The Secretary shall issue advisory opinions as to the following matters:

(A) What constitutes prohibited remuneration within the meaning of section 1128B(b).

(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

(C) Whether an arrangement or proposed arrangement satisfies such criteria with which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

(D) What constitutes remuneration to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b)(3).

(3) Matters Not Subject to Advisory Opinions.—Such advisory opinions shall not address the following matters:

(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

(4) Effect of Advisory Opinions.—

(A) BINDINGS AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) Failure to Seek Opinion.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1129A, or 1128B.

(5) Regulations.—
"(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

(i) the procedure to be followed by a party applying for an advisory opinion;

(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

(iii) the interval in which the Secretary shall respond to a request; and

(iv) the reasonable fee to be charged to the party requesting an advisory opinion.

(b) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A), the Inspector General shall provide for—

(i) the Secretary shall be required to respond to a party requesting an advisory opinion by no later than 30 days after the request is received; and

(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

(c) SPECIAL FRAUD ALERTS.—

(i) IN GENERAL.—

(A) DELISTING FOR SPECIAL FRAUD ALERTS.— Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be a 'special fraud alert'.

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(ii) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert are relevant in any of the circumstances described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128a(b)(4) (42 U.S.C. 1320a-7(a)) is amended to read as follows:

"

(F) In the case of a conviction of an individual or entity under subsection (b) or (c), the period of the exclusion shall not be less than 1 year.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128a(b)(4) (42 U.S.C. 1320a-7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(B) in the heading, by striking "Conviction" and inserting "Conviction and"; and

"(C) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor''.

SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128a(c)(3) (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the end the following new subparagraph:

"(D) in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(c) FELONY CONVICTING RELATING TO HEALTH CARE FRAUD.—

In the case of an exclusion of an individual or entity under subsection (b) of this section, 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 was 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), the period of the exclusion shall be not less than 1 year.".

 SEC. 213. CONSEQUENTIAL EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128b(7) (42 U.S.C. 1320a-7(b)) is amended by adding at the end the following new paragraph:

"(B) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

"(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128a(i)(6) of the act constituting the basis for the conviction or exclusion described in subparagraph (B); or

"(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

(B) FOR PURPOSES OF SUBPARAGRAPH (A), THE TERM 'SANCTIONED ENTITY' MEANS AN ENTITY—

"(i) that has been convicted of any offense described in subsection (a) in paragraph (1), (2), or (3) of this subsection; or

"(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.''

SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FAILING TO COMPLY WITH STATUTORY OBLIGATIONS.

(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)(B)(i) (42 U.S.C. 1320c-5(b)(1)) is amended by striking "may prescribe, except that such period may not be less than 1 year'’.

(b) 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'’.

(c) 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.

SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—Section 1156(i)(1) (42 U.S.C. 1320c-5mm(i)(1)) is amended by striking "the Secretary may terminate" and all that follows and inserting "in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6) or (6)(C) (which are applicable on the eligible organization if the Secretary determines that the organization—

"(e) has failed substantially to carry out the contract; and

"(f) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; and

"(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).

(b) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1156(i)(6) (42 U.S.C. 1320c-5mm(i)(6)) is amended by adding at the end the following new subparagraph:

"(C) the case of a determination made by paragraph (1), the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:
SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) In General.—Title XI (42 U.S.C. 13101 et seq.), as amended by sections 203 and 205, is amended by inserting after section 1128 the following new section:

"HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

"SEC. 1128B. (a) GENERAL PURPOSE.—

(1) A Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected or will have substantial likelihood of adversely affecting an individual covered under the organization's contract.

(2) If the determination is for a violation of section 1129B, the amendments made by this section shall apply to written agreements entered into on or after January 1, 1997.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) The Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

(2) The Secretary is authorized to conduct any other investigation and compliance procedures established by the Secretary under which—

(3) the Secretary is satisfied that the deficiency that is the basis of the determination has directly adversely affected an individual covered under the organization's contract.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) The information in this database shall be available to Federal and State government agencies and health care providers, suppliers, or practitioners who are the subject of a final adverse action taken against a health care provider, supplier, or practitioner.

(2) A health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(3) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) The information in this database shall be available to Federal and State government agencies and health care providers, suppliers, or practitioners who are the subject of a final adverse action taken against a health care provider, supplier, or practitioner.

(2) The Secretary shall, by regulation, establish procedures to assure that the accuracy of the information is maintained.

(3) The Secretary shall, by regulation, establish procedures to assure that the accuracy of the information is maintained.

SEC. 222. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1997.
"(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

(2) PRACTITIONER.—The term "licensed health care agency" shall include: "licensed practitioner," and "practitioner" mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services to any individual without authority holds himself or herself out to be so licensed or authorized.

(3) GOVERNMENT AGENCY.—The term "Government agency" shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to, the Department of Defense and the Veterans Administration.

(D) State law enforcement agencies.

(E) State medical fraud control units.

(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(4) HEALTH PLAN.—The term "health plan" has the meaning given such term by section 1128(c).

(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(b)."

"(6) IMPROVED PREVENTION IN ISSUANCE OF MEDICAL NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following new sentence: "Under such system, the Secretary may implement at the end the following new sentence:

1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following new sentence: "Under such system, the Secretary may implement"

"(B) by inserting after paragraph (3) the following new paragraph:

(3) In subsection (i)—

(A) by redesigning paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

(2) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128(f)), the portion of such amounts as is determined to have been paid by the program shall be re- paid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Coverage Availability and Affordability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).

(3) In subsection (i)—

(A) in paragraph (2), by striking "title V, XVIII, XIX, or XX of this Act" and inserting "a Federal health care program (as defined in section 1128(f))";

(B) in paragraph (4), by striking "a health insurance or medical services program under title XVIII or XIX of this Act" and inserting "a Federal health care program (as so defined)"; and

(C) in paragraph (5), by striking "title V, XVIII, XIX, or XX" and inserting "a Federal health care program (as so defined)";

(4) By adding at the end the following new subsection:

"(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary of the department or agency with jurisdiction over such program and references to the Inspector General of the department to the Inspector General of the applicable department or agency. In this section shall be deemed to be references to the Inspector General of the applicable department or agency.

(2) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this subsection the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(1) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(2) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(3) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

(4) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN ENTITIES.—Section 1128(a) (42 U.S.C. 1320a-7(a)) is amended—

(1) by striking "or" at the end of paragraph (1)(D);

(2) by striking ", or" at the end of paragraph (2) and inserting "; or";

(3) by striking the semicolon at the end of paragraph (3) and inserting ";"; and

(4) by inserting after paragraph (3) the following new paragraph:

(4) In the case of a person who is not an organization, the term "indirect ownership or control" includes an entity that a person knows or should know is a general partner, managing member, or any other person or entity that a person knows or should know will result in a greater payment to the individual than the person the knowledge 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 so defined.

(5) REMUNERATION DEFINED.—Section 1128(a) (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 care or services for free or for other than fair market value. The term "remuneration" does not include:

(A) The waiver of coinsurance and deductible amounts by a person if—

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person—

(B) The failure to collect coinsurance or deductible amounts after making reasonable collection efforts; or

(C) Involves for any permissible waiver as specified in section 1128(b)(3) or in regulations issued by the Secretary;

(D) Differentials in coinsurance and deductible amounts as specified in any benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims have been submitted and do not meet the standards as defined in regulations promulgated by the Secretary not later than March 28, 1996
180 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996 or (C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1997.

SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a±7a(a)) is amended—

(A) in paragraphs (1) and (2), by inserting "knowingly" before "premoves" each place it appears; and

(B) in paragraph (3), by striking "gives" and inserting "knowingly gives or causes to be given"

(2) DEFINITION OF STANDARD.—Section 1128A(l) (42 U.S.C. 1320a±7a(l)), as amended by section 231(g)(2), is amended by adding at the end the following paragraph:

"(7) The term 'should know' means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth of the information, or

(B) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

"(b) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1997.

SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a±7a(b)) is amended by adding at the end the following new paragraph:

"(3) (A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

(i) $5,000, or

(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1833(a)(2)(A) in the case of home health services furnished to the individual.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to certifications made on or after the date of the enactment of this Act.

Subtitle E—Revisions to Criminal Laws

SEC. 241. DEFINITIONS RELATING TO FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 223 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

Whoever knowingly executes, or attempts to execute, a scheme to defraud any health care benefit program; or

(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 care benefit program, 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 fined under this title or imprisoned not more than 20 years, or both; and if the violation is committed for profit, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

(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."

(c) CRIMINAL FINES DEPOSITED IN FEDERAL TREASURY.—The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act (42 U.S.C. 1395(l)) any amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 242. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"§ 669. Theft or embezzlement in connection with health care

(1) Whoever embezzles, steals, or otherwise without authority knowingly converts to the use of any person other than the rightful owner, or intentionally misappropriates, any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.

(c) 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:

"§ 669. Theft or embezzlement in connection with health care."
Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena requiring the production of any record (including books, papers, документов, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person may possess or have custody, care, or control. A subpoena shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

(b) Service.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other authorized person appointed by or under law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

(c) Enforcement.—In the case of contumacy or failure to obey a subpoena issued under this section, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is held or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The Attorney General, or any officer authorized by the Attorney General, may in the name of the United States, issue an order compelling the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony concerning the matter involved in the investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

(d) Immunity from Civil Liability.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the terms of the subpoena entered on a true copy thereof by the person serving it shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

(e) Limitation on Use.—(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information, or the action or investigation arises out of and is directly related to receipt of health care or financial assistance leading to a civil or criminal prosecution involving any Federal agency participating in the Health Care Fraud and Abuse Control Program.

(f) Good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, the physician-patient relationship, and to the public.

(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(g) Clerical Amendment.—The table of sections at the beginning of chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

"3486. Authorized investigative demand procedure.

(c) Conforming Amendment.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting "or a Department of Justice subpoena (issued under section 3485 of title 18)," after "subpoena.

SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) In General.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

"(6) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

(b) Conforming Amendment.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting "or (a)(6)" after "(a)(5)"

(c) Property Forfeited Deposited in Federal Hospital Insurance Trust Fund.—(1) In general.—After the payment of the costs of asset forfeiture has been made, and notwithstanding any other provision of law, the Secretary of Health and Human Services shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 301(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) Costs of Asset Forfeiture.—For purposes of paragraph (1), the term "costs of the asset forfeiture" means:

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeiture, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for:

(i) contract services;

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return to the United States; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal prosecution involving any Federal agency participating in the Health Care Fraud and Abuse Control Program;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with reimbursement or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrue during the period giving rise to the forfeiture and the date of the forfeiture order.

SEC. 250. RELATION TO ERISA AUTHORITY.

Nothing in this subtitle shall be construed as affecting the authority of the Secretary of Labor under section 502(b) of the Employee Retirement Income Security Act of 1974, including the Secretary's authority with respect to violations of title 18, United States Code (as amended by this subtitle).

Subtitle F—Administrative Simplification

Sec. 249. Federal Health Care Forfeitures

It is the purpose of this subtitle to improve the medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, and the health insurance portability and accountability act of 1996, to enhance the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment and prescription of standards and requirements for the electronic transmission of certain health information.

SEC. 252. ADMINISTRATIVE SIMPLIFICATION.

(a) In General.—Title X (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

"PART C—ADMINISTRATIVE SIMPLIFICATION "DEFINITIONS"

"Sec. 1171. For purposes of this part:

(1) CLEARMHERVERSE.—The term "clearhouse" means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

(2) CODE SET.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, diagnostic codes, or medical procedure codes.

(3) HEALTH CARE PROVIDER.—The term "health care provider" includes a provider of goods or services (as defined in section 1851(u)), a provider of medical or other health services, and any person furnishing health care services or supplies.

(4) HEALTH INFORMATION.—The term "health information" means any information, whether oral or recorded in any form or medium, which relates to the past, present, or future physical or mental health or condition of an individual, the payment of health care to an individual, or the past, present, or future payment for health care to an individual.

(5) HEALTH PLAN.—The term "health plan" means any plan which provides or pays the cost of health benefits. Such term includes the following, and any combination thereof:

(A) Part A or part B of the medicare program under title XVIII;

(B) The medicare program under title XIX;

(C) A medicare supplemental policy (as defined in section 1851(g)(i));

(D) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficient comprehensive coverage of a benefit so that the policy should be treated as a health plan).

(E) Health benefits of an employee welfare benefit plan, as defined in section 3(1) of such Act.

(F) An employee welfare benefit plan or arrangement which is established or maintained for the purpose of providing health benefits to the employees of 2 or more employers.

The health care program for active military personnel under title 10, United States Code.
(H) The veterans health care program under chapter 17 of title 38, United States Code.

(I) The Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS), as defined in section 1073(a) of title 10, United States Code.

(J) The Indian health service program under chapter 71 of title 25, United States Code.

(K) The Federal Employees Health Benefits Plan under chapter 89 of title 5, United States Code.

(L) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term ‘individually identifiable health information’ means any information, including graphic information collected from an individual, that—

(A) is created or received by a health care provider, health plan, employer, or clearinghouse;

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(7) STANDARD.—The term ‘standard’, when used with reference to a data element of health information or a transaction referred to in section 1172(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 through 1174.

(8) STANDARD SETTING ORGANIZATION.—The term ‘standard setting organization’ means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS

Sec. 1172. (a) APPLICABILITY.—Any standard adopted under this part shall apply, in whole or in part, to the following persons:

(A) A health plan.

(B) A clearinghouse.

(C) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1172(a)(3).

(D) REDUCTION OF COSTS.—Any standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

E. ROLE OF STANDARD SETTING ORGANIZATIONS.

(1) IN GENERAL.—Except as provided in paragraph (2), any standard adopted under this part shall be a standard that has been developed, adopted, or modified by a standard setting organization.

(2) SPECIAL RULES.—

(A) DIFFERENT STANDARDS.—The Secretary may adopt a standard that is different from any standard developed, adopted, or modified by a standard setting organization, if—

(i) the different standard will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

(ii) the standard is promulgated in accordance with the procedures described in subsection (c) of section 306 of the Public Health Service Act (42 U.S.C. 242k(k)) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register any recommendation of the National Committee on Vital and Health Statistics regarding the adoption of a standard under this part.

(B) APPLICATION TO MODIFICATIONS OF STANDARDS.—This section shall apply to any modification of a standard (including an addition to a standard) adopted under section 1174(b) in the same manner as it applies to an initial standard adopted under section 1174(a).

STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS

Sec. 1173. (a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are appropriate for—

(A) the financial and administrative transactions described in paragraph (2); and

(B) other financial and administrative transactions determined appropriate by the Secretary with respect to the goals of improving the operation of the health care system and reducing administrative costs.

(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are the following:

(A) Claims (including coordination of benefits or equivalent encounter information).

(B) Claims attachments.

(C) Enrollment and disenrollment.

(D) Eligibility.

(E) Health care payment and remittance advice.

(F) Premium payments.

(G) First report of injury.

(H) Claims status.

(I) Referral certification and authorization.

(2) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

(3) USE OF IDENTIFIERS.—The standards adopted under paragraphs (1) shall specify the purposes for which a unique health identifier may be used.

C. CODE SETS.

(1) IN GENERAL.—The Secretary shall adopt standards that—

(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

(B) establish code sets for such data elements if no code sets for the data elements have been developed.

D. DISTRIBUTION.—The Secretary shall establish and implement procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

E. SECURITY STANDARDS FOR HEALTH INFORMATION.—

(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

(A) take into account—

(i) the technical capabilities of record systems used to maintain health information;

(ii) the costs of security measures;

(iii) the need for training persons who have access to health information;

(iv) the value of audit trails in computerized record systems; and

(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

(B) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

(2) SAFEGUARDS.—Each person described in section 1172(a)(2) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards.

(A) To ensure the integrity and confidentiality of the information;

(B) To protect against any reasonably anticipated threats or hazards to the security or integrity of the information; and

(C) Otherwise to ensure compliance with this part by the officers and employees of such person.

E. PRIVACY STANDARDS FOR HEALTH INFORMATION.—The Secretary shall adopt standards with respect to the privacy of individually identifiable health information transmitted in connection with the transactions referred to in subsection (a)(1). Such standards shall include standards concerning at least the following:

(1) The rights of an individual who is a subject of such information.

(2) The procedures to be established for the exercise of such rights.

(3) The uses and disclosures of such information that are authorized or required.

F. ELECTRONIC SIGNATURE.—

(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures with respect to the transactions referred to in subsection (a)(1).

(B) EFFECT OF COMPLIANCE.—Compliance with the standards adopted under subpart (A) shall be deemed to satisfy Federal requirements for a written signature with respect to the transactions referred to in subsection (a)(3).

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"(2) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this part shall be construed to prohibit payment for health care services or health plan premiums by debit, credit, or preauthorized payment from another source, or other electronic means.

"(g) TRANSFER OF INFORMATION AMONG HEALTH PLANS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of Health Insurance Portability and Accountability Act of 1996, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

"(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

"(1) IN GENERAL.—Except as provided in subsection (a) of section 1173(a), the Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of Health Insurance Portability and Accountability Act of 1996, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

"(2) ADDITIONAL RULES.—

"(A) FIRST 2-MONTH PERIOD.—Except with respect to additions and modifications to code sets under paragraph (b), the Secretary may not adopt any modification to a standard adopted under this part during the 2-month period beginning on the date the standard was adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

"(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

"(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

"(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

"REQUIREMENTS

"SEC. 1175. (a) CONDUCT OF TRANSACTIONS BY PLANS.—

"(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction, the health plan may not refuse to conduct such transaction as a standard transaction.

"(2) LIMITATIONS.—

"(A) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act that constitutes an offense punishable under section 1177.

"(B) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a violation of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

"(C) FAILURES DUE TO REASONABLE CAUSE.—

"(1) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

"(i) the failure to comply was due to reasonable cause and not due to willful neglect; and

"(ii) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or exercising reasonable diligence would have known, that the failure to comply occurred.

"(2) EXTENSION OF PERIOD.—

"(a) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

"(b) TIME TO COMPLY.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

"(c) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not due to willful neglect, a penalty imposed under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be disproportionate relative to the compliance failure involved.

"EFFECT ON STATE LAW

"SEC. 1178. (a) GENERAL EFFECT.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall supersede any contrary provision of State law, including any provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

"(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall not supersede a contrary provision of State law, if the provision of State law—

"(A) imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications under this part with respect to the privacy of individually identifiable health information; or

"(B) is a provision of a State law, rule, or regulation.
SEC. 253. CHANGES IN MEMBERSHIP AND DUTIES
OF THE NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.

Section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)) is amended—
(1) by striking paragraph (1), by striking “and” in clause (iii), and inserting “and”;
(2) by amending paragraph (2) to read as follows:

“(2) The members of the Committee shall be appointed from among persons who have distinguished themselves in the fields of health statistics, electronic interchange of health care information, privacy and security of electronic information, population-based public health, purchasing or financing health care services, integrated computerized information systems, health services research, consumer interests in health information, health data standards, epidemiology, and the provision of health care to the elderly. The Secretary shall be appointed for terms of 4 years.”;
(3) by redesignating paragraphs (3) through (5) as paragraphs (4) through (6), respectively, and inserting after paragraph (2) the following:

“(3) Of the members of the Committee—

(A) 1 shall be appointed, not later than 60 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, by the Speaker of the House of Representatives after consultation with the Minority leader of the House of Representatives;

(B) 1 shall be appointed, not later than 60 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, by the President pro tempore of the Senate after consultation with the minority leader of the Senate; and

(C) 6 shall be appointed by the Secretary.”;
(4) by amending paragraph (5) (as so redesignated) to read as follows:

“(5) The Committee shall—

(A) assist and advise the Secretary—

(i) to delineate statistical problems bearing on health and health services which are of national interest; and

(ii) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;

(iii) to determine, approve, and revise the terms, definitions, classifications, and guidelines for health information and health services, their distribution and costs, for use (i) within the Department of Health and Human Services, (ii) by all programs administered by the Secretary including the Federal-State-local cooperative health statistics system referred to in subsection (e), and (iii) to the extent possible as determined by the extent of the energy involved, by the Department of Veterans Affairs, the Department of Defense, and other Federal agencies concerned with health and health services;

(iv) with respect to the design of and approval of health statistical and health information systems concerned with the collection, processing, and tabulation of health statistics within the Department of Health and Human Services, with respect to the Cooperative Health Statistics System established under subsection (e), and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j)(1);

(v) to review and comment on findings and proposals developed by other organizations and make recommendations for their adoption or implementation by local, State, national, or international agencies;

(vi) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest;

(vii) to issue an annual report on the status of the Nation’s health, its health services, their distribution and costs, and to make proposals for improvement of the Nation’s health statistics and health information systems; and

(viii) in complying with the requirements imposed on the Secretary under part C of title XI of the Social Security Act; and

(B) shall study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;

(C) shall report to the Secretary not later than 4 years after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996 recommendations and legislative proposals for such standards and electronic exchange of such information; and

(D) shall be responsible generally for advising the Secretary and the Congress on the status of the implementation of part C of title XI of the Social Security Act; and

(5) by adding at the end the following:

“(7) Not later than 1 year after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, and annually thereafter, the Committee shall submit to the Congress, and make public, a report regarding—

(A) the extent to which persons required to comply with part C of title XI of the Social Security Act are cooperating in implementing the standards adopted under such part; and

(B) the extent to which such entities are meeting the privacy and security standards adopted under such part and the types of penalties assessed for noncompliance with such standards;

(C) whether the Federal and State Government agencies are receiving information of sufficient quality to meet their responsibilities under such part;

(D) any problems that exist with respect to implementing such standards;

(E) the extent to which timelines under such part are being met.”;

SEC. 261. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS.


(1) in clause (iii), by striking “clause (i)” and inserting “clause (ii)”; and

(2) by adding at the end the following:

“(iv) For purposes of this subparagraph, a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to ‘duplicate’ any health benefits under this title, under title XIX, or under a health insurance policy, and subclauses (i) and (III) of clause (i) does not apply to such a policy.

(2) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), providing benefits for long-term care, nursing home care, home health care, or community-based care and that coordinates against or excludes items and services available or paid for under this title and (for purposes of this sentence and (B), after the date of enactment of this clause) that discloses such coordination or exclusion in the policy’s outline of coverage, is not considered to ‘duplicate’ health benefit under this title.

(III) For purposes of this clause, the terms ‘coordinates’ and ‘coordination’ mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes items and services available or paid for under this title.

(iv) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed under any applicable subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance contract which is not a Medicare-related plan, and under which the policy, if any, or the insurance policy, if any, that discloses such coordination or exclusion in its outline of coverage, is considered to ‘duplicate’ health benefits under this title.

(b) CONFORMING AMENDMENTS.—Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

(1) in paragraph (1), by striking “clause (i)” and inserting “with respect to clause (ii)”;

(2) by striking “and” and inserting “or”;

(3) by inserting “(B)” after “(A)”;

(4) by striking “(i)” and inserting “(ii)”; and

(5) by striking “clause (i)” and inserting “clause (ii)”.
(B) by striking "", (ii) the sale" and all that follows up to the period at the end; and
(2) by striking subparagraph (D).

Subtitle H—Medical Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 271. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to—
(1) an action for damages arising from a vaccination and brought in the event that title XXI of the Public Health Service Act applies to the action; or

(b) PREEMPTION.—This subtitle shall preclude any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preclude any State law that provides for defenses or places limitations on a person’s liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) FOREIGN IMMUNITY AND CHOICE OF LAW OF VENUE.—Nothing in subsection (b) shall be construed to—
(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of the Foreign Sovereign Immunities Act of 1976;
(2) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or
(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys’ fees or costs of litigation, if any, shall be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHING QUESTION OF GROUND.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 272. DEFINITIONS.

As used in this subtitle:
(1) ACTUAL DAMAGES.—The term “actual damages” means damages awarded to pay for economic loss.
(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; “ADR”;determined by a decision of the United States Supreme Court in eBay Inc. v. MercExchange, LLC (152 F.3d 1324 (Fed. Cir. 1998)), that “ADR” means a system established under Federal or State law that provides for the resolution of health care liability actions in a manner other than through health care liability actions.
(3) CLAIMANT.—The term “claimant” means any person who brings a health care liability action against any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant’s decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant’s legal guardian.
(4) CLEAR AND CONVINCING EVIDENCE.—The term “clear and convincing evidence” means evidence that, measured or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.
(5) COLLATERAL SOURCE PAYMENTS.—The term “collateral source payments” means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided to a claimant, for the same injury or wrong caused by the defendant, as a result of an injury or wrongful death, pursuant to—
(A) any State or Federal health, sickness, income-disability, accident or workers’ compensation Act; or
(B) any health, sickness, income-disability, or accident insurance policy that provides health benefits or income-disability coverage; or
(C) any contract or agreement of any group, organization, partnership, or corporation, to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and
(D) any other publicly or privately funded program.
(6) DRUG.—The term “drug” has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).
(7) ECONOMIC LOSS.—The term “economic loss” means any pecuniary loss resulting from the wrongful conduct of another, including loss of earnings or earnings capacity, loss of business or employment opportunities, or other losses related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunity, or any other benefits related to employment, medical expense loss, replacement services loss, or loss due to death, burial costs, and loss of business or employment opportunity;
(8) HARM.—The term “harm” means any legally cognizable wrong or injury for which punitive damages may be imposed.
(9) HEALTH BENEFIT PLAN.—The term “health benefit plan” means—
(A) a hospital or medical expense incurred policy or certificate;
(B) a hospital or medical service plan contract;
(C) a health maintenance subscriber contract;
(D) a multiple employer welfare arrangement or other benefit plan (as defined under the Employee Retirement Income Security Act of 1974), or
(E) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act), that provides benefits with respect to health care services.
(10) HEALTH CARE LIABILITY ACTION.—The term “health care liability action” means a civil action brought in a State or Federal court against a health care provider, an entity that is engaged in the delivery of health care services, or a person or group, organization, partnership, or corporation that provides or reasonably likely to be provided health care services.
(11) HARMFUL CONDUCT.—The term “harmful conduct” means conduct that provides for the resolution of health care liability actions in a manner other than through health care liability actions.
(12) HEALTH CARE PROVIDER.—The term “health care provider” means any person
that is engaged in the delivery of health care services in a State and that is required by the laws of the State to be licensed or certified by the State to engage in the delivery of such services.
(13) HEALTH CARE SERVICE.—The term “health care service” means any service for which payment may be made under a health benefit plan, regardless of the reason for payment, including the delivery or administration of such service.
(14) MEDICAL DEVICE.—The term “medical device” has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).
(15) NONECONOMIC DAMAGES.—The term “noneconomic damages” means damages payable for an injury or wrong other than that required for proof beyond a reasonable doubt.
(16) PERSON.—The term “person” means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.
(17) PRODUCT SELLER.—The term “product seller” means a person who, in the course of a business, conducts business or employs agents who sells, distributes, rents, leases, prepares, blends, packages, labels a product, is otherwise involved in placing a product in the stream of commerce, or otherwise participates in the harm-causing aspect of a product.
(18) PUNITIVE DAMAGES.—The term “punitive damages” means damages awarded against any person not to compensate for actual injury, but to punish or deter such person or others from engaging in similar behavior in the future.
(19) STATE.—The term “State” means each of the several States, the District of Columbia, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 273. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 281. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the Statute of Limitations period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no event after the expiration of the 5-year period that begins on the date the alleged injury occurred.

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TREATMENT OF NONECONOMIC DAMAGES—

(1) LIMITATION ON NONECONOMIC DAMAGES.—

The damages for noneconomic harm that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, unless the claimant establishes by clear and convincing evidence to be substantially out of proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) PROPORTIONAL AWARDS.—The amount of punitive damages that may be awarded in any health care liability action subject to this subsection shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or $250,000, whichever is greater. This paragraph shall be applied by the court and shall not be disclosed to the jury.

(3) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages, and the court shall not deem this subsection to preempt or supersede any State or Federal law to the extent that law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(5) DRUGS AND DEVICES.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceed $50,000, a person shall not be required to pay any single, lump-sum payment, but shall be permitted to make such payments periodically on when the damages are found likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If the claimant introduces evidence of such payments, the court shall determine the amount of such payments and may introduce evidence of collateral source payments. If the claimant introduces evidence of such payments, the court shall determine the amount of such payments and may introduce evidence of collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to a judgment for the claimant's medical expenses. The court shall determine the amount of such payments and may introduce evidence of collateral source payments. If the claimant introduces evidence of such payments, the court shall determine the amount of such payments and may introduce evidence of collateral source payments.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to any action that is settled as well as an action that is resolved by a fact finder.

SEC. 283. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action, or any additional provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments that are identical or substantially similar to provisions in this section, shall not be admissible as evidence and shall not affect the provisions relating to such matters in this subtitle.

TITLE III—TAX-RELATED HEALTH CARE LIABILITY ACTIONS

SEC. 300. 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—Medical Savings Accounts

SEC. 301. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VI of subchapter B of chapter 1 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

\(\text{-(a) Deduction Allowed.—In the case of an individual who is an eligible individual for the taxable year, the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.}\)

\(\text{(b) Limitations.—}\)

\(\text{(I) IN GENERAL.—Except as otherwise provided in this subsection, the aggregate amount allowed as a deduction under subsection (a) to an individual for the taxable year shall not exceed—}\)

\(\text{(A) The lesser of—}\)

\(\text{(i) $2,000, or}\)

\(\text{(ii) the annual deductible limit for any individual covered under the high deductible health plan, or}\)

\(\text{(B) in the case of a high deductible health plan covering the taxpayer and any other eligible individual who is covered under any other high deductible health plan.}\)

The preceding sentence shall not apply if the spouse of such individual is covered under any other high deductible health plan.

(2) SPECIAL RULE FOR MARRIED INDIVIDUALS.

(A) IN GENERAL.—This subsection shall be applied separately for each married individual.

(B) SPECIAL RULE.—If individuals who are married to each other are covered under the same high deductible health plan, then the amounts applicable under paragraph (1)(B) shall be divided equally between them unless they agree on a different division.

(C) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid by all individuals.

(D) AGGREGATE AMOUNT OF DEDUCTIBLES REQUIRED TO BE PAID BY ALL INDIVIDUALS.

The aggregate amount of deductibles required to be paid by all individuals.

(E) QUALIFIED MEDICAL EXPENSES.—In determining the aggregate amount of deductibles required to be paid by all individuals. The aggregate amount of deductibles required to be paid by all individuals.

(F) TAXABLE YEAR.—For purposes of this section, the term "taxable year" means the calendar year that the individual is an eligible individual for the taxable year.

SEC. 301A. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action, or any additional provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments shall be identical or substantially similar to provisions in this section.
equal to ½ of the limitation which would
(but for this paragraph and paragraph (3) be
determined under paragraph (1) if the facts
and circumstances as of the first day of such
month were such that a high deductible health
plan covered under a high deductible health plan were true for
the entire taxable year.
(5) DENIAL OF DEDUCTION TO DEPEND-ENT'S INTEREST SHALL BE ALLOWED UNDER
this section to any individual with respect to
whom a deduction under section 151 is allow-
able to another taxpayer for a taxable year
beginning in the calendar year in which such
individual's taxable year begins.
(6) Definitions.—For purposes of this sec-
tion—
(1) Eligible individual.—
(A) In general.—The term 'eligible indi-
vidual' means, with respect to any month,
any individual who—
(i) who is covered under a high deductible
deplan as of the 1st day of such month,
and
(ii) who is not, while covered under a high
deductible health plan, covered under any
health plan—
(1) which is not a high deductible health
plan,
(2) which provides coverage for any
benefit which is covered under the high
 deductible health plan,
(3) health insurance paying a fixed amount per
day (or other period) of hospitalization.
(B) Certain coverage disregarded.—
Subparagraph (A)(ii) shall be applied without
regard to—
(1) coverage for any benefit provided by
permitted insurance,
(2) coverage (whether through insurance
or otherwise) for accidents, disability, dental
care, vision care, or long-term care.
(C) high deductible health plan.—The term 'high deductible
health plan' means a plan which—
(1) has an annual deductible limit for
each individual covered by the plan which is
not less than $1,500, and
(2) has an annual limit on the aggregate
amount of deductibles required to be paid
with respect to all individuals covered by the
plan which is not less than $3,000.
Such term does not include a health plan if
substantially all of its coverage is coverage
described in paragraph (1)(B). A plan shall
not fail to be treated as a high deductible
health plan by reason of failing to have a de-
ductible or an annual limit on the amount of a
deductible for such care is required by
State law.
(D) permitted insurance.—The term 'per-
mitted insurance' means—
(A) Medicare supplemental insurance,
(B) insurance if substantially all of the
coverage provided under such insurance re-
lates to—
(1) liabilities incurred under workers' compensation
laws,
(2) tort liabilities,
(3) liabilities relating to ownership or use of property,
or
(4) other similar liabilities as the Secretary may specify by
regulation.
(C) insurance for a specified disease or illness,
and
(D) insurance paying a fixed amount per
day (or other period) of hospitalization.
(E) medical savings account.—For pur-
poses of this section—
(1) Medical savings account.—The term 'medical savings
account' means a trust created or organized in the United States exclu-
sively for the purpose of paying the qualified medical expenses of the account holder, but only if the governing instrument creating the trust meets the following re-
quirements:
(A) Except in the case of a rollover con-
tribution described in subsection (f)(5), no
contribution will be accepted—
(i) unless it is in cash, or

(ii) to the extent such contribution, when
added to previous contributions to the trust
for the calendar year, exceeds $4,000.
(B) The trustee is a bank as defined in
section 4003(n), an insurance company as defined in section 816, or another person
who demonstrates to the satisfaction of the Sec-
retary that the manner in which such person
will administer the trust is consistent with the
requirements of this section.
(C) No part of the trust assets will be
invested in life insurance contracts.
(D) No part of the trust will not be com-
mingle with other property except in a
common trust fund or common investment
fund.
(E) The interest of an individual in the balance in his account is nonforfeitable.
(F) QUALIFIED MEDICAL EXPENSES.—
(A) In general.—The term qualified medical expenses means, with respect to an
account holder, amounts paid by such holder
for medical care (as defined in section 213(d)) for such individual, the spouse of such indi-
vidual, and any dependent (as defined in sec-
tion 152) of such individual, but only to the
extent such amounts are not compensated
for by insurance or otherwise.
(B) Health plan may not be pur-
chased from account.—
(i) In general.—Subparagraph (A) shall not apply to any
insurance payment.
(ii) Exception.—Subparagraph (A) shall not apply to any expense for coverage under—
(I) a health plan during any period of con-
tinuous coverage required under any Federal
law,
(ii) a qualified long-term care insurance contract (as defined in section 7702B(b)), or
(iii) a health plan during a period in which the individual is receiving unemployment
compensation under any Federal or State
law.
(C) Account holder.—The term 'account holder' means the individual on whose behalf
the medical savings account was established.
(D) Certain rules to apply.—Rules simi-
lar to the following rules shall apply for pur-
poses of this section:
(1) Section 219(d)(2) (relating to no deduc-
tion for rollovers).
(2) Section 219(f)(3) (relating to time
when contributions deemed made).
(C) except as provided in section 106(b),
section 219(f)(5) (relating to employer pay-
ments).
(2) Distribution of Account Holder.—
The term 'account holder' means the individual on whose behalf the medical savings account was established.
(D) Certain rules to apply.—Rules simi-
lar to the following rules shall apply for pur-
poses of this section:
(1) Section 219(d)(2) (relating to no deduc-
tion for rollovers).
(2) Section 219(f)(3) (relating to time
when contributions deemed made).
(E) Except as provided in section 106(b),
section 219(f)(5) (relating to employer pay-
ments).
(2) Distribution of Account Holder.—
The term 'account holder' means the individual on whose behalf the medical savings account was established.
(D) Certain rules to apply.—Rules simi-
lar to the following rules shall apply for pur-
poses of this section:
(1) Section 219(d)(2) (relating to no deduc-
tion for rollovers).
(2) Section 219(f)(3) (relating to time
when contributions deemed made).
(E) exception for distributions after
age 59½.—Subparagraph (A) shall not apply if the payment or distribution is made after the
account holder attains age 59½.
(F) rollover contribution.—An amount
is described in this paragraph as a rollover
contribution if it meets the requirements of
subparagraphs (A) and (B).
"(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a medical savings account to the account holder to the extent the amount received by such medical savings account for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

(2) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in such an account to the individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 70(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a medical savings account with respect to which the spouse is the account holder.

(3) COST-OF-LIVING ADJUSTMENT.—Amounts received for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) shall be treated as not contributed.
(B) an individual retirement account described in section 408(a),
(C) an individual retirement annuity described in section 408(b),
(D) a medical savings account described in section 220(d), or
(E) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.

(h) Failure To Provide Reports on Medical Savings Accounts.

(1) The amendment of section 6666 (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

(a) In general—If a person required to file a report under such provision referred to in this subparagraph fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

(b) Provisions.—The provisions referred to in this paragraph are—

(1) sections 1201(a) and 1201(b) (relating to individual retirement plans), and
(2) section 220(d) (relating to medical savings accounts).

(i) Exception From Capitalization of Policy Acquisition Expenses.—Subparagraph (A) of paragraph (1)(d) (defining a qualified insurance contract) is amended by striking “and” at the end of clause (ii), by striking the period at the end of clause (iii) and inserting “and”, and by adding at the end the following new clause:

“(iv) any contract which is a medical savings account (as defined in section 220(d)).

(j) Section Reference.—

(1) The table of sections for part VII of chapter 11 is amended by striking “and” at the end of subparagraph (A) of section 220(d).”.

(k) Effective date.—

(1) The table of sections for part IV of subchapter B of chapter 11 is amended by adding at the end the following new item:

“Sec. 221. Medical savings accounts.

Sec. 221. Cross reference.”

(2) The table of sections for part IV of subchapter C of chapter 11 is amended by adding at the end the following new section:

“Sec. 2057. Medical savings accounts.”

(l) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) In General.—(1) ALLOWANCE OF DEDUCTION.—

(A) In general.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount which—

(i) is paid, assigned, or pledged as collateral for a loan, or
(ii) borrowed, other than as provided in subparagraph (E) or paragraph (2)(C),

(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

(F) such contract meets the requirements of subsection (f).

(2) SPECIAL RULES.—

(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be described in subparagraph (A) or paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(B) SPECIAL RULES RELATING TO MEDICAL CARE.—

(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payer.

(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

(c) Reduced Premiums.—Paragraph (1) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid for the contract. Any refund on a complete surrender or cancellation of the contract shall be includable in gross income to the extent that any deduction or exclusion was allowable with respect to such premiums.

(d) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—

(1) IN GENERAL.—If the aggregate amount of periodic payments under all qualified long-term care insurance contracts with respect to an insured for any period exceeds $10,000, the dollar amount in effect for such period

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under paragraph (3), such excess payments shall be treated as made for qualified long-term care services only to the extent of the costs incurred by the payee (not otherwise compensated) for qualified long-term care services provided during such period for such insured.

(2) PERIODIC PAYMENTS.—For purposes of paragraph (1) of this subsection, the term "periodic payment" means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

(3) DOLLAR AMOUNT.—The dollar amount in effect under this subsection shall be $175 per calendar year after 1997, the dollar amount contained in subparagraph (B) of paragraph (1) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213d(10).

(e) 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 a rider on or as part of a life insurance contract—

(1) this section shall apply as if the portion of the contract providing such coverage is a separate contract.

(2) APPLICATION OF 7702.—Section 7702(c)(12) (relating to the applicability of the guidelines for premium limitations) 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) against the life insurance contract’s cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage 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).

(3) APPLICATION OF SECTION 212.—No deduction shall be allowed under section 212(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 7702(f)(12). This section shall apply as if the portion of the contract providing such coverage is a separate contract.

(4) PORTION DEFINED.—For purposes of this subsection, the term "portion" means any long-term care insurance contract which provides employees with coverage under which—

(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the excess of the amount of reimbursement which is reasonably available to a participant for such coverage is less than 50 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably determinable shall be determined on the basis of the underlying coverage.

(c) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Subsection (f) of section 7702B is amended by adding at the end the following new paragraph:

(9) CONTINUATION OF LONG-TERM CARE COVERAGE NOT REQUIRED.—A group health plan shall not be treated as failing to meet the requirements of this subsection solely by reason of failing to provide coverage under any qualified long-term care insurance contract (as defined in section 7702B(b)) for periods described in section 7702B(f)(1) to the extent such coverage is a separate contract.

(d) 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 qualified long-term care insurance.".

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1996.

(2) CONTINUATION OF EXISTING POLICIES.—In the case of any contract issued before January 1, 1997, which met the long-term care insurance requirements of the State in which the contract was used at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as if it provided qualified long-term care insurance coverage under which—

(i) a participant is covered for medical care if such service is provided during such period for such insured.

(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

(i) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

(ii) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

(f) CANCELLATION OF CONTRACTS TREATED AS NOT PAID FOR MEDICAL CARE.—An amount paid for a qualified long-term care insurance contract (as defined in section 7702B(c)) provided by an individual shall be treated as not paid for medical care if such service is provided—
"(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with whom the individual bears a relationship;

"(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 any of paragraphs (1) through (8) of section 252(a). This paragraph shall not apply for purposes of section 101(b) with respect to reimbursements through insurance.

(3) Paragraph (6) of section 213(d) is amended—

(A) by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)"; and

(B) by striking "paragraph (1)(C)" in subparagraph (A) and inserting "paragraph (1)(D)".

(4) Paragraph (7) of section 213(d) is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

(c) EFFECTIVE DATE.—

(1) In General.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

(2) DEDUCTION FOR LONG-TERM CARE SERVICES.—The nonforfeiture provisions of section 7702B(c) of the Internal Revenue Code of 1986, as added by this Act, are amended by inserting the following new subsection:

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report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet any waiting period or because of any applicable preexisting condition.

(iii) Section 20 (relating to filing requirements) is amended by adding at the end the following new paragraph:

(A) the issuance of a qualified accelerated death benefit rider under an arrangement with the organization, for purposes of this section, the term ‘qualified accelerated death benefit rider’ means any rider on a life insurance contract that is not in conflict with or inconsistent with the standards established under such Code.

SEC. 328. EFFECTIVE DATES.

(a) In General.—The provisions of, and amendments made by, this part shall apply to contracts issued after December 31, 1996.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 331. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of a policyholder or certificateholder (or representative) who is a terminally ill individual,

(2) in the case of any amount received under a life insurance contract by reason of the death of an individual who is a chronically ill individual (as defined in section 7702B(c)(2)), or

(3) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

Subtitle D—Treatment of Accelerated Death Benefits.

SEC. 332. 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 the following new subsection:

(1) in the case of any amount paid to any taxpayer other than the insured, an insurer, or any person related to the insured or such insurer, the term ‘qualified accelerated death benefit rider’ means any rider on a life insurance contract that is not in conflict with or inconsistent with the standards established under such Code.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 333. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual, the term ‘qualified accelerated death benefit rider’ means any rider on a life insurance contract that is not in conflict with or inconsistent with the standards established under such Code.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 334. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 335. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 336. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 337. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 338. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 339. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 340. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) In General.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

(1) in the case of any amount received under a life insurance contract by reason of the death of such a policyholder or certificateholder (or representative) who is a terminally ill individual.

(b) Effective Date.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 341. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS.

(a) In General.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

(2) Any membership organization if—

(A) such organization is established by a State exclusively to provide coverage for high-risk individuals (as defined in paragraph (1) of section 213(d) on a not-for-profit basis to individuals described in subparagraph (B) through—

(i) insurance issued by the organization, or

(ii) a health maintenance organization under an arrangement with the organization,
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“(B) the only individuals receiving such coverage through the organization are individuals—

(i) who are residents of such State, and

(ii) by reason of the existence of a history of a medical condition, are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization at a reasonable rate which is substantially in excess of the rate for such coverage through the organization, and

(C) the composition of the membership in such organization is specified by such State, and

(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual.”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle F—Organizations Subject to Section 833

SEC. 351. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c)(1) (relating to organization to which section applies) is amended by striking at the end the following new paragraph:

“(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

(B) APPLICATION.—An organization is described in this subparagraph if—

(i) it is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations, and

(ii) it is not a Blue Cross or Blue Shield organization or organization maintenance organization.”;

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after December 31, 1996.

TITLE IV—REVENUE OFFSETS

SEC. 400. 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—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

SEC. 401. REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS.

(a) IN GENERAL.—Section 593 (relating to reserves for losses on loans) is amended by adding at the end the following new subsection:

“Termination of Reserve Method.—

Subsections (a), (b), (c), and (d) shall not apply to any taxable year beginning after December 31, 1995.

(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

(I) IN GENERAL.—In the case of any taxpayer who is required by reason of subsection (f) to change its method of computing reserves for bad debts—

(A) such change shall be treated as a change in a method of accounting,

(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

(C) the net amount of the adjustments required to be taken into account by the taxpayer under this paragraph shall—

(i) be determined by taking into account only applicable excess reserves, and

(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

(II) APPLYING TO TAXABLE YEARS.—

(A) IN GENERAL.—For purposes of paragraphs (1) and (2), the term ‘applicable excess reserves’ means the excess (if any) of—

(1) the applicable excess reserves described in subsection (c)(I) (other than the supplemental reserve) as of the close of the taxpayer’s last taxable year beginning before December 31, 1995, over the amount which would be the balance of the reserve taken into account under subparagraph (A)(ii) of this subsection, and

(2) the lesser of—

(II) the balance of such reserves as of the close of the taxpayer’s last taxable year beginning before January 1, 1988, or

(III) the balance of the reserves described in clause (I), reduced in the same manner as under subparagraph (A) of section 585(b)(2), to the extent that such reserves described in clause (I) and this clause.

(B) SPECIAL RULE FOR THRIFTS WHICH BECOME SMALL BANKS.—In the case of a bank (as defined in section 581) which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995—

(i) the balance taken into account under subparagraph (A)(ii) shall not be less than the amount which would be the balance of such reserves at the close of the last taxable year before the disqualification year over the balance taken into account under paragraph (2)(A)(ii) of this subsection.

(II) the amount of such adjustment.

(C) RECAPTURE OF PRE-1988 RESERVES WHERE TAXPAYER CEASES TO BE BANK.—If, during any taxable year beginning after December 31, 1995, a taxpayer to which paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in paragraph (2)(A)(ii) and the supplemental reserve; except that such reserves shall be taken into account ratably over the 6 taxable year period beginning with such taxable year.

(4) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN.—

(A) IN GENERAL.—In the case of a bank which meets the residential loan requirement of subparagraph (B) for the first taxable year beginning after December 31, 1995, or for the following taxable year—

(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

(ii) such taxable year shall be disregarded in determining—

(II) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

(III) the amount of such adjustment.

(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such year is not less than the base amount for such year.

(C) RESIDENTIAL LOAN.—For purposes of this paragraph, the term ‘residential loan’ means any loan described in clause (v) of section 7701(a)(19)(C) but only if such loan is incurred in acquiring, constructing, or improving the principal residence or other residence of such clause.

(D) BASE AMOUNT.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning on or before December 31, 1995. At the election of the taxpayer, 6 taxable years during each of such 6 taxable years, the preceding sentence shall be applied without regard to the taxable year in which such principal amount is the highest principal amount in such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after such date, and if made for such taxable year, shall apply to the succeeding taxable year unless revoked with the consent of the Secretary.

(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995—

(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A) and, there shall be taken into account only the excess reserves (as defined in section 585(b)(2)) at the close of the last taxable year before the disqualification year over the balance taken into account under paragraph (2)(A)(ii) of this subsection.

(II) the amount of such adjustment.

(6) SUSPENDED RESERVE INCLUDED AS SECTION 381(c) ITEMS.—The balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection and the supplemental reserve shall be treated as items described in section 381(c).

(7) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 501(c) and exempt from taxation under section 501(a)—

(A) any amount required to be included in the gross income of the taxpayer which results from the conversion of this subsection shall be treated as derived from an unrelated trade or business (as defined in section 513), and

(B) for purposes of paragraph (3), the credit union shall not be treated as if it were a bank.

(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection and section (e), including regulations providing for the application of such subsections in the case of acquisitions, mergers, spin-offs, and other reorganizations.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 501 is amended by adding at the end the following new sentence:

“Paragraphs (1)(A), (2)(A), and (4) of the section are referred to in paragraph (1) of this subsection shall not apply to any taxable year beginning after December 31, 1995.”

(2) Subsection (e) of section 52 is amended by striking paragraphs (2) and (3) as redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (3).

(4) Section 246 is amended by striking subsection (f).
such stock may be redeemed). Which is 30 days after the earliest date that
after October 31, 1995, and before the dis-
stock if—
any distribution with respect to preferred
made by subsection (b)(7) shall not apply to

chapter H of chapter 1 is amended by strik-

is amended by striking ``or to which section

subsection (f).

amended by striking ``or 593''.

graphs (2) and (3), respectively, and
inserting ``The'', paragraph (2), the'' in paragraph (1) and in-

amended—
(A) by striking "Except as provided in paragraph (2), the" in paragraph (1) and in-

"The",
(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as para-
graphs (2) and (3), respectively, and
(C) by striking in paragraph (2) (as so re-
designated) all that follows "subsection" and insert-

a period.
(11) Paragraph (3) of section 599(e) is amended by adding at the end the following new sentence: "This paragraph shall not apply to any distribution of all of the stock of a bank (as defined in section 561) to
another corporation if, immediately after the distribution, such bank and such other cor-
poration are members of the same affiliated group as defined in section 1362 and the pri-

visions of section 5(e) of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect.''
(12) Section 1038 is amended by striking subsection (f).
(13) Clause (ii) of section 1042(c)(4)(B) is amended by striking "or 593''.
(14) Subsection (c) of section 1277 is amend-
ed by striking "or to which section 593 ap-
plies".
(15) Subparagraph (B) of section 1361(b)(2) is amended by striking "or to which section 593 ap-
plies".
(16) The table of sections for part II of sub-
chapter H of chapter 1 is amended by strik-
ing the items relating to sections 595 and 596.
(c) EFFECTIVE DATES.—
(1) IN GENERAL.—Except as otherwise pro-
vided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1995.
(2) SUBSECTION (b)(7).—The amendments made by subsection (b)(7) shall not apply to any distribution with respect to preferred stock if—
(A) such stock is outstanding at all times after October 31, 1995, and before the dis-

tribution, and
(B) such distribution is made before the date which is 1 year after the date of the en-
actment of this Act (or, in the case of stock which may be redeemed, if later, the date which is 30 days after the earliest date that such stock may be redeemed).
(3) SUBSECTION (b)(8).—The amendment made by subsection (b)(8) shall apply to prop-
erty held in taxable years beginning after December 31, 1995.
(4) SUBSECTION (b)(10).—The amendments made by subsection (b)(10) shall not apply to any distribution of stock by a taxpayer if such interest has been held by such taxpayer at all times after October 31, 1995.

Subtitle B—Reform of the Earned Income Credit

SEC. 411. EARNED INCOME CREDIT DENIED TO INDIVIDUALS NOT AUTHORIZED TO BE EMPLOYED IN THE UNITED STATES.

(a) IN GENERAL.—Section 32(c)(1) (relating to individuals eligible to claim the earned income credit) is amended by adding at the end the following new subparagraph:
"(i) such individual’s taxpayer identification number, and
"(ii) if the individual is married (within the meaning of section 70B), the taxpayer identification number of such individual’s spouse.
(b) SPECIAL IDENTIFICATION NUMBER.—Section 32 is amended by adding at the end the following new subsection:
"(1) IDENTIFICATION NUMBERS.—Solley for purposes of subsections (c)(1)(F) and (c)(3)(D), a taxpayer identification number means a social security number issued to an individual by the Social Security Adminis-

tration (other than a social security number issued pursuant to clause (ii) or (that portion of clause (iii) that relates to clause (ii)) of section 205(c)(2)(B)(i) of the Social Security Act.).
"(2) EXTENSION OF PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Section 6213(g)(2) (relating to the definition of mathematical or clerical errors) is amend-
ed by striking "and" at the end of subpara-

graph (D) of section 6213(g)(2) and inserting a comma, and by inserting after subparagraph (E) the following new subparagraph:
"(E) an omission of a correct taxpayer identification number required under section 32 (relating to the earned income credit) to be included on a return, and
"(F) an omitted or incorrect taxpayer identification number required under section 32 (relating to the earned income credit) to be included on a return, and

(1) IN GENERAL.—Section 877 is amended by adding at the end the following new sentence: "This paragraph shall not apply to an individual if—
"(A) such individual is described in a sub-

paragraph of paragraph (2) of this subsection, and
"(B) within the 1-year period beginning on the date of the loss of United States citizen-
ship, such individual submits a ruling re-
quest for the Secretary’s determination as to whether such loss has for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B.
"(2) INDIVIDUALS DESCRIBED.—
"(A) DUAL CITIZENSHIP, ETC.—An individual is described in this subsection if—
"(i) the individual became at birth a citi-

zener of the United States and a citizen of another country and continues to be a citizen of such other country, or
"(ii) the individual becomes (not later than the close of a reasonable period after loss of United States citizenship) a citizen of the country in which—
"(i) such individual was born,
"(ii) if such individual is married, such indi-

vidual’s spouse was born, or
"(iii) either of such individual’s parents were born.
"(B) LONG-TERM FOREIGN RESIDENTS.—An individual is described in this subsection if, for each year in the 10-year period ending on the date of loss of United States citizen-
ship, the individual was present in the Unit-


ated States for 30 days or less. The rule of sec-

tion 701(b)(3)(D)(ii) shall apply for purposes of this subparagraph.
"(C) RENUNCIATION UPON REACHING AGE OF MAJORITY.—An individual is described in this subsection if the individual attains age 18 after the date of loss of United States citizen-
ship occurs before such individual attains age 18.
"(D) INDIVIDUALS SPECIFIED IN REGULA-

tions.—An individual is described in this subparagraph if the individual is described in a category of individuals prescribed by regu-
lation by the Secretary.
"(2) TECHNICAL AMENDMENT.—Paragraph (1) of section 877(b) of such Code is amended by striking "subsection (c)" and inserting "subsection (d)."
"(3) TREATMENT OF PROPERTY DISPOSED IN NONRECOGNITION TRANSACTIONS; TREAT-

MENT OF DISTRIBUTIONS FROM CERTAIN CON-

TROLLED FOREIGN CORPORATIONS.—Sub-
section (d) of section 877 of such Code is amended by adding at the end the following new sub-
section:
"(1) SOURCE RULES.—The following items of gross income shall be treated as income from sources within the United States:
"(A) SALE OF PROPERTY.—Gains on the sale or exchange of property (other than stock or debt obligations) located in the United States:
"(B) STOCK OR DEBT OBLIGATIONS.—Gains on the sale or exchange of stock issued by a dom-

estic corporation or debt obligations of
United States persons or of the United States, a State or political subdivision thereof, or the District of Columbia.

(C) INCOME OR GAIN DERIVED FROM CONTROLLED FOREIGN CORPORATIONS.—Income or gain derived from a foreign corporation that is controlled by reason of owning or otherwise possessing the significant ownership (as defined in section 956(a), as modified by subparagraph (A), or is considered owning by applying the ownership rules of section 956(b), at any time during the 2-year period ending on the date of loss of United States citizenship, more than 50 percent of—

(i) the total combined voting power of all classes of stock entitled to vote of such corporation, or

(ii) the total value of the stock of such corporation, and

(iii) to the extent such income or gain does not exceed the earnings and profits attributable to such stock which were earned or accumulated before the loss of the citizenship and during periods that the ownership requirements of clause (i) are met.

(2) GAIN RECOGNITION ON CERTAIN EXCHANGES.—

(A) IN GENERAL.—In the case of any exchange of property to which this paragraph applies, notwithstanding any other provision of this title, such property shall be treated as sold for its fair market value on the date of such exchange, and the gain shall be recognized on such exchange in whole or in part for purposes of this subtitle.

(B) EXCHANGES TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any exchange during the 10-year period described in subsection (a) if—

(i) the gain would not (but for this paragraph) be recognized on such exchange in whole or in part for purposes of this subtitle.

(ii) income derived from such property was from sources within the United States (or, if so derived, would have been from such sources), and

(iii) income derived from the property acquired in the exchange would be from sources outside the United States.

(C) EXCEPTION.—Subparagraph (A) shall not apply if the individual enters into an agreement with the Secretary which specifies that any income or gain derived from the property acquired in the exchange (or any other property which has a basis determined by reference to any such property) during such 10-year period shall be treated as from sources within the United States. If the property transferred in the exchange is disposed of by the person acquiring such property, such agreement shall terminate and any gain which was not recognized by reason of such agreement shall be recognized as of the date of such disposition.

(D) SECRETARY MAY EXTEND PERIOD.—To the extent provided in regulations prescribed by the Secretary, subparagraph (B) shall be applied with respect to an exchange of property during any 15-year period beginning 5 years before the loss of United States citizenship for the 10-year period referred to therein.

(E) SECRETARY MAY REQUIRE RECOGNITION OF GAIN IN CERTAIN CASES.—To the extent provided in regulations prescribed by the Secretary—

(i) the removal of appreciated tangible personal property from the United States, and

(ii) any other occurrence which (without regard to this paragraph) results in a change in the source of the income or gain from property from sources within the United States to sources outside the United States, shall be treated as an exchange to which this paragraph applies.

(3) SUBSTANTIAL DIMINISHING OF RISKS OF OWNERSHIP.—For purposes of determining whether this section applies to any gain on the sale or exchange of any property, the running of the 10-year period described in subsection (a) shall be suspended for any period during which the individual's risk of loss with respect to the property is substantially diminished by—

(A) the holding of a put with respect to such property (or similar property), or

(B) the holding by another person of a right to acquire the property, or

(C) a short-term transaction.

(4) CREDIT FOR FOREIGN TAXES IMPOSED ON UNITED STATES SOURCE INCOME.

(A) IN GENERAL.—Subsection (a) of section 877 is amended by adding the following new sentence: "The tax imposed solely by reason of this section shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section.

(B) Subsection (a) of section 877, as amended by subsection (a), is amended by inserting "(after any reduction in such tax under the last sentence of such subsection)" after "such subsection."

(e) COMPARABLE ESTATE AND GIFT TAX TREATMENT.

(1) ESTATE TAX.—

(A) IN GENERAL.—Subsection (a) of section 2010(b) is amended to read as follows:

"The tax imposed solely by reason of this subsection shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section.

(B) The tax imposed solely by reason of this subsection shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section.

(2) GIFT TAX.—

(A) IN GENERAL.—Subsection (c) of section 2503 is amended by inserting "and by reason of section 877(c)" after "subparagraph (A) of section 2503(a)."

(B) Subsection (c) of section 2503, as amended by paragraph (A), is amended by inserting "and by reason of section 877(c)" after "subsection (A)."

(3) EXCEPTION.—

(A) CERTAIN INDIVIDUALS.—Paragraph (2) shall not apply in the case of a donor who, within the 10-year period ending with the date of transfer, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

(B) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of subparagraph (A), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 2107(b) for the taxable year under the provisions of this paragraph or if such individual is so treated under section 2107(b) for any taxable year before the taxable year under the provisions of this paragraph.

(C) EXCEPTION FOR CERTAIN INDIVIDUALS.—Subparagraph (B) shall not apply to a decedent meeting the requirements of section 877(c)(1).

(D) CREDIT FOR FOREIGN GIFT TAXES.—The tax imposed by this section solely by reason of the provisions of this paragraph shall be credited with the amount of any gift tax actually paid to any foreign country in respect of any gift which is taxable under this section solely by reason of the provisions of this paragraph.

(f) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.

(A) IN GENERAL.—Section 877 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

"(f) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

(1) A nonresident alien individual who ceases to be a lawful permanent resident of the United States who—

(i) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(a)(20)),

(ii) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country, shall be treated for purposes of this section in the same manner as if such resident were a citizen of the United States who lost United States citizenship on the date of such cessation or commission.

(2) LONG-TERM RESIDENT.—For purposes of this section, the term "long-term resident" means an individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the event described in subparagraph (A) or (B) of paragraph (1) occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country.
''(3) SPECIAL RULES.—

(A) EXCEPTIONS NOT TO APPLY.—Subsection (c) shall not apply to an individual who is treated as provided in paragraph (1).

(B) EXCEPTION.—In applying paragraph (1) for purposes of determining any tax imposed by reason of this subsection, property which was held by the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.

''(4) AUTHORITY TO EXCEPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.

''(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry into effect the provisions of this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''

(2) CONFORMING AMENDMENTS.—

(A) Section 2107 is amended by striking subsection (e) and inserting after such subsection (f) as redesignated the following:

``(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry into effect the provisions of this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''

''(c) CROSS REFERENCE.—

For comparative treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''

(B) Paragraph (2) of section 2107(e) (as amended by subsection (c)) is amended by adding at the end the following new subparagraph:

``(2) SPECIAL RULE.—In applying paragraph (1) for purposes of determining any tax imposed by reason of this subsection, property which was held by the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.\n
''(4) AUTHORITY TO EXCEPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.\n
''(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry into effect the provisions of this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''

(2) CONFORMING AMENDMENTS.—

(A) Section 2107 is amended by striking subsection (e) and inserting after such subsection (f) as redesignated the following:

``(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry into effect the provisions of this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''

''(c) CROSS REFERENCE.—

For comparative treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''

(2) Special Rule.—In applying paragraph (2) of section 2107(e) (as amended by subsection (c)) is amended by adding at the end the following new subparagraph:

``(2) SPECIAL RULE.—In applying paragraph (1) for purposes of determining any tax imposed by reason of this subsection, property which was held by the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.\n
''(4) AUTHORITY TO EXCEPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.\n
''(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry into effect the provisions of this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''

(2) CONFORMING AMENDMENTS.—

(A) Section 2107 is amended by striking subsection (e) and inserting after such subsection (f) as redesignated the following:

``(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry into effect the provisions of this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''

''(c) CROSS REFERENCE.—

For comparative treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''

(g) Effective Date.—

(1) GENERAL.—The amendments made by this section shall apply to—

(A) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(B) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after February 6, 1995.

(2) Special Rule.—In general, in the case of an individual who performed an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)-(4)), before February 6, 1995, but who did not, on or before such date, furnish to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of such act, the amendments made by this section and section 11249 shall apply to such individual except that—

(i) the 10-year period described in section 877(a) of such Code shall not expire before the end of the 10-year period beginning on the date such statement was furnished, and

(ii) the 1-year period referred to in section 877(c) of such Code, as amended by this section, shall not expire before the date which is 1 year after the date of the enactment of this Act.

(B) Exception.—Subparagraph (A) shall not apply if the individual establishes to the satisfaction of the Secretary of the Treasury that such loss of United States citizenship occurred before February 6, 1994.
The Chair recognizes the gentleman from Texas [Mr. ARCHER].

Mr. ARCHER. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and include extraneous materials on the bill, H.R. 3103.

Mr. Speaker, I yield such time as he may consume to the gentleman from Ohio [Mr. HOBBON].

(Mr. HOBBON asked and was given permission to revise and extend his remarks.)

Mr. HOBBON. Mr. Speaker, I rise in support of the bill.

Mr. Speaker, I want to thank the members and staff of the Commerce and Ways and Means Committees for including administrative simplification in the Health Coverage Availability and Affordability Act. This provision is based on legislation that Tom Sawyer, Nancy Johnson, and I introduced earlier in this Congress.

We have the most advanced health care services in the world due mainly to our success in using technology. We can use this same technology to improve the way our health care system is run. Our provision moves the barriers that have prevented modern technology from replacing outdated, paper-based health information systems.

Today, the lack of uniform standards for financial and administrative health information is a barrier to modernizing health information systems. Most health plans already transmit data electronically, but the data is nonstandard or incomplete, and cannot be used to coordinate benefits or effectively track fraud and abuse.

Uniform standards for health information would enable the private sector to reduce paperwork (which adds nearly 10 cents to every health care dollar), expose fraud (which is difficult to do in a confusing, disjointed paper system), and provide consumers with the information they need to compare health plans and services.

The Health Care Financing Administration [HCFA] is implementing a Medicare transaction system for handling standardized Medicare claims. Under current law, HCFA has the authority to adopt Government standards for health information, and to mandate the use of those standards by the private sector.

Our administrative simplification provision, as it was included in this bill, limits HCFA to adopting standards that already have been developed by a voluntary, consensus process that has included input from the private and public sectors. It establishes a process for the standardization of health data that builds on progress in the private sector.

Our provision was developed over several years in a cooperative effort between the private and public sectors. Political support for our proposal was secured in a bicameral—introduced as H.R. 1766 by Representatives Dave Hobson, Tom Sawyer, and Nancy Johnson, and as S. 872 by Senators Kit Bond and Joseph Lieberman.

Also, as the original author of this provision, I want to clarify that our intention is that health benefits under employee welfare benefit plans would not include hospital or fixed indemnity, specified disease, accident, disability income, dental, and vision benefits.

These provisions and the overall bill respond to the need for health care reform in a responsible way. I encourage Members to vote for the bill.

Mr. ARCHER. Mr. Speaker, I yield 30 seconds to the gentleman from Ohio [Mr. KASICH], the chairman of the Committee on the Budget.

Mr. KASICH. Mr. Speaker, I want to congratulate all of the chairmen on what we are producing here today, which is a fantastic improvement in the lives for all Americans who have been held hostage from changing jobs because of a lack of portability, which we guarantee in this bill, and to give them security in knowing that they have the ability to be secure in their homes are being removed with this bill.

This is a great day for the American people, a great day for the American family, and I applaud it without socializing the system. I thank my colleagues for producing this bill.

Mr. ARCHER. Mr. Speaker, I yield such time as he may consume to the gentleman from Georgia [Mr. COLLINS].

(Mr. COLLINS of Georgia asked and was given permission to revise and extend his remarks.)

Mr. COLLINS of Georgia. Mr. Speaker, I rise in full support of this legislation.

Mr. Speaker, the health care reform legislation now under consideration by the Republican-controlled House of Representatives draws a dramatic contrast against the health care reform legislation considered by Congress in 1994 under a Democrat majority.

The legislation of 1994, crafted by President Clinton and introduced by the Democrat leader, Mr. Richard Gephardt, would have created a new government agency with authority over most of the health care choices each private citizen makes.

This year, however, under a Republican-controlled House, we are considering health care reform legislation that avoids the expansion of government bureaucracy. This legislation responds to the views and concerns expressed by American citizens during the 1994 health care debate when we defeated the Clinton socialistic health care proposal.

This year's reform legislation will provide greater access to health care without increasing government bureaucracy. It will eliminate permanent preexisting condition limitations; ensure greater insurance portability so those who change jobs will have access to coverage; offer greater tax fairness for individuals; provide tax deductible contributions to medical savings accounts targeting those middle-income families who, in today's market, face the most difficult challenge in obtaining coverage.

MSA's create more fairness for small employers and their employees by eliminating barriers to coverage. As a small business owner, I know first hand what kind of limitations small businesses face when trying to establish health care coverage for their employees. Often, providing health care becomes too complicated or too expensive for these employers.

MSA's will be an ideal way for small businesses to assist employees in obtaining health care coverage. MSA's may very well mean the difference between those employees who have no insurance and those that have access to affordable health care.

MSA's will provide the maximum degree of portability for employees. When an employee leaves, he or she will take the MSA to the next job.

MSA's will ultimately reduce the long-term care expenditures of Medicare and Medicaid by promoting the purchase of long-term care insurance. The provision will allow individuals to make a tax-free withdrawal for the purposes of paying long-term care insurance premiums. Long-term is among the largest expenditures in entitlement health care programs. Encouraging citizens to purchase coverage in the private markets means reduced costs to the taxpayers.

MSA's will provide the maximum amount of choice for health care consumers. Individuals and families will have the maximum amount of control over the choices they make in their health care. Maximizing the ability of the consumer to choose means increased competition and cost savings for that individual or family purchasing health coverage.

MSA's have a long history of bipartisan support. In 1994, the Democrat party leader, Representative Gephardt, endorsed MSA's. In 1994, Senator Paul Simon introduced legislation to establish MSA's. In addition, States...
have passed State-level legislation that exempt MSA deposits from State-level taxes.

Mr. Speaker, the MSA provision is one of several very important health care reform components of the Health Coverage Availability and Affordability Act. The health care debate began during the last Congress. Today, in the 104th Congress we are fulfilling the commitment to enact common sense health care reform that will provide greater portability and accessibility of health care for all Americans.

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

Mr. Speaker, today the House considers the Health Coverage Availability and Affordability Act of 1996. This bill, Mr. Speaker, is truly historic. After years of talking about health reform, we are now, with the new Republican majority in this House, going to enact health reform. Most importantly, H.R. 3103 reflects what Americans want in health reform because it addresses the two issues that concern our citizens the most, the affordability and accessibility of health insurance coverage and health care.

A key to increasing the availability of health insurance is insuring portability of coverage if a breadwinner changes jobs. No one should ever say no to a new job simply because he or she fears that the new health insurance company will say no to them. This bill tells workers that they will not have to worry about preexisting conditions limiting their ability to get coverage if they change jobs.

Both to increase the availability and affordability of health care coverage, we establish medical savings accounts. Deductions for MSA’s with health insurance protection ought to be an option available to working Americans. MSA’s offer Americans the ultimate in portability because, with an MSA, you take the money with you and retain the savings to spend on your health care needs, regardless of a change in your employment or life circumstances.

A new study by the Joint Committee on Taxation demonstrates that 650,000 out of the 1 million people who will be covered by MSA’s earn between $40,000 and $75,000 a year while another 120,000 people who will choose MSA’s earn below $40,000 per year.

This bill will give Americans the ability to get coverage by raising the deductibility of health insurance for 3.2 million self-employed Americans. At the beginning of this Congress the deduction had expired. Congress increased it to 30 percent last year, and now we increase it to 50 percent.

H.R. 3103 also provides important incentives for Americans to protect their families through the purchase of long-term care insurance, and it allows for accelerated death benefits for those with terminal illnesses such as cancer or HIV. Both of these important measures were part of our Contract With America.

Our bill makes health insurance and medical care more affordable by attacking a key health care cost driver that runs up costs for everyone, and that is fraud and abuse. It is tough on health care crooks by creating new criminal penalties for health care fraud, expanding other penalties and providing the necessary funds for Federal investigator to route out health care crime.

Another cost driver this bill addresses is the current quagmire of paperwork. The bill will make the process cheaper and easier by promoting a common claims form and electronic transmission of this information.

Finally H.R. 3103 undermines one of the major cost drivers, and that is medical malpractice. It gives real reform and will promote health insurance pooling for small employers.

The bill was truly a group effort by four of the House committees with health jurisdiction. I cannot stress enough what leadership provided in developing this joint initiative by the gentleman from Illinois [Mr. HASTERT] and all the chairmen of the committees involved and their subcommittee. I am particularly grateful for the contribution the bill’s chief cosponsor, the Committee on Ways and Means’ Subcommittee on Health chairman, the gentleman from California [Mr. THOMAS].

Availability and affordability, two issues important to all Americans; both are the prescription for real achievable private sector health care reform this year. I am confident my colleagues will join me in supporting the Health Coverage Availability and Affordability Act of 1996.

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

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

Mr. Speaker, this bill is called the Health Coverage Availability and Affordability Act, but it ain’t. Because of the medical savings accounts and other provisions in here, the Republicans have managed through some legislative sleight of hand to turn a silk purse into a sow’s ear.

The Democratic substitute will, in fact, bring back the Roukema-Kassbaum-Kennedy bill with some technical corrections to make sure that it limits preexisting conditions, and would by far be a better bill, a truly bipartisan bill, one that will pass in the Senate and one that would in fact be signed by the President.

Now, if the Republican intention is to fill up prime time with a bill that they know will pass, it is to me a very sick trick to play on the seniors.

First of all, this bill purports to increase the deduction for self-employed, but really it only does it for 50 percent, and that is in 2003. The Democratic alternative does it at 8 percent, and it does it right up front and pays for it. It is not filimflamming the American public into thinking they are getting something that they are not.

It is also a bad bill because the insurance reforms are weaker. It limits individuals to just one policy and guarantees issue only to small firms of less than 50 people. The rest are out on the street. It spends over $2.5 billion of taxpayers’ money and then their taxes.

We should save easy anti-fraud money for Medicare trust fund relief. Not only are the MSA’s a bad policy, they are a payoff to the Golden Rule Insurance Company who has contributed almost $1.5 million to Speaker Gingrich’s political operations.

If that is not bad enough policy, I do not know what is.

This bill actually increases costs in traditional insurance pools. The MSA’s, the mean ones, will drive up the rates for most people.

The GOP has mislabeled their bill, I suspect intentionally. The GOP anti-fraud provisions contain 3 pro-fraud loopholes: advisory opinions, harder proof for civil monetary penalties, and they are allowing kickbacks in managed care plans. The CBO, the Republican CBO, says their plans will cost the system a billion dollars in tax breaks.

If that is not bad enough policy, I do not know what is.

The payoffs to the AMA is in the malpractice caps that reward doctors. I would remind Members that it was released today that there are over 13,000 doctors convicted of sex crimes and other crimes who are still practicing in this country, who will go untouched if the Republicans remove the malpractice caps.

Mr. Speaker, the GOP expatriate language is too weak. We should do the Dingell-Spratt-Bentsen substitute, and give the people true portability and true reform.

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

Mr. ARCHER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut [Mrs. JOHNSON], the most respected chairman of the Subcommittee on Oversight of the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman, the chairman of the committee, for yielding time to me.

Mr. Speaker, this is a great day or night for Americans. Health security is important to every man, woman, and child. Tonight we take a giant step toward guaranteeing coverage, in spite of preexisting conditions, protecting millions of Americans and their families.

There is also another related MSA tax incentive reform bill, and in fact, with our former colleague Rod Chandler, introduced the first legislation to enable small businesses to group together to provide
lower cost insurance for businesses. Tonight we bring a lot of that thinking. 5 years old, to fruition, and for the first time, we are going to put on the President's desk a reform bill that will really directly affect the lives of our constituents. For them the opportunity to move from job to job, developing their careers, without fear of losing health coverage for their spouse and children.

Twenty-five million workers and dependents are affected by changes in employment alone. 5 million of them, the population because it might jeopardize Sen.

Mr. Speaker, I yield 3 minutes to the distinguished gentlewoman from Connecticut [Mrs. KENNELLY].

Mrs. KENNELLY. Mr. Speaker, this could have been a great night in this Chamber. In fact, we came very close to having this a great night in this Chamber.

Mr. Speaker, Senator KASSEBAUM and Senator KENNEDY introduced a piece of legislation, very simple, very precise, very direct. What that legislation said was, "If you lose your job or if you change your job and you have a pre-existing health condition, you will not lose your health insurance."

What happened? Senator KASSEBAUM daily appealed to her colleagues to keep the bill direct and simple. This very afternoon, Senator BRADLEY stood next to Senator KASSEBAUM. He was very much interested, as many of us have been, that if you have a baby you should be allowed to stay in the hospital for 48 hours. What did he say? He said, "I will not put forth my amendment because it might jeopardize Senator KASSEBAUM's bill."

Mr. Speaker, did that happen over in this side of the House? It certainly did not. The bill that we have before us tonight has 303 additional pages of insurance changes. As I listened to people talk, and we have talked about this bill all day, I hear some on the majority side say that the legislation that we have, we have a very definite policy objective: namely, to make health insurance more affordable. How I wish that was true.

However, two of the most controversial riders, tax breaks for medical savings accounts, and an exemption from State insurance laws for certain health plans, could actually make health insurance higher for many, many people. After all, the cost of health care. Both of these provisions would promote risk skimming, which puts the healthiest Americans in a separate health care plan. For anyone who knows about insurance, you know when you do not have a decent risk pool, the risk pool does not work. We can help millions of Americans by doing a simple, good bill.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from New York [Mr. HOUGHTON], a respected member of the Committee on Ways and Means.

(Mr. HOUGHTON asked and was given permission to revise and extend his remarks.)

Mr. HOUGHTON. Mr. Speaker, I would like to talk on the portability issue. I think it is an important one. I know that a lot of people have talked on it. It will not be the last discussion about this. However, I think it is important. I know a little bit about it, and it is really at the heart of this whole bill.

Mr. Speaker, basically what it does is to free up somebody to work wherever he or she wants. That is not a bad concept. You work for company A and you move to company B, but company B does not have any health insurance program. You get a job at company B, but at a far less salary. You would rather take the job at company B. You cannot do it. You cannot help your family.

Under this condition, you must be given an opportunity to have an insurance policy yourself or through the company, irrespective of where you are working or irrespective of the preexisting conditions. It makes a lot of sense, Mr. Speaker. I fully endorse this. I can see its benefit.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Speaker, I thank my friend, the gentleman from California, for yielding me this time.

Mr. Speaker, let me say to my good friend, the chairman of the Committee on Ways and Means, this bill has certainly changed since it left the Committee. In fact, it has expanded it to include the self-employed. That is unfortunate and it is wrong. It is not the last discussion on it. It will not be the last discussion about this. However, I think it is important. I know a little bit about it, and it is really at the heart of this whole bill.

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Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from California [Mr. HERGER], another respected member of the Committee on Ways and Means.

Mr. HERGER. Mr. Speaker, I believe that the gentleman for yielding time to me.

Mr. ARCHER. In 1996, an estimated 3.1 million self-employed Americans will be unfairly denied adequate tax relief for their health insurance costs. Individuals that receive health care coverage through their employers do not pay taxes on those benefits while self-employed individuals are only allowed to deduct 30 percent of what they spend on health care insurance.

Mr. ARCHER. This mere 30 percent deduction is inadequate, discriminatory, and discourages the self-employed from obtaining proper medical coverage and care. While this bill doesn’t completely end this inequitable tax treatment of the self-employed, it moves us closer to that goal by increasing the health care deduction for the self-employed to 50 percent.

Mr. ARCHER. I urge my colleagues to support the self-employed in this country by adopting this much-needed legislation.

Mr. STARK. Mr. Speaker, I yield 4 minutes to the gentleman from Michigan [Mr. LEVIN].

Mr. LEVIN. Mr. Speaker, I support Kennedy-Kassebaum. This bill before us now is not Kennedy-Kassebaum plus, it is Kennedy-Kassebaum minus. In a way, this bill is the story of this session so far. When the Republicans have a chance to do something good, they ruin it by overreaching. They simply cannot resist excess, and they cannot resist turning a bipartisan bill, which Kennedy-Kassebaum is, into a partisan one.

Mr. Speaker, why is this Kennedy-Kassebaum minus? I think it is very clear, when someone who is covered by group insurance leaves and must have individual insurance, there is going to be less protection for affordability under the bill we have here than Kennedy-Kassebaum, period. It is likely that the individual will pay more.

Second, they have included MSA’s, which are likely to draw the healthiest, ablest, and most attractive of the self-employed. Let me just say one thing about MSA’s. They are really a potential tax shelter for wealthy people, because if you put money into them, you do not pay Social Security taxes. You indefinitely defer income taxes. And if you keep them until death, you avoid estate taxes. IRA’s are structured to avoid that kind of sheltering. What these MSA’s, as the Republicans here in the House, once again going to an extreme, what they have done is to promote also tax sheltering for very wealthy families.

One last point, and we have made it a number of times, on fraud and abuse. Why make it tougher for the Government to impose civil and monetary penalties in the case of fraud and abuse? Why do that? Why do you require that the proof be recklessness instead of negligence, when the Government relies on the providers, the tens of thousands, to submit accurate bills? The Mr. ARCHER. Do not understand what pressure group you are reacting to, but it is bad for the public at large.

So for all of these reasons, I urge that we reject this bill. Unfortunately, once again, they have gone much too far. Now, they have exceeded like excess, as has been said many years ago. I think we have no alternative but then to vote for the substitute. Let us do Kennedy-Kassebaum, taking care of the self-employed. Let us not go backward. Let us not turn this into a political issue. This reform is long overdue.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana [Mr. McCrery], a respected member of the Committee on Ways and Means.

Mr. McCrery. Mr. Speaker, medical savings accounts will provide flexibility to give the American people the freedom to personally manage and even save a portion of their health care dollars. By granting consumers complete control, MSA’s allow working men and women and their families to tailor health care spending to their individual needs. This element of personal responsibility will lead to more cost-conscious and cost-efficient spending choices.

MSA’s are entirely portable from one job to another and provide total freedom when choosing a family’s health care provider. In the case of a serious illness or injury, MSA beneficiaries will continue to have comprehensive medical coverage through a high-deductible health plan which meets those high costs. But we allow individuals plan for their future long-term care needs by allowing MSA funds to be used to purchase long-term care insurance or services.

In short, Mr. Speaker, MSA’s provide hard-working American families the ultimate in health insurance: choice, flexibility, and portability.

Mr. STARK. Mr. Speaker, I yield 4 minutes to the gentleman from Washington [Mr. McDermott].

Mr. McDermott. Mr. Speaker, asked and was given permission to raise and extend his remarks.

Mr. McDermott. Mr. Speaker, I wish that we were out here voting on the Kennedy-Kassebaum-Roukema bill, but we are not. HIAA, the Health Insurance Association of America, did not want that bill to come to the floor, and so we have this bill we have before us. This bill was written by, or at least for, the insurance industry.

The legislation’s data collection. I mentioned that under the rule, they collect data, they have electronic clearhouses that can shift that information. There is no privacy protec-
people for things that are covered by Medicare. We could not duplicate without saying to the old folks: This policy covers what is under your Medicare.

Now, any old folk would say to that: Well, that is stupid. Why should I buy that now?

So they quit selling those policies. This bill says that an insurance company can go out selling something all over the place that covers what is covered by Medicare. It is simply an opportunity to legalize their fraud.

This is a bad bill. Vote for Dingell, Spratt, and Bentsen.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Minnesota [Mr. RAMSTAD].

Mr. RAMSTAD. I thank the gentleman for yielding me the time.

Mr. Speaker, last year alone, $31 billion was lost to Medicare fraud and abuse, Medicare and Medicaid fraud and abuse. Everyone here talks about doing something about waste, fraud and abuse in our health care system.

This bill finally does something to eliminate these parasites on our health care system.

Mr. Speaker, our bill establishes the Medicare integrity program, which increases the authority of Medicare to prevent payments for fraudulent, abusive or erroneous claims.

We, for the first time, require the Health Care Finance Agency to use state-of-the-art computer software, the same type used by private insurers, and to hire private sector companies with proven track records to prevent fraud and abuse. This will result, according to the CBO, in a net savings of almost $2 billion over the next 6 years.

The other provisions that fight health care fraud and abuse are listed on this chart, Mr. Speaker. I urge approval of this bill to get at waste, fraud, and abuse.

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

It is interesting that the previous speaker spoke about parasites. I think here to enlighten us about parasites. Is the gentleman from Virginia [Mr. MORAN], who will tell us about the Golden Rule Insurance Company, which gave Mr. GINGRICH's political operations over $1.5 million, which is why we are discussing these MSA's.

Mr. Speaker, I yield 3 minutes to the gentleman from Virginia [Mr. MORAN].

Mr. Speaker, at the request of the gentleman from California [Mr. STARK] has explained, I think we know why MSA's are included in this legislation and why the Republican Party wants so much to make them into law. The principal beneficiary of this legislation would be Golden Rule Insurance Co.

All we have to do is to track the campaign contributions to the Speaker and GOPAC and the Republican committee.

Let me explain why the Democrats are not supporting Golden Rule Insurance Co. and their medical savings accounts. In the 1992 annual statement, only 54 cents out of every premium dollar was actually going into medical costs. Imagine. Half of the revenue went into shareholder profits and the like.

Let me explain why the State of Vermont kicked these medical savings accounts out of Golden Rule Insurance Co. out of the State. It is because half of the people in Vermont, 5,000 people have these policies, half of them found that in the tiny writing at the bottom that Golden Rule had excluded whole body parts from coverage. They excluded their arm, their leg, their back, their hips, their hands, their legs, their circulatory system. Imagine excluding these things from coverage.

Let me tell you why I think the State of Kentucky had so much problem with Golden Rule Insurance Co. Golden Rule Insurance Co. does not want to cover newborns. They will not cover them until they prove that the newborn is healthy. Kentucky passed a law that says you have to cover newborns for Mr. Speaker's 60 days of life.

Golden Rule sued the State because they do not want to cover newborns for the first 30 days of life.

Mr. Speaker, let me tell my colleagues about some other folks who were treated differently. Carl Cherlesh of Aurora, IL, Golden Rule rejected her insurance for a brain tumor, $39,000. They would not cover it. They said that she listed her weight as 190 pounds but that it was actually 210 pounds.

Let me tell you about another Golden Rule policyholder who suffered a stroke, $20,000 in bills. James Anderle was a Milwaukee barber. It turns out that they said he had a pre-existing condition, that he had the flu, and that this was a preexisting condition. And so they did not want to cover it.

Claims for $49,000 were denied Harry Baglayan, a self-employed repairman. He underwent bypass surgery. They said he did not tell them that he had nausea 4 months earlier, and that was a preexisting condition.

I will just quote from the Wall Street Journal, which, it seems to me, probably has a little bit of credibility around these parts. The Wall Street Journal says that they are a sham, that in fact they are most known for cherry picking. In fact, when a claim actually is accepted, they wind up suing the beneficiary and the State. They have piled up $1 billion in assets. That is a sham. We should not include this in our bill.

Mr. ARCHER. Mr. Speaker, I yield myself 15 seconds simply to say that the previous speaker made a very interesting emotional presentation. It just so happens that I have no relevance to what we are talking about today.

Mr. Speaker, I yield 1 minute to the gentleman from Texas [Mr. SAM JOHNSON].

Mr. JOHNSON of Texas. Mr. Speaker, medical savings accounts are for middle-income America. There is a chart that proves it. Medical savings accounts, therefore, must be part of any health care plan we pass. They are an important option for both employers and employees. They give enhanced portability, preserve consumer choice, allow retirement savings and contain cost.

Medical savings accounts offer all Americans the opportunity to buy a plan that best meets their individual needs.

Mr. Speaker, middle-income Americans are my constituents. They repeatedly tell me that one of the most important things that they want is the ability to choose their own doctor. Medical savings accounts do that. They will allow people to achieve control over health care dollars, make it more cost-conscious and bring down the total cost of medical care for everyone.

Medical savings accounts are good for America. Medical savings accounts offer Americans a freedom they deserve.

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

Mr. PORTMAN. Mr. Speaker, I yield 1 minute to the gentleman from Ohio [Mr. PORTMAN].

Mr. PORTMAN. Mr. Speaker, I rise today in strong support of the bill and I do so because I think it will provide greater security to millions of working Americans by eliminating some significant obstacles to health care.

I think this is precisely the kind of health care reform, Mr. Speaker, that the American people have called for. It is targeted reform. It is incremental reform. It makes health care improvements to an imperfect system.

Let me give my colleagues an example. This bill helps level the playing field between those who are self-employed and those who work for corporations. The health insurance deduction for the self-employed goes from 30 percent to 50 percent over a 7-year period. With this single step, we are making health care more affordable for 3.2 million Americans, many of those Americans who are now uninsured, many of those Americans who are now uninsured. That means the mom and pop grocery store down the street. That means that our favorite barber. That means that our local mechanic. All of these people may be self-employed.

In my State of Ohio alone, this enhanced deduction will affect more than 50,000 farm families. It makes sense. Corporations receive a significant deduction, and it is only fair that the self-employed do, too.
March 28, 1996

CONGRESSIONAL RECORD – HOUSE

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about the exorbitant costs of long-term care. People like our parents and grandparents are paying about $40,000 a year for nursing home care. If they do not have the money, Medicaid requires that they lose virtually everything or legally hide everything before they can get help with long-term care from the government.

Currently, there is no provision in the Tax Code that relates to long-term care expenses. Most people incorrectly believe that private insurance will pick up the tab when they need it. But this is simply not the case for 98 percent of long-term care recipients. This bill incorporates the Ensign amendment that treats long-term care expenses as tax-deductible medical expenses. Some of my senior Democratic Ways and Means Committee members have told me they have been trying to do this for over 10 years. Best of all, it is fully paid by making billionaires who renounce their U.S. citizenship for tax purposes pay their taxes. This should have been done years ago, and certainly we should all support this bill with this amendment.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Nebraska [Mr. CHRISTENSEN], a respected member of the Committee on Ways and Means.

(Mr. CHRISTENSEN asked and was given permission to revise and extend his remarks.)

Mr. CHRISTENSEN. Mr. Speaker, I rise today to speak in favor of a provision that will help senior citizens in my home State of Nebraska, and throughout the country.

What I am referring to are the provisions in this bill that dramatically improve the way we treat long-term care, making long-term care more affordable and accessible.

This bill puts long-term care on a level playing field with other important tax deductions and provides a much-needed incentive for individuals to take personal responsibility for their long-term care needs.

First, this legislation requires that long-term care insurance be treated like accident and health insurance, meaning that it will generally be excluded from an employee’s gross income for tax purposes.

Second, thanks in large part to my colleague Mr. ENSIGN from Nevada, this bill provides that many long-term care expenses will now be deductible.

We as a nation must come together in a bipartisan fashion to put an end to a long-term care system that pulls seniors into poverty and forces taxpayers to step in to bear the burden.

This legislation does just that. Once again we are doing what we said we would do by ensuring a bright future for our senior citizens.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from New York [Mr. RANGEL].

(Mr. RANGEL asked and was given permission to revise and extend his remarks.)

Mr. RANGEL. Mr. Speaker, I think the Republicans should be lauded for attempting at least to pick up the pieces of what has to be a concern to all Americans, and that is inadequate health care for most of our citizens, especially those people who are working in the private sector and do not have insurance. They are not insured by the Federal Government, because they make too much money, and, of course, they do not have enough money to get their own insurance.

But what do the Republicans want? What I am referring to are the provisions in this bill that allows tax exemptions for people who can afford just to put it in a bank account and if they make certain that it is a high deductible, that is that the only time that they can use it is for catastrophic diseases, then it just seems to me that what we are doing is allowing the insurance companies to cherry-pick and select those people who are healthy and then those people who are not healthy that can come right back and fall on the regular public system that is there.

What we do need is a comprehensive insurance program that really was the one that was initiated before, and perhaps it was consumed at one time, but we cannot forget that there are 40 million people out there in the United States that have no insurance at all, and these are the people that are the most vulnerable and these are the people that I want to have these types of savings accounts which are there to protect those who already have it.

I think that instead of just selecting those parts of the people that they believe would give political support, that what we have to have in this country is an insurance, a health insurance system where every American, regardless of how much money they have or whether they do not have any at all, can say in this great country that people will not have to worry because they lack access to health care.

All over we see we are cutting back the public share. If we want to do more in the private sector, let it be fairer.

Mr. ARCHER. Mr. Speaker, I yield myself 1 minute.

I think the debate, Mr. Speaker, has been very curious today. On the one hand, the Democrats accuse us of overreaching, of having too comprehensive of a bill. This is the same people that gave us the unbelievably complex Government takeover of the entire health care system in 1994. It is fascinating. And then they come and say, oh, we are concerned about insurance companies taking a part of the money paid on the premiums and not spending it on health care, but they want to deny medical savings accounts where the individual spends his or her own money without regard to a third-party payer.

There is an enormous inconsistency here, but in a sense it is consistent because in 1994 they wanted to deny choice to the people of this country and now they want to deny choice to the people of this country to have their own medical savings accounts.

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

Mr. STARK. Mr. Speaker, I yield myself the balance of my time.

I would just suggest that the Republicans would like to spend almost $4 billion on long-term care insurance at the same time they cut $90 billion out of Medicaid, which is long-term care for the poorest. It is true that we had a bill that would have provided health insurance to all Americans, and there are 40 million Americans out there uninsured who obviously the Republicans do not give a damn. All they care about are the rich, who can enjoy the medical savings accounts.

So if you do not have insurance and your children do not have insurance, the Republicans are doing nothing. If you are very rich or you know some rich people, they get helped by this bill.

The Dingell-Spratt-Bentsen amendment would be the bill to support, would get us the Kennedy-Kassebaum bill, which does all the good things on a bipartisan basis that we need to do and does away with the claptrap that has been added to this bill with the awful intention of killing it, which to me is cynical, and it is cynical because it is going to hurt the poor and the elderly while it helps the rich, like Ross Perot and the friends of the Republicans. And that is not what this country needs.

There are 40 million people out there who do not, whose COBRA benefits could protect them; 3½ million who will expire. The Republicans voted against extending it.

Support the Dingell-Spratt-Bentsen amendment.

Mr. ARCHER. Mr. Speaker, I yield the balance of my time to the gentleman from California [Mr. THOMAS], the highly respected, helpful creator of and a part of this bill, the chairman of the health subcommittee of the Committee on Ways and Means.

Mr. THOMAS. Mr. Speaker, I thank the chairman, the gentleman from Texas [Mr. ARCHER], for yielding me this time. I want to compliment him as I want to compliment the chairman of the other committees, the gentleman from Virginia [Mr. BLILEY] and the gentleman from Pennsylvania [Mr. GOODLING]. It really is exciting, and I am pleased that this new majority for the first time in more than 40 years has a work product on the floor that could not be produced by the former majorities.

The Democrats had more than 40 years. In fact, it has been more than 30 years since the last health insurance bill has been on the floor. The Democrats owned Washington in the entire 103rd Congress; the Democrats had a majority in the House. They had a majority in the Senate. They had a President. Not one product to deal with the plight of the American worker, so eloquently described by the Democrats.
over and over again, on this floor ever came to the floor. We were never pro-
vided the opportunity to help. We had the opportunity to hear of the plight of the poor worker just as we did a few minutes ago. The gentlewoman from Connecticut, Ms. Stavish, asked about the plight of a me-
tered person, and I am sure he is and he has been for a long time and he was during the entire time the Demo-
crats were in the majority.

The major committees in the House, not just one committee, the proper committees of responsibility have come together and we have produced H.R. 3103. It is not too much, it is not too little, it is just right about for re-
sponsible and reasonable health care reform. We have actually accomplished a modest improvement for the self-em-
ployed. We moved their deductibility from 30 percent to 50 percent, respect-
ively. That is really all that we thought was prudent and appropriate.

Criticism from the minority over this? Absolutely, fast enough.

Who was it that left those same self-
employed without any protection whatsoever for the entire calendar year of 1994? All of a sudden they want to do something for these people. When they were in the control they did absolutely nothing. They allowed the deducti-

bility for health care to lapse. When you were running the place, why were not you more responsible?

The Gentleman from California [Mr. Stark] did not find anything for these people who now cannot

afford insurance. They will be allowed under the Tax Code, long overdue, and never done by the Democrats when they were in the majority.

Finally, the heart of the matter: The American worker will no longer have to worry about changing jobs or losing insurance

H.R. 3103 is a good bill support it.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Virginia [Mr. Bliley] is recognized for 22½ minutes and the gentleman from Michigan [Mr. Dingell] is recognized for 22 minutes.

The Chair recognizes the gentleman from Virginia [Mr. Bliley].

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

Mr. Speaker, I rise in support of the substitute to H.R. 3103, The Health Coverage Availability and Afford-
ability Act of 1996. During my tenure in Congress, I do not recall the House ever passing a health insurance market reform bill. We are about to take an historic action to change that.

The legislation before you today makes health care itself, the most import-
tant, it makes health insurance cov-

erage both available—and affordable—

for millions of Americans.

The substitute represents a consen-
sus agreement that was developed as a result of the hard work that was done by one or more insurers and guaran-
tee providers to address the interrelated issues of ac-
cessibility and affordability of health insurance coverage.

The provisions of this bill within the jurisdiction of the Commerce Commit-
tee are designed to deal with the dif-
ficult problem of job lock, or, put more simply, an employee's reluctance to change jobs because of pre-existing condition exclusions related to health coverage. This bill will ensure that indi-

viduals who have an opportunity to move to new or better jobs will not have to face limitations in their coverage for pre-existing medical condi-
tions that will affect them or their families. This bill will also assure peo-
ple in group health plans that they cannot be excluded from coverage, or from renewing their coverage, based on their health status. It provides limits and prohibitions on the use of exclusions related to health coverage.

The Commerce Committee reported provisions also provide for guaranteed availability of coverage to employees in the small group market. Each in-
surer that offers coverage in the small group market would have to accept every small employer and every eligi-
ble individual within the group.

The bill would also ensure portability of health insurance for qualifying indi-

viduals moving from group to individ-

ual coverage. This is achieved by giving States flexibility to achieve in-
dividual coverage through a variety of means that include risk pools, group conversion policies, open enrollment by one or more insurers and guaran-
tee groups.

The bill also contains a number of other provisions which we strongly support. It allows small employers to take advantage of pooling so they can purchase affordable health insurance coverage. It reforms the medical mal-
practice system which will help con-

tain costs and it provides for new health choices for those who want to purchase medical savings accounts.

It also includes provisions on fraud and abuse and administrative sim-

plification. The General Accounting Office has estimated that fraud and abuse accounts for one out of every ten dollars spent on health care. Regret-
tably, fraud and abuse contribute to the ever-increasing cost of health care, it also leads to a lack of confidence in the health care system and its providers. Providing concrete laws and guidelines and stringent pen-
alties for fraud and abuse will ensure the continued integrity of the nation's health care system.

The administrative simplification provisions are needed to ensure that the current system of transmitting financial and administrative data. Much of this information is cur-
rently transmitted in an electronic for-

mat. However, there is not a uniform
standard and there are no consistent security standards or safeguards regarding the use of this information. I urge my colleagues to join me in supporting this bill which will begin to help solve some very real problems for many of our citizens.

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

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Speaker, today we choose between the people who carry a lunchbox to work, and the people who carry Gucci briefcases and wear imported loafers. The people who carry lunchboxes aren't asking for special favors or special treatment. They're not asking for a tax loophole. What they want is very simple. When they change jobs, or if they fall prey to downsizing or if a loved one contracts cancer or diabetes, they want to be able to buy health insurance. That's all.

I am afraid that this very modest request from the people who carry lunchboxes is going to fall on deaf ears in this House. The majority has instead constructed a monument to the influence industry. We can pass a bill that makes health insurance portable and prohibits discrimination or restrictions because of pre-existing conditions. This simple bill would help 25 million Americans. Another provision in this bill on the tax deductibility of health insurance for the self-employed would help 3 million Americans.

We could pass that bill, sail it through the Senate, and have it on the President's desk for signature tonight. Instead, we're going to be voting on a Christmas tree bill adorned with ornaments special interests. And like a Christmas tree, it's soon going to be put out on the lawn for garbage pickup. I know whose side I'm on. I'm voting with the people who carry lunchboxes. I urge my colleagues to do the same.

Mr. Speaker, I submit the following material for the RECORD:

HEALTH CARE? YOU COMPARE
H.R. 3103 BASE TEXT

A stripped-down Roukema/Kassebaum bill: no choice of plans for workers who lose their jobs; forces small businesses with more than 50 workers; preempts State laws that protect consumers.

Limits deductibility of health insurance premiums for the self-employed to 50%.

Controversial Medical Savings Accounts. Controversial medical malpractice law changes.

Controversial repeal of protections for seniors so they won't be ripped off by sale of useless, duplicative health insurance policies.

Controversial provisions overriding state insurance laws.

Controversial provisions making it harder to find anyone who goes broke.

DINGELL/SPRATT/BENTSEN

A clean Roukema/Kassebaum bill: full portability; protection against discrimination due to preexisting conditions; guaranteed renewal.

Increases deductibility of health insurance premiums for the self-employed from 30% to 65%.

No other controversial provisions to weigh down the bill, slow down the conference, or provoke a Presidential veto.

Keep it simple. Clean. Give the American people what they need.

Support the substitute. Oppose H.R. 3103's base text.

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

Mr. BLILEY. Mr. Speaker, I yield myself 30 seconds to respond to my good friend, the gentleman from Michigan.

What a difference, my colleagues, 2 years makes. On this very night, the night before we broke for our Easter recess, 2 years ago, I sat over there next to my then chairman, the gentleman from Michigan, and said, "Mr. Chairman, the President's bill is too heavy. It is too much. It is socialized medicine. We can't move it. We ought to take up the Rowland-Bilirakis bill, bipartisan bill, which was modest, like our bill, and deal with it and mark it up in committee." He said "It can't be done. I am afraid that this moment is both satisfying and, at the same time, deeply ironic. For, now, the House finally has the opportunity to approve health care reforms many of us have advocated for many years. The irony lies in the fact we could have accomplished many of these reforms over 2 years ago if the former leadership had been willing to act and the current administration willing to compromise.

Despite all the political attacks you may hear today—and make no mistake, they are political attacks—health care reform is an idea whose time has come—again and again. The problems we seek to fix today we identified long ago along with many of the solutions.

Many of you in this Chamber may remember that during the 103d Congress, Congressman Roy Rowland and I introduced consensus health reform legislation. The Rowland-Bilirakis bill was the only true bipartisan bill—but we never got our day in court. Not one vote was ever scheduled on our proposal despite broad support for the provisions contained in the bill.

Despite the great hue and cry in 1994 for reform, my own Commerce Committee did not even schedule a mark-up on my bill—or any other version of health reform. Today, we have the opportunity to change all that.

We finally have the opportunity to cast a historic vote on a health reform package which contains many of the items advocated by the Rowland-Bilirakis bill in the last Congress.

Like my previous proposals, this legislation will raise deductions for the self-employed, enact provisions on fraud and abuse, promote administrative simplification, establish pooling for small employers, provide for medical malpractice reform, and ensure insurance portability.

To be sure, not all items in this legislation are precisely as we proposed back in 1994. But many of the core items have been subject to bipartisan agreement in the past and should now be viewed in a similar light. I urge my colleagues, on both sides of the aisle, to set aside any remaining differences and pass this bill.

Indeed, it is the somewhat mystifying when I hear that this bill is somehow too loaded up. And it is a little more than ironic when the main criticism of the previous Rowland-Bilirakis bill was that it didn't do enough. You can't have it both ways. We have to do something to resolve problems in our health care system now, in this Congress. We never had the chance in 1994.

Health care is too expensive. This bill will help make health care more affordable for millions of families. Access to health care is too restricted—this bill allows policies to be carried from one job to another. Too many people have too few choices with regard to health care—this bill will increase the number of opportunities we all have to secure an effective health care plan for our family.

These are problems we can solve now and which will improve the lives of millions of working Americans. We cannot let this moment pass without passing this bill. I strongly urge my colleagues to support our efforts to improve our Nation's health care delivery system and help make health care in this country both more accessible and affordable.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey [Mrs. ROUKEMA].

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Speaker, I am very happy to be here today. Many of my colleagues know that I am the House sponsor of the Kassebaum-Kenney health insurance reform package. If I had my way, we would be debating and quickly passing a clean version of that legislation.

The portability and the guaranteed issue that it will deliver to 30 million Americans now.

Kassebaum-Kenney-Roukema is legislation that has been cosponsored in the House by a wide multitude of bipartisan support and in the Senate, Senate Committee on Labor and Resources, it was passed unanimously. It deserves bipartisan support.
The American people want health care reform, and they need it. They are sick and tired of partisan bickering and political gamesmanship. They want results and they want them now.

Unfortunately, I fear the Hastert omnibus bill, which within the last 24 hours two prominent Republican leaders in the Senate, Senator Kasbaum and Senator Bennett, have confirmed their firm opposition to an omnibus bill. I think we should keep that in mind today.

I expect that if this should be blocked and it should end up in gridlock, I expect that the American people will hold us responsible in November.

Now I do not get me wrong. Some of the reforms that are not part of the Kassebaum-Roukema bill, such as medical malpractice reforms, I have supported in the past and will continue to support. But let us understand and be frank about it. Whether we support them or do not support them, the key components, medical, expansion and medical savings account, let us understand and be frank about that, that medical malpractice reform, medical savings account and ERISA expansion are very controversial ideas, they are complex, and they demand individual consideration as individual pieces of legislation.

Mr. Speaker, I again say that we must answer to the American people and pass this legislation in its clean form tonight.

Mr. Speaker, I rise this evening in support of commonsense health insurance reform.

Many of my colleagues know that I am the House sponsor of the Kassebaum-Kennedy health insurance reform package. If I had my way, we would be debating and quickly passing a "clean" version of the Kassebaum-Roukema plan today and the portability and guaranteed issue that it presents to 30 million Americans.

Kassebaum-Roukema is legislation that has been cosponsored by 193 House members, and which the Senate Labor and Human Resources Committee approved unanimously.

The American people want healthcare reform. They are sick and tired of partisan bickering and political gamesmanship. They want results and they want them now.

Unfortunately, I fear the Hastert omnibus package will inevitably lead to more gridlock and inaction. And I fear that, in the end, the American people will not get the common sense reforms that they deserve.

I think it should be noted right here and now that within the last 24 hours and inaction. And I fear that, in the end, the American people will not get the common sense reforms that they deserve.

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I expect that if this should be blocked and it should end up in gridlock, I expect that the American people will hold us responsible in November.

Now I do not get me wrong. Some of the reforms that are not part of the Kassebaum-Roukema plan—such as medical malpractice reforms—I have supported in the past, and will continue to support in the future.

However, there can be no doubt that certain elements of the underlying bill (such as medical malpractice reform, medical savings accounts, and ERISA expansion) should be fully debated by the Congress on a case-by-case basis—not wrapped up into one gigantic package. Each one of these components is complex and controversial and should be properly considered.

In the past, I have been a very strong advocate of medical malpractice reforms so that physicians can stop practicing defensive medicine in order to insulate themselves from frivolous lawsuits that only lead to over-utilization of the health care system and higher liability insurance premiums. I will vigorously support these reforms in the future as well.

Nevertheless, I recognize that medical malpractice reform is a very controversial idea that faces serious obstacles in the Senate, and perhaps a veto by President Clinton.

With regard to medical savings accounts, I have some very serious reservations about this idea. While the notion of empowering individuals to make their own health care decisions has a certain amount of merit, I am concerned that medical savings accounts could, in the long term, serve to ruin the health insurance market.

Medical savings accounts could serve to segregate the population into two groups: Young, healthy people using medical savings accounts and older, sicker people in conventional health plans. If this kind of risk-segregation occurs, the medical insurance premiums for older, sicker individuals would skyrocket beyond imagining.

I refuse to support health reform legislation that makes this scenario a reality. Medical savings accounts should be reviewed and debated on their own merit—not as part of some, larger package.

Finally, I want to discuss my concerns about those provisions in the omnibus package that expand the ERISA pre-emption of state insurance laws.

For many years, I served as the ranking minority member of the then House Education and Labor Subcommittee on Labor and Management Relations, which had jurisdiction over ERISA, the Employee Retirement Income Security Act. ERISA was passed to protect workers in pension and health plans. It is designed to give private employees certain benefit protections because of an illness in the family would be covered by a new employer’s insurance, group-to-group portability. Now a worker who is between jobs and cannot get individual coverage for his preexisting condition would be able to get coverage, group-to-individual portability. Now the small business employee, whose employer cannot afford to purchase the firm’s five employees because one of them has a chronic illness, would be able to afford health insurance.

Mr. Speaker, this bill makes it easier for Americans to get and keep health insurance. It is important that this bill includes medical savings accounts. They will return control over health care spending to consumers, save money, and lower health care overutilization. I am pleased that this bill also increases the health insurance deduction for self-employed individuals from 30 percent to 50 percent by the year 2003. While big businesses have been able to deduct all their health care costs, millions of self-employed individuals have been left without a similar benefit. That is not fair. We must give people more incentives and more options to carry health insurance for their families.

The Health Coverage Availability and Affordability Act will also crack down on fraud and abuse, saving millions of dollars. This, too, would keep the cost of your premiums down.

Mr. Speaker, finally, medical malpractice reform will help hold down the cost of defensive medicine and help keep premiums down. If medical care is more affordable, more people will have real access to it.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey [Mr. Pallone].

Mr. PALLONE. Mr. Speaker, I am so pleased that my colleague, the gentlewoman from New Jersey [Mrs. Roukema] spoke just before me, because basically she pointed out that what we
would offer security to millions of Americans in need of basic health care coverage. I say let us do those things that we can agree on. That is preexisting condition and portability.

We have to stop the unjust practice of denying those with preexisting conditions. Many people who need insurance the most cannot get it because of these preexisting conditions. Another 4 million Americans who have insurance are afraid to leave their jobs, fearing that they might never be insured at another job again.

Mr. Speaker, we should ask ourselves, how many are throwing themselves, begging for a medical savings account? That is for the healthy and for the wealthy. All our constituents are definitely knocking down our doors, demanding us to cut important services like Medicare and Medicaid and education so that we can spend billions on creating medical savings accounts.

There are too many controversial malpractice reforms in this bill. Why do we have to load it up? Why can we not do like the other body does and pass a bill like Roukema-Kennedy? That is what we were elected to do. We all said we would do it. Now we have other political agendas that might prevent a good bipartisan health package from being enacted.

Mr. Speaker, will what be the ultimate result of increasing the costs of health insurance who remain and do not opt for the medical savings accounts? There will be fewer people insured, fewer people insured.

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

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the gentleman from New Mexico [Mr. Richardson].

(Mr. RICHARDSON asked and was given permission to revise and extend his remarks.)

Mr. RICHARDSON. Mr. Speaker, the chance for a bipartisan health care reform may be slipping away because some have taken a good idea and loaded it up with a lot of gifts to special interests. Why do we not put the American people first for a change?

Mr. Speaker, we all agree there are a few nice things that we could make to our health care system that would cost the American taxpayer nothing, would offer security to millions of Americans in need of basic health care coverage. I say let us do those things that we can agree on. That is preexisting condition and portability.

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Mr. Speaker, I yield 2 minutes to the gentleman from Georgia [Mr. Norwood].

Mr. NORWOOD. Mr. Speaker, I rise today in support of the Health Care Coverage, Availability and Affordability Act. In this time of economic insecurity and increasing pressure on America's working-class families, this bill is a common sense approach to health care access that also makes health care more affordable. In 1993, the Clinton administration and the liberals in Congress lined up behind the big government socialized medicine plan. This plan was an utter failure, not because the American people did not want security in their health care but because it was the wrong approach, though our Committee on Commerce in the 103d Congress had the right approach with the gentleman from Florida [Mr. Bilirakis] and Dr. Rowland of whom do not have coverage, many corporations were paying more.

Mr. Speaker, I yield to the gentleman from Massachusetts [Mr. Studds].

Mr. STUDDS. I yield to the gentleman from Virginia [Mr. Bliley].

Mr. BLILEY. Mr. Speaker, how much time is remaining on both sides?

The SPEAKER pro tempore (Mr. Combest). The gentleman from Virginia [Mr. Bliley] has 11 minutes remaining, and the gentleman from Michigan [Mr. Dingell] has 12½ minutes remaining.

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

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the gentleman from Maryland [Mr. Hoyer].

Mr. HOYER. Mr. Speaker, I rise in support of the Kassebaum-Roukema-Kennedy legislation. I rise lamenting the fact that we will not take "yes" for an answer. Very frankly, the Kennedy-Kassebaum-Roukema bill was bottled up in the Senate until the heat got so high recently that the Republican in the Senate who then publicly admitted holding up the bill said no, let it go forward.

Mr. Speaker, all of us in a bipartisan way agree that we ought to preclude
preexisting conditions being an impediment to our citizens getting insurance. All of us believe that people ought not to be locked into their jobs because they do not have portability of health care security through their insurance. All of us believe that in a bipartisan way. That is what the gentleman from New Jersey [Mrs. ROUKEMA] was saying. That is what Senator KASSEBAUM is saying from Kansas. But we are having trouble taking yes for an answer.

Mr. Speaker, I personally believe that the medical savings account, although superficially appearing to provide some options, in fact will increase the cost for those who are less healthy and less wealthy. That is not just a fancy phrase. I think it is reality.

In addition, as my colleague, the gentleman from Maryland [Mr. CARDIN] expressed when he spoke on Ways and Means, our State is very concerned about precluding it from making determinations. In fact, we are stopping States from having the flexibility that our Republican colleagues say they ought to have.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. STEARNS], a distinguished member of the committee. (Mr. STEARNS asked and was given permission to revise and extend his remarks.)

Mr. STEARNS. Mr. Speaker, I rise in support of the Archer/Billey bill because I believe the issue of genetic privacy is of tremendous importance. I introduced H.R. 2690, the Genetic Privacy and Nondiscrimination Act of 1995. My bill would ban discrimination based on a person's genetic profile. I wish to acknowledge my colleague and good friend Representative JOE KENNEDY who is helping me on the other side of the aisle. He and I are working together on this bill.

With new forms of genetic testing able to reveal an individual's likelihood of contracting a number of diseases, the possibility arises that employers and health insurers could use that information to discriminate. This is a civil rights issue. People who are already at risk due to their genetic makeup shouldn't have to worry about the additional hardship of losing their job or health insurance.

Like a companion bill introduced by Senators MARK HATFIELD and CONNIE MACK, H.R. 2690 would also ban the disclosure of genetic information by anyone without the written authorization of the individual. This safeguard would protect the privacy of individuals who would rather their genetic information be kept private.

I am pleased that I was able to add a portion of my bill to the Archer-Billey bill.

Mr. BLILEY. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from New Jersey [Mr. MENENDEZ].

Mr. MENENDEZ. Mr. Speaker, I rise in support of the bill which gives us an opportunity to pass a reform we know will be signed by the President.

In the last Congress we saw the demise of comprehensive health care reform and those who objected to that initiative said too many. We ended up with nothing. Hundreds of thousands of New Yorkers and millions of Americans continued to languish in the insecurity of no health care coverage.

Today we can address one major concern of millions of working Americans, the fear of moving from job to job because of the possible loss of comprehensive health insurance. We can eliminate the condition referred to as job lock and free up opportunities for working men and women to seek new employment.

We also have an opportunity to provide necessary protection for those who are suffering. Illnesses of those who are trapped in a job solely because of their inability to become insured if they leave their position. We have the opportunity to eliminate the discriminatory practice of denying continued health care to people with diabetes and other illnesses for which insurance coverage has been nearly impossible to obtain.

But the committee's bill contains provisions which are unacceptable to me. As I saw in the Senate and which, if included, may end any hope of enacting even modest health care reform, and I hope this is not the cynical reason behind the bill.

Twenty- five percent of my constituents have no health care insurance whatsoever. If we have to enact health care reform one step at a time, so be it. But let us take the first step today by insuring more people, liberating them in their choices through the adoption of the Demo plan.

Mr. BLILEY. Mr. Speaker, I yield 1½ minutes to the gentleman from Pennsylvania [Mr. FOX].

Mr. FOX of Pennsylvania. Mr. Speaker, I rise in support of the Archer-Billey bill, which will be the antidote to the problem we have in the United States of making sure we have sufficient coverage for all Americans. In this Congress, we are debating once again whether the American people are going to have health care insurance.

The solution to the problem, I believe, Mr. Speaker, is in fact contained in H.R. 302. The reforms before us here in the House reform current health care insurance practices to make health insurance more available and more affordable.

The bill encourages insurance companies to provide coverages to the workers who co-pay contributions provided plan to another. It gives the portability everybody wants. They lose their job and move to a job without coverage. It allows small employers to join together to purchase group health insurance for the business and do so for their employees, and allows self-employed individuals, Mr. Speaker, to deduct increasing percentages of their health insurance premiums from their income taxes.

This is an idea whose time has arrived, and I would ask for my colleagues to support this legislation for those reasons, but still a few more.

It allows organizations such as trade associations and chambers of commerce to voluntarily associate to purchase health insurance which would be available to all member organizations. Further, it provides incentives to encourage individuals and their employers to purchase insurance in lieu of health insurance premiums. Finally, Mr. Speaker, it increases penalties for fraud.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Ohio [Mr. BROWN].

Mr. BROWN of Ohio. Mr. Speaker, three years ago the insurance industry spent $100 million to kill comprehensive health care reform. How many of these companies are ominously silent on this Gingrich special interest health care bill. One politically active insurance company located in Indiana would benefit handsomely under the Gingrich plan that makes a special interest giveaway by the State of Indiana larded onto the Republican bill. Medical savings accounts will enrich a select group of high-end catastrophic providers, skim the well-off and the healthy out of the insurance pool, and increase costs for everyone left behind.

This Gingrich special interest plan is a bill written by the insurance companies, of the insurance companies, and for the insurance companies. Approximately $20 million Americans are without health care and without health insurance. A majority of these Americans are from working families, working hard, paying their taxes, playing by
the rules. They need our help in this Chamber tonight.

Mr. Speaker, pass the Dingell substitute. Defeat the Gingrich special interest bill.

Mr. BLILEY. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Georgia [Mr. KINGSTON].

Mr. KINGSTON. Mr. Speaker, I find it appalling that the Democrats would bring in this special interest thing. The integrity of the debate; is it possible to have a honest debate any more at all?

I mean if my colleagues want to talk about special interests, read yesterday's Hill newspaper article. The American Trial Lawyers just gave $2.2 million to candidates last year, 94 percent going to Democrats opposed to this bill because it has tort reform. My colleagues want to talk about special interests; weigh in, because my colleagues are the ones who are in the pocket of the American trial bar.

Let the real issue here. Medical savings accounts give choice to Americans. It takes it away from our Washington bureaucrat command and control and puts it in the hands of the American public where it belongs. That is what our constituents want. They want to start making their own decisions on health care, they are going to decide a whole lot of other things, like they may need somebody else to represent them in Congress.

I think it is important to also know that our colleagues are standing one more time against small businesses by opposing legislation that would allow pet stores and clothing stores and barber shops to pool together and buy their insurance as a group.

Mr. DINGELL. Mr. Speaker, I yield ½ minutes to the distinguished gentleman from Vermont [Mr. SANDERS].

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

Mr. Speaker, more women in the United States are injured and killed through domestic violence than by automobile accidents, muggings, and rapes by strangers combined. Domestic violence is a terrible plague in American society.

Given that reality, it is an absolute outrage that a number of insurance companies deny health insurance to women who have been battered and who have been victims of domestic violence. These companies argue that domestic violence is a pre-existing condition and that it might not be profitable for them to insure these women. Under these conditions women are being abused twice, first by their batterers and, secondly, by the insurance companies who refuse to insure them and their families.

Mr. Speaker, I am delighted that both the Republican and Democratic health care bills before us tonight include the Kennedy-Kassebaum bill that passed the Senate with God forbid, bipartisan support, the most insidious of those provisions are those that provide for medical savings accounts because they would set off a chain reaction.

First, they encourage the healthy and particularly the wealthy who can afford the high deductibles of MSA's to opt out of their current insurance pool. That shrinks the insurance pool needed to keep premiums more affordable for everybody.

Next, that is injury to hard-working middle-income people left behind in the pool because they are going to see their premiums go up, they are going to have to make up the loss of the healthiest and wealthiest.

And, finally, to add insult to injury, the same middle-income workers paying higher premiums will also be paying taxes to replace the tax breaks handed to those who can afford these accounts.

Mr. Speaker, that is wrong, and I urge my colleagues to support the substitute which is a clean Kennedy-Kassebaum-Roukema bill. It is real reform with several clean good steps toward real health insurance. It eliminates the denials for pre-existing conditions when someone changes jobs, it eliminates some of the job lock which keeps people from changing jobs due to fear of losing their insurance, it reduces the burden on the self-employed by raising their health insurance deduction to 50 percent.

Mr. BLILEY. Mr. Speaker, I have only one speaker left, and I reserve the balance of my time. I understand I have the right to close.

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Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Connecticut [Ms. DELAURO].

Ms. DELAURO. Mr. Speaker, we have a real opportunity tonight to do something for the working families in this country. The American public is clamoring for health care relief. It is one of the fundamental concerns of the people of this country. People in this Nation are frightened that they will lose their jobs, that they will lose their health care, that they will be denied health insurance because of a preexisting condition that they may have or that their children may have.

Mr. Speaker, the Kassebaum-Kennedy-Roukema bill takes a first step toward addressing these problems. It is a good bill, it is a bipartisan bill. It addresses the needs of the American people. Do not load up the bill with politically contentious issues that are designed to kill this bill, this opportunity for health care reform. It is wrong. It is not what the people of this Nation have sent us here to do. It is not what our jobs are about.

Mr. Speaker, the authors of this bill have asked for a clean bill, not to be loaded up. Mrs. Kassebaum earlier
today said, "I think there are some who, by design, would like to see problems." The Washington Times today says that "Riders Imperil Health Care Reforms," and it says that "House and Senate Republicans said they planned to address the House of Representatives' retraining of a popular health insurance re-form bill, clouing chances for quick passage."

The gentleman from Virginia [Mr. BLILEY] himself has said that, "If you load the wagon, it is hard to pull." Do not sacrifice health care re-form. Do not sacrifice the American public for special interests tonight. It is wrong to do that. We have a golden opportunity to do something, not for the special interests, but for the American people, for the working families of this country who deserve to have relief from the perils of a disas-trous illness. Vote against this bill, vote against the substitute.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentle-man from California [Mr. Fazio].

Mr. FAZIO of California. Mr. Speaker, when President Clinton stood here a few months ago and announced his sup-port for a bill that had been authored by Senator KASSEbaum and the gentle-woman from New Jersey, Mrs. ROUKEMA, to be joined by the gentlemen from Massachusetts, Senator TED KEN-NEDY, and Senator JOSEPH KENNEDY, the coun-try was ecstatic. They were convinced for the first time we would actually do something about the need to make health insurance portable and to pre-vent prior conditions from making insur-ance unaffordable or unaffordable to many people.

Tragically, we are here tonight de-bating a bill that goes far beyond that consensus, that moves us into conflict on issues like MSAs, that are a pure giveaway to a gentleman from Indiana named Mr. Rooney, who legitimate in-surance salesmen in my district claim they would never sell policies for.

We have watered down portability, we have watered down the ability to prevent prior conditions from being remedied in this legislation, because we have taken an approach that does not really give people what they have been told they will get. They will pay more if there are fortunate enough at all to be able to continue to have health care. They are not going to be able to keep the kind of plan they have had.

This proposal ensures they will pay more. These paybacks mean everyone else will have to pay more for their insurance. The Democratic substitute will help tens of millions of Americans keep their health insur-ance when they switch jobs, regardless of their condition.

The Democratic substitute addresses sev-eral fundamental problems.

If an employee who has been covered for at least 18 months switches or loses his or her job, that employee could buy insurance without exclusions for pre-existing medical condi-tions.

Workers will no longer be locked into jobs or prevented from starting their own businesses for fear of losing their own coverage.

The substitute also contains an increase in the deductibility of health insurance for the self-employed.

Greater deductibility serves two important goals.

First, greater deductibility increases afford-ability. Increasing deductibility will help millions of farmers, small businesses, and other work-ing families afford the high cost of health care insurance.

Second, greater deductibility ensures greater fairness in our tax code. Corporations have long enjoyed full deductibility for their health insurance costs. It is time to narrow the gap between Wall Street and Main Street.

Let us not miss this opportunity to enact health care insurance reform that will benefit millions of hard-working Americans. I urge a yes vote on this substitute.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentle-man from Massachusetts [Mr. MARKEY] to conclude debate on this side.

Mr. MARKEY. Mr. Speaker, it is with sorrow and frustration that I rise to oppose this bill. Reform of our health care system is long overdue. The fact that some 40 million Americans do not have health insurance is an absolute disgrace, and it is high time that we do something about it. Last week the Committee on Commerce unanimously approved legislation that would have provided at least some relief to millions of hardworking American families by ending job lock and limiting the use of preexisting condition clauses.

It was a good first step. It was incremen-tal, to be sure. It would have guaran-teed that health care was affordable, but at least it would have been acces-sible. It was modest, and for that reason I had hoped that a large majority of Members from both sides of the aisle could support it.

Mr. Speaker, my mother always says that a half a loaf is better than none, and I supported that bill, even though it was really only a couple of slices. I know the American people want the whole loaf. Unfortunately, the leadership has taken a couple of good, whole-some Democratic health insurance reforms and slapped a whole lot of extraneous junk food on top, creating a health care hoagie of medical savings ac-counts, caps on medical malpractice awards, and other unhealthy additives. These anchovies and olives and onions are sure to tickle the taste buds of a very few special interests, but cause heartburn for millions of consumers.

Barry Goldwater's old words can be twisted here this evening, because now the Republican Party believes that extremism and the defense of special in-terests is no vice. "The American Medical Association wants it, we will just toss it into this bill."

Mr. Speaker, it is with pleasure that I yield the balance of my time to the gentleman from Illinois [Mr. HASTERT], the chief deputy whip, a gentleman who has worked tirelessly on this legislation.

The SPEAKER pro tempore [Mr. COMBEST]. The gentleman from Illinois [Mr. HASTERT] is recognized for 4½ minutes.

Mr. HASTERT. Mr. Speaker, I thank the chairman of the Committee on En-ergy and Commerce for yielding time to the gentleman from Illinois. I thank all of those chairmen of the committees who have worked together to make this bill possible, and the sub-committee chairman, and I would be remiss if I did not thank the staff of the House, many committees, who did an excellent job in working together to make sure that this bill was successful.

Mr. Speaker, I have heard a lot of outrageous statements from the other side of the aisle tonight, and even one from our side of the aisle. But it ques-tions me, it wonders me, I guess you would say, who are those special inter-ests that everybody is talking about? Is it the small businessman who needs to have the ability, the deductibility; that if he has a small business and wants to get his workers covered, 85 percent of which are people who work today and do not have insurance and end up in situations with one family member that works for a small business, that we give them the ability to pool that and take it to the marketplace with the same advantages that big business gets? Is that a special in-terest?

Is it a special interest for a family who wants to get health care and make changes of their own, instead of having an HMO or a doctor or an insurance company tell them, is that the special interest they talk about?

Maybe, Mr. Speaker, there are some dinosaurs still in this Congress that do not want to have change, some dino-saurs that still want to have big Fed-eral health care take care of everything, and take over everything, and if they cannot have it their way, then they are going to do the very mini-mal things they may include to cover the ladies and gentlemen of this country and the families of this country.

Mr. Speaker, we have traveled a long road in a short period of time with this
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reform bill. For that, I applaud the cooperation of everybody. It must be noted that with this legislation, we have succeeded where previous Congresses have failed, and we have put together reforms in the health care delivery system that will help people today. Our legislation will lower the cost of health care insurance while making it more available and affordable to middle-income American families.

Who among our critics will deny that health insurance is too expensive? Who among our critics will deny that American families should have more control over their health care spending? Who among our critics will deny that patients deserve more health care dollars than bureaucrats and trial lawyers? I have listened with intent interest, and the charges of some of the members of the minority party are just outrageous.

They claim our bill does too much, that it goes too far, and that it is too ambitious for this Congress. This claim, combined with the Republicans' claim that the administration's approach was too big, was far too big. The Kennedy approach now mounted by the President is just too small. Our health care plan is just right for the American family.

Our colleagues in the other body deserve a great deal of credit for trying to remove the barriers created by pre-existing conditions. It is a needed reform, and it is contained in our bill. This bill gives people who lose or change jobs the insurance that they can keep their health insurance when they need it most.

One other misstatement of fact. The Senate has not passed the Kennedy bill. It has only moved out of committee. Only yesterday the letter comes out of the Senate that the leadership in the U.S. Senate approves of our bill. They ratify our bill. They commend us for doing well, for doing more for the American people.

I have to say that a letter from the small business groups in this country says that this is the right thing to do for the American working people, for those people who have to carry a lunch bucket to work. It gives them choice, it gives them coverage, and Mr. Speaker, the time has come to pass this legislation. I ask for its approval.

The SPEAKER pro tempore. Pursuant to the rules, the gentleman from Pennsylvania [Mr. GOODLING] will be recognized for 15 minutes, and the gentleman from Missouri [Mr. CLAY] will be recognized for 15 minutes.

Mr. GOODLING. Mr. Speaker, I yield myself 4½ minutes.

(Mr. GOODLING asked and was given permission to revise and extend his remarks.)

Mr. GOODLING. Mr. Speaker, today this House of the people has a historic opportunity to cast their vote for landmark legislation designed to address the health insurance concerns expressed by the people.

For nearly three decades the American people have looked to Congress to improve private health insurance accessibility, affordability, and accountabil- ity. All along, efforts to nationalize health care have deprived our people of the added security that would result from the common sense and bipartisan elements of targeted health insurance reform contained in our bill and considered here. These elements, such as health insurance portability, renewability, and pooling for small employers, have been long debated and included in various legislative proposals offered by the members of the Economic and Educational Opportunities Committee and many others.

These needed well-targeted reforms did not advance in the last Congress because of the failed efforts by the President to promote his government-run run health care system. The Americans were not fooled—the elements of the President’s plan proved too costly, too bureaucratic, and would have led to health care rationing. However, our efforts here today give evidence that we are seriously taking President Clinton at his word which was given in his State of the Union address last year, “Let’s do it step by step; let’s do whatever we have to do to get something done” in regard to incremental health insurance reform.

That is why the legislation before us is deliberately more modest in scope. Rather than trying to create a new health care system, the Health Coverage Availability and Affordability Act seeks to build on those elements of the Nation’s employment-based system that work well—namely the fully insured and self-insured group health plans under ERISA—while at the same time making the important changes to the current system needed.

The changes called for by the American people, like the people who have spoken at my town meetings in York, PA, include helping end job-lock for employees seeking new employment by limiting preexisting condition restrictions under the new employer’s plan and eliminating such restrictions for those who maintain continuous health insurance coverage. This proposal, like the bill reported by our Committee, does that.

In addition, an employer would not be able to exclude new workers from their company health plan simply because that worker or a member of his or her family may have a serious health condition. Such individuals would have to be permitted to enroll and be able to choose a benefit package under the plan. If family coverage is offered under a group health plan, spouses who lose other coverage and newborns would have to be allowed to be enrolled.

Smaller businesses have also expressed concern that insurers not be able to drop their coverage because of the health status of their employees. The legislation addresses this concern by prohibiting insurers and multiple employer plans from failing to renew health insurance coverage because of adverse claims experience or other reason.

The many witnesses who spoke at our committee’s hearings stressed that making health insurance more affordable was the key to making it more available to the American worker and his or her family. Therefore, the legislation contains provisions that will help achieve the goal of expanding coverage to the nearly 34 million individuals in working families who now do not have health insurance coverage. It does this by clarifying the ERISA law to allow employers, especially smaller employers, to form multiple employer plans through the associations that represent the Nation’s trades and businesses and by allowing employers and employees to choose and negotiate for the type of coverage they need and can afford.

In 1974, Congress enacted the Employee Retirement Income Security Act or, as it came to be known, ERISA. In doing so, Congress shaped and put into place the cornerstone of our country’s employee benefits law. More importantly, it laid the foundation upon which employers and negotiated multiemployer plans have been able to successfully provide benefits to workers and their families, including pensions, health, and other benefits. As Dr. Richard Lesher, president of the U.S. Chamber of Commerce, has testified, "Our membership is convinced that preservation of ERISA is a critical step on the road to significant health care reform. We support H.R. 995 [the bill reported by the Committee] as it builds upon ERISA by including needed insurance market reform.

"This is one issue on which employers and unions agree. For example, Mr. Robert Georgine, chairman of the National Coordinating Committee for Multiemployer Plans, stated in testimony that: "Given this reality [that there will be no employer mandate] the next best approach is a policy that encourages an expansion of voluntary, employment-based coverage without imposing additional costs on existing health plans."

That is exactly what the legislation before us accomplishes.
Under subtitle C of the bill, multiple employer plans could self-insure or fully insure, gaining all of the advantages this entails including economies-of-scale and lower costs. Small employers who now do not have access to coverage, or cannot afford it, would be automatically eligible for more affordable health coverage through the plans sponsored by their business and trade associations. Together with other provisions of the bill, such as the increase in the deduction of health insurance costs for the self-employed, this legislation will unleash small employers into a more competitive health insurance marketplace, thus enabling them to secure more affordable health coverage in the same manner as do larger employers.

Subtitle C also brings more accountability to the health insurance market. The Department of Labor inspector general, Mr. Charles Masten, testified that this is necessary and important legislation to stop health insurance fraud perpetrated by bogus unions and other illegitimate operators. Legitimate plans will be made accountable and fraudulent schemes will be halted when these provisions are enacted.

In sum, subtitle C and the other provisions of the Health Coverage Availability and Affordability Act present this Congress with perhaps its best opportunity since the passage of ERISA to afford all Americans access to affordable health insurance for many American families.

The measure is superior to other bills in either body in regard to protecting the American worker and his family and offering the opportunity for true portability of health insurance coverage. Instead of the likelihood that the mobile worker’s next employer will also be offering a health plan, the fact that small employers strongly support the pooling provisions in the bill is testament to the vast potential multiple employer plans have for expanding coverage and reducing the cost-shifting from the uninsured to the insured worker that currently takes place.

The House bill is also more protective under its portability provisions. The bill would allow a 60-day lapse in coverage before portability protection could be lost. It also has extended the period of pre-existing conditions that would be interrupted while other bills would allow only a 30-day lapse in coverage to terminate an employee’s portability protection. The House bill has also been crafted carefully to be both more protective and administrable with regard to the evidence employers must give to receive portability credit for prior coverage. It is anticipated that under the House bill most group health plans would utilize the simpler portability rule which credits employees with period of prior coverage for purposes of reducing a new 12-month preexisting condition period which would be applicable were the prior coverage actually covered the preexisting condition—a potentially lengthy and costly determination.

The House bill has also been carefully drawn to avoid issues that made the Clinton plan so unpalatable such as provision group health plans to include particular forms or types of benefit.

In sum, the provisions of the Health Coverage Availability and Affordability Act represent the best opportunity in decades for American workers and their families to gain increased access to more affordable and accountable health insurance coverage. I urge my colleagues to vote for this workable responsible targeted health insurance reform bill. The American people will thank you for the increased security they will have when you make history by passing this landmark health coverage legislation.

Mr. CLAY. Mr. Speaker, I yield myself 3 minutes.

Mr. CLAY. Mr. Speaker, I rise in opposition to H.R. 3103. The Republican leadership is passing up a golden opportunity today to pass a realistic, bipartisan health reform bill. Instead of bringing to the floor the Roukema-Kassebaum-Kennedy bill, the leadership is bringing up for consideration H.R. 3103. This bill is so weighted down with complex, controversial, and special interest provisions that it could doom health reform for 1996.

Members will have a chance, however, to vote for sensible, bipartisan health reform legislation today. The Democratic substitute is the Roukema bill, and I urge my colleagues to support it.

The Nation cries out for the reasonable, constructive approach of the Roukema bill. Democrats and Republicans should unite behind this bill. It has broad bipartisan support in both Houses of Congress. The President has said he will sign it.

The House Republican leadership is on the verge of dashing the hopes of 80 million of people who are on the verge of blocking the modest legislative objectives of a large, bipartisan group of Members in the House and Senate.

Mr. SPEAKER, included in H.R. 3103 is a proposal to exempt self-funded, multi-employer health plans, or MEWA’s, from State law. This proposal is opposed by the National Conference of State Legislatures and the National Association of Insurance Commissioners.

The large, self-funded health plans created by this bill would be financial disasters waiting to happen. There is a reason Congress delegated responsibility for regulating MEWA’s to the States in 1963. While many legitimate, successful MEWA’s exist, the MEWA business continues to attract unscrupulous operators and to experience an inordinate failure rate.

Considering the fraud and abuse that has long been associated with MEWA’s, it is incredible that the bill would grandfather existing MEWA’s. The bill would immediately exempt large, existing MEWA’s—the good, the bad, and the ugly—from State solvency and insurance laws. Having obtained this instant “Good Housekeeping Seal of Approval,” unscrupulous and inadequately financed operators could begin preying on the public—one step ahead of the Labor Department which might investigate the application for a Federal certificate.

The bill’s solvency standards are inadequate to the task assigned to the Labor Department to regulate hundreds of multistate, multiemployer health plans enrolling up to as many as 20 million people. Consumers could find very little standing behind a Federal MEWA if it should get into financial trouble.

This bill is an ironic example of legislative forum shopping; it greatly expands Federal authority over the private sector. The Federal Government for the first time would be in the business of chartering and regulating the solvency of privately run, national health plans.

Perhaps nothing the Republicans have passed during the 104th Congress would increase Federal financial exposure more than this bill’s MEWA provision. It would only be a matter of time before a large, multistate MEWA would go under, leaving consumers with millions of dollars in unpaid medical bills. Is that the kind of policy we want to see?

The large, self-funded health plans associated with not having to comply with the cost savings asso- ciated with not having to comply with State solvency and insurance rules, multi-employer health plans or the cost savings associated with not having to comply with State solvency and insurance rules, will make being a Federal MEWA an extremely attractive option for existing multiemployer plans and trade association plans that currently offer
fully insured products to their members. Many of these plans would seek to become federally chartered self-funded MEWAs. And, many employers that now offer an insured product to their employees—through Blue Cross-Blue Shield or other carriers—will transfer their coverage to these federal MEWAs.

These federal, self-funded MEWAs will siphon healthier, younger groups from traditional insurance markets and, as a consequence, will undermine those markets as well as State health reform efforts. Health insurers fear that groups can exit the insurance market, premiums will rise, forcing some individuals to drop coverage. In addition, shrinkage in the size of insurance markets means a shrinkage in both a State's insurance premium tax base and high risk pool assessment base: H.R. 3103 would cost States millions and millions of dollars in lost revenues—revenues which States use to finance high risk pools for the uninsured. This bill will make it more difficult for States to maintain and expand their efforts to expand coverage to the uninsured. That would be a travesty.

I urge Members to oppose H.R. 3103 and to support the Democratic substitute.  


Hon. NEWT GINGRICH, Speaker of the House, Washington, DC.

Dear Mr. Speaker: I am writing to comment upon the "Health Coverage Availability and Affordability Act of 1996," H.R. 3160, adopted by the House Rules Committee yesterday and scheduled for a vote by the full House of Representatives today. As you are aware, over the last few weeks, the National Association of Insurance Commissioners' (NAIC) Special Committee on Health Insurance (the "NAIC Committee"), together with the National Conference of State Legislatures ("NCSL") and the National Association of Insurance Commissioners' (NAIC) Special Committee on Health Insurance (the "NAIC Committee"), have made substantial progress in increasing accessibility and affordability of health insurance to individuals and their families. The NAIC Committee has made clear that the intent of Subtitles A and B is to provide additional clarity for individuals and families who are seeking health insurance coverage.  

We commend the additional clarifications made within Title I,Subtitle D, Section 192, relating to State Flexibility to Provide Greater Protections for保费 holders. The bill contains provisions which would allow States to make their own decisions as to how they would regulate insurance companies in their states. As a result, States may be able to provide greater protection for their citizens.  

We support the thrust of Subtitles A and B of Title I, NCSL opposes Subtitle C of Title I of H.R. 3160 since it would significantly erode existing state authority and the deregulation of the health insurance market. The bill strips States of their oversight responsibilities over a significant class of health insurance companies and thereby creating an unlevel playing field between regulated insurers and high risk pool organizations. This provision thus promotes unfair competition and could significantly diminish state premium tax income. State budgetary impact of the bill is unclear. The bill only allows States to apply premium taxes to newly-formed or newly-operating arrangements. Any arrangement that can argue they were "already operating" in a state cannot be taxed on a level playing field with state-regulated insurers. This provision thus promotes unfair competition and could significantly diminish state premium tax income. States that have been regulated have already invested time and monies into developing a regulatory structure. State's regulatory structures have evolved over time and are a critical component of the health insurance market. Those States that do not have them may be at a disadvantage. States may not have the resources to implement federal regulations.  

This bill does not preempt state law. We appreciate the efforts of the States to maintain and expand their efforts to expand coverage to the uninsured. This bill will make it more difficult for States to maintain and expand their efforts to expand coverage to the uninsured. That would be a travesty.

I urge Members to oppose H.R. 3103 and to support the Democratic substitute.
Mr. BUYER. Mr. Speaker, I rise to enthusiastically support H.R. 3160. The bill includes key small business health insurance reform that was in H.R. 995, reported by the Economic Opportunities

for plan participants. NCSL supports and encourages the development of public and private purchasing cooperatives and other innovative ventures that permit individuals and groups to negotiate affordable health care coverage on the same basis as large groups. We also believe that these entities should and must be regulated and that consumers must be protected, a task which remains to be done at both the state and federal government levels to strike a reasonable balance for MEWAs. NCSL urges you to retain the state role in regulating MEWAs.

States have made tremendous progress in reforming the small group insurance market. Since 1990 at least, 43 states have enacted laws that require employers to renew coverage for guaranteed renewal; 37 states have enacted laws that require carriers to offer coverage to small groups regardless of the health status of their employees or previous claims experience (guaranteed issue); and 45 states limit pre-existing condition waiting periods and require carriers to give individuals credit for previous coverage. In addition, similar efforts are underway in a number of states with respect to the individual insurance market. Since 1991 at least, 16 states have enacted laws that require insurers to renew coverage for guaranteed renewal; 31 states have enacted guaranteed issue; and 22 states have limited pre-existing condition waiting periods. Twenty-four states have established state high-risk health insurance pools that are enrolled over 100,000 individuals last year. Finally, states are continuing to work with MEWAs to strike a balance between reasonable state regulation, plan flexibility and consumer protection.

NCSL joins the many other groups in urging you to move forward without further delay on these incremental, but important steps toward health reform. NCSL looks forward to working with you and your colleagues in the future as we work together toward expanding health care access and affordability.

Sincerely,

William Pound, Executive Director.
Committee: It gives small employers the right to form groups for the purpose of self-insuring or fully insuring and thereby gain access to affordable health care with the economies of scale that large employers and union plans have under ERISA, it appears.

The problem of the uninsured is predominately a problem of small business lacking access to affordable insurance. Eighty-five percent of the 40 million uninsured are in families with at least one employed worker, the majority of whom work in small business. Small businesses face health insurance premiums 30 percent higher than larger companies due to higher administration costs, and an additional 30 percent more due to costly State mandated coverages.

Small business people—through the National Federation of Independent Business—call this reform “A remarkable advancement for small businesses over current law.” It is a massive improvement over what NFIB says I am going to be quoting from a letter to them.

NFIB is seeking to correct a basic unfairness in our health care system. Big business is allowed health insurance under a different set of rules than small business. Because of ERISA, large self-insured businesses are exempted from State law in their health plans while small business is stuck with State insurance coverage mandates . . . and other forms of regulation. This inequity between big business and small business in large part explains why the promises by HMOs, group providers and the private sector to absorb a good portion of the uninsured are going down, while small business premiums are going up.

H. R. 360 would stop this unfairness by allowing small firms to band together across State lines to purchase health insurance with nearly the same exemption from State law that big business has. Small employers will be able to cut their premiums by as much as a third. The legislation gives small firms almost every advantage they lack in purchasing health insurance today.

As I have indicated, big business has all of these advantages.

Achieving this is NFIB’s highest health reform priority. Any substitute that does not directly address this inequity between big and small business is unacceptable to the more than 600,000 members of NFIB.

Of course, NFIB is but one of dozens of employer groups that support this approach. It is backed by the Chamber of Commerce, National Association of Manufacturers, National Association of Wholesalers, the National Restaurant Association, the National Retail Federation, the church groups, and many others, and I might also add, by labor unions that understand how valuable this type of legislation is.

A report in the Chicago Tribune entitled “Free the Health Insurance Market” expressed it this way: “Freed of the need to offer 50 different policies, an organization such as the National Restaurant Association could negotiate with insurers to offer a basic policy to all its members. Without mandating coverage or capping premiums—two odious features of President Clinton’s failed reform plan—the (bill) spurs the private insurance market to absorb a good portion of the Nation’s 41 million uninsured, the vast majority of whom either have jobs or have a jobholder in he family.”

Unless we do something there by the end of this year, what do you think could happen to health care plans under the incorrect assumption that it is the responsibility of the States to provide health care for all?

Mr. Speaker, many of the Governors had concerns about the original H.R. 995 as introduced last year. I am pleased to report that we worked very closely with many of them over the past year, and we addressed their concerns. Several changes were made that are acceptable to the Governors and the employer community.

Let me ask this one question, and think about it: Who benefits from this legislation? Who benefits from the small business people through the National Federation of Independent Business all over America and who produce most of our new jobs.

I urge my colleagues to vote no on the substitute that stands on final passage of H.R. 3160. Allow employees of small businesses the same kind of access to affordable health care as that available to employees of large businesses.

Section-by-Section Analysis of Provisions Relating to ERISA Group Health Plans Considered by the Committee on Economic and Educational Opportunities in the Health Insurance Affordability Act of 1996

Subtitle A—Coverage Under Group Health Plans Sec. 101. Portability of coverage for previously covered individuals, and Sec. 102. Limitation on preexisting condition exclusions; no application to certain newborns, adopted children, and pregnancy.

Group health plans, insurers, and health maintenance organizations would be prohibited from imposing a preexisting condition exclusion with respect to preconditions for which medical advice, diagnosis, or treatment was received or recommended within the 6 months prior to becoming insured. In the event that the individual was a late enrollee, the preexisting condition exclusion could not exceed 18 months.

Preexisting condition exclusion limitations could not be applied to newborns and adopted children as long as these individuals become insured within 30 days of birth or adoption, for adoption. Pregnancy could not be treated as a preexisting condition. In addition, genetic information could not be considered a preexisting condition, so long as the information was not received or recommended within the 6 months prior to becoming insured. In the event that the individual was a late enrollee, the preexisting condition exclusion could not exceed 18 months.

Preexisting condition exclusions or limitations could not be applied to newborns and adopted children and the aggregate period of any qualified prior coverage. Prior coverage would not be credited toward a preexisting condition limitation period if the individual was denied a period of coverage under a group health plan.

Group health plans, insurers, and health maintenance organizations (HMOs) would be required to provide for special enrollment periods for eligible individuals who lose other sources of coverage if certain conditions were met. An individual would have to be allowed to enroll under at least one benefit option if (1) the employee (or dependent) had been covered under another group health plan at the time coverage was previously offered, (2) that the individual lost their coverage as a result of certain events (loss of eligibility for coverage, termination or employment, or reduction in the number of hours of employment), and (4) the employee requested such enrollment within 30 days of termination of the coverage.

The intent that a group health plan provided family coverage, the plan could not require, as a condition of coverage of a beneficiary or participant in the plan a waiting period that is applicable to the beneficiary who is a newborn, an adopted child or child placed for adoption, or a spouse, at the time of marriage, if the participant has met the above conditions for eligibility as a participant. The bill defines timely enrollment as being within 30 days of the birth, adoption,
or marriage if family coverage was available as of that date.

Renewability requirements apply to certain arrangements to assure continued access to health coverage for employees. A group health plan which is a multiemployer plan, a multiemployer plan (as defined in section 101 of ERISA), and a multiemployer welfare arrangement (providing medical care) may not deny an employer whose employees are covered by such a plan or arrangement continued access to the same or other coverage under the terms of such plan or arrangement other than (1) for nonpayment of premiums or contributions, (2) for fraud or other intentional misrepresentation of material fact by the employer, (3) for noncompliance with material plan or arrangement provisions, (4) because the plan or arrangement other than (1) for nonpayment of premiums or contributions, (5) for a failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement, (6) in the case of an arrangement to which subparagraph (D), (E), or (F) of section 3(40) of ERISA applies, to the extent necessary to meet the requirements of such subparagraph, or (7) in the case of a multiemployer welfare arrangement (as defined in section 701 of such Act), for failure to meet the requirements under part 7 of ERISA for exemption under section 4980B of such Act. A failure to meet the requirements of such subparagraph would be subject to a civil money penalty.

Sec. 130. Guaranteed Renewability of Group Coverage

A group health plan, insurer, or HMO that failed to meet the requirements would be subject to a civil money penalty. Rules similar to those imposed under the COBRA penalty would apply. The maximum amount of any penalty would be $100 for each day the failure occurred. In determining the penalty, the person being assessed for failure would be required to take into account the previous record of compliance of the person being assessed with the applicable requirements of the Act, the gravity of the violation, and the overall limitations for unintentional failures under the IRC COBRA provisions.

Sec. 131. Guaranteed Availability of Group Health Insurance Coverage

This section provides for guaranteed availability of group health insurance coverage. A group health plan, insurer, or HMO that failed to meet the requirements would be subject to a civil money penalty.

Sec. 132. Guaranteed Renewability of Group Coverage

This section provides for guaranteed renewability of group coverage. If an insurer or HMO offered health insurance coverage in the small group market, then that insurer or HMO would have to renew or continue that coverage in the small group market even if the failure to renew or continue the coverage would have to be renewed or continued in forced at the option of the employer. (An insurer or HMO could modify the coverage offered to a group health plan so long as the modification was effective on a uniform basis among group health plans with that type of coverage.) Exceptions to the guaranteed renewal penalty provisions apply in the event that the employer failed to pay the premiums, committed fraud, violated the participation rules, or moved outside the service area.

Sec. 133. Guaranteed Availability of Group Health Insurance Coverage Through Multiple Employer Pooling Arrangements

This section defines the terms: insurer, fully-insured, medical care (as under current law), multiemployer health plan, participating employer, and state insurance commissioner. It also contains restrictions on the ability of states to fully regulate such entities. Specifically, existing section 134(b)(1)(ii) of ERISA provides that this section does not apply to a fully insured or fully self-insured arrangement, any law of any State which regulates insurance may apply only to "the extent not inconsistent with this section," and the Department of Labor (DOL) may issue an exemption from
Section 702 clarifies that only certain legitimate association health plans and other arrangements of the sort that are not fully insured are eligible for an exemption and thereby treated as ERISA employer welfare benefits plans. This is accomplished by clarifying the definition of a "significant association health plan" and thereby the definition of an "employer welfare benefits plan" as set forth in section 701(b)(6)(B) of ERISA. States are preempted from regulating employee welfare benefit plans, but an exception is made under section 702 to allow states to regulate welfare benefit plans established by bona fide health plans for persons in a "group" that is eligible for a class exemption.
fully community ranked individual health insurance coverage offered by insurers and HMOs, or (2) requires insurers offering group health coverage to reimburse insurers individual or group plans for losses resulting from policies under their coverage on an open enrollment basis. Regulations may also apply certain limitations to single industry plans.

Under section 708, a state could assess new association-based MEHPs (former March 26, 1996, non discriminatory state premium taxes set at a rate no greater than that applicable to any insurer or health maintenance organization offering health insurance coverage in the state. MEHPs existing as of March 6, 1996 would remain exempt from state premium taxes; however, if they expand into a new state, the state could apply comparable taxes.

Section 162. Affordable and Available Fully-Insured Health Coverage Through Voluntary Health Insurance Associations.

This section adds a new subsection (d) to section 514 of ERISA which provides for the establishment of Voluntary Health Insurance Associations (VHIAs). Under this section, a VHIA is defined as a multiple employer welfare arrangement, maintained by a qualified association, under which all medical care is insured, underwritten, and retained by the employer excluded as a participating employer (subject to minimum participation requirements of an insurer), under which the enrollee's covered benefits and the costs of such coverage are paid for by agreements which include benefits which they want and which they can afford. Under this section, a state which certifies to the Secretary that it provides "guaranteed access" to a VHI, the right to offer coverage in the small group market (or otherwise regulate such VHI with respect to such coverage), except as described in the present section, is considered to provide such guaranteed access if (1) the state certifies that at least 90% of all state residents are covered by a group health plan or a VHIA; (2) the state, or the small group market, provided for guaranteed issue of at least one standard benefits package and for rating reforms designed to make health insurance coverage more affordable. In a state without such guaranteed access, VHIAs could offer coverage in the small group market in the state as long as they meet the standards for such entities.

This section also provides a limited exception to the above rule to accommodate certain large, multi-state arrangements. This section clarifies the scope of ERISA to self-insured multiple employer welfare arrangements. The state opted out of the paragraph above does not apply to VHIs that meet the following criteria: (1) the sponsor operates in a majority of the 50 states and at least 2 of the regions of the country; (2) the arrangement covers or will cover at least 7,500 participants and beneficiaries; and (3) under the terms of the arrangement, either the qualified association does not exclude from membership any small employer in the state, or the arrangement accepts every small employer in the state that applies for coverage.

In addition, the state opted out of the paragraph above does not apply to a state in which an arrangement operates on March 6, 1996 and under the terms of the arrangement, either the qualified association does not exclude from membership any small employer in the state, or the arrangement accepts every small employer in the state that applies for coverage.

The above exceptions for multi-state plans and existing plans do not apply to any state which has ever adopted a law providing for guaranteed issue of fully community ranked individual health insurance coverage offered by insurers and HMOs to any holder of a qualified association as defined in section 3(40)). The treatment of a single employer arrangement is similar to that permitted under current law. This section amends the definition of MEWA to exempt certain collective bargaining arrangements (as described in the National Labor Relations Act, the Railway Labor Act, and similar state laws). The last state law requires the Secretary to "find" that a collective bargaining agreement exists, but no such finding has ever been issued. It is unlikely that additional conditions must be met for such a plan to be a statutorily excluded collectively bargained arrangement and thus not a MEWA. These include:

(1) The plan cannot utilize the services of any licensed insurance agent or broker to solicit or enroll employers or pay a commission to any insurance intermediary or other entity; (2) the employer organization or other entity sponsoring the plan or arrangement must certify annually to the Secretary the plan has met the requirements; (3) if the plan or arrangement is not fully insured, it must be a multiple employer plan meeting specific requirements of the Labor Management Relations Act (i.e., the requirement for joint labor-management trustee-ship under section 302(c)(15)(B)).

(5) If the plan or arrangement is not in effect as of the date of enactment, the employer organization or other entity sponsoring the plan or arrangement must have existed for at least 3 years or have been affiliated with another entity which has existed for at least 3 years, or demonstrate to the Secretary that certain of the above requirements have been met. Sec. 166. Treatment of church plans.

This section adds a new section 709 to ERISA permitting church plans to voluntarily elect to apply to the Department of Labor for an exemption under section 514(d)(6)(B) and in accordance with new ERISA Part 7. An exempted church plan would, with certain exceptions, have to comply with the provisions of ERISA Title I in order to receive an exception from state law. The election to be covered by ERISA would be irrevocable. A church plan is covered under this section if the plan provides benefits which include medical care and some or all of the benefits are not fully insured.
MEWA or collectively-bargained arrangements may result in criminal penalties; (4) the provision for cease activity orders for arrangements found to be neither licensed nor otherwise regulated under State insurance law, or operating in accordance with the terms of an exemption granted by the Secretary under new part 7; and (5) the provision for the removal of the fiduciary or board of trustees of a MEWA to comply with the required claims procedure under ERISA.

Sec. 188. Cooperation between Federal and State authorities.

This section amends section 506 of ERISA (relating to coordination and responsibility of agencies with respect to enforcing ERISA and related laws) to specify State responsibility with respect to self-insured Multiple Employer Welfare Plans and Voluntary Health Insurance Associations. A State may enter into an agreement with the Secretary to delegate to the State of some or all of the Secretary’s authority to enforce provisions of ERISA applicable to exempted MEHPs or to VHIAs. The Secretary is required to enter into the agreement if the Secretary determines that delegation to the State would not result in a reasonable assurance of quality of enforcement. However, if the Secretary delegates authority to a State, the Secretary can continue to exercise such authority concurrently. The Secretary is required to provide enforcement assistance to the States with respect to MEWAs. Sec. 189. Filing requirements for multiple employer welfare arrangements offering health benefits.

This section amends the reporting and disclosure requirements of ERISA to require MEWAs offering health benefits to file with the Secretary a registration statement within 60 days before beginning operations (for those that start after January 1, 1998) and no later than February 15 of each year. The section also requires MEWAs providing medical care to issue to participating employers certain information including summary plan descriptions, contribution rates, and the status of the arrangement (whether fully-insured or an exempted self-insured plan). Sec. 190. Single annual filing for all participating employers.

This section amends ERISA’s section 110 (relating to the assurance of methods of compliance with reporting and disclosure requirements) to provide for a single annual filing for all participating employers of fully insured MEWAs. Sec. 191. Effective date; transitional rule.

This section provides that, in general, the amendments made by this title are effective January 1, 1998. In addition, the Secretary is required to issue all regulations needed to carry out the amendments before January 1, 1998. The section provides for transition rules for self-insured MEWAs in operation as of the effective date so that those applying to the Secretary for an exemption from the Secretary for an exemption from State regulation are deemed to be excluded from ERISA applicable to exempted MEHPs or to VHIAs. The sections also provide for a ‘pre-existing coverage’ look-back period that is shorter than 6 months. The ERISA savings clause states that, except as provided specifically in subtitle C, nothing in this Act shall be construed to affect or modify the provisions of section 514 of ERISA (relating to federal preemption of state laws relating to employee benefit plans).

Sec. 193. Effective Date.

In general, except as otherwise provided for in this title, the provisions of this title would apply with respect to: (1) group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1998; and (2) individual insurance coverage issued, renewed, in effect, or operated on or after January 1, 1998. The provisions of this title shall be construed so as not to result in any unnecessary deterioration of the quality of health care or to impose any unnecessary administrative burden. The Secretary of HHS, Treasury, and Labor would be required to issue regulations on a timely basis as may be required to carry out this title.

Sec. 194. Rule of Construction.

Nothing in this title or any amendment made thereby may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage under this title or through regulation. Mr. CLAY. Mr. Speaker, I yield 3 minutes to the gentleman from Texas, Mr. Gene Green.

Mr. GENE GREEN of Texas. Mr. Speaker, I would like to thank my colleague and ranking member from Missouri, Mr. Clay, for yielding me the time.

Mr. Speaker, I rise in opposition to H.R. 3103, and a little background. I would like to give an example from the state of Texas. In 1973 we changed laws so that people who buy group insurance would know what they are purchasing. Here today I see this bill would possibly take that away unless the Department of Labor somehow says, OK, we are going to have this minimum benefit. This protection would be no longer available, at least on the local level, that the States have decided need to be provided to the purchasers of insurance.

Unlike block grants, States have tested and successfully regulated MEW’s, and there is no compelling reason or need to preempt State authority in this area.

Mr. CLAY. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey [Mr. Andrews].

[Mr. ANDREWS asked and was given permission to revise and extend his remarks.]

Mr. ANDREWS. Mr. Speaker, I would like to thank the gentleman from Missouri [Mr. Clay], the ranking member, for yielding me this time.

Mr. Speaker, there are two sets of ideas before the House tonight. There is a set of ideas on which there is disagreement, whether we should limit the amount people can recover if they are a victim of malpractice; whether or not people should have medical savings accounts; whether or not there should be pooling arrangements for small businesses. There is legitimate disagreement about those things.

But there are two sets of ideas on which there is virtual unanimous agreement, broad consensus that we should make it illegal to say you cannot deny someone an insurance policy
by because they have been sick, and that people should be able to take their insurance from job to job.

Mr. Speaker, logical people would say that we put aside the things on which we cannot agree and debate about them and try to refine them and deal with them another day and then we take the things on which we do agree and pass them on so we can send them to the President of the United States and make them law.

But we are not going to do that. What we are going to do tonight in the bill that is before us is take a lot of controversial provisions and maybe pass them out of here and send them to a conference that will, in likelihood, I believe they will wither on the vine and die.

Now, this is not just another cynical example of the cynical exercise of how politicalis practiced in our country. It is more than that. It has a lot to do with real people in real families and their real lives.

Mr. Speaker, the American people understand this. A woman with breast cancer has had a triple bypass heart operation, a shipyard worker who has had asbestosis can be denied health insurance coverage now because the have been sick. If he substitute offered by the gentlewoman from New Jersey [Mrs. Roukema] does not pass tonight, they will still be denied that coverage. We need to make it illegal, illegal for an insurance company in this country to say to that woman with breast cancer of that man with asbestosis or that person who has had the triple bypass operation that we are not going to sell you a policy or that we are going to charge you the Moon and the stars to buy the policy. A unanimous vote in a Senate committee said they agreed with that. Dozens of Republicans and Democrats, if not hundreds around here, have said they agree with that. The President of the United States has said he would sign that. But unless the Roukema substitute passes, we are not going to do that.

Do the right thing tonight. Vote “yes” on the Roukema substitute and “no” on this bill.

Mr. CLAY. Mr. Speaker, I yield 2 minutes to the gentleman from New York [Mr. Engel].

Mr. ENGEL. Mr. Speaker, I thank the ranking member for yielding me this time.

Mr. Speaker, this bill ought to be defeated. We should be considering a clean version of the Kennedy-Kassebaum-Roukema health reform bill and I say would that the reason we are not considering a clean version of the Kennedy-Kassebaum-Roukema health reform bill is because the Republican leadership really does not want to see health care reform come into law. They will not want to see it defeated. But, quite frankly, they do not have the guts to say it. So they are weighing this bill down with all kinds of extraneous things that do not belong in the bill, knowing full well that this will kill the bill.

The Senate is going to pass a clean version. The President has said he will sign a clean version, and yet what we are doing today is political charade. We are not passing a clean version, we are deliberately not passing the version the Senate is passing, and we know that the President will not agree.

So it is a charade. And, again, the Republican leadership has not had the guts to say the truth. You know, the gentleman from Texas [Mr. DELAY], the Republican whip, had it right before, when he said on the House floor, and I quote the gentleman from Texas from his speech on the House floor, “This is blatant politics and blatant hypocrisy.” Except he was wrong in directing it to me and the Democrats. It seems to me the blatant, as the gentleman from Texas [Mr. DELAY] said, “blatant politics and blatant hypocrisy” is of the gentleman from Texas [Mr. DELAY] and the Republican leadership because they do not have the guts to say we are against health care reform; instead, they are just weighing down this bill with a bunch of nonsense.

We believe that portability ought to become law. We believe that preexisting conditions is not a reason to deny people health care coverage. The Roukema bill does that. The Roukema bill will pass. The Roukema bill has the votes to pass, yet what they are doing is making it impossible for the Roukema bill to pass, and that to me is, quote, as the gentleman from Texas [Mr. DELAY] says, “blatant politics and blatant hypocrisy.”

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentlewoman from Kansas [Mrs. MEYERS].

(Mrs. MEYERS of Kansas asked and was given permission to revise and extend her remarks.)

Mrs. MEYERS of Kansas. Mr. Speaker, I rise in strong support of H.R. 3103 because it allows small employers to form Multiple Employer Health Plans [MEHPs] which can cross State lines. Small businesses operate closer to the bottom line than larger businesses, and are often unable to obtain coverage at any price. They pay higher premiums if they do obtain coverage, and cannot count on stable premiums. MEHPs can self insure, in which case they would not be required to register and maintain substantial capital reserves—a minimum of $400,000 or 25 percent of the expected claims—which was higher.

MEHPs would allow small employers to band together around the country, thereby avoiding expensive State-managed benefits. Right now, small businesses pay up to 30 percent more in premiums than big businesses that can make use of ERISA exemptions. MEHPs could allow small employers to form MEHPs across State lines.

I urge my colleagues to support 3103.
portability, to provide health care for workers who lose their jobs. Let me give an example of why this is important. IBM has laid off 40,000 people; AT&T 40,000 people. These people are hard workers. They have children that may be in their care. Yet, now health insurance companies can say, "We don't want to cover you anymore." If you vote for the Roukema Bill, the Kennedy-Kassebaum bill, you will allow these hard-working Americans to take their insurance with them and then insure who you choose. Now being prejudiced against these people.

Vote for our children. Vote for our hard-working people in America, and vote for commonsense bipartisanism. 

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentleman from Michigan [Mr. KNOLLENBERG].

Mr. KNOLLENBERG. Mr. Speaker, I rise in strong support of H.R. 3103 and commend my colleague, the gentleman from Illinois [Mr. FAWELL] for his efforts in bringing this legislation, which is badly needed, to the floor.

H.R. 3103 is not about big insurance companies or some Government takeover, as some would suggest. It is about providing coverage for millions of uninsured. And it allows them to get it on an accessible and affordable basis.

H.R. 3103 is about providing insurance to those millions of people that are currently unable to get insurance. For too long this system has stacked the deck against small business. Big businesses, such as GM, IBM, I just heard, have the luxury of providing employees insurance through self-insuring, while small businesses lack the resources to self-insure. This bill directly addresses the inequality by allowing small businesses to join together to self-insure.

Mr. Speaker, Kassebaum-Kennedy is a Cadillac coverage program, one size fits all, without affordability. I urge my colleagues to vote for H.R. 3103.

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentleman from Florida [Mr. WELDON].

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding me this time.

I rise in strong support of this bill for a variety of different reasons, probably chief of which is that it will allow many small employers to pool their resources together and purchase health care coverage. This is an advantage the has been held by large corporations for many years and has been denied small businesses, and, as a consequence of that, those small businesses have to pay a much higher premium and they therefore choose not to provide coverage.

I would like to also additionally briefly address the issue of medical savings accounts. We have heard a lot of discussion about how bad these supposedly are, but I would assert that if medical savings accounts were available to the employees that work for Members of the minority, the majority of their employees would select medical savings accounts because medical savings accounts truly give the health care consumer the freedom to choose how to spend their health care dollars. It has been shown repeatedly that they over and over save a considerable amount of money. One of the biggest problems in our health care system is the third-party payer system.

Mr. CLAY. Mr. Speaker, I yield the balance of my time to the gentleman from New York [Mr. OWENS].

[Mr. OWENS asked and was given permission to revise and extend his remarks.]

Mr. OWENS. Mr. Speaker, the Dingell-Kennedy-Kassebaum substitute is a modest but significant step forward for health care. I rise in support of the substitute. It is good that we are here addressing problems such as portability or increased deductibility for small businesses and preexisting condition discrimination. These small steps forward are important to millions of American people should not be missed.

Mr. CASTLE. Mr. Speaker, I am proud to be an original cosponsor of H.R. 3103. Approximately 17 percent of our nonelderly population does not have health care insurance coverage in the United States of America. This very important piece of legislation decreases that rank of the uninsured, that 17 percent, by making health insurance more readily available and affordable. Many things we should have done many years ago: Guaranteeing the portability of health insurance for workers changing or leaving jobs, limiting the ability of insurers to use preexisting conditions to deny health insurance coverage, making health insurance more affordable by reforming malpractice laws and cracking down on fraud and abuse, and several other measures which are here.

This focused reform bill compliments the efforts of States to expand health insurance coverage within their borders rather than superseding them.

I would like to say a word or two about those who argue that this would kill Kassebaum-Kennedy. This bill does not kill what our colleagues in the Senate have accomplished. This bill builds upon the sound principles to expand availability of Kassebaum-Kennedy, but also addresses affordability, which is not addressed in that bill.

Mr. Speaker, I encourage all of us to support this excellent piece of legislation.

Mr. GOODLING. Mr. Speaker, I yield 30 seconds to the gentleman from Illinois [Mr. FAWELL].

Mr. FAWELL. Mr. Speaker, I think all one can say, I would just commend the leadership on this side of the aisle. I would like to point out, too, that you will notice that one, no one on this side of the aisle, criticized the legislation that that side is pushing. Yet I think it is fair to say we have had an abundance of criticism from that side.

We are simply asking that small employers have the rights that mid-sized and large employers have had for a long time, and that is to be self-insure. They preempt state law. You have heard it say there are 138 million people today under the ERISA law.

Mr. DeFAZIO. Mr. Speaker, I rise in opposition to H.R. 3103, the so-called "Health Coverage Availability and Affordability Act," and in support of the Democratic substitute, H.R. 3102.

We all agree that the American system of health care is in dire need of an overhaul. Health care costs are skyrocketing out of control. Having doubled in the last decade, they're far beyond the reach of any American who's uninsured and can't afford exorbitant insurance premiums. Four million Americans lost health insurance between 1988 and 1994. Millions more are just a pinkslip away from losing all of their health care coverage.

There are provisions in H.R. 3103 that I support. I agree that it is high time Congress corrects some of the more egregious practices of insurance companies. Denying insurance to individuals because of pre-existing conditions, genetic information, or a history of
domestic violence is outrageous. It is a good
time to ban these practices.
I've supported legislation that would correct
these policies. I've authored legislation that
would prohibit using domestic violence as a
risk factor. I've also co-sponsored the Ken-
ney-Kassebaum-Roukema health care reform
bill, which has the support of Senate Repub-
licans and Democrats as well as the Presi-
dent.

The Democratic substitute would replace
H.R. 3103 with language from the Kennedy-
Kassebaum-Roukema bill. This bill would ex-
and access to health insurance for Ameri-
cans by increasing portability and limiting in-

surance companies' ability to deny coverage
because of pre-existing conditions. The politi-
cal consensus for the Kennedy-Kassebaum-
Roukema bill means that it could become law
in a matter of weeks.

But H.R. 3103 embraces controversial, divi-
sive policies that doom any chance of insur-
ance reform and minimal health security for
the American people.

As a long-time advocate of fiscal respon-
sibility, I must oppose the provisions in this bill
establishing generous Medical Savings Ac-
counts [MSAs]. The MSAs would result in a
significant loss of taxpayer dollars without a
substantial revenue offset. Under this bill, indi-
viduals could deposit up to $2,000 annually and
families up to $4,000 in tax-free MSAs. The Joint
Committee on Taxation has esti-
mated that this provision alone would cost the
U.S. taxpayers approximately $2 billion. This
flies in the face of the deficit reduction goals
to which this Congress purports to aspire.

The Republican leadership counters that the bill
contains budgetary savings to offset the revenue
loss from MSAs. This assertion is
laughable and cynical. The budgetary savings are
achieved through "reforms" in the Medi-
care program—the health plan for America's
senior citizens. This is the same Medicare pro-
gram that the Republicans claim is in such a
dire financial crisis.

Any savings achieved through Medicare re-
forms should be used to shore up the Medi-
care trust fund. Failing that, these savings should
not be given to a select group of individuals and
families to help them pay premiums for private
health insurance.

Individuals who choose to open MSAs will
likely be healthier, wealthier and younger than
average. Unfortunately, the majority of the
Medicare population is among the older and
sicker and would not benefit from MSAs. The Repub-
lican leadership's bill would, therefore, steal money from Medicare recipients to pay for
tax breaks for the limited number of individ-
uals who can afford MSAs.

Under H.R. 3103, penalties for defrauding
the Government through Federal health care
programs, such as Medicare and Medicaid,
will be stifled. Furthermore, the bill will re-
quire the Secretary of Health and Human Ser-
tices and the Attorney General to jointly
establish a national health care fraud and
abuse control program to coordinate Federal,
State and local law enforcement to combat
fraud with respect to health plans.

In addition, the "Health Coverage Availabil-
ity and Affordability Act of 1996" will require the
Secretary of Health and Human Services
to exclude from Medicare and State health
care programs for a minimum of 5 years indi-
viduals and entities who have been convicted of
felony offenses relating to health care fraud;
require beneficiaries to provide the Secretary
with an explanation of each item or service for
which payment was made under Medicare;
and require the Secretary to establish a pro-
gram to encourage individuals to report sus-
spected fraud and abuse in the Medicare pro-
germs.

I firmly believe that the fraud and abuse pro-
visions in H.R. 3103 are long overdue and
represent a serious effort to reduce fraudulent
activity, which drives up the cost of health
care for everyone. The Government Reform
and Oversight Committee, which I chair, has
heard several hearings on this very issue, and
I feel strongly that we need to act now to
crack down on health care fraud and abuse.

Also, as a representative of a largely rural
district, I am pleased to see provisions in H.R.
3103 that will allow small businesses to join
together to form purchasing cooperatives. This
provision exempts small businesses from cer-
tain State insurance regulations—an exemp-
tion that big business now enjoys. This
change will make health insurance affordable
for small businesses who cannot afford it at
the present time—a problem that is particularly
noticeable in rural areas. Some predict that
small employers will be able to cut their busi-
ness premiums by as much as a third, even
while paying lower premium taxes, which is
provided for under the bill. This provision
will certainly increase access to quality health care
to rural individuals.

Again, I urge my colleagues to support this
sensible, responsible approach to health care
reform.

Mr. GILMAN. Mr. Speaker, I rise in strong
support of H.R. 3103, the Health Coverage
Availability and Affordability Act and urge my
colleagues to support this well intentioned bill.

As one of the Republican cosponsors of the
Roukema/Kassebaum/Kennedy portability
measure, I am acutely aware of the need for
Congress to approve a health coverage meas-
ure which will ensure working people and fami-
lies that they will always have access to health
insurance regardless of their health,
their family's health, or their employer. Accord-
ingly, I commend my colleague, Representa-
tive ROUKEMA, for her efforts in the House to
bring this portability measure before the
House today.

Similarly, I am pleased that the House will
have an opportunity to make a good bill better.
In addition to making health insurance more
available to all Americans, H.R. 3103 makes it
more affordable and provides more choices.

H.R. 3103 will provide incentives to encour-
age individuals, and their employers, to make
tax deductible contributions—in lieu of health
insurance premiums—to a specialized savings
account [MSA] to be used at a later date for
health expenses; it increases penalties for fraud
and abuse of the health care system; and allows self employed individ-
uals and small businesses to voluntarily asso-
ciate to purchase health insurance which
would be available to all member organiza-
tions.

All of these provisions mentioned above will
help our Nation's farmers, self-employed,
and small business entrepreneurs to provide health
insurance for their families and employees.

Though H.R. 3103 may not be a perfect bill
it does provide important health insurance re-
forms that will ensure broad health coverage
for our constituents.

Furthermore, this measure is a step in the
right direction. I look forward to working further
with my colleagues on health care reform
measures which will protect those Americans
who currently do not have health insurance
coverage.

I urge my colleagues to support H.R. 3103.

Mr. STENHOLM. Mr. Speaker, in an effort to
keep health insurance affordable, I am moving
through the legislative process, I rise with
some reservation to support H.R. 3103, the

My record clearly reflects my strong support
of health insurance reform. In addition to ef-
forts on rural health issues and system-wide
reform, I have worked for many years to make
health insurance both accessible and afford-
able for millions of underserved Americans,
many of whom reside in the 17th District of
Texas. In one very recent example, I heard
from a constituent who has been employed
for the last 10 years with her sister in a bookkeeping and secretarial
business. At one point, she had hospitalization
insurance, but the price of the policy continually
increased to the point that she finally had to drop it because she could no longer afford it. She now worries about the health and economic vulnerability of her situation.

While this legislation does not specifically address all of her needs, I believe certain provisions, such as portability of health insurance, limitation on pre-existing conditions, increased tax deductibility for the self-employed, and guaranteed availability of insurance for small employers, are definitely steps in the right direction.

Because the Senate has taken the lead on a health insurance reform bill which the President has pledged to sign, I must express my concerns about the political ramifications of loading this bill down with some of the more controversial provisions that have been included here today. I recall just a few years ago, during a similar health care debate, when my friends on the other side of the aisle were criticizing Democrats for “overreaching” on health care reform proposals. Now, I fear we are back there.

Like many Members of this body, I would like to see additional health care reforms, including reforms to develop rural health networks and preserve rural health services. Facing political reality, however, I realize that this might be the proper vehicle to achieve these goals.

I am also concerned that rather than promoting the goals of greater health insurance access and affordability, some provisions in this bill may have the reverse impact in the long run because sufficient safeguards were not added to the provisions. For example, I have strongly supported small employer pooling arrangements with effective certification and solvency standards, as well as protections to ensure that the plan is large enough to manage risk. However, I am worried that the pooling section of this legislation fails to meet those concerns.

I am especially concerned that the bill we are considering today includes provisions and changes which were made after the Committees of jurisdiction reported out their components of the bill.

While I am not convinced that this House bill meets many of my concerns, I do believe that these issues can be worked into the insurance reform process. The bipartisan spirit of keeping the process moving forward, I intend to vote yes on final passage. It is my hope that we not let another opportunity to achieve some type of bipartisan health care reform pass us by, simply because we again overreach the boundaries of consensus. That is why I am cautiously supporting H.R. 3103, with the hope that the conference committee will inject bipartisan common sense into the process and develop a health insurance reform bill that will get a Presidential signature.

After all, without both a congressional majority and a Presidential signature, my constituents in the 17th district, or Americans anywhere else, will receive no benefit from this political exercise. In the final analysis, I would hope that the goal for us weighed not in political, special interest terms, but in terms of caring for the health needs of our un- and under-insured populations.

Mr. HORN. Mr. Speaker, there has been a campaign of misinformation about this legislation. Americans have been told that this bill would deny them continued health insurance coverage for alternative medical treatments. This is untrue.

This bill does not deal with health insurance coverage for alternative medical treatments. This is an issue that must be addressed by the States. H.R. 3103 only requires that each State implement a mechanism to ensure individual coverage.

This bill does increase choices for health care delivery systems by providing for medical savings accounts. With these accounts, Americans can utilize their health care dollars for whatever treatment fits their needs. That is the way to ensure that alternative medical treatments remain available for anyone who wants them.

Mr. FRANKS of Connecticut. Mr. Speaker, H.R. 3103, the Health Care Coverage Availability and Affordability Act will ensure that Americans have access to health care coverage. More importantly, however, the bill will insure that people do not lose their insurance coverage when they switch jobs.

During the March 17th hearing this subcommittee held on insurance reform I stated that I had worked for both small businesses and for Fortune 500 companies. During my formative years in Congress I saw first-hand the concern of individuals who have worked hard and suddenly found themselves without employment or insurance coverage. These individuals worry about how they will make their insurance payments to COBRA. COBRA benefits are supported individuals during periods of unemployment, but without a job how can the individual keep up his or her COBRA payments. They can’t, so they simply slip through the cracks in our insurance industry. These are the individuals that we must be most concerned with.

This same scenario can be applied to the self-employed. Should a self-employed individual’s company fail, what would happen during the period of unemployment. I have recently reintroduced legislation I sponsored during the 103d Congress. My bill would allow us to look at the situation I just described in a similar fashion to the way in which we look at unemployment compensation, with the exception that the employer will not have to contribute. While a person is employed, why not have that person contribute to an unemployment trust. The employee would be able to contribute money to the trust and then access it during periods of unemployment. We also need this kind of return.

The bill before us today brings about much-needed reform to the insurance industry in this country. It addresses such important issues as portability and pre-existing conditions. Individuals will no longer have to remain in a job they do not like in order to maintain insurance coverage. Under this bill if an individual changes jobs his or her insurance coverage will not be reduced. Under current law insurance companies will no longer be able to deny coverage to individuals with pre-existing conditions.

H.R. 3103 addresses the problem of medical malpractice costs. The bill establishes uniform standards for health care liability suits brought in court. Malpractice lawsuit awards are capped at $250,000 for non-economic damages and $250,000 or three times the non-economic damages for punitive damages. This capping of damages will aid in driving down health care costs. This bill will allow organizations, like trade associations, to voluntarily associate to purchase health care insurance. This insurance would then be available to all member organizations. The voluntary association organizations for the purpose of buying health insurance will allow them to increase their purchasing power, thus allowing them to purchase insurance at a significant savings.

This bill provides relief to self-employed individuals by allowing them to deduct increasing percentages of their health insurance costs from their income taxes. This provision, like many of the others contained in this bill, will make the purchasing of health insurance more affordable. This is especially important for self-employed individuals because all too often they fall through the cracks in our health insurance industry.

Penalties for fraud and abuse of the federally funded health care system are increased under this legislation. Overcharging, double billing, and charging for services not rendered has become too prevalent. These types of fraud cost consumers 5 to 10 percent of their health care dollar. This results in higher health care costs as well as higher insurance premiums.

Finally the bill allows for the establishment of medical savings accounts, MSA’s. MSA’s will bring about changes to health insurance. These accounts will place the consumer in charge of his or her health care. The consumer will have total control over his or her health care. This will allow the consumer to spend his or her health care dollars as he or she wants.

Mr. PARKER, the legislation before us takes important steps toward reforming the health insurance industry in this country. I applaud this legislation and look forward to its passage. Thank you and I yield back the balance of my time.

Mr. OXLEY. Mr. Speaker, I rise today in support of the Health Coverage Availability and Affordability Act of 1996. This bill includes provisions I have long supported on paper work reduction.

I am pleased to see that today, the House will have the opportunity to vote on these and other needed reforms. Legislation aimed at making health insurance more available and affordable while reducing administrative work is long overdue. While President George Bush introduced similar legislation in 1992, the then Democrat-controlled Congress blocked its consideration. It was not until the defeat of President Clinton’s nationalized health care system that a consensus coalesced around these market-based reforms.

Currently, excessive paperwork, redtape, and duplicative administrative costs add nearly 10 cents to every health care dollar spent in the United States. In response to this concern I introduced legislation during the 102d Congress, along with our former colleague, Alex McMillan, to reduce these unnecessary costs through the establishment of uniform health claims and electronic billing standards.

Following this first ever-standing bill on billing simplification, my Ohio colleague, DAVE O’BOSTON, took up the cause, improving upon our work. Congressman O’BOSTON’s work has been integral in the promotion of the benefits of a uniform electronic billing system.

Mr. Speaker, I support the passage of the Health Care Coverage Availability and Affordability Act. American working families need and deserve the flexibility and cost-saving measures this bill provides.

Mr. PARKER. I want to congratulate the many Members who have been instrumental
in bringing to the floor this important health care reform legislation.

In the 103d Congress, a number of us worked diligently on a similar, incremental package that would have corrected many identifiable problems in our health care delivery system.

Unfortunately, we never had an opportunity to vote on such a measure. Today, however, I am pleased that we will finally be able to tell our constituents that help is on the way—changes will be made to address many of their health care concerns.

The passage of this legislation will assure people that they can change jobs and obtain group health insurance coverage through a new employer, without pre-existing condition limitations.

For those individuals who are between jobs and have been unable to obtain coverage due to a pre-existing condition, this bill will make it possible for them to do so.

For small employers, new pooling arrangements and an increased deduction for health insurance premiums will make it easier for them to purchase insurance coverage for their employees.

For individuals and families, medical savings accounts will now be available that allow them to control their own health care decisions and costs.

And for the many States like my own that provide health care coverage for uninsured high-risk individuals, this bill will clarify the tax-exempt status of State-established health insurance risk pools.

Currently, such risk pools are not automatically exempt from Federal income taxes. This bill provides the necessary legislative fix to assist States in making much-needed medical insurance available to uninsured residents.

Of course, this bill, like the proposal I worked on in the last Congress, also includes provisions addressing such important needs as administrative simplification, fraud and abuse elimination, and medical malpractice reform.

In closing, we are taking the critical first steps toward a health care delivery system that is more accessible and affordable.

H.R. 3103 establishes a strong foundation on which future reforms in our health care delivery system can be based.

We should not let this opportunity to improve the Nation’s health care system slip away once again.

Mr. CONYERS. Mr. Speaker, medical malpractice is a widespread and serious problem in our society. Studies have established that it is the third leading cause of preventable death, second only to those deaths associated with heart disease and alcohol abuse. More than 1.3 million hospitalized Americans, or nearly 1 in 25, are estimated to be injured annually by medical treatment, and about 100,000 such patients, or 1 in 400, die each year as a direct result of such injuries.

Unfortunately, in federalizing this State law matter, the Republican proposals would abjectly decimate the protections the states have provided for against medical malpractice and other forms of misconduct. A summary of these provisions follows:

A. Statute of Limitations/§ 281—Prohibits victims from bringing any state health care liability action more than two years after an injury is discovered or five years after the negligent conduct that caused the injury first occurred. Such a proposed new federal statute of limitations takes no account of the fact that many injuries caused by medical malpractice or faulty drugs often take years to manifest themselves. Thus under the proposal, a patient who is negligently inflicted with HIV-infected blood and develops AIDS six years later would be forever time barred from filing a medical malpractice or product liability claim.

B. §250,000 Cap on Non-economic Damages/§282(a)(1)—Caps the award of non-economic damages in medical malpractice actions at $250,000. Although this two-tiered cap scheme is somewhat more flexible than a dollar cap, it is not clear that non-dollar caps do not provide significant savings. Using information derived from a 1992 GAO study, the ABA’s Special Committee on Medical Professional Liability found that state tort reform proposals “have not had any measurable impact on overall health [care] costs” and that personal health care spending had doubled between 1982 and 1990, regardless of the type of “reforms” adopted. A 1986 GAO study on the impact of specific tort changes on medical malpractice claims revealed that claims and insurance costs continue to rise despite state-adopted limits on victim compensation.

Even the total elimination of malpractice torts would provide only negligible savings to the health care system. According to separate reviews by the U.S. Department of Health and Human Services, the amount of all liability premiums paid in the United States represents less than 1% of the Nation’s health care costs. And factoring in the costs of so-called “defensive medicine” would not result in any significant additional savings to the health care system, according to both the CBO and the Congressional Office of Technology Assessment.

An additional concern with caps on non-economic damages is that they could unfairly penalize those victims who suffer the most severe injury and are most in need of financial security. Although harder to scientifically measure, non-economic damages compensate victims for real losses—such as loss of sight, disfigurement, inability to bear children, incontinence, inability to feed or bathe oneself, or loss of a limb. And non-economic damage caps have been found to have a disproportionately negative impact on women, minorities, the poor, the young, and the unemployed; since they generally have less wages, a greater proportion of their losses is non-economic.

C. Joint and Several Liability/§ 283(a)(2)—Eliminates the state doctrine of joint and several liability for non-economic damages. This will allow wrongdoers to profit at the expense of innocent victims, rather than forcing tortfeasors to allocate liability among themselves, as has traditionally been the case under state law. And since women, minorities, and the poor generally earn less wages, such limitations on non-economic damages could have a disproportionately negative impact on these vulnerable groups.

D. Limits on Punitive Damages/§ 282(b)—Caps punitive damage awards at the greater of $250,000 or three times economic damages; limit the state law standard for the award of punitive damages to intentional or wanton medical misconduct. (In fact, studies have shown that only 265 medical malpractice punitive awards were awarded in the United States in the 30 years between 1963 and 1993.) By insulating grossly negligent conduct, this proposed new federal standard for establishing punitive damages comes close to criminalizing tort law. Permitting defendants to bifurcate proceedings concerning the award of punitive damages may well lead to far more costly and time-consuming proceedings, again working to the disadvantage of injured victims.

And banning punitive damages for FDA-approved products is likely to have a disproportionate impact on women, since they make up the largest class of victims of medical products.

E. Periodic Payments/§ 282(c)—Grants wrongdoers the option of paying damage awards in excess of $50,000 on a periodic basis. This provision would apply not only to future economic damages realized over time, such as lost wages, but to non-economic losses, like the loss of a limb, that are realized at one time. As initially written, this proposal does not seek to protect the victim from the risk of nonpayment resulting from future insolvency by the wrongdoer or to specify that future payments should be increased to offset inflation or to reflect changed circumstances.

F. Collateral Source and Subrogation/§ 282(d)—In most states under the collateral source rule, a victim is able to obtain compensation for the full amount of damages incurred, and his or her health insurance provider is able to seek subrogation in respect of its own payments to the victim. This ensures that the true cost of damages lies with the wrongdoer while eliminating the possibility of double recovery by the victim. The Republican proposal would turn this idea on its head by allowing tortfeasors to introduce evidence of potential collateral payments owing from the insurer to the victim. This could have the effect of shifting costs from negligent doctors to the health insurance system in general and taxpayers in particular, resulting in increased health premiums paid by workers and businesses.

Another problematic feature of Republican malpractice proposals has been their one-sided, anti-victim nature. For example, their proposal allows States to enact more restrictive caps and damage limitations, but not permit the states freedom to grant victims any greater legal rights. Their proposals also ignore a number of complex legal issues. For example, in the state law context, various common law principles of comparative negligence in litigation discussions will inevitably lead to confusing conflicts, not only within the federal and state courts, but also between federal and state courts.
I urge opposition to these proposals which would harm victims and insulate wrongdoers from liability.

Mr. NEAL of Massachusetts. Mr. Speaker, one lesson that both Democrats and Republicans learned from the health care reform debate in the 103d Congress is that retaining access to affordable health insurance is an anxiety that plagues most American families.

We exhausted the health care debate a few years ago in this Congress searching for ways to do it all—to make health care cheaper, better, and more accessible for everyone. And though we didn’t pass health care reform legislation at that time, the fact that we are here today talking about limiting pre-existing condition exclusions and making health insurance portable—two consensus issues that Democrats and Republicans both support—is proof that our efforts did not fail.

I’d like to take a moment today to applaud our President for choosing to act upon America’s health care concerns, and for having the courage to bring the issue of health care reform to the forefront of our national agenda.

The United States, and Massachusetts in particular, is home to the best quality health care in the world, and it is our job as Members of this House to make quality care available to all Americans. The pre-existing condition limits and portability provisions in this bill meet this goal.

We also have a unique opportunity today to make health insurance more affordable to the self-employed by increasing the deductibility of health insurance premiums. Under current law, the self-employed are allowed a 50 percent deduction. The bill before us today gradually increases the deduction to 50 percent and 50 percent is not phased in until 2003.

The Democratic substitute addresses this issue in a more sensible and equitable manner. The Democratic substitute would increase the deduction to 50 percent in 1997 and 80 percent in 2002. Affordability is the greatest barrier to expanding health coverage. Increasing the deduction to 50 percent in 1997 will help make insurance affordable to those who lack coverage. Now, the self-employed may be able to fit into their budget the cost of health insurance.

Equity in the tax code should be one of our primary focuses. Corporations are allowed to deduct 100 percent of the cost of providing health insurance. Narrowing the gap between corporations and the self-employed restores greater tax equity.

Self-employed businesses range in spectrum from family farms to sole practitioners. These businesses are a vital part of our economy. We need to make health care affordable for them.

I urge you to support the Democratic substitute which tackles the issues where there is agreement and will make a difference in the health care of Americans.

Mrs. VUCANOVICH. Mr. Speaker, it took many years of debate, and thousands of town hall meetings, but by George, I think we’ve got it.

Congress has finally stepped up to the plate to ensure that Americans are able to obtain health insurance. Too many Americans are shut out of health care insurance because of preexisting conditions, or because they change jobs. With one swing of the bat in the first inning of the game, we have successfully completed a “Triple A”—much better than a triple play. The bill provides “A”-availability, “A”-fordinability and “A”-accountability. It helps employees who try to obtain health insurance, employers who try to provide health insurance, and the bill tackles the high cost of health care.

It makes good on promises by raising the health deduction for self-employed to 50 percent by the year 2003, provides citizens the opportunity to contribute to Medical Savings Accounts, and allows individuals to deduct long-term care. The House Committees’ team has made the advancement up to third base, and it’s up to the rest of us to take it home. I urge my colleagues and teammates to support this historic bill.

Mr. CUNNINGHAM. Mr. Speaker, today I rise in support of Health Coverage Availability and Affordability Act, H.R. 3103, particularly the provisions which will provide small employers with the ability to reduce health insurance costs through the formation of multiple employer arrangements [MEWAs]. H.R. 3103 will bring affordable coverage to millions of Americans who currently are uninsured, and will also provide greater assurance that those who already have health coverage will not lose it when they change jobs.

Without the small employer pooling provisions, any incremental health reform measures only addresses the problem of security for those who currently have health insurance. However, by providing small business with the same tools that are already available to large corporations in obtaining health coverage, we can also help the problem of the uninsured.

Eighty-five percent of the forty million uninsured are persons in families with at least one employed worker, and the majority of these workers are employed in small businesses. As small business becomes a larger portion of the economy, more and more people will find themselves employed by smaller companies. Thus, if we are ever going to make health care affordable for the uninsured, it is imperative that we provide small business with the same opportunities that already are available to large corporations for keeping health costs down.

Small employer pooling arrangements must operate uniformly across state lines, just like large employer arrangements do currently. We must provide a market-oriented, 21st century solution to the problem of the uninsured.

I urge you to vote in favor of H.R. 3103 to increase health care security and affordability for American workers.

Mr. LAZIO of New York. Mr. Speaker, I rise today in proud support of H.R. 3103, the Health Coverage & Affordability Act of 1996, of which I am a cosponsor.

This is a day which I have been looking forward to since I first took office over 3 years ago. Today, we are taking a long overdue step to provide real, substantive change to our health care system which will help working class families across America, and in my home district of Long Island.

For far too long, many Americans have worried that losing a job or having a pre-existing condition would jeopardize the portability of their health insurance.

Because of this bill, workers will continue to have coverage if they change or lose their job—even with preexisting conditions. General Accounting Office [GAO] statistics show that 12 million workers with employer-based insurance leave their jobs every year, and millions more lose their jobs. H.R. 3103 would benefit up to 25 million Americans per year, including those who face job-lock, by eliminating the preexisting condition exclusions for persons with prior health insurance coverage.

An important feature of H.R. 3103 will eliminate discrimination based on genetic information. This would allow thousands of men and women to undergo genetic testing needed to preserve their health without the fear of losing their health insurance or not being able to acquire it. This protection is essential for the women of Long Island, where instances of breast cancer are among the highest in the country. With H.R. 3103 in place, these women can be tested for BRCA-1, a gene linked to the disease, without fear of losing the insurance needed to meet their medical needs.

As a result of our efforts today, health care will become more affordable. H.R. 3103 tackles the problem created by rampant fraud and abuse that drives up the cost, and will increase penalties for those who commit fraud and abuse. Importantly, this bill also increases the health insurance deduction for self-employed individuals from 30 percent to 50 percent by 2003, and allows taxpayers to make tax-deductible contributions to a medical savings account.

I urge my colleagues to support this bill and these reforms which will ease some of those worries of families who are already being squeezed by high taxes and falling wages by ensuring availability, affordability, and account-

Mr. KLECZKA. Mr. Speaker, Americans will today witness firsthand an overt effort by the Republican leadership to sink a much-needed piece of legislation for the sake of preserving their cozy relationship with special-interests. A perfectly good insurance reform bill introduced by Senators KENNEDY and KASSEBAUM and Representative ROLIKEMA in the House has been loaded with extra, controversial provisions that will make it difficult, if not impossible, to pass into law.

While modest, the original bill could help 21 million Americans by waiving the pre-existing condition exclusions for individuals who have had continuous health coverage. As many as 4 million people who are currently “locked” into their jobs for fear of losing needed health coverage for themselves or their family would benefit from the bill’s national portability standards.

Yet, despite the fact that this bill will benefit 25 million Americans, Republicans in the House do not support it. In the Ways and Means Committee, the Kennedy-Kassebaum-Roukema bill did not receive one Republican vote. Apparently, 25 million hard-working Americans are not enough to convince the GOP that we need this legislation. Evidently,
unless it has the blessing of the Health Insurance Association of America it is not worth voting for.

Why else would these Members condition their support for insurance reform on adding "sweeteners" like medical liability provisions that limit the legal rights of malpractice victims? Why do private A-1 permit insurance companies to sell Medicare beneficiaries unnecessary and costly policies that duplicate benefits they already have?

The Republican bill (H.R. 3103) includes other items that will likely meet strong opposition in the Senate, namely, controversial provisions that effectively limit the ability of States to enact health care reforms by pre-empting existing state regulations on multi-employer health plans. Already, a large percentage of employers are exempt from state reforms under the ERISA. With this provision, Congress takes even more health plans out of states' reach.

This add-on is especially puzzling since it flies in the face of the States' rights argument we have been hearing over and over from the Republicans. They want to block grant Medic- aid, welfare, public housing, senior employ- ment programs and other Federal initiatives and let the states administer and regulate them. Why not health care reform? Their own argument that the states can do things better and more efficiently than the Federal Govern- ment contradicts this new policy.

As one of only four Democrats that cast their vote in favor of the Ways and Means insurance reform legislation, I strongly support providing my constituents with health coverage they can afford to take to job to job. But, I differ from my Republican colleagues in one important re- spect. Not only do I support it—I also want it to pass. This final version of the bill bends over backwards so far to please so many spe- cial interests that it severs the spine that holds it together and paralyzes the legislative proc- ess.

Mr. Speaker, I support the clean Democratic substitute, which is identical to the original Kennedy-Kassebaum-Roukema bill and I urge my colleagues to do likewise. The SPEAKER pro tempore (Mr. COMBRE). All time for debate has ex- pired.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. DINGELL

Mr. DINGELL. Mr. Speaker, as the designee of the minority leader, under the rule, and on behalf of myself and my two colleagues, the gentleman from South Carolina [Mr. SPRATT] and the gentleman from Texas [Mr. BENTSEN], I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the na- ture of a substitute is as follows:

Amendment in the nature of a substitute offered by Mr. DINGELL. Strike all after the enacting clause and in- sert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Insurance Reform Act of 1996".

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

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SUBTITLE F—MISCELLANEOUS PROVISIONS

Sec. 191. Health coverage availability study.

Sec. 192. Effective date.

Sec. 193. Severability.

SEC. 100. DEFINITIONS.

As used in this title:

(i) Beneficiary.—The term "beneficiary" has the meaning given such term under section 3(9) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)).

(ii) Employee.—The term "employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(iii) Employer.—The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

(iv) Employee health benefit plan.—(A) In general.—The term "employee health benefit plan" means any employee welfare benefit plan, governmental plan, or church plan (as defined in paragraphs (1), (2), and (3) of section 3(30) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(30))), or a plan described in section 3(30) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(30)), (v) Workers compensation or similar insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, medical care, and any combination thereof.

(xii) A health insurance policy providing benefits only for accident, and disability insurance.

(xiii) Coverage for a specified disease or illness.

(xiv) Hospital or fixed indemnity insur- ance.

(ix) Short-term limited duration insur- ance.

(xv) Credit-only, dental-only, or vision-only insurance.

(xvi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, medical care, and any combination thereof.

(xvii) A health insurance policy providing benefits only for accident, and disability insurance.

(xviii) Coverage for a specified disease or illness.

(xix) Hospital or fixed indemnity insur- ance.

(x) Credit-only, dental-only, or vision-only insurance.

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(x) Credit-only, dental-only, or vision-only insurance.

(12) SECRETARY.—The term "Secretary", unless specifically provided otherwise, means the Secretary of Labor.

(13) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Subtitle A—Group Market Rules

SECTION 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

In General.—

(1) NONDISCRIMINATION.—Except as provided in subsection (b), section 102 and section 103—

(A) a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase such coverage, and

(B) an employee health benefit plan or a health plan issuer offering a group health plan may establish eligibility, continuation of eligibility, enrollment, or premium; contribution requirements under the terms of such plan, except that such requirements shall not be based on health status (as defined in section 100(9)).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall prevent the establishment of a health plan issuer from establishing premium; discounts or modifying otherwise applicable copayments or deductibles in return for participation in health promotion and disease prevention.

(b) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering a group health plan may cease offering coverage to group purchasers under the plan if—

(A) the health plan issuer ceases to offer coverage to any additional group purchasers; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered participants and beneficiaries (and additional participants and beneficiaries) as expected (except to the extent that because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer were required to offer coverage to additional group purchasers.

Such health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered participants and beneficiaries (and additional participants and beneficiaries) can be expected (except to the extent that because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer were required to offer coverage to additional group purchasers.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only required to exercise the limitations provided for in paragraph (1) if the health plan issuer offers coverage to group purchasers under such plan on a first-come-first-served basis.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to prevent a State from requiring health plan issuers offering group health plans to act consistently with the State's laws.

(2) INvoluntary OFFering OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to require a health plan issuer to involuntary offer group health plan coverage to any particular market. For the purposes of this paragraph, the term "market" means either the large employer market or the small employer market (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees).

SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COVERAGE.

(A) IN GENERAL.—

(1) GROUP PURCHASER.—Subject to subsection (b), a group health plan shall be renewed or continued in force in a health plan issuer at the option of the group purchaser, except that the requirement of this subparagraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the group purchaser in accordance with the terms of the group health plan or where the group purchaser has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser; or

(C) the termination of the group health plan in accordance with subsection (b); or

(D) the failure of the group purchaser to meet contribution or participation requirements in accordance with paragraph (3).

(2) PARTICIPANT.—Subject to subsections (b) and (c), coverage under an employee health benefit plan or group health plan may be renewed or continued in force, if the group purchaser elects to continue to provide coverage under such plan, at the option of the participant (or beneficiary where such right exists under the terms of the plan or under applicable law), except that the requirement of this paragraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the participant or beneficiary in accordance with the terms of the employee health benefit plan or group health plan or where the group health plan has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to participation for coverage or claim for benefits;

(C) the termination of the employee health benefit plan or group health plan;

(D) loss of eligibility for continuation coverage as described in section 142(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136 et seq.); or

(E) failure of a participant or beneficiary to meet requirements for eligibility for coverage under an employee health benefit plan or group health plan that are not prohibited by this title.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection, nor in section 101(a), shall be construed to—

(A) preclude a health plan issuer from establishing employer contribution rules or group participation rules for group health plans as allowed under applicable State law;

(B) preclude a plan defined in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1100(37)) from establishing employer contribution rules or group participation rules;

(C) prevent the health plan issuer providing notice to each group purchaser covered under a group health plan of this type and in offering such coverage to group purchasers under a group health plan of this type, the option to purchase such coverage; and

(D) in exercising the option to discontinue a group health plan of this type and in offering or renewing such plan, the health plan issuer may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition established by the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered participants or beneficiaries who may become eligible for coverage under the group health plan.

(2) DISCONTINUANCE OF ALL GROUP HEALTH PLANS NOT OFFERED.—

(A) IN GENERAL.—In any case in which a health plan issuer elects to discontinue offering all group health plans in a State, a group health plan may be discontinued by the health plan issuer only if—

(i) the health plan issuer provides notice to the applicable certifying authority (as defined in section 142(d)) and to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan, and

(ii) all group health plans issued or delivered for issuance in the State or discontinued and coverage under such plans is not renewed.

(3) APPLICATION OF PROVISIONS.—The provisions of this paragraph and paragraph (3) may be applied separately by a health plan issuer to each group health plan.

(b) TERMINATION OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer offers to each group purchaser covered under a group health plan of this type, the option to purchase any other group health plan currently being offered by the health plan issuer; and

(c) IN exercising the option to discontinue a group health plan of this type and in offering or renewing such plan, the health plan issuer may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition established by the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered participants or beneficiaries who may become eligible for coverage under the group health plan.

TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A network plan that arranges for the financing and delivery of health care services to participants and beneficiaries covered under such plan, may continue or discontinue participation under such plan to participants or beneficiaries who neither live, reside, nor work in an area in which such network plan is offered, but only if such denial is applied uniformly, without regard to health status of particular participants or beneficiaries.

(2) NETWORK PLAN.—As used in paragraph (1), the term "network plan" means an employee health benefit plan or a group health plan that arranges for the financing and delivery of health care services to participants or beneficiaries covered under such plan, in whole or in part, through arrangements with providers of health care services.

(d) COBRA COVERAGE.—Nothing in subsection (a)(2)(E) or subsection (c) shall be construed to affect any right to COBRA continuation coverage as described in section 6 of paragraph (2)(B) of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

SEC. 103. POSSIBILITIES OF HEALTH COVERAGE AND LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

In General.—An employee health benefit plan or a group health plan that arranges for the financing and delivery of health care services to participants or beneficiaries covered under such plan, may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition established by the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered participants or beneficiaries under the plan only if—
(1) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan; (2) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth or placement for adoption, experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan; or (3) the limitation or exclusion applies to a pregnancy.

SEC. 105. DISCLOSURE OF INFORMATION.

(a) Disclosure of Information by Health Plan Issuer.—

(1) in general.—In connection with the offer of any group health plan to a small employer (as defined under applicable State law, if not so defined, an employer with not more than 50 employees), a health plan issuer shall provide a Notice of the availability of any group health plan to a small employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer’s right to change premium rates and the factors that may affect changes in premium rates; (B) the provisions of such group health plan relating to renewability of coverage; (C) the provisions of such group health plan relating to any preexisting condition provision; and (D) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

(b) Disclosure of Information to Participants and Beneficiaries.—

(i) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan; (ii) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth or placement for adoption, experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan; or (iii) the limitation or exclusion applies to a pregnancy.

(c) Special Enrollment Periods.—

(1) in general.—Subject to paragraph (4) secure documentation to a participant or beneficiary within the 12-month period following the termination of such plan. Pursuant to regulations promulgated by the Secretary, the duty of an employee health benefit plan to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such employee health benefit plan provides documentation to a participant or beneficiary that includes the following information:

(A) the dates that the participant or beneficiary was covered under the plan; (B) the dates that the participant or beneficiary was covered under the plan for periods that are shorter than those provided for in paragraph (1); and (C) experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan because of a change in the employment status of a family member who—

(i) through marriage, separation, divorce, death, birth or placement for adoption of a child; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(d) Affiliation Periods.—With respect to a participant or beneficiary who would otherwise be eligible to receive benefits under an employee health benefit plan or a group health plan but for the operation of a preexisting condition limitation or exclusion, if such plan provides for a preexisting condition limitation or exclusion of benefits relating to the treatment of a preexisting condition, such plan may impose an affiliation period on such participant or beneficiary to the extent that such participant or beneficiary would otherwise be eligible to receive benefits under the plan. An employee health benefit plan or a group health plan issuer offering a group health plan may also use alternative methods to address adverse selection as approved by the applicable certifying authority (as defined in section 142(d)). During such an affiliation period, the plan may not be required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(e) Preexisting Conditions.—For purposes of this section, the term "preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, counseling, treatment, or services were recommended or received within the 6-month period ending on the day before the effective date of the coverage (without regard to any waiting period).

(f) State Flexibility.—Nothing in this section shall be construed to preempt State laws that—

(1) require health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than those provided for in paragraph (1); or

(2) allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 30-day period provided for under subsection (b)(3); unless such issuers are preempted by section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 104. SPECIAL ENROLLMENT PERIODS.

In the case of a participant, beneficiary or family member whose coverage is terminated under a group health plan, individual health plan, or employee health benefit plan, or

(a) experiences a change in employment status, as described in section 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of coverage, other than under a COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(b) experiences a change in employment status, as described in section 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of coverage, other than under a COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan because of a change in the employment status of a family member who—

(i) through marriage, separation, divorce, death, birth or placement for adoption, experiences a change in family composition; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) Indexed Information—

(i) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan; (ii) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth or placement for adoption, experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan; or (iii) the limitation or exclusion applies to a pregnancy.

(d) Disclosure of Information by Health Plan Issuer.—

(1) in general.—In connection with the offer of any group health plan to a small employer (as defined under applicable State law, if not so defined, an employer with not more than 50 employees), a health plan issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer’s right to change premium rates and the factors that may affect changes in premium rates; (B) the provisions of such group health plan relating to renewability of coverage; (C) the provisions of such group health plan relating to any preexisting condition provision; and (D) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

Information shall be provided to small employers under this paragraph in a manner determined to be understandable by the average small employer and shall be sufficiently accurate and comprehensive to reasonably inform small employers, participants and beneficiaries of their rights and obligations under the group health plan.

(b) Disclosure of Information to Participants and Beneficiaries.—

(1) in general.—Section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by striking "102(a)(1)," and inserting "102(a)(1) that is not a material reduction in covered services or benefits provided," and inserting the following new sentences: "If there is a modification or change described in section 102(a)(1)
that is a material reduction in covered services or benefits provided, a summary description of such modification or change shall be furnished to participants not later than 60 days after the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Reform Act of 1996, providing alternative mechanisms to deliver such summaries. The Secretary shall require health benefit plans to notify participants of material reductions in covered services or benefits.

(2) PLAN DESCRIPTION AND SUMMARY.---Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended---

(A) by inserting "including the office or title of the individual who is responsible for approving or denying claims for coverage of benefits" after "type of administration of the plan";

(B) by inserting "including the name of the organization responsible for financing claims" after "source of financing of the plan";

(C) by inserting "including the office, contact, or title of the individual at the Department of Health and Human Services with which participants may seek assistance or information regarding their rights under this Act and title I of the Health Insurance Reform Act of 1996 with respect to health plans that are not offered through a group health plan, after "benefits under the plan":

Subtitle B—Individual Market Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY

(a) LIMITATION ON REQUIREMENTS.---

(1) IN GENERAL.---Except as provided in subsections (b) and (c), a health plan issuer described in paragraph (2) may not, with respect to any individual health plan from which participants may seek assistance or information regarding their rights under this Act and title I of the Health Insurance Reform Act of 1996, require that:

(A) participants must be covered under a group health plan; and

(B) plans offered are subject to a preexisting condition clause.

(2) PLAN DESCRIPTION AND SUMMARY.---Sec-

tion 102(b) of the Employee Retirement Income Sec-


(3) APPLICABLE CAPACITY LIMIT.---

(1) IN GENERAL.---Subject to paragraph (2), a health plan issuer offering coverage to individuals under an individual health plan may cease enrolling individuals under the plan if---

(A) the health plan issuer ceases to enroll any new individuals; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered individuals will be impaired if the health plan issuer is required to enroll additional individuals.

Such a health plan issuer shall be prohibited from offering coverage after a cessation in enrollment for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.---A health plan issuer offering coverage to individuals under an individual health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) MARKET REQUIREMENT.---

(1) IN GENERAL.---The provisions of subsection (a) shall not be construed to require that a health plan issuer offer group health plans to group purchasers offering individual health plans to individuals.

(2) CONVERSION POLICIES.---A health plan issuer offering coverage to individuals under an individual health plan shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(3) MARKETING OF PLANS.---Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering coverage under such plans to maintain a network of health care providers.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE

(a) IN GENERAL.---(1) The term "network plan" means an individual health plan that arranges for the financing and delivery of health care services to individuals covered under such health plan, in whole or in part, through arrangements with providers.

(b) TREATMENT OF NETWORK PLANS.---In the case of a health plan which offers a network plan that offers coverage under this paragraph for a 5-year period beginning on the date of the discontinuation of the last plan not so renewed.

(2) NETWORK PLAN.---As used in paragraph (1), the term "network plan" means an individual health plan which offers a network plan that offers coverage under this paragraph for 5 years beginning on the date of the discontinuation of the last plan not so renewed.

SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS

(a) IN GENERAL.---With respect to any State law with respect to which the Governor of the State notifies the Secretary of Health and Human Services that such State law will achieve the goals of sections 110 and 111, and that is in effect on, or enacted after, the date of enactment of this Act (such as laws providing for guaranteed issue, open enrollment, renewal, and other health care pools, or mandatory conversion policies), such State law shall apply in lieu of the standards described in sections 110 and 111 unless the Secretary of Health and Human Services determines, after considering the criteria described in subsection (b)(1), in consultation with the Governor and Insurance Commissioner or other insurance regulatory official of the State, that such State law does not achieve the goals of providing access to affordable health care coverage for the individuals described in sections 110 and 111.

(b) DETERMINATION.---

(1) IN GENERAL.---In making a determination under subsection (a), the Secretary of Health and Human Services shall only---
(A) evaluate whether the State law or program provides guaranteed access to affordable coverage to individuals described in sections 110 and 111; (B) evaluate whether the State law or program provides coverage for preexisting conditions (as defined in section 103(e)) that were covered under the individuals' previous group health plans or employee health benefit plan for individuals described in sections 110 and 111; (C) evaluate whether the State law or program provides standards for reform of the individual health insurance, or any combination thereof; (D) evaluate whether the application of the standards described in sections 110 and 111 will have an adverse impact on the number of individuals in such State having access to affordable coverage.  

(2) NOTICE OF INTENT.—If, within 6 months after the date of enactment of this Act, the Governor of a State notifies the Secretary of Health and Human Services that the State intends to enact a law, or modify an existing law, described in subsection (a), the Secretary of Health and Human Services shall not make a determination under subsection (a) prior to January 1, 1998.

(3) NOTICE TO STATE.—If the Secretary of Health and Human Services determines that a State law or program does not achieve the goals described in subsection (a), the Secretary of Health and Human Services shall provide the State with adequate notice and reasonable opportunity to modify such law or program to achieve such goals prior to making a final determination under subsection (a).

(c) ADOPTION OF NAIC MODEL.—If, not later than 9 months after the date of enactment of this Act—

(1) the National Association of Insurance Commissioners (hereafter referred to as the "NAIC") has adopted a model standard or any combination thereof; (2) PHASE-OUT OF STATE—If the Secretary of Health and Human Services determines that a State law or program does not achieve the goals described in subsection (a), the Secretary of Health and Human Services shall provide the State with adequate notice and reasonable opportunity to modify such law or program to achieve such goals prior to making a final determination under subsection (a).

Subtitle C—COBRA Clarifications

SEC. 131. DEFINITIONS.

(a) In General.—As used in this title, the term "individual health plan" means any contract, policy, certificate, or other arrangement offered by an individual health benefit plan issuer that provides or pays for health benefits (such as provider and hospital benefits) and that is not a group health plan under section 300bb–2.

(b) Arrangements Not Included.—Such term does not include the following, or any combination thereof—

(i) Any dependent for accident, or disability income insurance, or any combination thereof—

(ii) Coverage for a specified disease or illness.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Policies for the elderly or dependent of the individual.

(v) Workers' compensation or similar insurance.

(vi) Workers' compensation or similar insurance.

(vii) Automobile medical payment insurance.

(viii) Coverage for a specified disease or illness.

(ix) Hospital of fixed indemnity insurance.

(x) Short-term, limited duration insurance.

(xi) Credit-only, dental-only, or vision-only insurance.

(xii) A health insurance policy providing benefits only for long-term care, nursing care in non-hospital facilities, home care, home health care, community-based care, or any combination thereof.

(xiii) Any combination thereof.

(xiv) Any combination thereof.

(xv) Any combination thereof.

(xvi) Any combination thereof.

(xvii) Any combination thereof.

(xviii) Any combination thereof.

(xix) Any combination thereof.

(xx) Any combination thereof.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974—

(1) Period of Coverage.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by inserting "or a beneficiary-family member of the individual", after "an individual"; and

(ii) by striking "at any time during the initial 18-month period of continuing coverage under this part".

(B) in subparagraph (D)(i), by inserting before " or " the following " or "; except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1996; and

(C) in subparagraph (E), by striking "at the time of a qualifying event described in section 603(2)" and inserting "at any time during the initial 18-month period of continuing coverage under this part".

(2) Election.—Section 605(1)(C) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(1)(C)) is amended—

(A) in clause (i), by striking "or" at the end thereof;

(B) in clause (ii), by striking the period and inserting ";"; and

(C) by adding at the end thereof the following new clause:

"(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the plan for such individual is determined to have been disabled.".

(3) Notices.—Section 605(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(3)) is amended by striking "at the time of a qualifying event described in section 603(2)" and inserting "at any time during the initial 18-month period of continuing coverage under this part".

(4) Birth or Adoption of a Child.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding after the end thereof the following new provision:

"Such term shall also include a child who is born to or placed for adoption with the coverage under this part.".

(5) Period of Coverage.—Section 602(2) of the Internal Revenue Code of 1986 (26 U.S.C. 101) is amended—

(A) in clause (i), by striking "or" at the end thereof;

(B) in clause (ii), by striking the period and inserting ";"; and

(C) by adding at the end thereof the following new clause:

"(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the plan for such individual is determined to have been disabled.".

(6) Notices.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding after the end thereof the following new provision:

"Such term shall also include a child who is born to or placed for adoption with the coverage under this part.".

(7) Period of Coverage.—Section 603(2) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking "or" at the end thereof;

(B) in clause (ii), by striking the period and inserting ";"; and

(C) by adding at the end thereof the following new clause:

"(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the plan for such individual is determined to have been disabled.".

(8) Notices.—Section 607(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding after the end thereof the following new provision:

"Such term shall also include a child who is born to or placed for adoption with the coverage under this part.".

(9) Period of Coverage.—Section 602(2) of the Internal Revenue Code of 1986 (26 U.S.C. 101) is amended—

(A) in clause (i), by striking "or" at the end thereof;

(B) in clause (ii), by striking the period and inserting ";"; and

(C) by adding at the end thereof the following new clause:

"(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the plan for such individual is determined to have been disabled.".

(10) Notices.—Section 607(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding after the end thereof the following new provision:

"Such term shall also include a child who is born to or placed for adoption with the coverage under this part.".

(11) Period of Coverage.—Section 602(2) of the Internal Revenue Code of 1986 (26 U.S.C. 101) is amended—

(A) in clause (i), by striking "or" at the end thereof;

(B) in clause (ii), by striking the period and inserting ";"; and

(C) by adding at the end thereof the following new clause:

"(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the plan for such individual is determined to have been disabled.".
tion of such cooperatives. For purposes of this title, a health plan purchasing cooperative shall be governed by a Board of Directors that shall be composed of a board cross-section of representatives of employers, employees, and individuals participating in the cooperative. A health plan purchasing cooperative may provide reimbursement to such members for the reasonable and necessary expenses incurred by the members in the performance of their duties as members of the Board.

(3) Conflict of Interest.—No member of the Board of Directors (or family members of such members) nor any management personnel of the cooperative may be employed by, be a consultant of, be a member of the board of directors or, be affiliated with an agent, of, or otherwise have a proprietary interest in any health plan issuer, health care provider, or agent or broker. Nothing in the preceding sentence shall limit a member of the Board from purchasing coverage offered through the cooperative.

(d) Membership and Marketing Area.—(1) Membership.—A health plan purchasing cooperative may establish maximum limits on the size of employers who may become members of the cooperative, and may determine whether to permit individuals to become members. Upon the establishment of such membership requirements, the cooperative shall, except as provided in subparagraph (B), accept all employers (or individuals (or individuals residing within the area served by the cooperative who meet such requirements as set forth in such subparagraph (B)), except that such membership requirements shall not apply in regions (such as remote or frontier areas) in which compliance with such membership requirements for participants, beneficiaries, or individuals based on health status, age, sex, or any other characteristic is not possible.

(e) Duties and Responsibilities.—(1) General.—A health plan purchasing cooperative shall—

(A) enter into agreements with multiple, unaffiliated health plan issuers, except that the requirement of this subparagraph shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible.

(B) enter into agreements with employers and individuals who become members of the cooperative.

(C) participate in any program of risk-adjustment or reinsurance, or any similar program, that is established by the State.

(D) prepare and distribute to participating cooperative health plan issuers (including information about cost, quality, benefits, and other information concerning group health plans and individual health plans offered through the cooperative).

(E) actively market to all eligible employers and individuals residing within the service area.

(F) act as an ombudsman for group health plan or individual health plan enrollees.

(2) Permissible activities.—A health plan purchasing cooperative may perform such other functions as necessary to further the purposes of this title, including—

(A) collecting and analyzing premiums and performing other administrative functions;

(B) collecting and analyzing surveys of enrollee satisfaction;

(C) charging membership fee to enrollees (such fees may not be based on health status) and charging participation fees to health plan issuers;

(D) cooperating with (or accepting as members) employers who provide health benefits to participants and beneficiaries only for the purpose of negotiating with providers, and

(E) negotiating with health care providers and carriers.

(f) Limitations on Cooperative Activities.—A health plan purchasing cooperative shall not—

(1) perform any activity relating to the licensing of health plan issuers.

(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative (other than a group health plan or individual health plan);

(3) establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements for participants, beneficiaries, or individuals based on health status;

(4) operate on a for-profit or other basis where the legal structure of the cooperative permits profits to be made and not returned to the members of the cooperative, except that a for-profit health plan purchasing cooperative may be formed by a nonprofit organization—

(A) in which membership in such organization is not based on health status.

(B) that accepts as members all employers or individuals on a first-come, first-served basis, subject to any established limit on the maximum size of and employer that may become a member; or

(5) perform any other activities that conflict or are inconsistent with the performance of its duties under this title.

(g) Limited Preemptions of Certain State Laws.—

(1) In General.—With respect to a health plan purchasing cooperative that meets the requirements of this section, State group rating laws shall be preempted.

(2) Health Plan Issuer Rating.—With respect to a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative, that meets the requirements of this section, State premium rating requirements laws, except to the extent provided under subparagraph (B), shall be preempted unless such laws permit premium rates negotiated by the cooperative to be less than rates that would otherwise be permitted under State law, if such rating disparities are calculated on a basis of health status or demographic factors.

(B) Exception.—State laws referred to in subparagraph (A) shall not be preempted if such laws—

(i) prohibit the variance of premium rates among employers, plan sponsors, or individuals that are members of health plan purchasing cooperatives in excess of the amount of such variations that would be permitted under such State rating laws among employers, plan sponsors, and individuals that are members of the cooperative; and

(ii) prohibit a percentage increase in premium rates for a new rating period that is in excess of that which would be permitted under such State rating laws.

(C) Benefits.—Except as provided in subparagraph (D), a health plan issuer offering a...
group health plan or individual health plan through a health plan purchasing cooperative shall comply with all State mandated benefit laws that require the offering of any services, facilities, supplies, or services of any class or type of provider.

(3) Exception.—In those states that have enacted laws authorizing the issuance of alternative benefit plans to small employer health plan issuers, the provisions of this title shall apply to such alternative benefit plans and to small employer health plan issuers to the same extent as they apply to group health plans and individual health plans.

(4) Enforcement of Standards.—Notwithstanding the provisions of any other law, the Secretary may conduct an examination, investigation, or audit of any group health plan or individual health plan issuer, or any State plan administrator, or any State enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the requirements of this title. A State that fails to substantially enforce the requirements of standards established under this title pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the requirements of standards established under this title pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the requirements of standards established under this title pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the requirements of standards established under this title pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the requirements of standards established under this title pursuant to an enforcement plan filed by the State with the Secretary.

Subtitle E—Application and Enforcement of Standards

SEC. 141. APPLICABILITY.

(A) IN GENERAL.—A requirement or standard required under this title shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and require-ments that are inconsistent with, and are not in direct conflict with, this title and provide greater protection or benefit to participants, beneficiaries, or enrollees.

(B) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to affect or modify the provisions of the Employee Retirement Income Security Act of 1974.

(C) LIMITATION.—Nothing in this title shall be construed to affect the provisions of the Employee Retirement Income Security Act of 1974.

SEC. 201. ENFORCEMENT OF STANDARDS.

(a) H EALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan offered, sold, renewed, or otherwise created health plan purchasing cooperative the be the only type of purchasing arrangement permitted to operate in a State.

(b) RULINGS OF CONSTRUCTION.—Nothing in this title shall be construed to prevent a State from establishing, implementing, or continuing in effect standards that are inconsistent with, and are not in direct conflict with, this title and provide greater protection or benefit to participants, beneficiaries, or enrollees.

(c) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to affect or modify the provisions of the Employee Retirement Income Security Act of 1974.

(D) EXCEPTION.—Nothing in this title shall be construed to affect or modify the provisions of the Employee Retirement Income Security Act of 1974.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) H EALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan offered, sold, renewed, or otherwise created health plan purchasing cooperative the be the only type of purchasing arrangement permitted to operate in a State.

(b) RULINGS OF CONSTRUCTION.—Nothing in this title shall be construed to prevent a State from establishing, implementing, or continuing in effect standards that are inconsistent with, and are not in direct conflict with, this title and provide greater protection or benefit to participants, beneficiaries, or enrollees.

(c) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to affect or modify the provisions of the Employee Retirement Income Security Act of 1974.

(D) EXCEPTION.—Nothing in this title shall be construed to affect or modify the provisions of the Employee Retirement Income Security Act of 1974.

SEC. 203. ENFORCEMENT OF STANDARDS.

(a) H EALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan offered, sold, renewed, or otherwise created health plan purchasing cooperative the be the only type of purchasing arrangement permitted to operate in a State.

(b) RULINGS OF CONSTRUCTION.—Nothing in this title shall be construed to prevent a State from establishing, implementing, or continuing in effect standards that are inconsistent with, and are not in direct conflict with, this title and provide greater protection or benefit to participants, beneficiaries, or enrollees.

(c) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to affect or modify the provisions of the Employee Retirement Income Security Act of 1974.

(D) EXCEPTION.—Nothing in this title shall be construed to affect or modify the provisions of the Employee Retirement Income Security Act of 1974.
Sec. 224. Information reporting regarding foreign gifts.
Sec. 225. Modification of rules relating to foreign trusts which are not organized in a foreign country.
Sec. 226. Residence of estates and trusts, etc.

CHAPTER 3—REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS
Sec. 231. Repeal of bad debt reserve method for thrift savings associations.

SEC. 200. AMENDMENT OF 1996 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 B—Increase in Deduction For Health Insurance Costs of Self-Employed Individuals

SEC. 201. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) In General.—Paragraph (1) of section 162(l)(1) is amended to read as follows:

``(1) ALLOWANCE OF DEDUCTION.—
``(A) In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an equal dollar percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.
``(B) In applying the preceding percentage for purposes of subparagraph (A), the applicable percentage shall be determined under the following table:
``If taxable years beginning after December 31, 1996, such calendar year by substituting `1995' for `1992' in subparagraph (B) thereof. Any adjustment determined under section 1(f)(3) for such calendar year shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting 1995 for 1992 in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.

(b) Effective Date.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

CHAPTER 1—TREATMENT OF INDIVIDUALS WHO EXPATRIATE

SEC. 211. REVISION OF TAX RULES ON EXPATRIATION.

(a) In General.—Subpart A of part II of chapter B, and

(b) Mark to Market.—Except as provided in subsection (f), all property of a covered expatriate to which this section applies shall be treated as sold on the expatriation date at its fair market value.

(2) Recognition of Gain or Loss.—In the case of any sale under paragraph (1)—

(A) notwithstanding any other provision of this title, any gain arising from such sale shall not be taken into account for the taxable year of the sale unless such gain is excluded from gross income under part III of chapter B.

(B) any loss arising from such sale shall be taken into account for the taxable year of the sale to the extent otherwise provided by this title except that section 1092 shall not apply (and section 1092 shall apply) to any such loss.

(3) Exclusion of Certain Gain.—The amount of gain required to be includible in the gross income of any individual by reason of this section shall be reduced (but not below zero) by $600,000. For purposes of paragraph (1), all amounts of gain taken into account under subsection (f)(2) shall be treated in the same manner as an amount required to be includible in gross income.

(4) Election to Continue to Be Taxed as United States Citizen.

(A) In General.—If an expatriate elects the application of this paragraph—

(i) this section (other than this paragraph) shall not apply to the expatriate, but the property shall be subject to tax under this title, with respect to property to which this section would apply but for such election, in the same manner as if the individual were a United States citizen.

(ii) the limitation on amount of estate, gift, and generation-skipping transfer taxes in subsection (c) of section 2036 and section 2503(d) shall apply to transfers of property by reason of an election under subparagraph (A) shall not exceed the amount of income tax which would be due if the property were sold for its fair market value immediately before the time of the transfer or death (taking into account the rules of paragraph (2)).

(B) Requirements.—Subparagraph (A) shall not apply to an individual unless the individual—

(i) provides security for payment of tax in such form and manner, and in such amount, as the Secretary may require,

(ii) consents to the waiver of any right of the United States to any cause of action under the Internal Revenue Code of 1986.

(C) Definition of Covered Expatriate.—For purposes of subparagraph (A), any losses described in section 1(h) shall be treated as adequate security if—

(i) it is a bond in an amount equal to the deferred tax amount under paragraph (2)(A) for the property, or

(ii) the taxpayer otherwise establishes to the satisfaction of the Secretary that the security is adequate.

(Waiver of Certain Rights.—No election may be made under paragraph (1) unless the taxpayer consents to the waiver of any right under any treaty of the United States which would preclude assessment or collection of any tax imposed by reason of this section.

(5) Dispositions.—For purposes of this subsection, a taxpayer making an election under this subsection with respect to any property shall be treated as having disposed of such property.

(6) Election.—An election under paragraph (1) shall only apply to property described in the election and, once made, is irrevocable.

(5) Security.—For purposes of subparagraph (A), any losses described in section 1(h) shall be treated as having disposed of such property the basis of which is determined in whole or in part on the disposition.

(6) Dispositions.—Except to the extent provided in regulations, subparagraph (B) shall apply to a disposition whole or in part on the disposition.

(2) Deferred Tax Amount.—

(A) In General.—If an election under paragraph (1) is made, the term `deferred tax amount' means, with respect to any property, an amount equal to the sum of—

(i) the difference between the amount of tax paid for the taxable year described in paragraph (1)(A) and the amount which would have been paid for such taxable year if the election under paragraph (1) had not applied to such property plus

(ii) an amount of interest on the amount described in clause (i) determined for the period—

(A) beginning on the 91st day after the expatriation date, and

(B) ending on the due date for the taxable year described in paragraph (1)(B).

(7) Election.—An election under paragraph (1) shall be made no later than the due date for the taxable year in which the election is required to be made and shall be irrevocable.

(8) Dispositions.—An election under paragraph (1) shall only apply to property described in the election and, once made, is irrevocable.

(9) Security.—For purposes of paragraph (1) with respect to an interest in a trust with respect to which is required to be recognized under subsection (f)(1).

(C) Covered Expatriate.—For purposes of this section—

(I) in General.—The term `covered expatriate' means an expatriate—

(A) whose average annual net income tax (as defined in section 38(c)(1)) for the period of 5 taxable years ending before the expatriation date is greater than $100,000, or

(B) whose net worth as of such date is $500,000 or more.

If the expatriation date is after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to the dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting 1995 for 1992 in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.

II) the expatriation date is after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to the dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting 1995 for 1992 in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.

II) the expatriation date is after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to the dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting 1995 for 1992 in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.

II) the expatriation date is after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to the dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting 1995 for 1992 in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.

II) the expatriation date is after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to the dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting 1995 for 1992 in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.
"(I) In general.—Except as otherwise provided by the Secretary, this section shall apply to—

(A) any interest in property held by a covered expatriate for any taxable year if the expatriation date of the covered expatriate and the date the expatriation occurred are within any 15 taxable years ending with the taxable year in which the covered expatriate’s expatriation occurred, or

(B) any other interest in a trust to which subsection (f) applies.

(II) Foreign pension plans.—

(A) United States real property interests.—Any United States real property interest described in section 897(c)(2), other than stock of a United States real property holding corporation which does not, on the expatriation date, meet the requirements of section 897(c)(2).

(B) Interest in qualified trusts.—

(i) In general.—Any interest in a qualified retirement plan as described in section 4974(c), other than any interest attributable to contributions which are in excess of any limitation or which violate any condition for tax-favored treatment.

(ii) Foreign pension plans.—

(A) United States real property interests.—Any United States real property interest described in section 897(c)(2), other than stock of a United States real property holding corporation which does not, on the expatriation date, meet the requirements of section 897(c)(2).

(B) Interest in qualified trusts.—

(1) In general.—The term ‘expatriate’ means—

(A) any United States citizen who relinquishes his citizenship, or

(B) any long-term resident of the United States who ceases to be a lawful permanent resident of the United States within the meaning of section 7701(b)(1).

(2) Expiration date.—The term ‘expatriation date’ means—

(A) the date an individual relinquishes United States citizenship, or

(B) in the case of a long-term resident of the United States, the date of the event described in clause (i) or (ii) of paragraph (1)(B).

(3) Relinquishment of citizenship.—A citizen shall be treated as relinquishing his United States citizenship on the earliest of—

(A) the date the individual renounces his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 340(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)).

(B) the date the individual furnishes to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 340(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)-(4)).

(C) the date the Department of State issues to the individual a certificate of loss of nationality, or

(D) the date a court of the United States cancels a naturalized citizen’s certificate of naturalization.

Subparagraph (A) or (B) shall not apply to any individual unless the renunciation or voluntary relinquishment is subsequently approved by the issuance to the individual of a certificate of loss of nationality by the United States Department of State.

(4) Long-term resident.—

(A) In general.—The term ‘long-term resident’ means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the expatriation date occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country on such date under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

(B) Special rule.—For purposes of subparagraph (A), there shall not be taken into account—

(i) any taxable year during which any prior sale is treated under subsection (a)(1) as occurring, or

(ii) any taxable year prior to the taxable year referred to in clause (i).

(C) Definitions and special rule.—

(1) In general.—The tax imposed by subparagraph (a)(iv) shall be imposed on the trust and each trustee of the trust—

(I) the tax determined under paragraph (1) and subsection (a) shall not exceed $500,000.

(II) the tax determined under paragraph (1) shall be imposed on the trust and each trustee of the trust—

(i) the highest rate of tax imposed by section 1511(b), for periods after the date the interest accrues, or

(ii) the tax determined under paragraph (1) shall be imposed on the trust and each trustee of the trust—

(A) which is organized under, and governed by, the laws of the United States or a State, or

(B) which is organized, under, and governed by the laws of a foreign country, and for which the Secretary requires that at least 1 trustee of such trust is a United States citizen.

(2) Allocated expatriation gain.—For purposes of this paragraph, the allocable expatriation gain with respect to any beneficiary, any interest in a trust, or a covered expatriate holding an interest in a qualified trust shall be determined by applying paragraphs (A) through (D) of this subparagraph to—

(i) the tax determined under paragraph (1) as if subparagraph (B)(ii) were not in effect and as if the amount determined under subparagraph (B)(ii) were substituted for such tax as the amount treated as not sold by reason of this paragraph.

(ii) a special rule provided in paragraph (G) of this subparagraph.

(3) Allocated expatriation gain.—For purposes of this paragraph—

(A) the tax imposed by subparagraph (A)(ii) shall be imposed on the trust and each trustee of the trust—

(i) the tax determined under paragraph (1) shall be imposed on the trust and each trustee of the trust—

(A) which is organized under, and governed by, the laws of the United States or a State, or

(B) which is organized, under, and governed by the laws of a foreign country, and for which the Secretary requires that at least 1 trustee of such trust is a United States citizen.

(ii) the tax determined under paragraph (1) shall be imposed on the trust and each trustee of the trust—

(A) which is organized under, and governed by, the laws of the United States or a State, or

(B) which is organized, under, and governed by the laws of a foreign country, and for which the Secretary requires that at least 1 trustee of such trust is a United States citizen.

(iii) a special rule provided in paragraph (G) of this subparagraph.

(B) the tax imposed by subparagraph (A)( iii) shall be imposed on the trust and each trustee of the trust—

(i) the tax determined under paragraph (1) shall be imposed on the trust and each trustee of the trust—

(A) which is organized under, and governed by, the laws of the United States or a State, or

(B) which is organized, under, and governed by the laws of a foreign country, and for which the Secretary requires that at least 1 trustee of such trust is a United States citizen.

(ii) the tax determined under paragraph (1) shall be imposed on the trust and each trustee of the trust—

(A) which is organized under, and governed by, the laws of the United States or a State, or

(B) which is organized, under, and governed by the laws of a foreign country, and for which the Secretary requires that at least 1 trustee of such trust is a United States citizen.

(iii) a special rule provided in paragraph (G) of this subparagraph.

(C) the tax imposed by subparagraph (A)(iv) shall be imposed on the trust and each trustee of the trust—

(i) the tax determined under paragraph (1) shall be imposed on the trust and each trustee of the trust—

(A) which is organized under, and governed by, the laws of the United States or a State, or

(B) which is organized, under, and governed by the laws of a foreign country, and for which the Secretary requires that at least 1 trustee of such trust is a United States citizen.

(ii) the tax determined under paragraph (1) shall be imposed on the trust and each trustee of the trust—

(A) which is organized under, and governed by, the laws of the United States or a State, or

(B) which is organized, under, and governed by the laws of a foreign country, and for which the Secretary requires that at least 1 trustee of such trust is a United States citizen.

(iii) a special rule provided in paragraph (G) of this subparagraph.
which is not a vested interest. Such interest shall be determined by assuming the maximum exercise of discretion in favor of the beneficiary and the occurrence of all contingencies which would make such interest includible in gross income.

(iv) Adjustments.—The Secretary may provide for such adjustments to the bases of assets in a trust or a deferred tax account, and the procedures and circumstances for such adjustments, including the terms of the trust instrument and any letter of wishes or similar document, distributions, and the existence and functions performed by a trust protector or any similar advisor.

(3) Determination of beneficiaries' interest in trust.—

(A) Determinations Under Paragraph (1)—For purposes of paragraph (1), a beneficiary's interest in a trust shall be based upon all relevant facts and circumstances, including the terms of the trust instrument and any letter of wishes or similar document, and in the case of a trust which a shareholder, partner, or beneficiary is treated as holding directly under subsection (f)(3)(B)(i), and

(B) Other Determinations.—For purposes of this section—

(I) Constructive Ownership.—If a beneficiary of a trust is a corporation, partnership, or estate, the shareholders, partners, or beneficiaries shall be deemed to be the trust beneficiaries for purposes of this section.

(II) Taxpayer Return Position.—A taxpayer shall clearly indicate on its income tax return—

(i) the methodology used to determine that taxpayer's trust interest under this section, and

(ii) If the taxpayer knows (or has reason to know) that any other beneficiary of such trust is using a different methodology to determine such beneficiary's trust interest under this section.

(3) Termination of deferments, etc.—On the date any property held by an individual is treated as sold under subsection (a), notwithstanding any other provision of this title—

(I) any period during which recognition of income or gain is deferred shall terminate, and

(II) any extension of time for payment of tax shall cease to apply and the unpaid portion of such tax shall be due and payable at the time and in the manner prescribed by the Secretary.

(h) Imposition of Tentative Tax.—

(1) In general.—An individual is required to include any amount in gross income under subsection (a) for any taxable year, there is hereby imposed, immediately before the expatriation date, a tax in an amount equal to the amount of tax which would be imposed if the taxable year were a short taxable year ending on the expatriation date.

(2) Due date.—The due date for any tax imposed by paragraph (1) shall be the 90th day after the expiration date.

(3) Treatment of tax.—Any tax paid under paragraph (1) shall be treated as a payment of the tax imposed by this chapter for the taxable year to which subsection (a) applies.

(4) Deferred tax.—The provisions of subsection (b) shall apply to the tax imposed by this subsection to the extent attributable to gains and losses includible in gross income by reason of this section.

(i) Coordination With Estate and Gift Taxes.—

(1) In general.—Subsection (a) shall apply to any gift or bequest of property made by an individual solely by reason of section 2501(a)(3), and then shall be allowed as a credit against the additional tax imposed by section 2101 or 2501, whichever is applicable, solely by reason of section 2107 or 2501(a)(3) an amount equal to the increase in the tax imposed by this chapter for such taxable year by reason of this section.

(2) Regulations.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes and intent of this section and the regulations described in section 7701(b)(3).

(2) To prevent double taxation by ensuring that—

(i) appropriate adjustments are made to basis to reflect gain recognized by reason of subsection (a) and the exclusion provided by subsection (d)(3), and

(ii) the amount of a deemed sale under subsection (a) of an interest in a corporation, partnership, trust, or estate is reduced to reflect that portion of such gain which is attributable to an interest in a trust which a shareholder, partner, or beneficiary is treated as holding directly under subsection (f)(3)(B)(i), and

(2) which provide for the proper allocation of the exclusion under subsection (a)(3) to property to which this section applies.

(k) Cross Reference.—

For income tax treatment of individuals who terminate as United States citizenship, see section 7701(a)(47).

(b) Inclusion in Income of Gifts and Inheritances from Covered Expatriates.—

(1) Section 877(a)(4) is amended by adding at the end the following new subsection:

"(I) If the taxpayer knows (or has reason to know) that any other beneficiary of such trust is using a different methodology to determine such beneficiary's interest in a trust, the following additional tax shall be imposed if the taxable year to which subsection (a) applied (or would have applied) includes in gross income:

"(II) If the taxpayer knows (or has reason to know) that any other beneficiary of such trust is using a different methodology to determine such beneficiary's interest in a trust, the following additional tax shall be imposed if the taxable year to which subsection (a) applied (or would have applied) includes in gross income:

"(III) If the taxpayer knows (or has reason to know) that any other beneficiary of such trust is using a different methodology to determine such beneficiary's interest in a trust, the following additional tax shall be imposed if the taxable year to which subsection (a) applied (or would have applied) includes in gross income:

(2) Section 6039F is amended by adding at the end the following new subsection:

"(a) Requirement.—An individual shall not be treated as a United States citizen before the expatriation date unless:

"(i) the individual is a citizen,

"(ii) the mailing address of such individual, and

"(iii) information required under subsection (a) shall include—

(I) the individual’s principal foreign residence,

(II) the foreign country in which such individual is residing,

(III) the foreign country of which such individual is a citizen,

(IV) the case of an individual having a net worth of at least the dollar amount specified by the Secretary, information detailing the assets and liabilities of such individual, and

(V) such other information as the Secretary may prescribe.

(c) Penalty.—Any individual failing to provide a statement which includes any information required under subsection (a) shall be subject to a penalty for each year during any portion of which such failure continues in an amount equal to the greater of—

(1) 5 percent of the additional tax required to be paid under section 877A for such year, or

(2) 5 percent of the additional tax required to be paid under section 877A for such year, or..."
(2) $1,000, unless it is shown that such failure is due to reasonable cause and not to willful neglect.

(3) An officer who in good faith and with reasonable cause provides to the Secretary information relating to an income tax evasion (or any other violation of law) which results in the collection of tax exceeding $50 shall be reimbursed by the United States for reasonable expenses incurred in furnishing such information.

The appearance of persons or production of records by reason of a United States person being such an agent shall not subject such person to fines, penalties, or other punishment for any reason other than determining the correct treatment under this title of the amounts required to be taken into account under the rules of this subsection even if such trust has no United States activity, is engaged in a trade or business in the United States, or does not have a principal place of business in the United States. However, the absence of any United States activity, the fact that the United States has no significant tax interest in the trust, and the fact that such trust is not engaged in a trade or business or has no principal place of business in the United States shall not be taken into account under this subsection.

The Secretary shall, upon request of the party in interest, furnish the party with a copy of all records furnished to the Secretary under this subsection.

The Secretary shall not publish any information furnished to him under this subsection except under regulations prescribed pursuant to section 6601(e) of this title.

The Secretary shall prescribe such regulations as are necessary to carry out the purposes of this title and the provisions of this section.

The Secretary shall, upon request of the party in interest, furnish the party with a copy of any information furnished to the Secretary under this subsection except under regulations prescribed pursuant to section 6601(e) of this title.

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The Secretary shall, upon request of the party in interest, furnish the party with a copy of any information furnished to the Secretary under this subsection except under regulations prescribed pursuant to section 6601(e) of this title.
SEC. 6677. FAILURE TO FILE INFORMATION WITH RESPECT TO CERTAIN FOREIGN TRUSTS.

(a) CIVIL PENALTY.—In addition to any criminal penalty provided by law, if any notice or return required to be filed by section 6048—

(1) is not filed on or before the time provided in such section, or

(2) does not include all the information required pursuant to such section or includes incorrect information, the person required to file such notice or return shall pay a penalty equal to 35 percent of the gross reportable amount. If any failure described in the preceding sentence continues for more than 90 days after the day on which the Secretary mails notice of such failure to the person required to pay such penalty, such person shall pay a penalty (in addition to the amount determined under the preceding sentence) of $10,000 for each 30-day period (or fraction thereof) during which such failure continues after the expiration of such 90-day period. In no event shall the penalty under this subsection with respect to any failure exceed the gross reportable amount.

(b) SPECIAL RULES FOR RETURNS UNDER SECTION 6048(b).—In the case of a return required under section 6048(b)—

(1) the following person referred to in such section shall be liable for the penalty imposed by subsection (a), and

(2) subsection (a) shall be applied by substituting the term 'gross reportable amount' for the term 'gross reportable amount' means—

(1) the gross value of the property involved in the event (determined as of the date of the event) in the case of a failure relating to section 6048(a),

(2) the gross of the portion of the trust's assets at the close of the year treated as owned by the United States person in the case of a failure relating to section 6048(b)(1), and

(3) the gross amount of the distributions in the case of a failure relating to section 6048(c).

(c) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed by this section on any failure which is shown to be due to reasonable cause and not due to willful neglect.

(d) DEFICIENCY PROCEDURES NOT TO APPLY.—Subchapter B of chapter 63 (relating to deficiency procedures for income, estate, gift, and certain excise taxes) shall not apply to the property transferred.

(e) TECHNICAL AMENDMENT.—Subparagraph (a) of section 672(c)(2) is amended to read as follows:

"(A) in the case of a foreign corporation, such corporation is a controlled foreign corporation (as defined in section 957(a))."

SEC. 222. MODIFICATIONS OF RULES RELATING TO FOREIGN TRUSTS HAVING ONE OR MORE UNITED STATES BENEFICIARIES.

(a) TREATMENT OF TRUST OBLIGATIONS, ETC.—

(1) Paragraph (2) of section 672(a) is amended by striking subparagraph (B) and inserting the following new item:

"(B) TRANSFERS AT FAIR MARKET VALUE.—To any transfer of property to a trust in exchange for consideration of at least the fair market value of the property transferred.

(2) Subsection (a) of section 672 (relating to foreign trusts having one or more United States beneficiaries) is amended by adding at the end the following new paragraph:

"(3) CERTAIN OBLIGATIONS NOT TAKEN INTO ACCOUNT UNDER FAIR MARKET VALUE EXCEPTIONS.—

"(A) IN GENERAL.—In determining whether paragraph (2) applies to any transfer by a person described in clause (ii) or (iii) of subparagraph (C), there shall not be taken into account—

(i) except as provided in regulations, any obligation of a person described in subparagraph (C), and

(ii) to the extent provided in regulations, any obligation which is guaranteed by a person described in subparagraph (C).

(3) C ERTAIN OBLIGATIONS NOT TAKEN INTO ACCOUNT UNDER FAIR MARKET VALUE EXCEPTIONS.—

"(A) IN GENERAL.—In determining whether paragraph (2) applies to any transfer by a person described in clause (ii) or (iii) of subparagraph (C), there shall not be taken into account—

(i) the trust,

(ii) any grantor or beneficiary of the trust, and

(iii) any person who is related (within the meaning of section 6631(b)(1)(B)) to any grantor or beneficiary of the trust.

(b) REGULATIONS.—The Secretary shall—

(1) make regulations providing for the application of this subsection.

SEC. 233. FOREIGN PERSONS NOT TO BE TREATED AS OWNERS UNDER GRANTOR TRUST RULES.

(a) GENERAL RULE.—

(1) Subsection (f) of section 672 (relating to special rule where grantor is foreign person) is amended to read as follows:

"(f) SUBPART NOT TO RESULT IN FOREIGN OWNERSHIP.—

"(1) IN GENERAL.—Notwithstanding any other provision of this subpart, this subpart shall apply only to the extent such application results in an amount being currently taken into account (directly or through 1 or more entities) under this chapter in computing the income of a citizen or resident of the United States or a domestic corporation.

"(2) EXCEPTIONS.—

(A) CERTAIN REVOCABLE AND IRREVOCABLE TRUSTS.—Paragraph (1) shall not apply to any trust if—

(i) the power to revest absolutely in the grantor who is a United States person to the portion of such trust attributable to property transferred by such individual to such trust is exercisable solely by the grantor without the approval or consent of any other person or with
the consent of a related or subordinate party who is subversive to the grantor, or

"(ii) the only amounts distributable from such trust (whether income or corpus) during the life expectancy method, that made transfers of property distributable to the grantor or the spouse of the grantor.

(B) COMPENSATORY TRUSTS.—Except as provided in regulations, paragraph (1) shall not apply to any portion of a trust distributions from which are taxable as compensation fixed.

(3) SPECIAL RULES.—Except as otherwise provided in regulations prescribed by the Secretary:

"(A) a controlled foreign corporation (as defined in section 957) shall be treated as a domestic corporation for purposes of paragraphs (1) and

"(B) paragraph (1) shall not apply for purposes of applying section 1296.

(4) RECHARACTERIZATION OF PURPORTED GIFTS.—In the case of any transfer directly or indirectly from a partnership or foreign corporation which the transferee treats as a gift or bequest, the Secretary may recharacterize such transfer in such circumstances as the Secretary determines to be appropriate to prevent the avoidance of the purposes of this subsection.

(5) SPECIAL RULE WHERE GRANTOR IS FOREIGN PERSON.—

"(A) but for this subsection, a foreign person would be treated as the owner of any portion of a trust;

"(B) such trust has a beneficiary who is a United States person, such beneficiary shall be treated as the grantor of such portion to the extent such beneficiary has made transfers of property by gift (directly or indirectly) to such foreign person. For purposes of the preceding sentence, any gift shall not be taken into account if such gift would be excluded from taxable gifts under section 2503(b).

(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection, including regulations providing that paragraph (1) shall not apply in appropriate cases."

(2) The last sentence of subsection (c) of section 672 of such Code is amended by inserting "section (f) and" before "sections 674".

(b) CREDIT FOR CERTAIN TAXES.—Paragraph (2) of section 666(d) is amended by adding at the end the following new sentence: "Under rules or regulations prescribed by the Secretary, in the case of any foreign trust of which the settlor or another person would be treated as owner of any portion of the trust under subpart E but for section 667(f), the term ‘taxes imposed on the trust’ includes the allocable amount of any income, war profits, and excess profits taxes imposed by any foreign country or possession of the United States on the settlor or such other person in respect of trust gross income.''

(c) DOMESTIC CORPORATION FOR PURPOSES OF SUBPARAGRAPH (A).—

"(1) Section 643 is amended by adding at the end the following new subsection:

"(h) IN GENERAL.—The attribution of a domestic corporation for purposes of paragraph (1) of section 643 shall be treated as reduction proportionately the undistributed income of the domestic corporation for purposes of applying section 643(e) of such Code in determining the liability of such corporation for corporate income tax.''

"(2) EFFECTIVE DATE.—The amendments made by this section shall be applied to grants made on or after the date of enactment of this Act.''

The preceding sentence shall not apply to any portion of any such trust attributable to any transfer to such trust after September 19, 1995.

The provisions of this subsection shall be rounded under procedures specified by the Secretary in the Secretary's sole discretion such that subparagraph (A) thereof shall be applied by substituting 1995 for 1992.''

(5) IN GENERAL.—If the value of the aggregate foreign gifts received by a United States person which the recipient treats as a gift or bequest. Such term shall not include any qualified transfer (within the meaning of section 2503(e)(2)).

SEC. 224. INFORMATION REPORTING REGARDING FOREIGN GIFTS.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 6 of subpart A of part III of subchapter A of chapter 1 of subtitle A of the Internal Revenue Code of 1986 is amended by inserting after section 6039F the following new section:

"SEC. 6039G. NOTICE OF GIFTS RECEIVED FROM FOREIGN PERSONS.

(a) IN GENERAL.—If the value of the aggregate foreign gifts received by a United States person which the recipient treats as a gift or bequest shall be determined by the Secretary prescribing such information as the Secretary may prescribe regarding each foreign gift received during such year.

(b) FOREIGN GIFT.—For purposes of this section, the term ‘foreign gift’ means any amount received from a person other than a United States person which the recipient treats as a gift or bequest. Such term shall not include any qualified transfer (within the meaning of section 2503(e)(2)).

(c) PENALTY FOR FAILURE TO FILE INFORMATION.—

"(1) IN GENERAL.—If the value of the aggregate foreign gifts received by a United States person which the recipient treats as a gift or bequest shall be determined by the Secretary prescribing such information as the Secretary may prescribe regarding each foreign gift received during such year.

"(2) FOREIGN GIFT.—For purposes of this section, the term ‘foreign gift’ means any amount received from a person other than a United States person which the recipient treats as a gift or bequest. Such term shall not include any qualified transfer (within the meaning of section 2503(e)(2)).

"(A) CREDIT FOR CERTAIN FOREIGN TRUSTS THROUGH NOMINEES.—

"(1) Section 643 is amended by adding at the end the following new subsection:

"(h) IN GENERAL.—The attribution of a domestic corporation for purposes of paragraph (1) of section 643 shall be treated as reduction proportionately the undistributed income of the domestic corporation for purposes of applying section 643(e) of such Code in determining the liability of such corporation for corporate income tax.''

"(2) EFFECTIVE DATE.—The amendments made by this section shall be applied to grants made on or after the date of enactment of this Act.''

The preceding sentence shall not apply to any portion of any such trust attributable to any transfer to such trust after September 19, 1995.

The provisions of this subsection shall be rounded under procedures specified by the Secretary in the Secretary's sole discretion such that subparagraph (A) thereof shall be applied by substituting 1995 for 1992.''

(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this Act.

"(2) EXCLUSION FOR CERTAIN GIFTS.—The amendments made by this section shall not apply to any portion of any such trust attributable to any transfer to such trust after September 19, 1995.

"(3) TRANSITIONAL RULE.—If—

"(1) by reason of the amendments made by this section, any person other than a United States person ceases to be treated as the owner of a portion of a domestic trust, and

"(2) before January 1, 1997, such trust becomes a foreign trust, or the assets of such trust are transferred to a foreign trust;

no tax shall be imposed by section 1461 of the Internal Revenue Code of 1986 by reason of such trust becoming a foreign trust or the assets of such trust being transferred to a foreign trust.''

SEC. 225. MODIFICATION OF RULES RELATING TO FOREIGN TRUSTS WHICH ARE NOT GRANTOR TRUSTS.

"(A) MODIFICATION OF INTEREST CHARGE ON ACCUMULATION DISTRIBUTIONS.—Subsection (a) of section 669 (relating to interest charge on accumulation distributions from foreign trusts) is amended to read as follows:

"(A) GENERAL RULE.—For purposes of the tax determined under subsection (a) of section 669 (relating to interest charge on accumulation distributions from foreign trusts) is amended to read as follows:

"(1) INTEREST DETERMINED USING UNDERPAYMENT RATES.—The interest charge determined under this section with respect to any distribution is any interest which would be determined on the partial tax computed under section 665(b) for the period described in paragraph (2) using the rates and the methods prescribed by section 662 applicable to underpayments of tax.

"(2) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts received after the date of the enactment of this Act.''

The preceding sentence shall take effect on the date which is the applicable number of years before the date of the distribution which ends on the date of the distribution.

"(3) APPLICABLE NUMBER OF YEARS.—For purposes of paragraph (2)—

"(A) IN GENERAL.—The applicable number of years with respect to a distribution is the number determined by dividing—

"(i) the sum of the products described in subparagraph (B) with respect to each undistributed income year, by

"(ii) the aggregate undistributed net income.

The quotient determined under the preceding sentence shall be rounded under procedures prescribed by the Secretary.

"(B) PRODUCT DESCRIBED.—For purposes of subparagraph (A), the product described in paragraph (3) of subparagraph with respect to any undistributed income year is the product of—

"(i) the undistributed net income for such year,

"(ii) the sum of the number of taxable years between such year and the taxable year of the distribution (counting in each case the undistributed income year but not counting the taxable year of the distribution).

"(4) UNDISTRIIBUTED INCOME YEAR.—For purposes of this subsection, any term ‘undistributed income year’ means any prior taxable year of the trust for which there is undistributed net income, other than a taxable year during which all of which the beneficiary receiving the distribution was not a citizen or resident of the United States.

"(5) DETERMINATION OF UNDISTRIIBUTED NET INCOME.—Notwithstanding section 665, for purposes of this subsection, an accumulation distribution from the trust shall be treated as reducing proportionately the undistributed net income for undistributed income years.

"(6) PERIODS BEFORE 1996.—Interest for the period described in paragraph (2) which occurs before January 1, 1996, shall be determined—

"(A) by using an interest rate of 6 percent, and

"(B) without compounding until January 1, 1996.''

"(d) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts received after the date of the enactment of this Act in taxable years ending after such date.
(b) Abusive Transactions.—Section 643(a) is amended by inserting after paragraph (6) the following new paragraph:

"(7) Abusive Transactions.—The Secretary may prescribe such regulations as may be necessary or appropriate to carry out the purposes of this part, including regulations to prevent avoidance of such purposes, or to control all substantial decisions of the trust.

(c) Treatment of Loans from Trusts.—

(1) in General.—Section 643 (relating to definitions applicable to subparts A, B, C, and D) is amended by adding at the end the following new subsection:

"(i) Loans from Foreign Trusts.—For purposes of subparts B, C, and D, the term 'related person' as defined in section 585, and the term 'foreign trust' as defined in section 587, shall not include a foreign trust described in section 7701(a)(30)(D)."

(2) Conforming Amendment.—Paragraph (3) of section 7701(a) is amended to read as follows:

"(3) Foreign Estate or Trust.—The term 'foreign estate or trust' means any estate or trust other than an estate or trust described in section 7701(a)(30)(D)."

(3) Effective Date.—The amendments made by this subsection (A) to taxable years beginning after December 31, 1996, or (B) at the election of the trustor of a trust, to taxable years ending after the date of the enactment of this Act.

Such an election, once made, shall be irrevocable.

(d) Domicile Trusts Which Become Foreign Trusts.—

(1) in General.—Section 1493 (relating to imposition of tax to avoid income tax) is amended by adding at the end the following new paragraph:

"(7) A business transaction. The term 'related person' as defined in section 585, and the term 'foreign trust' as defined in section 587, shall not include a foreign trust described in section 7701(a)(30)(D)"

(2) Penalties.—Section 1494 is amended by inserting after paragraph (7) the following new paragraph:

"(7) A business transaction. Any failure to comply with any provision of this section as having been transferred, immediately before becoming a foreign trust, all of its assets to a foreign trust.

(2) Penalty.—Section 1494 is amended by adding at the end the following new subsection:

"(7) A business transaction. The term 'related person' as defined in section 585, and the term 'foreign trust' as defined in section 587, shall not include a foreign trust described in section 7701(a)(30)(D)."

(3) Effective Date.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

CHAPTER 3.—REPEAL OF BAD DEBT REERVE REQUIREMENT FOR THRIFT SAVINGS ASSOCIATIONS

SEC. 231. REPEAL OF BAD DEBT RESERVE REQUIREMENT FOR THRIFT SAVINGS ASSOCIATIONS

(a) in General.—Section 593 (relating to reserves for losses on loans) is amended by adding at the end the following new subsection:

"(f) Termination of Reserve Method.—

Subsections (a), (b), (c), and (d) shall not apply to taxable years beginning after December 31, 1995.

(g) 6-Year Spread of Adjustments.—

(1) in General.—In the case of any taxpayer who is required by reason of subsection (f) to change its method of computing reserves for bad debts,

"(A) such change shall be treated as a change in a method of accounting,

"(B) such change shall be treated as initiated by the taxpayer and as having been made with the concurrence of the Secretary, and

"(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a).

(i) shall be taken into account by taking into account only applicable excess reserves, and

(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

(2) Applicable Excess Reserves.—

(A) in general.—In determining paragraph (1), the term 'applicable excess reserves' means the excess (if any) of—

"(i) the balance of the reserves described in subsection (c)(1) (other than the supplementary reserve) as of the close of the taxpayer's last taxable year beginning before December 31, 1986, or

(ii) the lesser of—

"(i) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before (or on) December 31, 1995, or

(ii) the balance of the reserves described in subclause (i), reduced in the same manner as under section 585(b)(2)(B)(iii) on the basis of the taxable years described in clause (i) and this clause.

(B) Special Rule for Thrifts Which Become Small Banks.—In the case of a bank (as defined in section 581) which meets the requirements of a large thrift institution (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995, the balance taken into account under subparagraph (A)(i) shall not be less than the amount which would be the balance of such reserves as of the close of its last taxable year beginning before such date if the additions to such reserves for all taxable years had been determined under section 585(b)(2)(A), and

(2) Other OPENING BALANCE OF THE RESERVE FOR BAD DEBTS AS OF THE BEGINNING OF THE FIRST TAXABLE YEAR OF THE TAXPAYER TO WHICH THIS PARAGRAPH IS APPLIED IS NOT A BANK (AS DEFINED IN SECTION 585(C)(2)) FOR ITS FIRST TAXABLE YEAR BEGINNING AFTER DECEMBER 31, 1995, THE BALANCE TAKEN INTO ACCOUNT UNDER PARAGRAPH (1) SHALL BE TAKEN INTO ACCOUNT RATABLY OVER THE 6-TAXABLE YEAR PERIOD BEGINNING WITH SUCH TAXABLE YEAR.

(3) Recapture of Pre-1988 Reserves Where Taxpayer Ceases to Be a Bank.—If, during any taxable year beginning after December 31, 1995, a taxpayer to which this paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in paragraph (2)(A)(ii) and the supplemental reserve except that such reserves shall be taken into account ratably over the 6-taxable year period beginning with such taxable year.

(4) Suspension of Recapture If Residential Loan Requirement Met.—

"(A) in General.—In the case of a bank which meets the residential loan requirement of subparagraph (A) for its first taxable year beginning after December 31, 1995, or for the following taxable year, the following—

(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

(ii) such taxable year shall be disregarded in determining—

(A) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

(B) the amount of such adjustment.

(B) Residential Loan Requirement.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the percentage of the principal amounts of the residential loans made by the taxpayer during such year is not less than the base amount for such year.

(C) Residential Loan. For purposes of this paragraph, the term 'residential loan' means any loan described in clause (v) of section 7701(a)(30)(D) but only if such loan is made with the proceeds of such loan to the residence of the taxpayer who made such loans during the 6-taxable year period ending on or before December 31, 1995. The residence of the taxpayer who made most recent taxable years beginning on or before December 31, 1995.

"(D) Base Amount.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning on or before December 31, 1995. At the election of the taxpayer who made such loans during each of such 6 taxable years, the preceding sentence shall be applied without regard to
the taxable year in which such principal amount was the highest and the taxable year in which such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after such date, and, if made for such taxable year, shall result in the taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (4) of this subsection.

(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was a bank, (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995.

(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A)(iii), there shall be taken into account only the excess of the reserve for bad debts as of the close of the last taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (4) of this subsection.

(B) TREATMENT UNDER ELECTIVE CUTOFF METHOD.—For purposes of applying section 585(c)(3)(A)(ii) of this subsection, and (iii) no amount shall be includable in gross income by reason of such reduction.

(6) SUSPENDED RESERVE INCLUDED AS SECTION 585(c)(3)(A)(ii) AMOUNT.—The balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection and the supplemental reserve shall be treated as items described in section 585(c)(3)(A)(ii).

(7) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 591(b), the amount referred to in section (g)(2)(A)(ii) of this subsection, and (ii) no amount shall be includable in gross income by reason of such reduction.

(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection and subsection (e), including regulations providing for the application of such subsections in the case of acquisitions, mergers, spinoffs, and other reorganizations.

(b) CONFORMING AMENDMENTS.—

(1) Section (c) of section 591 is amended by adding at the end the following new sentence:

“(7)(A) The material preceding subparagraph (A) of section 593(e)(1) is amended by striking ‘‘by a domestic building and loan association or an institution that is treated as a mutual savings bank under section 591(b)’’ and inserting ‘‘by a taxpayer having a balance described in subsection (g)(2)(A)(iii)’’.

(8) (B) Paragraph (2)(A)(i) of section 593(e)(1) is amended in subparagraph (B) by striking ‘‘the’’ in the first taxable year beginning after December 31, 1995.

(9) (B) The balance taken into account by such taxpayer under paragraph (4) of this subsection shall not be reduced by the balance taken into account by such taxpayer under paragraph (4) of this subsection.

(10) Subsection (a) of section 60E is amended—

(A) by striking ‘‘Except as provided in paragraph (1) of this section and inserting ‘‘The’’.

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively.

(c) By striking in paragraph (2) (as so redesignated) all that follows ‘‘subsection’’ and inserting ‘‘The’’.

(11) Paragraph (2) of section 992(d) is amended by striking ‘‘or 593’’.

(12) Subsection 1038 is amended by striking subsection (f).

(13) Clause (ii) of section 1042(c)(4)(B) is amended by striking ‘‘or 593’’.

(d) Subsection (c) of section 1277 is amended by striking ‘‘or to which section 593 applies’’.

(e) Subparagraph (A) of section 136(b)(2) is amended by striking ‘‘or to which section 593 applies’’.

(f) The table of sections for part II of subchapter H of chapter 1 is amended by striking the items relating to sections 595 and 596.

(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, 1995.

(2) SUBSECTION (b)(7).—The amendments made by subsection (b)(7) shall not apply to any distribution with respect to preferred stock if—

(A) such stock is outstanding at all times after October 31, 1995, and before the distribution,

(B) such distribution is made before the date which is 1 year after the date of the enactment of this Act (or, in the case of stock which may be redeemed, if later, the date which is 30 days after the earliest date that such stock may be redeemed).

(3) SUBSECTION (b)(8).—The amendment made by subsection (b)(8) shall apply to property acquired in taxable years beginning after December 31, 1995.

(4) SUBSECTION (b)(10).—The amendments made by subsection (b)(10) shall not apply to any residual interest held by a taxpayer if such interest has been held by such taxpayer at all times after October 31, 1995.

(f) Mr. DINGELL. The SPEAKER pro tempore. Pursuant to the gentleman from Michigan [Mr. DINGELL] and a Member opposed will each control 30 minutes.

(a) The SPEAKER pro tempore. The SPEAKER pro tempore. The chair would state that because the gentleman from California [Mr. THOMAS] is a member of the Committee on Ways and Means, the gentleman from California would have the right to close.

Mr. DINGELL. Mr. Speaker, further parliamentary inquiry. Is it not the rule that the author of the amendment has the right to close?

The SPEAKER pro tempore. The manager of the bill has the right to close, and the Committee on Ways and Means is the reporting committee on the pending bill.

Mr. DINGELL. That is a rather extraordinary ruling.

Mr. THOMAS. Mr. Speaker, is it not unusual for the committee that offers the bill on which a Member offers a substitute to the committee bill not to close? Is that a rather unusual ruling, or is that the ordinary rule around this place and has been for years?

The SPEAKER pro tempore. The Chair indicated that the representative of the managing committee would have the right to close.

The Chair recognizes the gentleman from Michigan [Mr. DINGELL].

Mr. DINGELL. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Texas [Mr. BENTSEN], a coauthor of the amendment.

Mr. BENTSEN asked and was given permission to revise and extend his remarks.

Mr. DINGELL. Mr. Speaker, thank you from Michigan for yielding me time.

Mr. Speaker, earlier today, my wife called to tell me that our 2-year-old daughter Meredith had gotten hold of her sister’s cough medicine. The doctor ordered her to the hospital and my wife rushed her to the emergency room. As I left her, I was concerned about my daughter, but I didn’t worry about the bill. We in Congress have health insurance. Fortunately, Meredith is OK, and we need not worry about how we pay.

That is not the case for the young woman I recently met in my district who could not purchase health insurance because her daughter had a heart
condition. Her husband earns too much to be on Medicaid, nor does she want to receive such assistance. She only wants the right to buy health insurance, but her daughter's preexisting heart condition precludes that. The Bentsen-Spratling-Dingell substitute would prohibit discrimination based on such preexisting conditions and ensure that this family could finally provide health care for their child without falling into poverty.

Today, this House has the opportunity to pass simple, straightforward steps that will help millions of Americans like this Channelview, TX, family. If we focus on reforms that have broad, bipartisan support, and put aside for now those proposals that divide us, as this substitute does, we can begin to address the health care fears that weigh heavier on the minds of families across this country.

I urge my colleagues to keep in mind the people we are trying to help. Let us remember the 4 million Americans who are without health insurance today, including 4.6 million people in my home State of Texas. That is 1 million more Americans without insurance than when Congress last debated health care reform. Millions more face becoming uninsured if they lose or change jobs, and others are locked in jobs they do not want because they or a family member have a preexisting condition.

These are the people we must remember as we debate this issue today. That young mother in Channelview needs our help now. She and millions of other Americans do not have the luxury of waiting as we spend months, even years, debating the controversial, untested provisions, such as Medical Savings Accounts, that are in the bill before us. These provisions may even have merit. But they should not be allowed to hold up or kill the common-sense, bipartisan provisions in our substitute. The American people deserve what we in Congress have, and our substitute provides that.

This substitute tracks the bipartisan Health Insurance Reform Act of 1996 as introduced in the other body by Senators NANCY KASSEBAUM and EDWARD KENNEDY and as filed in the House by our Republican colleague, MARLENE McKEE. I want to congratulate my colleague from New Jersey for her leadership on this issue and urge her and others of us to join us in supporting this substitute.

This substitute ends insurance discrimination against people with preexisting health conditions. It guarantees people access to group or individual coverage if they change jobs, lose jobs, or get sick. It helps small businesses to join together and purchase more affordable coverage.

Our substitute makes one major addition to the bill. It creates a new class of insurance plans with deductibles to individuals and families. These plans could be the basis of a choice of private health insurance for individuals. We should encourage the development of private health plans. It is a market-based plan that the American people support, that addresses their real concerns, and that can become a reality tomorrow. The Republican bill fails this test and will take years to even come close to becoming law. My colleagues, tonight let’s forget we are Democrats and Republicans for one shining moment of compromise. Let us put victory for the American people and their health security ahead of political victory. Let’s do right by the American people and pass the Bentsen-Spratling-Dingell substitute.

Mr. Speaker, I yield 15 minutes to the gentleman from Virginia [Mr. BLILEY], the chairman of the Committee on Commerce, and ask unanimous consent that he be allowed to allocate said time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. Speaker, I yield myself 4 minutes.

Mr. Speaker, the special rule for coordination of long-term care policies has been misinterpreted by some in the administration. I want to clarify that the rule applies to policies that provide health care benefits only for long-term care and similar benefits, such as community-based care, and would not apply to a policy that covers other health care benefits. Mr. Speaker, we have been hearing for some time that all the Democrats want is Kassebaum. The gentleman from New York said “Let's have 'pure' Kassebaum.”

Let me tell you, what you have in front of you is not pure Kassebaum. As you might expect, the Democrats have changed the bill. They have told you they have only added things to it. They said, “We just wanted to help the self-employed more than the Republicans.”

You left the self-employed stranded for a whole year in 1994 when you were in the majority. Nice to have you come around and have you helping the self-employed. If this is supposed to be pure Kassebaum, why don't you include the items on page 105? Title III, miscellaneous provisions. “HMO’s allowed to offer plans with deductibles to individuals with medical savings accounts.” Kassebaum includes medical savings accounts and the ability to apply to an HMO to receive benefits while you have a medical savings account. You conveniently left that out. If you want pure Kassebaum, you would have MSA’s in the bill.

On page 106, Sense of the Senate. “It is the sense of the Senate that the Congress should take measures to further the purposes of this act, including any necessary changes to the Internal Revenue Code of 1986 to encourage groups and individuals to obtain health coverage and to promote access, equity, portability, affordability, and security of health benefits. That is exactly what the Committee on Ways and Means has done. The Senate committee cried out in the Kassebaum bill, ’We don’t have jurisdiction over the Tax Code, but if we
did, these are the kinds of things that we would do." And what they asked for, we have included in our bill.

Only one committee has looked at the Kassebaum bill in the Senate. It is not on the floor of the Senate. They did not have jurisdiction over the revenue code. Four committees in the House looked at our bill, and given our distinct and unique jurisdictions, we contributed to and improved to this bill. We did exactly what Senator Kassebaum asked us to do. We added items that expanded and promoted access, dignity, portability, affordability and security of health benefits.

Guess what you left in the bill? Notwithstanding all of the protestations on the floor about the Democrats in terms of States rights, and, after all, the Republicans are going to usurp the States rights, and, after all, the Republicans are going to usurp the States rights, take a look at page 91 in the Kassebaum bill.

It says in the Dingell substitute D(b), certification, number 2. State refusal to certify. It says, "If a state fails to implement a program for a certifying health plan purchasing cooperative in accordance with the standards under this act, the state agency shall certify and oversee operations of such cooperative's Federal preemption."

Notwithstanding all of your crocodile tears, about "pure" Kassebaum, the Feds have a role in play in your substitute. I would tell my Republican colleagues, beware: This is not Kansas.

This bill is not from Dorothy. It isn't even from Toto. It has been written and comes from the Land of Oz.

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

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey [Mrs. ROUKEMA] for yielding me time to express my strong support for his substitute to H.R. 3103, an omnibus package of health reform proposals.

The Dingell amendment is comprised, essentially, of two items: the so-called Kassebaum-Kennedy-Roukema health insurance reform package and a proposal to allow self-employed individuals to deduct 80 percent of their health insurance premiums, rather than the 30 percent current law allows for.

The difference between this package and H.R. 3103 is this simple: If the House approves the Dingell plan it can be quickly passed by the Senate and signed into law by President Clinton immediately. This will immediately deliver insurance portability; eliminate job lock and give guaranteed insurance to 30 million Americans who presently do not qualify.

H.R. 3103, as brought to the House floor today, cannot.

The Republican leadership's package, which contains several very controversial elements, faces a guaranteed Senate filibuster, or, if it were to ever get that far, a certain veto at the White House.

If you want to vote in support of health insurance reform legislation that will make a real difference in the daily lives of millions of Americans this year, support the Dingell alternative.

Anything else won't survive the legislative process, and is simply a political exercise rather than an attempt to enact commonsense, bipartisan health reforms.

I am very proud to be the House author of the companion bill to the Kassebaum-Kennedy measure, H.R. 2893—which currently has 193 cosponsors—17 Republicans and 176 Democrats—which encompasses precisely the kind of rational health reform that the Republicans so strongly advocated in 1993-94 when the 103d Congress was debating President Clinton's massive health care reform plan.

This modest package of insurance reforms would require health insurance plans portable for workers leaving one job for another; restrict the ability of insurance carriers to impose pre-existing condition limitations in their policies; and allow small employers to pool together to purchase health benefits for their workers.

A very strong and broad coalition has endorsed the Kassebaum-Roukema legislation including: The National Governors Association; the American Medical Association; the American Hospital Association; the National Association of Manufacturers; the Business Roundtable, and the AFL-CIO—on the Senate side, the U.S. Chamber of Commerce has endorsed the Kassebaum-Roukema package, too; the Healthcare Leadership Council, and the Independent Insurance Agents Association; and the ERISA Industry Committee [ERIC], and the American Association of Retired Persons [AARP] are just a few of the more prominent supporters of the Kassebaum-Kennedy-Roukema legislation.

I might add that, during his State of the Union speech 2 months ago, President Clinton endorsed this bill, and has repeatedly stated that he is prepared to sign the legislation if we can just move it through the Congress this year.

Some of the reforms in H.R. 3103—such as medical malpractice reforms—I have supported in the past, and will continue to support in the future as freestanding measures.

However, we must acknowledge that these issues raise significant policy questions.

Reforms such as medical malpractice and medical savings accounts should be debated by the Congress on an individual, case-by-case basis, particularly given the level of controversy that these proposals raise in both parties of the House and Senate.

In addition, it is highly unlikely that, given the limited number of legislative days in our session this year, the Senate would ever be able to pass such a contentious omnibus package of health reforms.

In fact, prominent Republican Senators have repeatedly and publicly stated their opposition to such an omnibus bill, as recently as a day or 2 ago. My friends in the Senate are not playing these games—the American people are sick and tired of bickering and political gamesmanship.

We must immediately enact common-sense, incremental health insurance reforms.

The General Accounting Office [GAO] has estimated that up to 30 million American citizens would benefit from the health insurance reforms incorporated in the Kassebaum-Roukema plan.

Let's not permit such a golden opportunity to help so many people slip through our collective fingers because of partisan politics.

In closing, Mr. Speaker, I urge my colleagues to join me in support of the Dingell substitute to H.R. 3103, because it's the right thing to do for the American people now.

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

Mr. BLILEY asked and was given permission to revise and extend his remarks.)

Mr. BLILEY. Mr. Speaker, first of all, with all due respect to my good friend and colleague from New Jersey [Mrs. ROUKEMA], we had a bipartisan plan in the last Congress authored by my good friend from Florida, the chairman now of our Subcommittee on Health and Environment of the Committee on Commerce, and the gentleman from Georgia who is no longer with us, Dr. Roy Rowland. I sat right over there on this night 2 years ago with then the chairman of my committee, and I said, you cannot move this massive socialized medicine bill of the President's. We have a good bipartisan bill and we ought to take it up. It was not enough for him.

Mr. Speaker, but now all of a sudden, this bill, which is more modest than the Bilarakis-Rowland bill, is too much. I find that rather ironic.

Mr. Speaker, I rise in strong opposition to the substitute. While it is a well-intentioned proposal, it simply falls short of the mark of ensuring that health insurance is both available and affordable.

Our bill is focused on the real problems people encounter in obtaining health insurance in the small business market. Small employers who are trying to provide their employees and their families with adequate coverage are being hindered by this substitute. They will not be able to purchase affordable health insurance coverage.

In addition, a recent letter from the National Association of Independent
Businesses points out that big business is in the position of purchasing health insurance under a different set of rules than small business. Their letter points out that the Health Coverage Availability and Affordability Act would stop big business from being able to band together across State lines to purchase health insurance with nearly the same exemption from State law that big business has. Achieving this is NFIB's highest health reform priority. And I quote from their letter: ""Any amendment that does not directly address this inequity between big and small business is unacceptable to more than 600,000 members of NFIB.""

Mr. Speaker, the Democratic substitute does not address this inequity. It is all form and no substance. Its pooling provisions simply allow the formation of purchasing cooperatives, which can be formed under current law. Thus, it falls short of the mark in addressing concerns of small business in reforming the small employer health insurance market.

Mr. Speaker, I would also like to point out to my colleagues that National Right to Life has raised a serious concern about the nondiscrimination language in the substitute. The nondiscrimination language could be read to apply to the content of a benefits package. Thus, the language could be used to remove the inclusion of elective coverage under the small employer health insurance plans. This problem has not been addressed in the substitute and remains an issue for pro-life Members.

In addition, the Democrat substitute fails to allow for medical savings accounts, an option that provides true portability for individuals, including the self-employed. It does not encourage the purchasing of long-term health insurance coverage, because it does not allow expenses for long-term care and long-term care insurance premiums to be tax deductible.

Mr. Speaker, it also fails to address the question of affordability because it does nothing to address the increased costs our current malpractice laws bring to the health care system.

Perhaps the substitute's most glaring omission is its failure to address the issue of fraud and abuse, which has also contributed to the high cost of health insurance coverage. According to the General Accounting Office, as much as 10 percent of total health care costs are lost to fraud and abuse. Given that annual health care costs in the United States are now approaching $1 trillion, fraud and abuse are costing taxpayers and policyholders large sums of money. Despite the enormity of the problem, GAO has concluded that only a small fraction of this fraud and abuse is detected. The failure of a health reform bill to address this issue is unfortunate.

The HHS Inspector General in a letter to the ranking member of the Committee on Commerce points out that the provisions in the Republican bill will help to reduce fraud and abuse. It states:

"Generally speaking, these provisions are excellent ... The bill contains many improvements to the laws intended to address health care fraud and, in our judgment, enactment of the provisions ... would be very effective in reducing the amount of fraud and abuse in the health care system ..."

Finally, I feel I must address the constant refrain we have heard that somehow Senator Kassebaum and Kas-

ned's bill, is the gold standard and cannot be amended. It is absolutely absurd for us to say that a bill cannot be improved. It is also rather naive for us to say that a bill that comes out of Committee will not be amended on the floor of that body where there are no germaneness rules and anything can be attached to any-

thing.

Mr. Speaker, do not expect a clean Kassebaum-Kennedy bill to come out of the Senate. I assure my colleagues that whatever we do tonight, we will be in conference.

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

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from South Carolina [Mr. SPRATT].

(Mr. SPRATT asked and was given permission to revise and extend his remarks.)

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

Mr. Speaker, I rise in strong support of Bentsen-Spratt-Dingell. There is a lot on our agenda about which the American people are undecided or divided, but clearly they want us to change the way that health insurance in this country is written. They want the law to say that if they lose their jobs or leave it, they can take their health insurance with them; if they have an illness, they have aright to keep their insurance and not be ostra-

ized by carriers; and about which the people are undecided or di-

vised.

Mr. Speaker, there is something else the American people want. They want an end to partisan bickering. Our sub-

stitute goes to both goals. It is not just a chance to change health insurance. It is a chance to do something bipartisan. We make health insurance portable. We take care of people with preexisting conditions, and we do it in a bipartisan bill, a bill that is unencumbered by pet provisions.

Mr. Speaker, the differences between the base bill, H.R. 3103, and our substitute, which is essentially Kennedy-Kassebaum-Roukema, are seemingly small but the differences are poten-

tially insidious.

First of all, let me just cover a couple. The base bill in our substitute says that if you lose your job, you can con-

vert from group to individual coverage once your extension under COBRA has expired. But in the substitute, we say that when you convert, you have the right to pick among the policies that an insurance company offers.

In the base bill, people lose this flexi-

bility. They have got a Hobson's choice. That is because the base bill has been amended to let the States re-

strict individuals to a single policy, and that one policy is bound to become the high-risk pool for all the defects and bad risks. That will make the premium cost excessive, probably beyond the reach of most people who need it, and we are not giving health insurance availability unless we give health in-

surance affordability.

Another provision very deep in this base bill which differs from the substitute. Both of us permit small em-

ployers to band together to purchase insurance, and, banded together, they can broaden their risk pool and get bet-

ter rates. So far, so good. But the base bill goes on to exempt multime
tier health plans from State regulations that govern other multime
tier health plans and places these under the Department of Labor. You got it. The Republicans want to give the Federal Government the power to regulate these insurance, self-insurance plans, and take it away from the State gov-

ernment.

Here, do not take it from me; listen to Mr. Grassley, a very respected member of this body from the other side of the aisle, now head of the Health Insurance Association of America, says about that particular provi-

sion of the main bill before us. He says,

"We strongly oppose the provision con-
taining in the House language which we believe will undermine the progress States have made in reforming their small em-

ployer insurance markets and leave an un-

stable health insurance market in its wake."

Mr. Speaker, we have a chance to pass a bipartisan bill, to keep this bill on track and I urge support for the bill.

Mr. Speaker, there is much of our agenda about which the people are undecided or divided. But clearly they want us to change the way health insurance is written. They want the law to say that if they lose their job or leave it, they don't have to lose their health insur-

ance—they can take it with them. And if they have an illness or injury, they can keep their insurance, and not be ostracized by carriers for a "preexisting condition."

There's something else people want: They want an end to partisan bickering.

Our substitute goes to both goals. It is not just a chance to change health insurance, it's a chance to do something bipartisan. We make health insurance portable; we take care of people with preexisting conditions; and we do it in a bipartisan bill, a bill that is unencumbered by pet provisions.

The differences between the base bill, H.R. 3103, and our substitute, which is the Ken-

nedy-Kassebaum-Roukema bill, are seemingly small but potentially insidious.

First of all, both the base bill and our sub-

stitute say that if you lose your job, you can con-

vert from group to individual coverage once your extension under COBRA has expired. But in the substitute, we say that when you convert, you have the right to pick among the policies that an insurance company offers.
Mrs. ROUKEMA tonight, and Senator KASSEBAUM several days ago, have all warned against overloading this bill with extraneous stuff, like medical savings accounts and malpractice reform. I am not opposed to all those add-ons; I’ve voted for malpractice reform; but what I fear is that this bill is an effort to smear our bill, to give it a bad name, to make patients think that we have not kept Medicare whole, that we have put in place to regulate the sale of multiemployer health plans from the State regulations that govern other multiemployer plans, and places these under the Department of Labor. In passing this bill, in particular on what it substitutes an adequately capitalized plan, the base bill, in the words of the Health Insurance Association of America, sets up “a very flimsy safety net for employees with self-insured, federally regulated coverage.” It puts the insured in peril of being in an unsound plan and not having coverage when it is needed. Our bill respects the competency of the States in this field, and leaves multiemployer insurance plans subject to State law.

Next, the base bill includes Medicare fraud and abuse provisions, and claims savings back into Medicare to boost the solvency of the Part A trust fund. Instead these Medicare funds are used to offset the tax revenues lost by allowing MSAs. This comes from the group that for the past year has told seniors that deep cuts in Medicare were needed to keep Medicare solvent. In 2003. On this subject, our substitute departs from Kennedy-Kassebaum-Roukema; it too increases the tax deduction for the self-employed, but we go to 80 percent by the year 2002. I am not altogether opposed to MSAs, but I would much rather use the tax offsets to cover the revenue losses to pay for a higher rate. More small businesses, more self-employed Americans, will benefit from being able to deduct 80 percent of their health insurance premiums than would benefit from medical savings accounts.

Finally, the base bill repeals current laws that we put in place to regulate the sale of policies that duplicate Medicare coverage. These protections were enacted to protect unsuspecting seniors from purchasing coverage that they already have under Medicare. The base bill opens a loophole that would allow insurers to sell Medicare beneficiaries a policy that duplicates Medicare coverage, but it does not limit that guarantee to one insurance policy. The person who converts may still have his premium rated, adjusted upward for a pre-existing condition; but he can also buy into an insurance pool with lots of other people who are ordinary, unrated risks. And while this bill gives them no one protection against higher premiums, our substitute leaves the States the power to regulate premiums, as many already have. And if you are in an insurance pool with ordinary risks, the States can limit the rated premium you have to pay for your policy, say, to 50 percent of the standard premium. But if you end up in a risk pool with all bad risks, there is no way to spread the cost and mitigate the premiums.

Next, the base bill, as well as our substitute, permits small employers to band together to purchase insurance. In banding together, they can broaden their risk pool and get better rates. But the base bill exempts multiemployer health plans from the State regulations that govern other multiemployer plans, and places these under the Department of Labor. In passing this bill, in particular on what it substitutes an adequately capitalized plan, the base bill, in the words of the Health Insurance Association of America, sets up “a very flimsy safety net for employees with self-insured, federally regulated coverage.” It puts the insured in peril of being in an unsound plan and not having coverage when it is needed. Our bill respects the competency of the States in this field, and leaves multiemployer insurance plans subject to State law.

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Next, the base bill raises the tax deduction allowed the self-employed to 50 percent of the premiums they pay, but reaches that level only in year 2003. On this subject, our substitute departs from Kennedy-Kassebaum-Roukema; it too increases the tax deduction for the self-employed, but we go to 80 percent by the year 2002. I am not altogether opposed to MSAs, but I would much rather use the tax offsets to cover the revenue losses to pay for a higher rate. More small businesses, more self-employed Americans, will benefit from being able to deduct 80 percent of their health insurance premiums than would benefit from medical savings accounts.

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savings from the Medicare Program because of an antifraud provision, and they use those savings to fund the tax breaks for medical savings accounts. Those are controversial issues. They should not be in a bill that can be passed on a bipartisan basis and turned into law.

There are things I would like us to do, because let us realize what we are not addressing is the problem of the 40 million uninsured in this country. We do not care what version of the bills we pass today, they are not going to be covered after all is said and done.

I think there are important changes we need in our health care system, but if we do not have a consensus to accomplish them, let us do what we can and pass the bill that would prevent this job lock and assure that people will get insurance if they leave their jobs and take another job or want to buy a private insurance policy.

I would urge support for the substitute. I will not go through the denigration of what the other people have to say what I do say is let us pass what we can into law. Let us not lose this chance.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. THOMAS], the chairman of the Health and Environment Subcommittee, a pioneer in health care reform, the man who led the bipartisan effort in the 103rd Congress.

Mr. BILIRAKIS. I thank the gentleman for yielding the time to me.

Mr. Speaker, I rise in opposition to this substitute, and yet without question I certainly support the goals of the substitute. Both bills address insurance portability, eliminate preexisting condition prohibitions, end job lock, and both bills address medical savings accounts.

The Kassebaum bill amends the HMO act to allow the offering of high deductible MSAs and it also provided a sense of committee resolution to encourage MSA’s. But that is where the common elements end. The substitute simply fails far short of the mark on true health care reform.

Our bill offers more options to the American people. My constituents are always asking me, I am sure my colleagues are, what Congress is doing to address fraud and abuse. What is Congress doing to eliminate unnecessary paperwork? When will our medical malpractice laws be changed? Our bill addresses these important areas.

In addition, it also extends the medical expenses deduction to long-term care services which is important to our seniors. A Band-Aid solution like the substitute proposes would not address more systematic problems which drive up costs and limit access to our health care system.

On health care reform, the American people deserve more than a Band-Aid. They deserve our best efforts to fix what we can in a system which everyone agrees needs reform.

Mr. BENTSEN. Mr. Speaker, I yield ½ minutes to the gentleman from Pennsylvania [Mr. KLINK].

(Mr. KLINK asked and was given permission to revise and extend his remarks.)

Mr. KLINK. Mr. Speaker, I just wanted to talk a little bit about the matter that is before us. One of the previous speakers made a point that I am disappointed in the particular effort called Roukema-Bilirakis. Mr. Speaker, While I respect both of the people greatly who came out with that effort, it did not pass this House, it did not have the necessary support, and so we are here today trying to figure out what should we take to make an improvement upon the trillion dollar industry that is health care in this Nation.

Mr. Speaker, I would suggest that Roukema-Kassebaum-Kennedy is that modest step. It is that first step that is going to help tens of millions of Americans keep their health insurance when they switch their jobs, regardless of preexisting health conditions.

The Republicans, though, in this House are proposing a health insurance reform that is not as strong as Roukema-Kassebaum-Kennedy. They are adding on what I believe to be special interest amendments and paybacks that are going to sabotage the first real attempt we had to able to take a bipartisanship step in the right direction for the working people of this country.

Now, we are talking about two editions, that in one instance the CBO is saying that the bill’s profraud loopholes are going to cost $400 million. Less revenue coming in, and enforcement of fraud is going to suffer. Why should we want to do this?

The MSA proposal is not going to fly in the Senate, it is not going to fly with the President. Why would the Republicans want to doom this package by adding these two things to it?

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. SHAW].

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

Mr. Speaker, tonight I rise to deliver to my congressional colleagues a message from the 180,000 Medicare beneficiaries who reside in my south Florida district, and that message is simply:

Stop the fraudulent and abusive practices against the Medicare Program, and do it now.

This substitute ignores the issue of fraud and abuse.

Mr. Speaker, this body has already voted for the Medicare fraud and abuse provisions that are included in this bill when it passed the Medicare Preservation Act, and, as we all remember, the Medicare Preservation Act was vetoed by President Clinton. Now we have another chance to move a step closer to saving the Medicare Program from bankruptcy.

This bill is the toughest and most serious effort in this Congress has made to stop fraud and abuse in the Medicare Program and health care generally with the new strong criminal penalties for offenses against the American people. I am proud to have contributed to this effort, and I know that when my constituents learn of their new rights under the Medicare Program, they will be proud of this Congress, too.

Let us pass this bill and save Medicare millions of dollars and save all the American taxpayers billions of dollars in reducing fraud and abuse.

Mr. BENTSEN. Mr. Speaker, I yield 1 minute to the gentleman from California [Ms. ROYBAL-ALLARD].

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise in support of the Democratic substitute. By correcting the most obvious deficiencies in the health insurance market, this legislation is a much-needed, albeit small step toward reforming our health care system, because it frees the American worker from job lock which prevents millions from taking better jobs for fear of losing their health care coverage.

It protects people with preexisting conditions by limiting the exclusion period and prohibiting employers and insurers from denying coverage to these individuals. It expands availability and access by prohibiting insurers from denying coverage to specific employee groups, and it increases the deduction for the self-employed to 80 percent in support of America’s small business.

The Democratic substitute brings a measure of fairness and justice to our health insurance system without the special interest provisions in the House Republican bill. I urge all Members to vote in favor of the Democratic substitute.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Connecticut [Mr. SHAYS], a distinguished member of the Committee on the Budget.

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

Mr. Speaker, a number of years ago the President came with his reform of health care. It was wide-reaching, it was well beyond what anyone in this House wanted to do, and now we have a bill that in my judgment is very sensible. It is very logical. The Roukema-Bilirakis bill never passed 2 years ago because it never had a vote. It never had a vote because unfortunately the other party was jealously guarding the jurisdictions of each committee.

This bill here has the input of the Committee on the Judiciary, the Committee on Commerce, the Committee on Ways and Means, and the Committee on Economic and Educational Opportunities, and in it there is a very significant portion of this bill dealing with fraud, title II, preventing health care fraud and another about 70 pages. I have a hard time understanding what is meant by a clean bill.

What is a clean bill that does not deal with waste, fraud, and abuse? We have been having hearings for decades about the waste, fraud, and abuse. That
so-called clean substitute ignores it completely. This bill here deals with waste, fraud, and abuse, and for the first time makes health care fraud a Federal offense, an all-payer system, not just for Medicare and Medicaid and Champange for all health care fraud. We are determined that this House is going to do something responsible.

I will just conclude by saying I am totally convinced that this House is going to pass a health care bill. It may not be exactly like this one when we deal with the House and Senate face to face, but it will be far better than the substitute bill presented. I urge my colleagues to take part in what we are doing. We are going after waste, fraud, and abuse for the first time in a serious way. It is happening under our watch. Be proud of it.

Mr. BENTSEN. Mr. Speaker, I yield 1 minute to the gentlewoman from California [Ms. WOOLSEY].

Ms. WOOLSEY. Once again, Mr. Speaker, the Gingrich Republicans are standing in the way of meaningful health reform and it's America's families who are going to wind up paying the price. While Speaker GINGRICH says his plan may make health insurance more available, it does nothing whatsoever to make it affordable.

Thankfully, for the American people, we have another choice before us today. We have the Democratic substitute. The one bill that will extend coverage to 25 million Americans. The one bill that has bipartisan support in the Senate. And the one bill that will be signed into law by the President.

To my colleagues on the other side of the aisle: Don't use your vote to scuttle significant health care reform this year. Instead, stand up for working families and support the Democratic substitute.

Mr. BENTSEN. Mr. Speaker, I yield ½ minutes to the gentleman from Illinois [Mr. DURBAN].

Mr. DURBAN. Mr. Speaker, several years ago I introduced legislation which allowed a full 100 percent deductibility of health insurance premiums for self-employed people. I represent a rural district. I represent a lot of farm families. It is very difficult for them to buy health insurance and if they do, it is expensive, and they find that they can only deduct now 30 percent of the cost of the premiums.

The real unfairness is the fact that corporations can deduct 100 percent of the cost of health insurance premiums. Self-employed people cannot. What we do with the Democratic substitute is to address this in an honest way. I hope some of my Republican colleagues will consider breaking ranks tonight and joining in this bipartisan approach to health care reform.

Let me tell the Members what we know now. The fastest growing sector in the American economy are self-employed people, people who are starting their own businesses. If you ask them their No. 1 headache, you are going to find, to your surprise, it is health insurance; how to pay for it, how to cover your family and a few employees.

What the Democratic substitute is to allow up to 80 percent deductibility over a period of several years. If Members take a look at the alternative on the Republican side, they will find they only reach 50 percent. This is a big difference for a small business owner.

I hope that some of my colleagues will think twice and join us. I think it is far better for us to come together, Democrats and Republicans, pass real health care reform, instead of trying to score some political victory for the Golden Rule Life Insurance Company. Let us do something for the real self-employed people who need a helping hand.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Illinois [Mr. WELLER], who knows full well that in the calendar year 1994 it was the Democrats who left the self-employed with no deductibility whatsoever.

Mr. WELLER. Mr. Speaker, I rise to oppose the substitute and support H.R. 3103, which deserves the votes of Democrats and Republicans. Mr. Speaker, H.R. 3103 addresses a real problem faced by almost 40 million Americans, 85 percent of whom are small business people, the self-employed, farmers, and their families and workers.

I have listened over the last several years to many families unable to afford health insurance. They say the prices of health insurance are too high if they are self-employed or work for small businesses. They are talking about some- thing in 2002. It is a promise, folks. I guess we just need to straighten out some things. To my friend who just talked over here about the deductibility, I guess plagiarism is one of the best compliments there is. To my friend, the gentleman from Illinois, who talked about the deductibility issue, it is interesting, it is the same folks who for years just let the deductibility for small businesses go to zero and then wonder why it is only 30 percent. We are going to move it to 50 percent. They are talking about something in 2002. It is a promise, folks. I would not count on that promise.

Mr. Speaker, also I would say to my good friend from New Jersey, who says that the Senate leadership wants this Kassebaum bill, it is interesting, she did not read her papers, because the Senate leadership endorses our bill. They are going to move an add-on to their substitute, trying to exactly what we have passed in this House tonight, so she might be apprised of that.

Mr. Speaker, we have heard a lot of outrageous claims on the other side of the aisle. I think now is the time of reckoning. This substitute is just a whisper in the dark. It does not do anything to help health care. We cover group-to-group, we cover group-to-indi- vidual, and we also make health care affordable for the American people. We are determined that this House, if we really want to help Americans from the shoestore and the barber shop and the truck drivers and the real people that work out there in
America, defeat this substitute, the farce out here that they are putting out as the substitute, and support the Republican bill.

Mr. BENTSEN. Mr. Speaker, I yield 1 minute to the gentleman from Maryland [Mr. CARDIN].

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

Mr. Speaker, I urge my colleagues to support this substitute, this alternative. It does two things, and it does them better than the Congressional bill. First, it provides for portability. It does it better than the underlying bill, because if you lose your job and you lose your insurance and you try to find an individual plan, the substitute allows you to have some options and lets you be able to buy an affordable individual plan.

The second thing this bill does is deal with the self-employed by allowing them to be able to deduct 80 percent of their premium, whereas the underlying bill is at 50 percent. It makes it better for the self-employed. Both of these issues enjoy strong bipartisan support. This bill, the alternate, if it is passed, will be signed quickly by the President, will be approved by the Senate. It can be a reality. It is stronger than the underlying bill, and it can be passed and enacted into law.

Mr. Speaker, I urge my colleagues to support the substitute.

Mr. Speaker, it is my privilege to yield 1 minute to the gentleman from Oregon [Mr. BUNN], who came here to make a difference, and he does.

Mr. BUNN of Oregon. Mr. Speaker, I am pleased tonight to say that the substitute is a good bill, but the Republican version is a better bill. We have a win-win tonight. I think we ought to be pleased with that.

Mr. Speaker, I am also delighted that we had the opportunity to address some of the Committee on Ways and Means. The Committee on Rules was willing to make the necessary changes to assure that this bill is a floor, not a ceiling, so that reforms like Oregon passed just last year will be maintained. I think we are on track to assure that Americans will have good, affordable health care, and State reforms which will stay on track.

Again, we have a win-win. Theirs is good, ours is great. I support maintaining the Republican version, which means saying no to a good substitute.

Mr. Speaker, let me start by saying that I am glad that we were able to protect State health insurance reform efforts within this bill. As many people brought to my attention, including my State insurance commissioner, State insurance reform efforts may have been jeopardized by specific language not exempting them within this bill. I am proud to say that the language currently in this bill is very similar to that of the Democratic substitute, and while I supported it, the differences I contained in that bill, I believe the Republican bill goes even further and ensures even broader coverage than that alternative. I am supporting the base bill and opposing the substitute.

I look forward to reforming our national health insurance laws as soon as possible. Mr. BENTSEN. Mr. Speaker, I yield 1½ minutes to the gentlewoman from California [Ms. WATERS].

(Ms. WATERS asked and was given permission to revise and extend her remarks.)

Ms. WATERS. Mr. Speaker, I am pleased to join with my colleagues in supporting the substitute. It is time to stop just talk about health care reform and take real action on health care reform. This substitute represents a sensible approach to health care reform, and it may be the only chance we have to enact affordable health care for the American people. This bill would prohibit many of the current unfair insurance practices which deny and exclude individuals and families with significant health problems. Insurers often deny health coverage for pre-existing conditions, the very illnesses most likely to require quality medical care.

Approximately 81 million Americans have medical conditions which could result in the denial of coverage. We know from recent studies that African-American women are dying at a faster rate from heart disease and stroke. Minority children are dying and experiencing more complications from asthma and other preventable respiratory diseases. We are seeing an increase in the infection rate for HIV and AIDS among young African-American males.

We know that low-income persons are dying because they simply cannot purchase the ability to live. Many of those who are fortunate enough to have insurance give up opportunities for new jobs because they are afraid of losing what little coverage they have. We must have portability. This substitute, while it does not address all health care concerns, does move in the right direction.

Mr. McCrery. Mr. Speaker, it gives me great pleasure to yield 2 minutes to the distinguished gentleman from Louisiana [Mr. McCrery], a member of the Committee on Ways and Means.

(Mr. MCCRERY asks and was given permission to revise and extend his remarks.)

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

Mr. Speaker, I want to congratulate the gentlewoman from New Jersey, the gentlewoman from North Carolina, the gentlewoman from South Carolina, the gentleman from Texas, for I think putting forth a well-intentioned effort to improve the lot of people in this country vis-a-vis the health insurance system. It is a good effort. However, in the face of what we should be doing in health care reform in this country, it is weak. It is watered down. It is half-hearted.

Mr. Speaker, we should not be so timid in this House to bend to the pressures of the President of the United States, who is up for reelection this year. We should do what we think is right for the American people in our health care system. If you go to a town meeting and listen to the people, what do they talk about? They talk about portability. That is a problem. We solved that in our bill. But what is the main thing they talk about? Cost. "Mr. Congressman, do something about the escalating cost in our health care system."

The substitute, regrettably, does nothing for cost containment. Our bill, on the other hand, has medical malpractice reform, which goes to the heart of the escalation of costs in the health care system. We attack fraud and abuse, waste in the system, which goes to the heart of cost escalation. We introduce a new concept, make it tax-advantaged, medical savings accounts, which will allow a lot of little people in this country to get health care coverage for the first time.

These are all things that we should be doing if we were not so timid. We need to vote against the substitute and vote for the underlying bill.

Mr. BENTSEN. Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. Gibson], the ranking member of the Committee on Ways and Means.

Mr. GIBBONS. Mr. Speaker, I want to take just a couple of minutes to explain why the medical savings account is not popular on our side of the aisle, and why it probably is pretty popular with my colleagues over here, our Republicans.

If we look at the average family in America, it has an average family income of $34,000 a year, $34,000 a year. That is what half of the taxpayers have. However, in the face of what we are doing here, in the face of what we are doing here, our colleagues over here, our Republicans friends.

So half of the people in the United States that we claim as constituents and part of our party get absolutely nothing out of these medical savings accounts. But what do we do for our very well-off friends?

Mr. Speaker, first of all, they can afford it. They get a large deduction percentage-wise in all of this as opposed to 2 or 3 percent for our folks. Second, do not even make them pay FICA tax on that cash that they get as income. So that is another tax reduction they get, and we have not even talked about it here.

Third, and this is the insult of all, this allows them to exclude it from their estate tax. Now, how many of our colleagues over here even have to worry about an estate tax? Obviously, many of our colleagues do. My colleagues exempt them from the estate tax.

Now, what do we have to have in the estate tax? Well, between husband and wife, they can have millions of dollars and not pay any estate tax. But when the last of the family dies, they have
Mr. BLILEY. Mr. Speaker, I yield 1 minute to the gentleman from Ohio [Mr. THOMAS].

Mr. HOBSO. Mr. Speaker, I rise in opposition to the substitute. I think the substitute is a laudable effort, but there are a lot of other things that we can do that are important to this issue. There is a partisan bill, it is called the Coburn-Sawyer, and it is called Bond-Lieberman in the Senate, and it is in our bill, it is not in this bill. It is the administrative simplification bill.

It gets rid of a lot of forms that have to be transferred around, a multiplicity of forms. It makes it simple. Everyone agrees that that is good. It also gets at fraud. Everyone agrees we ought to do that, but it is not in my colleagues' bill, and it should be in their bill. Everybody agrees that it is a good bill. There is a bipartisan bill, it is called the Bond-Lieberman. This part of the bill passed out of the committee to zip. It is a good piece of legislation, it ought to be passed. That is why I support our bill and do not support the substitute.

Mr. BLILEY. Mr. Speaker, I have no further requests for time. I yield my remaining 1 minute back to the gentleman from California [Mr. THOMAS].

Mr. THOMAS. Mr. Speaker, I have 5 minutes and I have one speaker left. Under the rules we have the right to close.

Mr. BENTSEN. Mr. Speaker, I yield the balance of my time to the chief sponsor of the amendment, the gentleman from Michigan [Mr. DINGELL], the ranking member of the Committee on Commerce.

Mr. DINGELL. My colleagues, this has been a good debate. I think we owe a great debt of gratitude to the distinguished gentlewoman from New Jersey [Mrs. ROUKEMA] for the leadership which she has shown in this matter which has brought us to where we are tonight, and I would urge my colleagues to appreciate her great effort in this matter.

Having said that, it is very important to us to look at the situation we confront here. As an old friend of mine once observed, the perfect good is the enemy of the good. That means that, if we load this bill down with a vast plethora of amendments, we are liable to get no bill at all.

I yield to no man in my devotion to the concept that we must change the medical practice in this country to afford greater opportunity in this country to afford greater opportunity in this country and greater security to all the people.

There is this that we had an opportunity before us in the last Congress and it was rejected. My Republican colleagues have made a great talk about what it was that we did in those days and what we are doing tonight. The hard fact of the matter is that neither of these bills solves the problem.

But the real fact is that the bill and the substitute which is offered by the Democratic Members has the ability to solve part of the problems of some 25 million Americans who need portability and who need protection against prohibitions on preexisting conditions in insurance policies. It also does something else. It ups the amount of deductibility to 80 percent for individuals and small business. That is extremely important in terms of making health insurance available to large numbers of people who would otherwise be denied that benefit.

So I urge my colleagues to support the simpler and the cleaner bill, and I would urge them to recognize that the special interest amendments which are inserted in the Republican bill accomplish nothing but benefiting special interests and denying people the real opportunity to access to meaningful health insurance.

Mr. Speaker, let us look a little bit at what is in the Republican bill. First of all, it is loaded down like a Christmas tree, and I am satisfied that it will wind up with the same fate of a Christmas tree, dumped on the lawn at the conclusion of the discussion. It affords no chance for workers who lose their jobs to have a choice of plans. It makes no guarantees of businesses with more than 50 workers. It preempts State laws that protect consumers. It limits the deductibility of insurance premiums only to 50 percent. It has the controversial medical savings plans which do only one thing, and that is to benefit the insurance companies that have spent millions of dollars lobbying for this particular benefit for themselves, to benefit those who are healthy and those who have money, not those who are ill and who have need.

It has vetoed over 100 different medical malpractice law changes. Now I happen to think we need some changes in medical malpractice, but I did not think that we need the changes that are here. It also makes it harder to catch and to punish wrongdoers. Perhaps one of the worst things that it does is that it repeals protections that we invested in seniors some years ago to prevent them from being ripped off by useless, duplicative health insurance policies under which they pay for the same benefits which they get from Medicare, but in which they are prohibited from collecting benefits because of clauses in the legislation and because the prior liability goes to the Medicare policies.

There are also controversial provisions in here which override State insurance laws.

Mr. Speaker, the hard fact is that tonight we should be working to make it simple. We should be working to make the proposition which will go to the President, which will pass quickly through the House and Senate, which will move easily through conference, and which will go to the President for quick and easy signature. To risk veto or to arrive at a situation where we do not help the some 25 million people who are dependent on the question of portability and who are afflicted with the problems of not being able to afford health insurance plans which will be made available under this legislation is both unwise and unnecessary and inconsistent with our responsibilities to the people.

I would hope that soon we will be able to address a really meaningful proposal for health insurance for all the people, to see to it that we provide that last element of security for the American people, which every American finds to be troublesome in the extreme, because it is an essential and important part of the security net which Americans think that every American should have. Regrettably, that choice is not before us. Regrettably, the Republican Members of this body have chosen not to move forward on that.

President Clinton tried to do that 2 years ago and it was rejected overwhelmingly on this side of the aisle. I would urge my colleagues to recognize that a little that we can get quickly which will really help people is a lot better than an illusory lot which will help no one and not become law and not help anybody.

I would urge my colleagues to therefore vote for the substitute which the Democratic Members will be offering tonight and to do something which is going to benefit all of the people and which will be of significant benefit to some 25 million who will derive benefits under the portability and under the preexisting provisions.

I urge my colleagues to vote in the interests of the country. I urge them to vote for the substitute. I urge them to support a proposal which will give us significant progress, rather than the assurance of further confusion, further controversy, and possible veto and loss of this legislation in the Senate or in a conference between the House and Senate.

Mr. Speaker, I yield myself 3 minutes, and ask unanimous consent to revise and extend my remarks.

Mr. Speaker, we are faced today with a simple choice: Will the House give the American people what they want—a straightforward, simple, and uncontroversial bill to reform health insurance, a bill that can go to conference with the Senate quickly and be enacted into law?

Or will the House doom the chances for enacting such a bill by erecting a Christmas tree, decorated with all manner of controversial ornaments?

I want to commend my colleague from New Jersey, Mrs. ROUKEMA, for recognizing the simplicity of this equation early on, and for introducing in the House the companion to Senator KASSEBAUM's bill in the Senate. The Kassebaum-Roukema bill has enjoyed widespread and bipartisan support. It has been endorsed by 135 organizations, including the
The American Health Care Association, the National Association of Manufacturers, and the Healthcare Leadership Council.

Many of us have tried, on a bipartisan basis, to persuade the leadership to keep this health insurance reform alive. I refer to the Roukema-Kassebaum bill and to tax deductibility of health insurance for the self-employed, another uncontroversial provision with broad support. But in spite of the very public pleas from both sides of the aisle, as well as from Representative ROUKEMA, Senator KASSEBAUM, and Senator BAGNALL on the Republican side, we have ended up instead with a Christmas tree.

The Dingell-Spratt-Bentsen substitute incorporates the Roukema bill as title I. The amendment is very simple. It ends discrimination against people with preexisting conditions so they can get health insurance. It guarantees that Americans who lose or change their jobs can get health insurance. It requires health insurance companies to renew people’s policies. And in title II, it increases the health insurance tax deduction for self-employed individuals from 30 percent to 80 percent, a major priority for small businesses and family farmers.

By voting for the substitute, my friends, you will be telling your constituents that you want the House to consider a bill that can be signed into law and become law. By voting against it, you will be telling them that there is no time to close, and I say I absolutely disagree.

Now, I know that many of my colleagues, on both sides of the aisle, do not happen to think of themselves as a Christmas tree reform. But in spite of the very public pleas from both sides of the aisle, as well as from Representative ROUKEMA, Senator KASSEBAUM, and Senator BAGNALL on the Republican side, we have ended up instead with a Christmas tree.

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accessibility, and we added affordability.

And there is a third part. We had strong provisions on fraud, and I particularly want to congratulate the gentleman from Oklahoma (Mr. Coburn), who has worked tirelessly in his first term to make sure that we have strong steps and strong penalties against fraud.

When the General Accounting Office reports that fraud may account for 10 percent of health care costs, that is $100 billion a year. We have anecdote after anecdote on this floor from Members who have had members of their family involved in situations of clear-cut fraud, when you watch on NBC as a woman reports that she called in to complain because they had charged her for an autopsy and, since she was still alive, she thought she had one, and their answer was that must have been an EKG. She said, “I did not have that either.”

We had one of our colleagues who walked in the day and, you know, his mother had called him, he heard us talking about fraud, and she said she got billed for two mammograms. She called the doctor’s office. She said, “You did not have two mammograms.” “Oh, yes. We must have done two mammograms.” She said, “I had a mastectomy 7 years ago. I know you did not do two mammograms.” Their next comment was, “What do you care?” The Government will pay the bill.

What this bill establishes is it directs the Secretary of Health and Human Services to establish a system for senior citizens to turn in fraud and to give senior citizens the power to help us silence the system, so people engaged in ripping you off, the taxpayer, and rip off the consumer of Medicare is better protected and has a better incentive to turn in fraud.

I would say if you want accountability, we have it. If you want access, we have better access. We give twice as long a period as Kennedy-Kassebaum between insurance without losing coverage, twice as long. We have a better system of access, and it is far more affordable under our bill than it is under the substitute.

So I would simply say to my friends, do not be partisan about this. Here is an occasion where we started in a bipartisan bill that was bipartisan in the Senate. We have improved the bill. Medical savings accounts is, in fact, an issue of great concern to some people. It is a brand-new idea. We believe it will help things.

I want the House to know that if the President sends up a veto signal, maybe we would have to back down. But we want a chance to convince him this is wrong to favor the trial lawyers over the patients and the doctors.

But all I would say to my friends is, the substitute is well-meaning, but it is inadequate. It is too little, it is too narrow, it is too small. We can do better.

We have listened, and we are doing something better. This is a better bill than Kennedy-Kassebaum. This is a more complete bill. This offers better access. It is more affordable, and it guarantees greater accountability, and it is worthy of your support.

I will just close with this point: Five major leaders in the Senate yesterday announced their endorsement of this bill. And this bill will almost certainly be offered in the Senate as the substitute for the earlier well-meaning, but weaker, bill that Kennedy-Kassebaum introduced, and, with our help, we can send a signal to the Senate. Let us get the job done a lot better, and let us do it for a lot more people. That is what I would say in the spirit in which we started on the substitute and “yes” on final passage.

Mrs. MINK of Hawaii. Mr. Speaker, I rise to speak in favor of the Democratic substitute to H.R. 3103.

Why are we considering H.R. 3103? H.R. 3103 was reported with only nine cosponsors. The Roukema bill, which the Democratic substitute is based on, has 193 cosponsors. Sel-dom do we have legislation with such widespread support. Instead of hearing the Roukema bill, we are spending time on legislation loaded with controversy and doomed to fail.

We now have before us an opportunity to provide relief for hardworking Americans enslaved to their health care policies.

The core of the Democratic substitute is twofold. First it will guarantee individuals leaving a job, where they are covered by group insurance, to be able to obtain group or individual insurance at their next job; and second, it will forbid insurance companies from denying coverage because of preexisting conditions. These are two very simple concepts with little opposition and if implemented would result in enormous social benefits.

In addition, both the Republican bill and the Democratic substitute increase the permitted health insurance tax deduction for self-employed individuals. The levels allotted in the Democratic substitute, however, are significantly higher. Health insurance costs for the self-employed are often a heavy burden. Tax deductions at the levels proposed in the Democratic substitute would ease this burden.

H.R. 1303 on the other hand contains many provisions which are not well thought out and will be harmful to the overall health care objectives.

One of these proposals relates to medical malpractice. Congress would more likely to choose the Democratic substitute because it would not grant a patient the opportunity to sue the insurance company, to be able to obtain group or individual insurance at their next job; and second, it will forbid insurance companies from denying coverage because of preexisting conditions. These are two very simple concepts with little opposition and if implemented would result in enormous social benefits.

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Mr. Chairman, while considering health care legislation today, we as a Congress must keep the process simple. There is no place for adding on special interest amendments and paybacks that will sabotage the passage of good reforms. We must also remember the working poor of this Nation that are effectively priced-out of the health insurance market.

Mr. Chairman, I encourage my colleagues to support the Democratic substitute to H.R. 3103 because the substitute does not contain any of the bill’s highly controversial provisions—such as medical savings accounts—that would jeopardize any possibility of enacting health insurance reform this year. The Kassebaum-Kennedy-Roukema bill, which assures health insurance portability, enjoys broad bipartisan support in both Chambers, and the President has endorsed it. We should not let the opportunity for enacting meaningful health reform slip away by loading down this bill with a number of controversial provisions.

Mr. VENTO. Mr. Speaker, I rise today to oppose the bill and support the Democratic substitute on this important issue of health insurance reform.

I rise today to oppose the bill and support the Democratic substitute on this important issue of health insurance reform. It is clear that there are serious problems with our current health care system. In 1994, Congress was working to address these problems and implement broad health care reforms, expanding access to health care coverage and reining in escalating health care costs. Those efforts were stymied, and during the past year and half Republicans have mostly concentrated on cutting back on health care, by attempting to slash Medicare and Medicaid. In fact half the specified savings in the GOP reconciliation plan was from health care, that’s half.

In the absence of broader health care reforms, Americans are relying on us to at least enact some limited but important insurance reforms. There is some bipartisan support for many of these issues today. Unfortunately, the Republican leadership is polarizing and threatening the enactment of these modest reforms. The GOP House leadership is seriously jeopardizing the bill by loading it up like a Christmas tree with controversial ornaments, like medical savings accounts and medical malpractice reform. These ornaments are a distraction from the issues and while they may be pretty to look at, we should certainly examine and consider these provisos separately, not as part of this basic agreement upon reforms.

In our reasonable functional health care system, insurance companies have too often taken steps to shift costs and deny health care coverage to people in order to lower their risk and increase their profit margin and competitiveness. The Democratic substitute is the best alternative today. It prohibits insurers and employers from limiting or denying coverage because of a preexisting condition. It would prohibit insurers from denying coverage to employers and prevent health plans from excluding any employee on the basis of health status. Health plans in the future would be required to offer coverage for groups and individuals as long as premiums paid. The Democratic substitute would also guarantee that individuals who leave group coverage will be able to purchase individual health insurance policies.

Millions of Americans would benefit from such legislation. It would allow people who want to change their jobs to take their health insurance with them, ending the phenomenon of job lock. It would end the unfair insurance practice of employing preexisting conditions as clauses of categories of persons. These changes proposed in the Democratic substitute are needed to increase health care security for working American families.

However, the Republican proposal is disingenuous and demonstrates today their policy path; solve health care problems by changing the topic. They have included a provision in their bill to establish medical savings accounts which will in essence drive health care costs up for most and balloon the deficit. This proposal means that the overall health system as healthier and wealthier people leave the traditional insurance risk pool. First of all most Americans cannot afford to put aside $2,000 a year into a tax-free account. People with existing health problems and without savings income would be left in the traditional insurance pool and will find it more difficult to afford escalating health care costs. I do not believe that this is the kind of change in the health care system that the American people want. This will further polarize and divide the concept of community rating. In fact, the main beneficiaries of this proposal will be the insurance companies.

For months, Republicans have delayed consideration of this bill until they were dismayed into bringing it to the floor by the President’s State of the Union statements. Now the Republicans are going to burden the bill by overloading the vehicle so that it will sink. The Republican political agenda apparently takes precedence over good people policy. The special interests wish list that the Republican leadership try to stuff into this bill thwarts the passage of the core insurance reforms necessary to secure health care coverage for millions of Americans. This is wrong and should be rejected.

Congress must respond to the needs of the American people and enact responsible health insurance reform, not sidetrack the issue and leave the American people in the lurch. I urge my colleagues to oppose the controversial provisions of the bill and support the Democratic substitute.

Mr. RICHARDSON. Mr. Speaker, voting for this substitute means that you are serious about allowing your constituents to have access to health insurance. This substitute is simple policy. If you want to tell insurance companies they cannot deny Americans who have beat a life-threatening disease or condition insurance coverage, vote for this substitute.

If you want to allow hard working families in your district to keep their health care when they change jobs, vote for this substitute.

If you want to help small businesses and entrepreneurs afford health care, vote for this substitute.

This substitute is a bipartisan effort. Republicans and Democrats in the Senate agree on it.

A Republican Member introduced this bill in the House and over 170 Democrats have co-sponsored it.

Mr. Speaker, this is not about partisan politics. It is about doing what is right for the American people. About giving working American families access to insurance coverage for themselves and their families.

The SPEAKER pro tempore (Mr. COMBEST). Pursuant to House Resolution 392, the previous question is ordered on the bill as amended.

The question is on the amendment in the nature of a substitute offered by the gentleman from Michigan (Mr. DINGELL).

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

Mr. BENTSEN. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make a point of order 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 192, nays 226, not voting 14, as follows: [Roll No. 104]
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Title I—Health Care Access, Portability, and Renewability

SECTION 1 SHORT TITLE.

This Act may be cited as the "Health Insurance Reform Act of 1996".

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

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Sec. 110. Individual Health Plan Portability.

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Sec. 112. State flexibility in individual market reforms.

Sec. 113. Definition.

As used in this title:

(1) BENEFICIARY.—The term ‘‘beneficiary’’ has the meaning given such term in section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(8)).

(2) EMPLOYEE.—The term ‘‘employee’’ has the meaning given such term under section 3(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3)).

(3) EMPLOYER.—The term ‘‘employer’’ has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

(4) EMPLOYEE HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ‘‘employee health benefit plan’’ means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (2), and (3) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3))) that provides or pays for health benefits (such as provider and hospital benefits) for participants and beneficiaries whether—

(i) directly;

(ii) through a group health plan offered by a health plan issuer as defined in paragraph (8); or

(iii) otherwise.

(B) RULE OF CONSTRUCTION.—An employee health benefit plan shall not be construed to be a group health plan, an individual health plan, or a health plan issuer.

(C) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof;

(ii) Medicare supplemental health insurance (as defined under section 1858(g)(1) of the Social Security Act);

(iii) Coverage issued as a supplement to liability insurance;

(iv) Liability insurance, including general liability insurance and automobile liability insurance;

(v) Workers compensation or similar insurance;

(vi) Automobile medical payment insurance;

(vii) Coverage for a specified disease or illness;

(viii) Hospital or fixed indemnity insurance;

(ix) Short-term limited duration insurance.
(x) Credit-only, dental-only, or vision-only insurance.
(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(9) FAMILIES.—
(A) GENERAL.—The term “family” means an individual, the individual’s spouse, and the child of the individual (if any).
(B) CHILD.—For purposes of subparagraph (A), this term includes any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(10) GROUP HEALTH PLAN.—
(A) GENERAL.—The term “group health plan” means any contract, policy, certificate or other arrangement offered by a health plan issuer to a group purchaser that provides or pays for health benefits (such as provider and hospital benefits) in connection with an employee health benefit plan.
(B) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:
(i) Coverage only for accident, or disability income insurance, or any combination thereof.
(ii) Medicare supplemental health insurance (as defined under section 1002(9) of the Social Security Act).
(iii) Coverage issued as a supplement to liability insurance.
(iv) Other insurance (including general liability insurance and automobile liability insurance).
(v) Workers’ compensation or similar insurance.
(vi) Automobile medical payment insurance.
(vii) Coverage for a specified disease or illness.
(viii) Short-term limited duration insurance.
(C) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(11) GROUP PURCHASER.—The term “group purchaser” means any person (as defined under paragraph (9) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)) or entity that pur- chases or helps to purchase group health plans from any individual health plan issuer or a group of individual health plan issuers.

(12) PLAN SPONSOR.—The term “plan sponsor” means any person (as defined under section 3(18) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(18))).

(13) SECRETARY.—The term “Secretary,” unless specifically provided otherwise, means the Secretary of Labor.

(14) STATE.—The term “State” means each of the several States, the District of Colum-
(2) DISCONTINUANCE OF ALL GROUP HEALTH PLANS.

(A) IN GENERAL.—In any case in which a health plan issuer elects to discontinue offering all group health plans in a State, a group health plan may be discontinued by the health plan issuer in the State.

(i) the health plan issuer provides notice to the applicable certifying authority (as defined in section 113) and to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan, and

(ii) all group health plans issued or delivered for issuance in the State or discontinued and coverage under such plans is not renewed.

(B) APPLICATION OF PROVISIONS.—The provisions of this paragraph and paragraph (3) may be applied separately by a health plan issuer—

(i) to all group health plans offered to small employers (as defined in applicable State law) or to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan, and

(ii) to all other group health plans offered by the issuer in the State.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any group health plan in the market sector (as described in paragraph (2)(B)) in which issuance of such group health plan was discontinued in the State during the 5-year period beginning on the date of discontinuation of the last group health plan not so renewed.

(C) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A network plan (as defined in paragraph (2)) may deny continued participation under such plan to participants or beneficiaries who neither live, reside, nor work in an area in which such network plan is offered, but only if such denial is applied uniformly, without regard to health status of particular participants or beneficiaries.

(2) NETWORK PLAN.—As used in paragraph (1), the term "network plan" means an employee health benefit plan or a group health plan that arranges for the financing and delivery of health care services to participants or beneficiaries covered under such plan, in whole or in part, through arrangements with providers.

(d) COBRA COVERAGE.—Nothing in subsection (a)(2)(E) or subsection (c) shall be construed to affect any right to COBRA continuation coverage as described in part 6 of subchapter B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

SEC. 103. PORTABILITY OF HEALTH PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition based on the fact that the condition existed prior to the coverage of the participant or beneficiary under the plan only if—

(1) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan;

(2) the limitation or exclusion does not apply to a participant or beneficiary covered under the plan who would otherwise be eligible to receive benefits under an employee health benefit plan or an individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan;

(c) LATE ENROLLEES.—Except as provided in subsection (a), with respect to a participant or beneficiary enrolling in an employee health benefit plan or group health plan during a time that is other than the first opportunity to enroll during an enrollment period of at least 30 days, coverage with respect to benefits or services relating to the treatment of a preexisting condition in accordance with subsection (a) and (b) may be excluded except the period of such exclusion may not exceed 18 months beginning on the date of coverage under the plan.

AFFILIATION PERIODS.—With respect to a participant or beneficiary who would otherwise be eligible to receive benefits under an employee health benefit plan or a group health plan but for the operation of a preexisting condition limitation or exclusion, if such plan does not utilize a limitation or exclusion of benefits relating to the treatment of a preexisting condition, such plan may impose an affiliation period on such participant or beneficiary not to exceed 60 days (or in the case of a late participant or beneficiary not to exceed 60 days from the date on which the participant or beneficiary would otherwise be eligible to receive benefits under the plan. An employee health benefit plan or a health plan issuer offering a group health plan may also use alternative methods to address adverse section as approved by the applicable certifying authority.

(e) PREEXISTING CONDITIONS.—For purposes of this section, the term "preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before the effective date of the coverage (without regard to any waiting period).

(f) STATE FLEXIBILITY.—Nothing in this section shall be construed to preempt State laws that—

(1) require health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than those provided for under this section; or

(2) allow other participants, and beneficiaries to be considered to be in a period of preexisting coverage if such individual, participant, or beneficiary experiences a lapse in coverage for a greater than the 30-day period provided for under subsection (b)(3).


SEC. 104. SPECIAL ENROLLMENT PERIODS.

In the case of a participant, beneficiary or family member—

(1) through marriage, separation, divorce, death, birth or placement of a child for adoption, experiences a change in family composition affecting eligibility under a group health plan, individual health plan, or employee health benefit plan;

(2) experiences a change in employment status, as described in section 606(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(b)), that causes the loss of eligibility for coverage, other than through a change in group health plan, individual health plan, or employee health benefit plan; or
beneficiaries of their rights and obligations.

2. Exception. With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under Federal or State law shall not be subject to the disclosure requirements of such paragraph.

3. Provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals, an individual health plan being defined in section 142(d) that the health plan issuer has adequate capacity, whichever is later.

(3) experiences a loss of eligibility under a group health plan, individual health plan, or employer health benefit plan because of a change in the employment status of a family member, an employee health benefit plan and each group health plan shall provide for a special enrollment period extending for a reasonable time after such event that would permit the participant to change the individual or family basis of coverage or to enroll in the plan if coverage would have been available to such individual, participant, or beneficiary but for the change in the employment status during a preenrollment period. Such a special enrollment period shall ensure that a child born or placed with a family member shall be deemed to be covered under the plan as of the date of such birth or placement for adoption if such child is enrolled within 30 days of the date of such birth or placement for adoption.

SEC. 105. DISCLOSURE OF INFORMATION.

(a) Disclosure of Information by Health Plan Issuer.—

(1) In general.—In connection with the offering of any group health plan to a small employer (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees), a health plan issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) the provisions of such group health plan relating to the availability of coverage; and

(C) the provisions of such group health plan relating to any preexisting condition.

(b) Health Plan Issuer.—A health plan is defined in section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) as amended.

Subtitle B—Individual Market Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.

(a) Limitation on Requirements.—

(1) In general.—Except as provided in subsections (b) and (c), a health plan issuer described in paragraph (3) may not, with respect to an eligible individual, as defined in subsection (b) desiring to enroll in an individual health plan—

(A) impose a limitation or exclusion of benefits otherwise covered under the plan for the individual based on a preexisting condition, unless such limitation or exclusion could have been imposed if the individual remained covered under a group health plan or employee health benefit plan (including providing credit for previous coverage in the manner provided under subsection (b));

(B) impose a requirement or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(c) Market Requirement.—

(1) In general.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) Conversion policies.—A health plan issuer offering group health plans to group purchasers under this title shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(b) Definition of Eligible Individual. —As used in subsection (a)(1), the term "eligible individual" means an individual who—

(C) the provisions of such group health plan concerning the health plan issuer's right to change premium rates and the factors that may affect changes in premium rates.

(2) Conversion Policies. —A health plan issuer offering group health plans to group purchasers under this paragraph for a group health plan to a small employer (as defined under applicable State law) shall amend the plan to any extent that such requirements are not prevented by law.

(3) Exception. —With respect to paragraph (2), a health plan issuer offering coverage under this paragraph for a group health plan under applicable State law shall not be construed to prevent a State from requiring health plan issuers offering coverage to individuals under an individual health plan to actively market such plan.

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—As used in subsection (a)(1), the term "eligible individual" means an individual who—

(1) is not eligible for coverage under a group health plan or an employer health benefit plan;

(2) has not had coverage terminated under a group health plan or employee health benefit plan for fraud or misrepresentation of material fact; and

(c) Market Requirement.—

(a) Limitation on Requirements.—

(1) In general.—Except as provided in subsections (b) and (c), a health plan issuer described in paragraph (3) may not, with respect to an eligible individual, as defined in subsection (b) desiring to enroll in an individual health plan—

(A) impose a limitation or exclusion of benefits otherwise covered under the plan for the individual based on a preexisting condition, unless such limitation or exclusion could have been imposed if the individual remained covered under a group health plan or employee health benefit plan (including providing credit for previous coverage in the manner provided under subsection (b));

(B) impose a requirement or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(c) Market Requirement.—

(1) In general.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) Conversion policies.—A health plan issuer offering group health plans to group purchasers under this title shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

9. Definition of Eligible Individual. —As used in subsection (a)(1), the term "eligible individual" means an individual who—

(A) was a participant or beneficiary enrolled under one or more group health plans, employee health benefit plans, or public plans established under Federal or State law, for not less than 18 months (without a lapse in coverage of more than 30 consecutive days) immediately prior to the date on which the individual is required to enroll in the individual health plan.

(b) Termination of Individual Health Plans.—Any individual health plan shall be prohibited from requiring new individuals to be enrolled if the plan sponsors may notify participants of material facts.

(c) A health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a group health plan if the health plan issuer does not previously provided such a health plan issuer to a small employer (as defined under applicable State law) shall amend the plan to any extent that such requirements are not prevented by law.

(d) Market Requirement.—

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—As used in subsection (a)(1), the term "eligible individual" means an individual who—

(A) was a participant or beneficiary enrolled under one or more group health plans, employee health benefit plans, or public plans established under Federal or State law, for not less than 18 months (without a lapse in coverage of more than 30 consecutive days) immediately prior to the date on which the individual is required to enroll in the individual health plan.

(b) Termination of Individual Health Plans.—Any individual health plan may terminate the individual if the health plan issuer has, if applicable, accepted and exhausted the maximum required period of continuous coverage as described in section 602(2)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(A)) or under an equivalent State program.

(c) APPLICABLE CAPACITY LIMIT.—

(1) In general.—Subject to paragraph (2), a health plan issuer offering coverage under an individual health plan may cease enrolling individuals under the plan if—

(A) the health plan issuer ceases to enroll any new individuals; and

(b) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)) that the health plan issuer has adequate capacity, whichever is later.

Such a health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a group health plan if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) Market Requirement.—

(1) In general.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) Conversion policies.—A health plan issuer offering group health plans to group purchasers under this title shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(3) Marketing of Plans.—Nothing in this section shall be construed to prevent a health plan issuer of establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion or disease prevention.

(3) Health Plan Issuer.—A health plan issuer described in this paragraph in a health plan plan issuer that is not eligible for coverage under a group health plan or an employer health benefit plan;

(b) has not had coverage terminated under a group health plan or employee health benefit plan for fraud or misrepresentation of material fact; and

(c) the termination of the individual health plan shall be prohibited from requiring new individuals to be enrolled if the plan sponsors may notify participants of material facts.

(f) A health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a group health plan if the health plan issuer does not previously provided such a health plan issuer to a small employer (as defined under applicable State law) shall amend the plan to any extent that such requirements are not prevented by law.

 Such a health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a group health plan if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) Market Requirement.—

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—As used in subsection (a)(1), the term "eligible individual" means an individual who—

(A) is not eligible for coverage under a group health plan or an employer health benefit plan;

(b) has not had coverage terminated under a group health plan or employee health benefit plan for fraud or misrepresentation of material fact; and


(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 180 days prior to the date of the expiration of the plan.

(B) the issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently available in the State or program provided by the health plan issuer to individuals, and

(C) in exercising the option to discontinue the individual health plan and in offering one or more alternative plans, the health plan issuer acts uniformly without regard to the health status of particular individuals.

(2) DISCONTINUATION OF ALL HEALTH PLAN ISSUER ELECTION TO DISCONTINUE ALL INDIVIDUAL HEALTH PLANS Ð IN ANY CASE IN WHICH A HEALTH PLAN ISSUER ELECTS TO DISCONTINUE ALL INDIVIDUAL HEALTH PLANS IN A STATE, AN INDIVIDUAL HEALTH PLAN MAY BE DISCONTINUED BY THE HEALTH PLAN ISSUER ONLY IF

(A) the health plan issuer provides notice to the applicable certifying authority (as defined in section 132(g)) and to each individual covered under the plan of such discontinuation at least 180 days prior to the date of the discontinuation of the plan; and

(B) the issuer delivers or mails notice of discontinuation of the plan in accordance with this section.

(3) PROHIBITION ON MARKET REENTRY. Ð IN THE CASE OF A DISCONTINUATION UNDER PARAGRAPH (2), THE HEALTH PLAN ISSUER MAY NOT PROVIDE COVERAGE FOR ANY INDIVIDUAL UNDER THE INDIVIDUAL HEALTH PLAN IN THE STATE INVOLVED DURING THE 5-YEAR PERIOD BEGINNING ON THE DATE OF THE DISCONTINUATION OF THE LAST PLAN NOT SO REENTERED.

(4) TREATMENT OF NETWORK PLANS. Ð IN GENERAL. Ð AS USED IN PARAGRAPH (1), THE TERM ``NETWORK PLAN'' MEANS AN INDIVIDUAL HEALTH PLAN THAT ARRANGES FOR THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES TO INDIVIDUALS THROUGH THE USE OF A NETWORK OF PROVIDERS, PHARMACISTS, OR OTHER HEALTH CARE PROFESSIONALS OR INSTITUTIONS.

B. ELECT. Ð IN ELECTING THE DISCONTINUATION UNDER SUBPARAGRAPH (A), THE SECRETARY OF HEALTH AND HUMAN SERVICES DETERMINES THAT THE STATE LAW OR PROGRAM PROVIDES FOR THE PROTECTION OF INDIVIDUALS UNDER THIS TITLE.

C. COBRA CLARIFICATIONS.

SEC. 121. COBRA CLARIFICATIONS.

(A) Public Health Service Act. Ð (1) Period of coverage. Ð Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)) is amended Ð

(A) in subparagraph (A)—

(i) by inserting ``(or a beneficiary-family member of the individual),'' after ''(individual);'' and

(ii) by inserting ``at the time of a qualifying event described in section 2203(2)'' and inserting ``at any time during the initial 18-month period of continuing coverage under this title'' in place thereof.

(B) in subparagraph (B), by inserting before ``(or)'' the following: ``(or);'' except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section based on the provision of the Health Insurance Reform Act of 1996; and

(C) in subparagraph (E), by striking ``at the time of a qualifying event described in section 2203(2)'' and inserting ``at any time during the initial 18-month period of continuing coverage under this title'' in place thereof.

(2) Election. Ð Section 2205(c)(1) of the Public Health Service Act (42 U.S.C. 300bb-5(1)(C)) is amended—

(A) in clause (i), by striking ``or'' at the end thereof.

(B) in clause (ii), by striking the period and inserting ``(or)'' and--

(C) by adding at the end thereof the following new clause:

(iii) in the case of an individual described in section 2202(2)(A) or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.

(3) Notices. Ð Section 2004(3) of the Public Health Service Act (42 U.S.C. 300bb-6(3)) is amended by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(4) Death or adoption of a child. Ð Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb-8(3)(A)) is amended by adding at the end thereof the following new flush text:

''Such person shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this title.''

(5) Workers’ compensation or similar insurance. Ð (A) Short-term health insurance. Ð Section 2208(22) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(22)) is amended Ð

(A) in the last sentence of subparagraph (A)—

(i) by inserting ``(or a beneficiary-family member of the individual),'' after ''(individual);'' and

(ii) in the last sentence of paragraph (2) by adding the following new sentence:

B. Health insurance policy providing benefits only for long-term care, nursing home care, health care community-based care, or any combination thereof.
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(2) Election.—Section 4980B(f)(1)(A) of the Internal Revenue Code of 1986 is amended by striking "at the time of a qualifying event described in paragraph (3)(B)" and inserting "at any time during the initial 18-month period of continuing coverage under this section."

(3) Notice.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking "at the time of a qualifying event described in paragraph (3)(B)" and inserting "at any time during the initial 18-month period of continuing coverage under this section."

(4) Birth or Adoption of a Child.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

"Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuing coverage under this section."

(5) Effective Date.—The amendments made by this section shall apply with respect to events on or after the date of enactment of this Act for plan years beginning after December 31, 1997.

Title I—Private Health Plan Purchasing Cooperatives

Subtitle A—Private Health Plan Purchasing Cooperatives

Section 131. Private Health Plan Purchasing Cooperatives

(a) Definition.—As used in this title, the term "private health plan purchasing cooperative" means a group of individuals or employers that, on a voluntary basis and in accordance with this section, form a cooperative for the purpose of purchasing health plans or group health plans offered by health plan issuers. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of insurance may not underwrite a cooperative.

(b) Certification.—

(1) In General.—If a group described in subsection (a) seeks to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Secretary of such intent, the Secretary is determined that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall provide written notice to the Secretary of such certification and the Secretary shall certify such group meets the requirements of this section in a timely fashion. Such each cooperative shall also be registered with the Secretary.

(2) State refusal to certify.—If a State refuses to certify if a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with this section and such group appropriately notifies the State and the Secretary of such intent, the Secretary is determined that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall provide written notice to the Secretary of such certification and the Secretary shall certify such group meets the requirements of this section in a timely fashion. Such each cooperative shall also be registered with the Secretary.

(3) Duties and Responsibilities.—

(A) General.—A health plan purchasing cooperative shall—

(1) enter into agreements with multiple, unaffiliated health plan issuers, except that such requirement shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible;

(2) enter into agreements with employers and individuals who become members of the cooperative;

(3) participate in any program of risk-adjustment or reinsurance or any similar program, that is established by the State;

(4) prepare and disseminate comparative health plan materials and information concerning group health plans and individual health plans offered through the cooperative;

(b) Notice to Members.—A health plan purchasing cooperative may perform such functions as are necessary to further the purposes of this title, including—

(A) collecting and distributing premiums and performing other administrative functions;

(B) collecting and analyzing surveys of enrollee satisfaction;
(C) charging membership fee to enrollees (such fees may not be based on health status) and charging participation fees to health plan issuers; (D) requiring with (or accepting as members) employers who provide health benefits directly to participants and beneficiaries only for the purpose of negotiating with providers; and (E) negotiating with health care providers and health plan issuers.

PROHIBITIONS ON COOPERATIVE ACTIVITIES.—A health plan purchasing cooperative shall not—

(1) permit any activity relating to the licensing of health plan issuers;
(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative relating to any group health plan or individual health plan;
(3) establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements for participants, beneficiaries, or individuals based on health status;
(4) operate on a for-profit or other basis where the legal structure of the cooperative permits the cooperative to be made and not returned to the members of the cooperative, except that a for-profit health plan purchasing cooperative may be formed by a nonprofit organization;
(A) in which membership in such organization is not based on health status; and
(B) that accepts as members employers or single-firm, single-firm basis, subject to any established limit on the maximum size of and employer that may become a member;
(5) perform any other activities that conflict or are inconsistent with the performance of its duties under this title.

LIMITED PREEMPTION OF CERTAIN STATE LAWS.—

(1) IN GENERAL.—With respect to a health plan purchasing cooperative that meets the requirements of this section, State fictitious group laws shall be preempted.
(2) HEALTH PLAN ISSUERS.—

(A) RATING.—With respect to a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative that meets the requirements of this section, State premium rating laws, enacted prior to the effective date provided under subparagraph (B), shall be preempted unless such laws permit premium rates negotiated by the cooperative to be less than or equal to, or otherwise adjusted on the basis of, the rates permitted under State law, if such rating differential is not based on differences in health status or demographic factors.

(B) EXCEPTION.—State laws referred to in subparagraph (A) shall not be preempted if such laws—

(i) prohibit the variance in premium rates among employers, plan sponsors, or individuals that are members of health plan purchasing cooperative in excess of the amount of such variance would be permitted under such State rating laws among employers, plan sponsors, and individuals that are not members of the cooperative; and
(ii) prohibit a percentage increase in premium rates for a new rating period that is in excess of that which would be permitted under State rating laws.

(C) IN GENERAL.—As provided in subparagraph (D), a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative shall not be required to meet the requirements of State mandated benefit laws that require the offering of any services, category or care, or services of any class or type of provider.

(D) IN GENERAL.—States that have enacted laws authorizing the issuance of alternative benefit plans to small employers, health plan issuers may offer such alternative benefit plans through a health plan purchasing cooperative that meets the requirements of this section.

RULE OF CONSTRUCTION.—Nothing in this section shall be construed to—

(1) require that a State organize, operate, or otherwise create health plan purchasing cooperatives;
(2) otherwise require the establishment of health plan purchasing cooperatives.

(3) require a plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State.

(4) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefit plans, or

(g) confer authority upon a State (or the Federal Government) that the State (or Federal Government) would not otherwise have to regulate group purchasing arrangements, coalitions, or other similar entities that do not desire to become a health plan purchasing cooperative in accordance with this section.

APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of paragraphs 1 and 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101) shall apply to a health plan purchasing cooperative as if such plan were an employee welfare benefit plan.

SUBTITLE F—APPLICATION AND ENFORCEMENT OF STANDARDS

SEC. 141. APPLICABILITY.

(a) CONSTRUCTION.—

(1) IN GENERAL.—A requirement or standard imposed under this title on a group health plan or individual health plan offered by a health plan issuer shall be deemed to be a requirement or standard imposed on the health plan issuer. Such requirements or standards shall be enforced by the State in surance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this title. In the case of a group health plan offered for sale or operated in such State by a plan purchasing cooperative, the requirements of standards established under this title in such State shall be subject to civil enforcement provided under sections 502, 504, 510, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) and (2)) and (1) and (2) to apply to any requirement set forth in this section shall be enforced with respect to any plan purchasing cooperative that meets the requirements of this title in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this title with respect to group health plans and individual health plans as provided for under the State, enforcement plan filed under subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, shall implement an enforcement plan meeting the standards of this title in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this title, each health plan purchasing in such State shall be subject to civil enforcement provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) and (2)) and (1) and (2) to apply to any requirement set forth in this section shall be enforced with respect to any plan purchasing cooperative, that meets the requirements of this title.

(b) LIMITATION.— Except as provided in sub section (c), the Secretary shall not enforce the requirements of standards of this title as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a State enforce the requirements of standards of this title in the case of the failure of a State to substantially enforce the requirements of standards of this title in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this title, each health plan purchasing in such State shall be subject to civil enforcement provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) and (2)) and (1) and (2) to apply to any requirement set forth in this section shall be enforced with respect to any plan purchasing cooperative, that meets the requirements of this title.

(c) CONTINUATION.—Nothing in this title shall be construed as requiring a group health plan or an employee health benefit plan to provide benefits to a particular part tion or group of employees as provided for under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that every group health plan and individual health plan issued, sold, renewed, offered for sale or operated in such State by a health plan issuer meet the standards established under this title pursuant to an enforce ment plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the State enforcement law.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—

(1) PREEMPTION OF STATE LAW.—With respect to employee health benefit plans, the Secretary shall enforce the reform standards established under this title in the same manner as provided for under sections 502, 504, 510, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) and (2)) and (1) and (2) to apply to any requirement set forth in this section shall be enforced with respect to any plan purchasing cooperative that meets the requirements of this title in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this title, each health plan purchasing in such State shall be subject to civil enforcement provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) and (2)) and (1) and (2) to apply to any requirement set forth in this section shall be enforced with respect to any plan purchasing cooperative, that meets the requirements of this title.

(d) APPLICABLE CERTIFYING AUTHORITY.—As used in this title, the term ‘‘applicable certifying authority’’ means, with respect to—

(1) health plan issuers, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved; and

(2) an employee health benefit plan, the Secretary.

(e) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this title.


Subtitle F—Miscellaneous Provisions

SEC. 191. HEALTH COVERAGE AVAILABILITY STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary, representatives of State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits, shall conduct a two-part study, and prepare and submit reports, in accordance with section 1411 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(e) EVALUATION.—Not later than January 1, 1998, the Secretary of...
Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning—

(1) an evaluation, based on the experience of States and regions, and such additional data as may be available, of the various mechanisms used to ensure the availability of reasonably priced health coverage to employers purchasing group coverage and to individuals purchasing coverage on a non-group basis; and

(2) whether standards that limit the variation in premiums will further the purposes of this Act.

(c) Evaluation of Effectiveness. Not later than 1996, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning the effectiveness of the provisions of this Act and the various State laws, in ensuring the availability of reasonably priced health coverage to employers purchasing group coverage and individuals purchasing coverage on a non-group basis.

SEC. 192. EFFECTIVE DATE.

Except as otherwise provided for in this title, the provisions of this title shall apply as follows:

(1) With respect to group health plans and individual health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1997, and

(2) With respect to employment-related health benefit plans, for the first day of the first plan year beginning on or after January 1, 1997.

SEC. 193. SEVERABILITY.

If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any person or circumstance shall not be affected thereby.

Mr. ARCHER (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. PALLONE. Mr. Speaker, I have4 offered an amendment to recommit with instructions with my colleague from Missouri [Ms. MCCARTHY] because I am concerned that we are about to go down a perilous path of ending any chances of health insurance reform. Our motion to recommit incorporates the Kennedy-Kassebaum-Roukema provisions without any additions. It would make it easier for workers who lose or change jobs to buy health coverage. It would limit the length of time that insurance could refuse to cover an applicant’s preexisting medical problem.

Mr. Speaker, there are two distinct choices that we can make with this next vote. This House can make the decision to support this motion and do the right thing for the American people, or the House can vote against this motion and tell the American people that it is more important to keep promises with various special interests. The Kennedy-Kassebaum-Roukema bill is a sound fiscal plan, available, because it would not impact the insurance risk pool by encouraging healthy individuals to drop their coverage. It has bipartisan support in both the Senate and the House of Representatives. The President has indicated that he will support the Roukema bill. The motion to recommit will ensure that this legislation is enacted into law.

Mr. Speaker, why does the Republican leadership insist on messing up this legislation with controversial poison pill amendments? One of the provisions that the Republican leadership insists on including is the medical savings accounts, which will favor the self-employed. The MSA's will be just another tax shelter for the rich. Americans who do not choose to join the MSA's because of the high risks involved will see their health insurance premiums increase. The MSA's, among other extraneous provisions, will guarantee the failure of any health insurance reform in this Congress. We all know this, Mr. Speaker. The gentlewoman from New Jersey [Mrs. ROUKEMA], who courageously took this legislation in her committee. So has her counterpart in the other body, Senator KASSEBAUM. These women should not be vilified tonight. Instead, they should be thanked for doing the right thing for the American people.

Mr. Speaker, tonight, the House is about to do the right thing tonight. I urge a “yes” vote on the motion to recommit if Members want health insurance reform this year.

Mr. Speaker, I yield to the gentlewoman from Missouri [Ms. MCCARTHY]. Ms. MCCARTHY. Mr. Speaker, I join with the gentleman from New Jersey in moving to recommit this bill to committee with instruction to report the Roukema bill, H.R. 2983, for final passage.

Kennedy-Kassebaum-Roukema has supported from the White House, from the American public, from the health care industry, and bipartisan support in the Senate. It is legislation which can be signed into law tonight.

To recommit puts sound public policy above special interests. To recommit assures American families of security by providing genuine health care reform. In a Congress that touts fiscal responsibility, to vote against this motion is fiscally irresponsible. I urge my colleagues to vote “yes” on this motion, to stand for true reform, to stand against special interests, to stand for the American people. Vote “yes” to recommit.

Mr. ARCHER. Mr. Speaker, I rise in opposition to the motion to recommit. I yield to the gentleman from California [Mr. THOMAS], chairman of the Subcommittee on Health of the Committee on Ways and Means.

Mr. THOMAS. Mr. Speaker, I really do not know who to direct my remarks to, because apparently this motion to recommit is Dingell minus the increase for the self-employed. Two of our colleagues on the other side, the gentleman from Illinois [Mr. Durbin], took the well and talked about how much better the Democrat substitute was because it did better for the self-employed. Now what we have here is Dingell lite.

Mr. Speaker, is it not interesting and, by the way how, cynical they were more for the self-employed if it was honey to attract people to the Democrat substitute? I am addressing my remarks to the 10 Republicans who went for the improvement of Kassebaum because of the self-employed provision. That is out. It lasted 5 minutes. Show your commitment, it did not draw enough, so it is not there because they believe in the self-employed and want to increase the deductibility, it was there to attract people. Since it did not get anybody, they pulled it out.

If you did not like Dingell, they will not like Dingell lite. Vote “no” on the motion to recommit.

Mr. ARCHER. Mr. Speaker, as I listen to this debate, I must say that I am puzzled by the reluctance of some Democrats to support a bill that will provide tens of millions of Americans with increased access to health care insurance at a more affordable price. What a strange turnaround from 2 years ago when my friends across the aisle stood up and fought for a big government takeover of our nation’s health care system. Here is a description of that plan that they offered and that they supported 2 years ago.

But tonight, they claim ours is too far reaching. It is simple, I yield back. The same people who presented this to us in 1994. It is broken, they said. Health care is in crisis. We must fix it. The President and Hillary Clinton know just how to get that done. Well, the big government Democrat prescription for our Nation’s health careills was rejected by the American people and properly so.

Mr. Speaker, America has the best health care system in the world, no thanks to government, but thanks to the Nation’s great private sector. The answer does not lie in big-government takeover of health care. Rather, the way to provide the American people with health care that is more available and affordable is through a targeted measure that relies on the strength of the private sector, not the government, and that is what this bill does.

It is a strong bill, a solid bill, a bill that will bring help to millions of needy Americans, and it does it by relying on the private sector, not the Government. It is exactly the right dose of medicine to cure our health care ills. So why do some, thankfully not all, but some Democrats oppose it? Mr. Speaker, I conclude the reason the Democrat leadership opposes this bill is because their big-government version of health care reform failed and they do not want to see the Republicans move forward with something that will succeed. They know that the House, the self-employed support, the majority one of the targeted reforms that we have proposed, but the Democrat leadership and their trial lawyer friends have rejected
a bipartisan approach to health care reform and instead offer only obstruction and opposition.

The Democrat opposition stems from sour grapes and special interests. Mr. Speaker, sour grapes and special interests. The bill we have today before us is a landmark. It is a bill that brings—to the provisions of clause 5 of rule 227—NOES—236

AYE—267

The vote was taken by electronic device, and there were—aes 182, noes 236, not voting 13, as follows:

[Roll No. 106]
The result of the vote was announced as above recorded. A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. Speaker, on rollcall No. 106, Passage of the Health Coverage Availability and Affordability Act, I was just outside the main door discussing a compromise with appropriators. Unfortunately, I missed the vote. Had I been present, I would have voted "yea."

RESIGNATION AS CONFEREE AND APPOINTMENT OF REPLACEMENT CONFEREE ON H.R. 3019, BALANCED BUDGET DOWNPAYMENT ACT, II

The SPEAKER pro tempore laid before the House the following resignation as a conferee:

Dear Mr. Speaker:

I hereby resign from the Committee on Appropriations. I hereby resign as a conferee:

The SPEAKER pro tempore. The resignation is accepted without objection, the resignation is accepted by the House as a conferee:

NAY—151

Abercrombie
Ackerman
Andrews
Baldacci
Barrett
Becker
Belenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clyburn
Coleman
Collins (M)
Conyers
Costello
Coyne
Defazio
Delarosa
Delums
Deutsch
Dicks
Dingell
Dixon
Doggett
Doyle
Durbin
Edwards
Engel
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson

NO VOTING—14

Mr. KENNEDY of Massachusetts and Mr. FOGLIETTA changed their vote from "yea" to "nay."

So the bill was passed.
In the long run this will result in lower cost to the taxpayers, and more efficient production of food for the market.

Were it not for the dogged determination and strong leadership of the chairman of the Agriculture Committee, the gentleman from Texas [Mr. DE LA GARZA], this bill might never have materialized in its present form.

Because this bill represents a change in 60 years of Federal farming policy, it has been one of the toughest farm bills ever in the history of this House to manage.

The distinguished gentleman from Kansas, who used to serve in the U.S. Marines, I will note, has demonstrated the guts to get it through. We are all in your debt, Mr. Chairman.

I would also like to commend the ranking minority member of the Agriculture Committee, the gentleman from Texas [Mr. DE LA GARZA], and the other members of the committee for the long hours of work they have put into working out this final product.

We have ended up with a bill that the President has said he is going to sign, and this is an indication of the degree to which concerns on both sides of the aisle have been taken into consideration.

Putting this all together required not only bipartisan cooperation, but also a willingness to work out differences between the House and the Senate.

Senator LUGAR, the chairman of the Senate Agriculture Committee, proved an astute advocate of the other body during long negotiations.

Finally I would like to thank the staff members on both sides of the aisle who worked on this conference agreement. Much of their work is not seen on the outside, but we who know how hard they work appreciate their efforts.

Mr. Speaker, as many of you know the dairy provisions in this conference agreement have been of particular concern. Since I represent one of the largest milk producing districts in the nation. We have ended up with a fair and workable dairy program, one that ends Government subsidies to processors of milk products, like butter, powder, and cheese, but continues a non-taxpaying funded liquid milk price stabilization program that will guarantee small dairy farmers a fair and reasonable price for their milk.

Finally, Mr. Speaker, we need to remember that the planting season is about to begin in some parts of the country, and that means that farmers need to know what the Government’s farm policy is going to be. This bill provides the answer to that question. And in order to consider this conference report, it is necessary to adopt this rule. Therefore, I ask for a “yes” vote on the rule and a “yes” vote on the conference report.

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

Mr. HALL of Ohio. Mr. Speaker, I yield myself such time as I may consume.

(Mr. HALL of Ohio asked and was given permission to revise and extend his remarks.)

Mr. HALL of Ohio. Mr. Speaker, this resolution, House Resolution 393, makes in order to consider the conference report on H.R. 2854, the Federal Agriculture Improvement and Reform Act, and it waives all points of order against the conference report.

The conference report on H.R. 2854 reauthorizes farm programs for 7 years. It replaces the current Federal programs with a new system of fixed annual cash payments that would eventually be phased out. The measure is a dramatic overhaul of our Nation’s farm laws, and if successful, it will cut Federal spending on agriculture, at the same time giving farmers greater flexibility in choosing which crops to plant.

The conference report also reauthorizes various overseas food assistance and export programs of the Department of Agriculture. This includes a 7-year reauthorization of the Food for Peace Program, which is known as Public Law 480.

This is a very important program that feeds millions of people around the world. I have seen the food being delivered, I have seen it being used, and I have seen it save lives.

During House consideration of the bill, I worked to include an amendment to make useful changes in the Public Law 480 program, and most of those changes were adopted by the conferees.

Mr. Speaker, I do regret that the technical change in the conference report made by the rule might reduce the ability to implement the program in the period near the end of the fiscal year, and I hope that Congress will monitor the effect of this change and be prepared to make any additional changes that are needed to the smooth operation of the program.

The conference report sets payments for farmers for the next 7 years, but I also regret that it only reauthorizes the food stamp program for 2 years. The food stamp program is a lifeline to the hungry in America and one of our most successful anti-poverty programs. I believe that they should be given the same kind of long-term assurance that the farmers receive.

Mr. Speaker, it is essential that Congress approve a farm bill quickly before the spring planting season begins, and I urge the adoption of the rule.

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

Mr. SOLOMON. Mr. Speaker, with all due respect to the Members on this side, we are going to ask them not to speak. We are going to have one unanimous consent statement and 1 minute to the distinguished Chairman of the Committee on the Budget, and that is going to be it. We are going to roll this thing.

Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. Goss], of the Committee on Rules.

(Mr. GOSS asked and was given permission to revise and extend his remarks.)

Mr. GOSS. Mr. Speaker, I rise in strong support of this brilliant, fair rule.

I thank the gentleman from Glens Falls for yielding me this time, and I rise in support of the rule for the farm bill conference report. This is a fair rule, and it follows standard House procedure for the consideration of conference reports while fixing an important technical mistake. However, Mr. Speaker, I do have some concerns with the underlying bill. It is clearly a mixed bag for southwest Florida. On the one hand, we have seen a real breakthrough in Federal efforts to restore the Everglades—the $200 million in this conference report, in conjunction with the additional land swap authority added in conference, provides a jump start to the joint efforts by the State, the Federal Government, and the south Florida water management district to restore the Everglades. This is a serious commitment, and a necessary one. We have not been good stewards of the Everglades and Florida Bay—a series of actions by the State, the federal government, agricultural interests and others has transformed a unique 50-mile wide fresh-water river and its surrounding ecosystem—and not for the better. The periodic sheetflow of fresh water has been reduced, rechanneled and regulated for the convenience of agricultural interests and residential developments—causing a rapid loss of habitat necessary to sustain fisheries, wetlands and wildlife. The nutrient pollution of this water has further degraded what habitat is left. Downstream, Florida Bay is dying. These situations have damaged resources that are vital to the economy and quality of life in Florida. We now understand that the once prevalent view that the Everglades is just a swamp is somewhat akin to looking at the grand canyon as just a big pothole.

There has been a renewed interest in the Everglades system over the past few years, and we have seen several efforts toward restoration, but it is time to get the ball rolling on a comprehensive, coordinated plan to save what remains of this national treasure.

And $200 million is a responsible sum to allocate. I do wish that we were more specific in identifying a funding source or sources for this money. Some of my Florida colleagues have suggested an assessment on agricultural interests that have benefited from the changes in the Everglades, and I think this idea should be given serious consideration. The taxpayers in south Florida are paying more than their fair share in State taxes and extra water fees. The State has agreed to match Federal funds 50–50. Still, while I think we have some work to do in finding an offset, I strongly support the Everglades provision in this bill and congratulate the conferees for their hard work.

Unfortunately, Mr. Speaker, I cannot support other aspects of this bill. For instance, the continuation of many large subsidy and price support programs concerns me. I recognize the difficulty involved in making significant changes in these programs. And there are some victories here—for instance, under this bill the dairy subsidy will be phased out over a 5 year period. But, the minor reforms in...
most of the price support and subsidy programs just aren't enough. I am disappointed that Congress has missed this opportunity to remove the heavy hand of Government from the agricultural marketplace. I do not believe it makes much sense to lock in place these special benefit programs for the next 7 years when the budget is committed to phasing out unnecessary Government spending and involvement in private enterprise.

Mr. SOLOMON. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Ohio [Mr. Kasich], chairman of the Committee on the Budget. I would like to add some accolades to somebody we know.

Mr. KASICH. Mr. Speaker, I want to thank the gentleman, and I think the Members here tonight should realize that, even though the hour is late, we are about to do something that is truly historic. That is to have the most sweeping change in the farm bill in over 40 years.

Basically, when people across this country say they could never understand people not to do anything, not to plant anything, this will make such a major reform of the crops that they will not ever have to ask that question again at the end of the day.

I think that the move towards the free market is where we ought to go. I think we could have saved a few more dollars; I think we could have reformed a few more crops, but I want to recommend that the freedom to farm act is a very positive step. The New York Times just the other day commended the committee for the most sweeping reform based on the free market that we have seen. I think it is an appropriate bill as we head into the 21st century. I want to congratulate the distinguished Chairman of the Committee on Agriculture [Mr. Roberts] who has done a yeoman's job and walked over an awful lot of hot coals in order to see this day actually happen. So I want to congratulate the Members on both sides of the aisle and to say I think the American people, when they understand what is in this bill, are going to give accolades to this Congress for having the courage to move the farm bill into the 21st century.

Mr. SOLOMON. Mr. Speaker, the majority is prepared to yield back all of its time and ask for a nonrecorded vote as soon as the minority yields back their time.

Mr. FAZIO of California. Mr. Speaker, I yield 2 minutes to the gentleman from California [Mr. Fazio].

Mr. FAZIO. Mr. Speaker, I know that the hour is late, and I do not oppose this bill. My point in speaking at this late hour is simple. Earlier today, the gentleman from Michigan [Mr. Bonior] made a motion which would address the issue of a minimum wage for the American worker, the majority decided to invoke a rule which would strike that motion on the premise somehow it was an unfunded mandate.

CBO has now ruled of course that motion did not constitute an unfunded mandate. But in this bill, there is an unfunded mandate, and of course the rule waives that. Now, that is not the first time. I am sure the majority will use its power whenever it so wish-es to deem something an unfunded mandate and then ignore another unfunded mandate which the Members with a fait accompli.

This was also typical of the three-fifths rule on tax increases. I cannot remember how many times we have waived that rule which we so proudly adopted on the opening day of this session.

My reason for speaking is not to the substance of this bill but a constant attention to the majority's propensity to constitute whatever rules it wishes in violation of whatever standards it has adopted, even in this Congress where it took such much credit for changing the way we do our business here. Many Members on both sides of the aisle, the gentleman from California [Mr. Connelly] to certainly the leader, decided that the unfunded mandate issue needed to be addressed.

Well, here, once again, we get the headline, and then when it comes down to implementation, we reject taking any action on this unfunded mandate. Yet we use it as an excuse when we do not want to deal with an issue that is unpopular for the majority but overwhelmingly popular in the country.

So, Mr. Speaker, I simply have to rise in order to avoid such misuse of the rules by the majority.

Mr. Speaker, I rise in reluctant support of the conference report to the bill H.R. 2854, the Federal Agricultural Improvement and Reform Act, better known as the 1996 farm bill.

In considering this legislation today, it is important to put it in some perspective, because as we all know, this was supposed to have been the 1995 farm bill. Since 1965, we have passed multiyear farm bills to reauthorize a wide variety of commodities, trade, research, conservation, rural development and nutrition programs. We passed farm bills in 1965, 1970, 1973, 1977, 1981, 1985, and 1990. The most recent two farm bills were passed with overwhelming bipartisan majorities.

But when 1995 came and the Republicans took over control of the House and Senate, they decided to adopt a different tact. They abandoned what in past years was a broad-based, bipartisan bill based on open debate about our national agriculture policies and priorities.

You might say that in their first year behind the plow, the GOP leadership used a new kind of fertilizer: partisan politics—to cultivate their favorite crop—political points.

Instead of debating this legislation in a systematic fashion throughout the year, the Republicans waited until the last minute in the year when appropriations bills, continuing resolutions, and debt ceilings held center stage. Then and only then, in a budget-driven exercise, GOP leaders decided to tie the farm bill's fate to controversial budget reconciliation legislation about which the Democratic President Clinton had expressed severe reservations.

The chairman of the Agriculture Committee could not even muster a majority of votes within his committee and was forced to use special procedures to have the Budget Committee report the so-called farm bill as part of the reconciliation bill.

Once the reconciliation bill was vetoed and the GOP strategy was shown to be flawed, farmers and consumers across the country watched the important authorizations for these programs expire. Farm bill consideration was forced to start from ground zero.

This is not the way to make national agriculture policy.

This is not the way to treat our largest industry, the United States' biggest employer, and our biggest export earner.

In short, this is not the way to treat American farmers and the millions of Americans who depend on them.

These legislative tactics caused needless anxiety across the country, and to what end? The end is the conference report we consider today—a bill in better balance—similar to those we have always brought forward in the past—that will move agriculture production forward in the years to come. But it is a bill we should have considered and passed into law many months ago.

The conference report contains all the traditional titles included in the farm bill in the farm bill in addition to the commodity titles—rural development, export promotion, foreign food assistance, domestic nutrition programs, and conservation.

I think the GOP leadership needs to ask itself what might have happened last year if they had approached this crucial legislation in the same spirit as reflected by the conference report today. My sense is you would have a very similar product but you would have avoided the specter of partisanship. Better yet, you would have saved our farmers months of needless anxiety.

Perhaps the GOP leadership considered the freedom to farm concept to be too controversial for any but heavy-handed and partisan tactics.

But farmers in California understand that we must move to a market-based farm economy. In fact, agriculture producers across the country have been positioning themselves, as we have in California, to take advantage of increased trade opportunities from NAFTA and GATT. Agribusiness has been making the investments necessary to respond to a growing, yet demanding and sophisticated world market.

However, for my part, I believe there are two flaws in this bill that require attention, even if they are not sufficient to require a "no" vote today.

First, the Senate voted down and the conference turned its back on a simple requirement that farmers in order to qualify for a freedom to farm payment. Certainly, most farmers will continue their historic pattern of farming while using the expanded flexibility in this bill to boost production and pursue new marketing opportunities. But there will be many marginal farmers who will view payments not linked to planting as a one-time opportunity to take the money and run. The horror stories of farm welfare in the years to come are easy to anticipate, and they will represent a black eye for American agriculture, which is already not well understood by many Americans. It is a black eye that easily could have been avoided.

Second, in moving to a market-oriented economy, we effectively have eliminated a...
safety net program for our program crop farmers that is linked to prices. Prices are high now, and trade is booming. But not every future year will turn out that way, and there are always special problems that arise affecting individual commodities. I am concerned that trade wars or other unpredictable events in future years will cause farmers otherwise might have weathered the storm if a safety net program were in place.

The conference has wisely included various conservation, export, research, credit, and promotion programs. These agriculture programs often will not be more than temporary programs, but they are at the heart of American agriculture’s success. Leaving them out of the House bill was a major mistake—one of the reasons I opposed the House version of this bill—and I’m pleased the conference has put them back in.

In the final analysis, this bill is not perfect, and lacking perfection, it is a bill we could have arrived at many months ago. Ultimately, the GOP leadership must ask themselves if their partisan tactics have produced an improved product—I think the answer is a resounding no.

Has the GOP leadership positioned Congress well to weather the charges of welfare for farmers that are likely to arise?

Could the GOP’s quest for budget savings have yielded much more easily by providing price-based safety net programs and being far more generous to research and trade promotion programs?

Only time will answer these questions as we watch the effects of the bill we consider today in the years to come. Congress must monitor the effects of this legislation carefully and be prepared to act again if necessary to ensure that American agriculture retains its preeminent position in the world.

Mr. HALL of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts [Mr. FRANK].

Mr. FRANK of Massachusetts. Mr. Speaker, I want to begin by not apologizing at all for speaking on a major piece of legislation in the House of Representatives. The majority’s manipulation of the schedule is outrageous enough, but now to say that this major piece of legislation, which the House majority leader a few years ago described I think aptly, he predicted welfare for farmers as he said in his introduction to the legislation piece. And I would not necessarily mind welfare for farmers, but they get 7 years of welfare, the AFDC recipients get 5, and of course there is no work requirements.

But for the House to spend so much time doing so little for so long, and then take up a major piece of legislation, and the leadership decides it will come up late at night and then to say oh, well, it is late at night, you cannot debate it. That is like the kid who kills his parents and say, have mercy, I am an orphan.

As the gentleman from California pointed out, before we were told that something is not an unfunded mandate, could not even be debated, the minimum wage, but this bill, according to CBO, has five unfunded mandates. And when it came before us as a bill, the Committee on Rules waived it. They would not even vote on that. So we get a bill with a lot of unfunded mandates. The first test of the new rule on unfunded mandates, they do not pay any attention to. They now are trying to browbeat the House into ignoring all of these important substantive issues, give the farmers welfare, spend billions of dollars. In the previous debate, there were 11 mandates, but it is 11:30, let us go home. Well, if my colleagues do not want to debate things at 11:30, they control the House, schedule them at a reasonable hour. But to take a major piece of legislation like this and then so manipulate the schedule that they want to sneak it through without adequate debate is unworthy of the House.

Mr. Speaker, we ought to debate these unfunded mandates. We ought to debate the magnitude of spending that farmers get billions of dollars for years for doing absolutely nothing whatsoever. I hope that the House will in fact repudiate these tactics.

Let us debate this. My colleagues have waited a very long time. We could pick an appropriate time of the day and debate it honestly and fairly, and do not come here, deliberately work the schedule this way and then say, oh, but we want to be nice to everybody, let us go home. If we want to go home, let them go home and let the rest of us stay here and do the business that we are paid to do.

Mr. HALL of Ohio. Mr. Speaker, I yield back the balance of my time.

Mr. SOLOMON. Mr. Speaker, I just want to tell the gentleman from Boston that this bill guarantees the people of Boston are going to have fresh milk for the next 7 years.

Mr. Speaker, I yield back the balance of my time. Mr. Speaker, I have arrived at many months ago. Ultimately, I hope the conference has arrived at many months ago. Ultimately, there is a program—there is no work requirements. I hope that the House will in fact repudiate these tactics.

The previous question was ordered. The resolution was agreed to. A motion to reconsider was laid on the table.

The text of Senate Concurrent Resolution 393 is as follows:

S. CON. RES. 49
Resolved by the Senate (the House of Representative concurring), That the Clerk of the House of Representatives strike paragraph (3), strike paragraph (2), strike “; and” at the end, insert “and” at the end, and strike paragraph (3).

Mr. ROBERTS. Mr. Speaker, pursuant to House Resolution 393, I call up the conference report on the bill (H.R. 2854) to modify the operation of certain agricultural programs.

The order of business is the consideration of the conference report on the bill (H.R. 2854).

Mr. Speaker, this conference report is considered as having been read. (For conference report and statement, see proceedings of the House of March 25, 1996, at page H2716.)

The speaker recognizes the gentleman from Kansas [Mr. ROBERTS] and the gentleman from Texas [Mr. DE LA GARZA] each will control 30 minutes.

Mr. VOLKMER. Mr. Speaker, I rise in opposition to the conference report. It is my understanding that the gentleman from Kansas [Mr. ROBERTS] and the gentleman from Texas [Mr. DE LA GARZA] are both proponents of it, and I would like to claim time in opposition.

The SPEAKER pro tempore. The gentleman from Texas [Mr. DE LA GARZA] is not opposed.

The SPEAKER pro tempore. The gentleman is not opposed. If the gentleman from Texas is not opposed, the gentle from Texas and Missouri each will be recognized for 20 minutes. The gentleman from Kansas [Mr. ROBERTS] will be recognized for 20 minutes, the gentleman from Texas [Mr. DE LA GARZA] will be recognized for 20 minutes, and the gentleman from Missouri [Mr. VOLKMER] will be recognized for 20 minutes.

The Chair recognizes the gentleman from Kansas [Mr. ROBERTS].

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

This has been a historic conference report, H.R. 2854, the Federal Agriculture Improvement and Reform Act of 1996. I call it historic because the Committee on Agriculture have produced a farm bill that represents a major departure from the past and a bold plan in regard to the future.

Mr. Speaker, I have some 16 pages of very pertinent comments in regard to the Freedom to Farm concept that we have passed, but I am going to revise and extend my remarks.

I call it historic because the Committee on Agriculture have produced a farm bill that represents a major departure from the past and a bold plan in regard to the future.

Mr. Speaker, I have some 16 pages of very pertinent comments in regard to the Freedom to Farm concept that we have passed, but I am going to revise and extend my remarks and we are going to try to expedite this bill to get it to the President as fast as possible.

Mr. Speaker, I have some 16 pages of very pertinent comments in regard to the Freedom to Farm concept that we have passed, but I am going to revise and extend my remarks.

And so as soon as we conclude this debate, we will try to make it just as short as possible to accommodate not only the farmers and ranchers of America, but my colleagues here who I know wish to go home.

Mr. Speaker, the House has before it today an historic conference report—H.R. 2854—the Federal Agriculture Improvement and Reform Act of 1996. I call it historic because the agriculture Committee have produced a farm bill that represents a major departure from the past and a bold plan for the future.

Embodied in the Conference Report before us today is that commonly referred to as the Freedom to Farm concept that I, along with Congressmen Barrett of Nebraska, introduced

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last August. Freedom to Farm was developed after the Committee conducted 19 field hearings and traveled over 60,000 miles last spring listening to over 10,000 farmers, ranchers, and the agribusiness community.

The original New Deal farm programs, over 60 years ago were based on the principle of supply management. Control supply and raise prices. Over the last 20 years the principal justification for the programs has been that farmers, ranchers, and the agribusiness community.

Today that system has collapsed as an effective way to deliver assistance to farmers. Worldwide agricultural competition usurps markets when we reduce production. World demand (along with the Conservation Reserve Program) was not only closed on that there have been no set-asides in wheat for five years—and none are projected in the foreseeable future, eliminating that justification for the programs. In short, the supply management policy has not only failed but has opened the door to a new direction that at first glance may seem to be a welcome change. The guarantee of a fixed (albeit declining) payment for seven years will produce for the markets, not government programs; provide a predictable and guaranteed phasing down of federal financial assistance.

By removing government controls on land use, FFA effectively eliminates the No. 1 complaint of farmers about the programs: Bureaucratic red tape and government interference. Complaints about endless waits at the county office; field sizes over which the right crop was planted to the correct amount of acres would be a thing of the past. Environmentalists should be pleased that the government will no longer force planting of surplus crops and promote over agriculture. Producers who want to introduce a rotation on their farm for agronomic reasons will be free of current restrictions. Allowing farmers to rotate their crops will allow them to reduce the use of pesticides, herbicides and fertilizer. This sample fact makes this bill the most “green” or environmentally friendly farm bill in my memory.

Under FFA, farmers can plant or idle all of their acres at their discretion. For the last ten years, in effect, farmers $6.6 billion under the present farm bill in my memory. The Freedom to Farm Act (FFA) was born of an effort to create a new farm policy from an entirely new perspective. Acknowledging that budget cuts were inevitable, FFA sets up a new set of goals and criteria for farm policy: Get the government out of the farmers’ fields yet still farm the ability to produce for the markets, not government programs; provide a predictable and guaranteed phasing down of federal financial assistance.
spectrum of farm, commodity and agribusiness groups, support for this proposal is strong. Most importantly, Freedom to Farm enjoys widespread support among individual farmers across the country who are fed up with complicated government programs, and exploded debt.

The following groups or individuals have endorsed either the Freedom to Farm Act or that concept as contained in H.R. 2854. I ask unanimous consent to insert in the record at this point a list of groups, organizations, and newspapers who have endorsed the Freedom to Farm concept:

**FARM AND TRADE ORGANIZATIONS**

American Farm Bureau Federation, National Corn Growers Association, National Grain Trade Council, National Grain & Feed Association, American Cotton Shippers, Iowa Farm Bureau Federation, Iowa Corn Growers Association, International Cattlemen's Association, Kansas Farm Bureau, Kansas Association of Wheat Growers, Kansas Bankers Association, Kansas Grain & Feed Association, Kansas Soybean Association, North Dakota Grain Growers Association, the Minnesota Association of Wheat Growers, the National Turkey Federation, the National Association of Livestock Processors, Agricultural Processing Association, National Food Processors Association, Agricultural Retailers Association, American Feed Industry Association, American Frozen Food Institute, Biscuit & Cracker Manufacturers Association, National Oilseed Processors Association, Millers' National Federation, and the Coalition for a Competitive Food and Agricultural System (representing 126 members).

**PUBLIC INTEREST ORGANIZATIONS AND REPRESENTATIVES**

U.S. Chamber of Commerce, Citizens Against Government Waste; John Frydenlund—The Heritage Foundation; Paul Beckner—Citizens for a Sound Economy; David Keating—National Taxpayers Union; Grover Noquist—Americans for Tax Reform; Barry Thompson—Winrock International, Assistant Secretary for Economics, USDA, Council of Economic Advisers; Dr. Robert L. Thompson, Wino Rock International, Assistant Secretary for Economics, USDA—Reagan Administration; the Ohio State University; and Dr. Barry Flinchbaugh, Kansas State University.

Clearly the support for the concept of Freedom to Farm is widespread. But this bill is more than just Freedom to Farm. There are other major reforms contained in this package. This bill renews the dairy industry. It instructs the Secretary to reduce the number of milk marketing orders in the nation. It phases out the price support. This bill is a major reform for American farmers in terms of conservation compliance and wetlands by injecting a little common sense into the process.

This bill has a very strong track record. It has strong embargo protection for the President. If we can't have a market-oriented farm policy and allow the State Department to destroy those markets through foreign policy embargoes. The American farmer remembers the Soviet Grain Embargo of 1980—what it nearly wiped out a generation of farmers. We can't go down that road again and this bill makes it more difficult for a President to choose that path.

This bill also contains the Committee on 21st Century Agriculture. As I have alluded to, this is a transition bill. But many farmers have raised the question of a transition of what? This bill charges the Commission to look at where we have been and where we should be going. Congress on the appropriate role of the Federal government in production agriculture after 2002.

This bill also authorizes existing research programs for two years while Congress can undertake an extensive review of the $1.7 billion we spend on agricultural research. The House Agriculture Committee has sent out 57 questions to the research community stakeholders asking them for their guidance. And last Wednesday, we began the hearing process that will hopefully lead to reform legislation that moves agricultural research in the direction of helping our farmers compete in a global marketplace against very tough competitors.

This bill takes a small stab at reforming the way USDA goes about buying its computers. In the past, the USDA through the Commodity Credit Corporation has spent hundreds of millions of dollars on computers and information systems, often without very much Congressional oversight. The result has been the various agencies of the USDA all have different computer systems with little ability to communicate. Several years ago the USDA embarked upon Infosphere supposedly to better manage its computer and information systems. The Clinton administration abandoned that and is proposing to spend $175 million next year on yet another computer purchasing extravaganza. This bill attempts to get a Congressional grip on those purchases and make them subject to greater Congressional review and accountability.

This bill reforms and streamlines the current rural development system by establishing the Rural Community Advancement Program (RCAP), which authorizes the Secretary to provide direct and guaranteed loans and other assistance to meet rural development needs across the country. The new program provides greater flexibility, state and local decision making and a simplified, uniform application process.

In summary, this bill is truly reform. It moves agricultural policy program policy into the 21st Century. I urge my colleagues to support it.

Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Wisconsin [Mr. Gunderson] for his remarks.

Mr. GUNDERSON. Mr. Speaker, I rise in support of this conference agreement.

Mr. Speaker, I say to my colleagues that we bring them the most difficult title of this conference report, the dairy title. It has been the most acrimonious, but I think we bring a consensus package today which represents the most comprehensive reform of dairy policy in the last 50 years.

What it does is first and foremost prepares us to deal with the inequities of dairy pricing across this country over the next 3-year period; and secondly, it allows us, the next 4 years to prepare for the American dairy farmer to successfully participate in the post-GATT world dairy economy.

This is significant legislation, and I would encourage everyone to support it.

Mr. Speaker, I would now like to take just a few moments go through the dairy chapter of the conference report section by section to describe the improvements the conference report has made in the House-passed bill.

Section 141 retains the dairy price support program for 4 years, but eliminates the budget assessment on producers. The support price will be set at $10.25/cwt in 1996, $10.20/cwt in 1997, $10.25/cwt in 1998, and $9.90/cwt in 1999. This level of support is higher than that provided by the Solomon-Dooley language in the House-passed bill, thereby assuring producers a higher income in the years.

During this period, the Secretary is authorized to alter how the support price is allocated between butter and nonfat dry milk in an effort to minimize price support program purchases and maximize exports of those commodities.

This section also terminates the dairy price support program on December 31, 1999, rather than on December 31, 2000, as the House...
passed bill would have done. This will allow the U.S. dairy industry to become competitive in the world market a full year before Solomon-Dooley would have. This is absolutely critical to the future of the industry because the Uruguay Round will free up about 25 percent of the world market for butter, nonfat dry milk, and cheese from subsidies by the end of the century.

Section 142 replaces the dairy price support program with a recourse loan program for processors of cheddar cheese, butter, and nonfat dry milk at a rate of $9.90/cwt of equivalent on a 3.67 butterfat basis. This marketing tool will be an important stabilizing tool as it enters the world market. It also serves a secondary purpose of maintaining a budget baseline for dairy commodity program outlays in the last 3 years of our 7 year budget cycle.

Section 143 provides for milk marketing order consolidation and pricing reform to be completed by USDA during the 3 years that follow the enactment of the bill. This is 2 years faster than the 5-year period proposed by the Solomon-Dooley language in the House-passed version.

In completing the consolidation of the current 33 Federal milk marketing orders into not less than 10 nor more than 14 orders, the Secretary will have to redesign the entire price surface for milk in this country from the basic formulas used for manufacturing milk to any differentials, for fluid (beverage) milk. Uniform component pricing for milk is specifically mentioned.

The bill language also specifically prohibits the Secretary from using the current fluid milk differential formulas in any way to achieve that new price surface. Rather, it suggests that he review utilization rates and multiple basing points, among other issues, when designing that new fluid milk pricing system. This will undoubtedly result in a flatter price surface for fluid milk and a more level playing field nationally.

All of the issues related to consolidation and pricing reform will be addressed through the information rulemaking process, assuring their completion within 3 years of the enactment of the legislation. There is a further safeguard to assure the timely completion of this reform in that, if the Secretary fails to complete these tasks within the allotted period of time, he will lose his authority to assess producers and handlers for marketing order services and administrative costs until those reforms are, indeed, completed.

Section 144 is offered in an attempt to exempt California from existing Federal standards for the solids not fact content in Class I (fluid) milk. Regrettably, this section is drafted in such a way that the State standards would become a barrier to interstate commerce in fluid milk and, as a result, will likely spawn years of additional lawsuits on this issue.

Section 145 resolves the so-called “section 102”—(California make allowance—issue which has, similarly, been the subject matter of frequent courtroom litigation. Specifically, section 102 of the 1990 farm bill is repealed and replaced, for a 4-year period, with a ceiling on State manufacturing allowances of $1.65/cwt for butter/nonfat dry milk and $1.80/cwt for cheese.

The section further clarifies that these ceilings are the numbers which result from a State’s yield and product price formulas, not the numbers which are plugged into and, then, adjusted by these formulas. If a manufacturing allowance resulting from the yield and pricing formulas of a State milk marketing order exceed these ceilings, processors in that State are precluded from selling surplus commodities to the Commodity Credit Corporation under the dairy price support program.

Section 146 extends the fluid milk promotion program through the year 2002. The House reluctantly accepted this provision even though we have not had hearings on this reauthorization to date. We will, in fact, have those hearings later this spring.

Section 147 directs the Northeast Inter-State Dairy compact. While this interstate agreement has little support on the House side, we were confronted with a situation in conference that threatened the entire farm bill process if the Northeast compact were not among the provisions of the conference report. Given the delay that the Reconciliation process already imposed on a new farm bill and the prospect of farmers beginning their planting season without a farm bill, the House conferees reluctantly agreed to include the Northeast compact that other farm bill provisions only after its proponents had agreed to the following limitations.

First of all, consent is granted to the compact only if the Secretary of Agriculture finds that there is a compelling public interest for the compact and, second, any consent will be terminated when the Secretary implements the consolidation and pricing reforms required by section 143.

Further, the compact over-order price would be applicable only to fluid milk, and the CCC would have to be reimbursed for any additional purchases of milk and the products of milk resulting from any increased milk production in the compact region in excess of the increase in milk production nationally.

Most importantly, the compact and its over-order price are not allowed to create a domestic trade barrier to milk and milk products coming into the compact region from other production areas around the country. While the mere establishment of an over-order price by the Compact Commission for use within the region would itself constitute a trade barrier, it would not be considered a prohibition or limitation on interstate commerce or the imposition of a compensatory payment, the Commission cannot require handlers bringing fluid milk into the region, either in bulk, packaged, or processor form, to add a compensatory payment or other up-charge to that milk.

In this regard, the language in condition number seven is clear and unambiguous—the Compact Commission cannot prohibit or otherwise limit milk or milk products from other regions of the country from entering the region, it must abide by the rules and regulations that the Federal Government has, for example, with respect to the classification of milk and the allocation of the proceeds from inter-order sales of milk, and it cannot use compensatory payments under condition 10(6) of the compact.

In short, Mr. Speaker, the legislation prevents the NorEast from using its compact in any way that could lead to the economic disadvantage or detriment of producers and processors in other regions of the country.

Section 148 requires the full funding of the Dairy Export Incentive Program for the Uruguay Round limits and gives the Secretary of Agriculture the sole discretion over the program to eliminate interagency disputes over the use of this program in the future.

Sections 149 and 150 authorize the Secretary to assist the American dairy industry in establishing one or more export trading companies autonomous of the U.S. government and to find sources of funding for their activities. These entities would, then, assist U.S. companies in entering and remaining competitive in the world market for cheese.

Section 151 requires the Secretary to study and report to the Congress on the impact that the new access cheese that our negotiators agreed to during the Uruguay Round proceedings will have on producer income and government purchases of cheese under the price support program.

Finally, section 152 re-emphasizes the authority of the National Dairy Board already has to use a portion of its annual budget to promote American dairy products internationally.

As you can see, Mr. Speaker, this is a good dairy bill. Not only does it get us into the world market for dairy faster and provide greater marketing tools for the dairy industry than the Solomon-Dooley provisions, but is also kinder to producer income and gets us order reform that the level domestic playing field faster than those Solomon-Dooley provisions. Accordingly, I recommend its adoption by my colleagues.

Mr. ROBERTS. Mr. Speaker, I yield to the gentleman from Pennsylvania [Mr. KIESER].

Mr. WALKER. Mr. Speaker, I would like to engage in a colloquy with the gentleman from Kansas regarding Section 892 of H.R. 2854, currently entitled “Other Data to Anticipate Potential Food, Feed, and Fiber Shortages or Excesses and to Provide Timely Information to Assist Farmers with Planting Decisions.” The gentleman from Michigan, Mr. Smith, and I worked out some language on how we can encourage the use of remote sensing data to aid farmers across this country, but the language contained in Section 892 of H.R. 2854 differs from what we agreed on and might be interpreted differently than is intended.

First of all, the title of the section conveys a different meaning than intended. It should indicate that the federal government’s role in this area is to assist farmers in using remote sensing data, not to provide the data directly. Subparagraph (b) of Section 892 directs the NASA Administrator and Secretary of Agriculture to work with the private sector to provide information, through remote sensing, on crop conditions, fertilization and irrigation needs, pest infiltration, soil conditions, projected food, feed, and fiber production, and any other information available through remote sensing. Some might interpret that to mean that “NASA should provide data directly to farmers, even if private remote sensing firms can already meet those needs. That is not what is intended by this paragraph.

Mr. ROBERTS. You are correct. That is not the intention of this language. There are excellent capabilities within NASA and the private sector to use remote sensing data for crop forecasting, precision agriculture, and projecting...
food yield. We do want to find innovative ways of bringing these capabilities to the benefit of the American farmer. Under Subparagraph (b), NASA and the Secretary of Agriculture should work with the private sector to teach farmers how to use remote sensing data from commercial data providers for the purposes you mentioned. The NASA Administrator or the Secretary of Agriculture should not interpret this to mean that they are to provide farmers with remote sensing data that the private sector is making available on the market.

Mr. WALKER. The NASA Administrator and the Secretary of Agriculture, then will not be allowed to compete with the private sector in providing earth remote sensing data, interpretation services, or tools to the agricultural community. It is also intended that NASA’s efforts under this provision be managed by the Earth Observation Commercial Application Program (EOCAP), based at the Stennis Space Center in Mississippi.

Mr. ROBERTS. Well, the gentleman is absolutely correct. The intention of this subparagraph is for the NASA administrator and the Secretary of Agriculture to help the commercial remote sensing industry better meet the needs of the agricultural community through development of new pre-commercial remote sensing technologies and interpretive tools. That way, we will ensure a steady stream of services and products that benefit American agriculture without adding to government expenditures or making American farmers dependent on the provision of government services. The EOCAP (E-OCAP) program has the most expertise in bringing these diverse requirements and capabilities together.

Mr. WALKER. Paragraph (c) also calls on the Secretary of Agriculture and the NADA Administrator to jointly develop a proposal to provide farmers and other prospective users with supply and demand information about food and fibers. We do not intend that this section or direct the NASA Administrator to conduct a program within NASA that does crop forecasting.

Mr. ROBERTS. The gentleman has hit the nail on the head again. This subparagraph is intended to urge the NASA Administrator to provide to the Secretary of Agriculture remote sensing data or interpretive tools that it develops under its normal activities, if and when such data and tools may be helpful in understanding the supply and demand for food and fibers. This is not intended to place any requirements for programs or research efforts on the NASA Administrator that add to NASA’s current responsibilities.
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this historic piece of legislation to this point.

I am pleased that Congress will pass the conference report tonight. It will unleash agriculture, the Nation’s single largest industry, from antiquated programs, and excessive Federal control.

As the largest newspaper in Nebraska said on yesterday, it will allow farmers to, and here I quote, “throw away the crutch of Government subsidies and break free from the unending flow of dictates from Washington.”

Mr. Speaker, in the interest of time and because of the lateness of the hour, I will conclude my remarks at this time and insert a longer statement in the RECORD.

Mr. Speaker, I rise today in support of the conference agreement on the Federal Agricultural Improvement Act.

As chairman of the General Farm Commodities Subcommittee, I traveled across the country last spring to receive testimony on our Nation’s farm policy. I chaired a total of eight different hearings. The full committee held many more. Farmers, bankers, producer groups, and agribusinesses all had a chance to be heard.

Mr. Speaker, there was a common theme running through that testimony the theme was give farmers the freedom to plant what they need to plant for the market, and give them the tools to do it. I’m pleased and even excited, that the 1996 farm bill does just that.

As I travelled my district this past weekend, listening to the excitement in farmer’s voices as they discussed their planting options, I couldn’t help but think of all the changes that have occurred in agriculture in America over the past few decades, and wonder why it took so long to reform farm policy.

Today, on farms across the country, computers and cellular phones are almost as common as tractors. Satellites, once used only at the Department of Defense, are now used to forecast weather, and track crop conditions.

On the other hand, federal farm programs have not changed. They have not adapted to changing markets and advances in technology.

Since the Great Depression, the federal government has attempted to maintain a federally determined income standard for farmers. The government offered loans, price supports, cash payments, and even placed restrictions on the use of agricultural land.

Our economy is based on risk taking and competition—with few restrictions. These programs have made American agriculture run counter to most other sectors of our economy. Unfortunately, agriculture in America has not been market oriented.

I am pleased that the House has before it today, a Farm Bill conference report that would allow producers to plant for the market, to make choices, to weigh risk, and to be in charge of their future. The FAIR Act reforms agriculture the American way, and I urge my colleagues to support the conference report.

Mr. VOLKMER. Mr. Speaker, I yield 3 minutes to the gentlewoman from New York [Mrs. LOWEY].

(Mrs. LOWEY asked and was given permission to revise and extend her remarks.)

Mrs. LOWEY. Mr. Speaker, I rise in opposition to this conference report.

Proponents of H.R. 2854 say that it represents reform of our antiquated federal agriculture policy. But I say it is business as usual.

Proponents of the bill say it reforms the peanut program—one of the most glaring examples of misguided agricultural policy. But that simply is not true. The cosmetic reforms included in this bill do not sufficiently address my concerns with this program.

The peanut program supports peanut quotas at the cost of $250 million in annual losses to American consumers and taxpayers. The GAO has estimated that this program pays $4.4 billion more each year for products with sugar in them. This is a result of this program. That is a total consumer price tag of almost $2 billion for these two programs.

This conference report also includes a provision that was placed in the bill during the markup hearings—without any debate or amended on the floor. The bill creates the mis-named Safe Meat and Poultry Inspection Panel to review and evaluate food safety procedures, adding another hurdle to the Food Safety policy that is already too burdensome for our Nation’s producers and extenders.

Mr. Speaker, this is an outrage. There are 4,000 deaths and 5 million illnesses annually in the U.S. as a result of food-borne pathogens. FSIS is trying to cut down this number, but they have been facing opposition every step of the way. This provision is another in a series of attempts to hinder their efforts. It was not in the House or Senate versions of the Farm Bill. It was not debated. It was not amended. Yet here it is in the conference report. This is no way to legislate.

Just last week Mike Taylor, the Undersecretary of Agriculture for Food Safety, came before the Agriculture Appropriations Subcommittee and told us how difficult it is for his agency to accomplish its goals of protecting our food supply with the limited budget it has been given. Now we are going to shoulder them with the fiscal burden of this panel. Unacceptable.

Mr. Speaker, the conference report is filled with provisions that send our agriculture policy in the wrong direction. We can do much, much better. I urge my colleagues to defeat this bill.

Mr. DE LA GARZA, Mr. Speaker, I yield 1 minute to the gentleman from Illinois [Mr. POSHARD], our distinguished colleague.

(Mr. POSHARD asked and was given permission to revise and extend his remarks.)

Mr. POSHARD. Mr. Speaker, I rise today in strong support of the Federal Agricultural Improvement and Reform Act conference report, because I believe this legislation is good for our farmers, environment, and rural communities. The bill also moves us closer toward our goal of balancing the Nation’s budget while allowing our farmers to provide consumers with high quality and low-cost food products.

This conference report provides our farmers with the flexibility they need to meet growing and changing market demands. Under the bill, farmers can plant most any crop on acreage subject to a production flexibility contract. In addition, these new production contracts will greatly lessen the amount of paperwork and time required of farmers who enrolled in farm programs of years past.

The conference report provides for continued marketing assistance loans to producers of program crops, as well as soybeans. In fact, the agreement includes an increase in the loan rate for soybeans that I am proud to say was added to the Senate bill by my Illinois colleague, Senator G. K. C. MCELLAN-BRAUN. The bill also reauthorizes the farm lending program, which has assisted many farmers and their families in my congressional district.

The conference agreement reauthorizes very important programs that assist our Nation’s farmers in continuing to be good stewards of our environment and lands, the Conservation and Wetlands Reserve Programs. These two programs have been very successful in protecting land, reducing cost of water pollution, and setting aside environmentally sensitive lands. While the conference report caps enrollment in the programs, it allows new acreage to be enrolled as idle land is taken out of the programs. The bill also provides $200 million annually for a new Environmental Quality Incentives Program which will provide technical and financial assistance to livestock producers and farmers to improve water quality.

The bill authorizes a new USDA Rural Community Advancement Program to provide grants, loans and loan guarantees to meet the rural development needs of our local communities. The agreement provides $300 million over 3 years for a fund for rural America which will be available for rural development and competitive research activities. In addition, the conference report reauthorizes USDA’s rural water programs.

I am pleased the agreement reauthorizes various Federal agricultural research, extension, and education programs. These programs are essential to the future of our Nation’s agricultural community and its future in the global marketplace. In Illinois, research and extension programs have played a major role in the Illinois agricultural community’s success as a domestic producer and exporter of farm commodities.

I thank the conferes for working swiftly on the conference report so that our farmers can begin planning and planting this year’s crops. This bill provides our farmers with flexibility,
our environment with effective and reasonable protections, and rural communities with new and expanded ways to invest in needed infrastructure and economic development. I truly believe this legislation is a step in the right direction in protecting these rural communities, and I urge my colleagues to join me in supporting this agreement.

Mr. VOLKMER. Mr. Speaker, I yield 4 minutes to the gentleman from Mississippi, Mr. TAYLOR, who is an outstanding legislator and knows a little about agriculture, quite a bit.

Mr. TAYLOR of Mississippi. Mr. Speaker, gentlemen and ladies, last year, during the welfare debate, I heard a speaker after speaker come to this floor and say that we had to end the practice of paying people to do nothing, that we should no longer pay people not to work.

Something remarkable happened that day. Every single Member of this body voted to no longer pay people for not working, and we supported the Republican coalition plan, the rest of the folks supported the Republican plan, but everyone supported at least one plan that would stop paying people for doing nothing. And it was remarkable, and it was a mistake.

Unfortunately in this bill there is a plan to pay people up to $80,000 a year per individual for 7 years to do nothing. You do not have to plant a crop, you do not have to work a field, you do not have to start the tractor, you do not have to do anything. You do not even have to try to farm, and you get $80,000 a year.

Earlier today this body by a majority voted to raise the debt limit up to $5.5 trillion. We are spending $2 million every 4 minutes on interest on the national debt. Where do we stop?

I am not going to criticize the whole bill, I am not going to criticize the whole bill, I hear to work fences, we are not going to have a work requirement. Very late at night, in the hopes there will be no debate, we are going to give $35 billion to able-bodied working people. As the majority leader said, “let’s give them welfare, let’s give them welfare, let’s give them welfare, and they will simply get that $35 billion.”

The inconsistency between the toughness that is meted out to the poor and the lavish and gentle treatment that goes to the favored political few is incomprehensible. What right do people have morally to condemn the poorest people in this country, not to even allow them to debate the minimum wage, to cut welfare, to cut Medicaid, to cut everything else. But the farmers, apparently free enterprise has no real meaning here.

Let us take $35 billion of deficit spending and simply give it to farmers because they happen to be farmers over the next 7 years. That is what is in the majority’s bill, and that is what they are trying to burp this discussion and have it late at night and hit and run, and not have it talked about.

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

Mr. FRANK of Massachusetts. I yield to the gentleman from Missouri.

Mr. VOLKMER. Mr. Speaker, I would like to point out to the House that to get this money, all you have to do is be in the program 1 year out of the last 5 years. If anybody would come to this House and say that I have been on welfare, I have been on AFDC, or on food stamps once in the last 5 years, and then I am entitled to 7 more years of it, we would say they are crazy, they are lunatic, that is crazy. But that is what this is. That is identical to what this is.

Mr. DE LA GARZA. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, I yield 1 minute to the gentleman from Texas, Mr. STENHOLM.

Mr. STENHOLM asked and was given permission to revise and extend his remarks.
Mr. STENHOLM. Mr. Speaker, I rise in support of H.R. 2854.

Mr. Speaker, it is with some considerable reservation that I stand here tonight encouraging my colleagues to vote “yes” for the 1996 FAIR (Federal Agricultural Improvement and Reform) Act. For a number of reasons we must put philosophical differences aside and think clearly and with conscientious conviction about who, not what we are supporting.

Today’s vote is for American farmers and the communities with families who sustain them. If this were March 1985 and we were debating future farm policy, but had functional farm laws in place, I would be adamant in my opposition to this legislation because it removes the safety net from under these peoples’ lives. Unfortunately, we don’t have that luxury today. At this stage in the game, with planting and credit decisions still in limbo, we must believe that any further delay only imperils the livelihoods of millions of people. Even with all it’s potential shortcomings and pitfalls, I have to accept this legislation as the best we can provide at this time. I would not have authored it, but the majority has spoken. Although I see many of the aspects of this bill will come back and haunt us, our debate, limited as it was, is over for now. We must move forward and provide some degree of predictability and assurance to our agricultural producers.

We need to stand back, remove emotion, and objectively view farm programs and their overall effects on society, it’s apparent to me that the level of stability offered to markets by our support has allowed the American farmer to become the envy of the world. No farm programs that I have today are perfect; they never will be. From a long view though, they have been successful. It may be the time to embark on new social experiments but we cannot ignore or forget what has worked in the past.

The current leadership believes in a textbook free market, but this completely ignores the role of other governments that don’t practice free trade. The recent GATT accord has not changed this. The European Union, for example, over the past 5 years outspent the United States 3 to 1 in terms of export subsidies, $10.6 billion versus less than $2 billion by the United States, and will be able to maintain its historical advantage under the GATT Agreement. American farmers cannot unilaterally disarm in an international marketplace. I don’t know of a single farmer who wouldn’t rather receive his income from the market-place, but the real world is subsidized agriculture. This is one of the areas where our Government must stand shoulder to shoulder with us. We must use all our tools to boost commodity prices, programs to help U.S. exporters compete in terms of price; second, programs to help importers obtain credit needed to purchase U.S. commodities; and third, programs to provide U.S. farm products as food aid.

All our efforts will be wasted however, if we neglect the infrastructure of rural America. We must continue to provide critical resources for rural communities as they work to address unmet needs at the local level. Water and sewer requirements alone cannot be met with the money that have been authorized. Rural research, education, extension, and seed money to develop value added programs are essential too, for rural economies to diversify and position themselves to compete in a rapidly changing global economy. Without public investment in stabilizing agriculture, you will witness further declines in rural America’s security and strength.

The provisions of the FAIR Act will result in dramatic adjustments in U.S. policy and contain numerous weaknesses. Over numerous years, the challenges confront U.S. agriculture—challenges of first, responding to competition in the global marketplace; second, ensuring a profitable, sustainable food and agriculture sector; third, safeguarding natural resources and the environment; fourth, ensuring balanced nutritionally healthy food supply; and revitalizing rural America. The stakes are high, but the opportunities and rewards are unlimited. Whether the agriculture industry continues its move forward or falls behind is largely dependent upon the vision and imagination of its participants. More importantly, we cannot be afraid to re-examine any policy as it relates to the vitality and stability of the sector it is meant to serve. With that in mind, I urge you to vote “yes” and put our farmers back to work.

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

Mr. Speaker, I would like to comment to the ones yelling “vote!” I am the one that tried to get the chairman to roll the vote so you would not have to be here.

Mr. Speaker, I first would like to point out to the House, as the gentleman who started this debate on our side from North Dakota pointed out, that we are not voting tonight in a hurry to do something that should have been done last year in regular time, but it was not done, and it is not the fault of those of us on this side. It is the fault, no question about it, of those that are in the majority did not do their job.

Now, the next thing, the decoupling that has taken place between asking farmers to do things to help provide a food supply for this country is gone. It is no longer in this bill. The farmer does not have to plan ahead, and in some parts of this country this year you are going to see less planting, you are going to see less rice, I will guarantee you, than we have ever had for years, and you are going to see other things happen.

I talked to some agricultural economists about this problem. Mr. Speaker, what you are going to see in the future, right now we have shortages, so you have good prices, so you are going to see production. You are going to see all-out production. In about 2 years, with good crops, we are going to have overproduction, we are going to have oversupply. The price is going to drop, and the loan rate is capped in this bill, which means a lot of farmers out there are not going to make money.

All farmers do not get this payment. Let me remind you of that. In my district, 60 percent of the farmers get nothing from this bill. The gentleman from Iowa who sits on the committee, in his district 85 percent of the farmers get $30,000 a year, on average. My farmers, even those 40 percent, only get $3,500. Down in parts of Texas, cotton country, you get up to $80,000. In parts of rice country, you get around $50,000 to $70,000.

There is no longer going to be a Federal crop program. It is gone, as good as gone. So when you look at that adequate food supply, you are going to see fewer farmers, you are going to see shortages, you are going to go back to the time, it is all history, you are going to go back to the time when there were no Government programs for farmers, and the big cycle starts now, not only in prices, but in food supply. Yes, in food supply. You are going to have ups and downs. And when you have the down, you understand, then you are going to have problems with people having food.

That is what you are getting out of this program. In the meantime, yes, big investors, bit people, 22 percent of that $36 billion is going to go to 2 percent of the farmers, and most of those people have never been on a farm. They are investors, most of them. Investors own farmers. They are going to get the big bucks.

Do not know why we cannot learn from history. I do not know why we have to go back to the days of old and go through the same problems with agriculture, but that is basically where this program leads you. In 7 years, we say we are going to wean them off after 7 years. I do not believe so. But there is going to be no incentives in this program for farmers to produce, as we do in our regular programs when we had the safety net.

We also have mechanisms to get people to produce certain crops so we can have additional crops if we need those crops. That is no longer here. That is gone. We have completely decoupled the programs of even what we call supply management from this bill completely. That is gone, folks. It is not in here anymore.

And this all is not new, this whole program is not brand new. But what is really interesting to me is to find that when this freedom to farm bill it, I call it freedom not to farm, first surfaced last summer, overwhelmingly rejected by most people, especially on this side.

Well, I will say this to you, the gentleman from Kansas, Mr. Chairman, you have been persistent. You have wore them down. You have not wore them down. You have been persistent. You have kept at it. And this all is not new, this whole program is not brand new. But what is really interesting to me is to find that when this freedom to farm bill it, I call it freedom not to farm, first surfaced last summer, overwhelmingly rejected by most people, especially on this side.

Mr. ROBERTS. Mr. Speaker, I yield such time as he may consume to the gentleman from Virginia [Mr. GOODLATTE].

Mr. GOODLATTE. Mr. Speaker, I ask and give permission to revise and extend his remarks.

Mr. GOODLATTE. Mr. Speaker, I thank the chairman for yielding me the time. This is strong support for this conference report, the most comprehensive reform of agriculture in my lifetime, the Federal Agricultural Improvement and Reform Act.
Mr. Speaker, I rise in strong support of this conference report and would like to congratulate my full committee chairman, Mr. ROBERTS and subcommittee chairman Mr. GUNDERSON for all their time and hard work.

For the first time Washington has seen fit to give producers the flexibility they have been demanding for too long. The Federal Agricultural Improvement and Reform [FAIR] Act finally allows our farmers and ranchers to produce for the market instead of the Government.

The FAIR Act fulfills the three goals that were set for this legislation: it transitions our agriculture sector towards the 21st century global economy; it saves the taxpayers billions of dollars; and it protects the environment.

The FAIR Act represents the most sweeping reform in agriculture policy in 60 years. It puts farmers, not the Government in charge of planting decisions. Farmers are no longer required to plant the same crops year after year to receive assistance, allowing greater crop rotation and less dependence on synthetic fertilizers and pesticides.

In addition to this the FAIR Act targets $1.2 billion over 7 years to assist crop and livestock producers with environmental and conservation improvements on the farm. Assistance can be used for animal waste management facilities, terraces, waterways, filterstrips, or other structural and management practices to protect water, soil, and related resources.

Producers, the first and best stewards of the land, are given enhanced flexibility to modify conservation practices if they can demonstrate that the new practices achieve equal or greater erosion control. It also takes measures to ensure the protection of the Florida Everglades, a national treasure.

This is the most environmentally friendly farm bill in history. We enhance the protection of the environment without new mandates, regulations, requirements or red tape. It makes the Federal Government a partner with producers in addressing environmental challenges, rather than an adversary. It is voluntary and incentive-based. Most importantly, it works.

Mr. ROBERTS. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. FOLEY].

(Mr. FOLEY asked and was given permission to revise and extend his remarks.)

Mr. FOLEY. Mr. Speaker, I give strong compliments to the chairman, Mr. ROBERTS, and Senator DOLE for their leadership on this excellent farm bill we are about to pass.

Mr. Speaker, I rise today in strong support of the conference report to accompany H.R. 2854, the Federal Agricultural Improvement and Reform Act, historic legislation to completely overhaul this Nation's farm policy. Yet, as we move toward a more market-oriented agricultural policy in this Nation, one fact is easily overlooked in this entire farm bill debate—and that is Congress is about to pass the most environmentally sensitive farm bill ever. All of this is done without any new mandates, regulations, requirements or bureaucratic red tape. It makes the Federal Government a partner with agricultural producers in addressing agricultural changes, rather than an adversary.

In particular, I am especially pleased that this conference report contains $200 million for funding of land acquisition and environmental restoration activities in one of our true national treasures—the Florida Everglades. Additionally, the bill does something that we should be all proud to support. It allows the Federal Government to dispose of surplus lands, up to $100 million, within the State of Florida for the purpose of acquiring additional environmentally sensitive lands in the Everglades.

As the author of this provision in the House, I would like to take this time to thank those Members of Congress who worked so hard on finalizing this issue. First of all, I would like to thank Representative Elder of Florida. The State of Florida, up to $100 million, from California, who was thrust into the role of attempting to reshape the legislation in conference and did an outstanding job in that role. Second, many thanks go to the House and Senate majority leadership—in particular Speaker NEWT GINGRICH who was especially instrumental in the role of discussing the idea of surplus land disposal for the purpose of environmental restoration. Senator BOB DOLE played a vital role in inserting this language in the Senate bill when it was originally considered earlier this year. Special thanks go to my colleagues from Florida, especially the State's two outstanding Senators, MACK and GRAHAM—both who worked in a bipartisan fashion to craft an acceptable provision to work on behalf of the Florida Everglades. Finally, thanks to my 299 Members of Congress who originally gave their stamp of approval to my amendment on February 29, 1996.

Since there is no report language accompanying the Everglades provisions, I would like to further take this opportunity as the author of the House provision to explain in greater detail some of the background behind this measure.

The Everglades ecosystem is a unique national treasure that includes the Kissimmee River, the Everglades, and Florida Bay. Its long-term viability is critical to tourism, fishing, recreational activities, and agricultural industries as well as to the water supply, economy and quality of life for South Florida's population of more than six million people. Additionally, the restoration of the Everglades will have direct benefits to the Government in that the Everglades ecosystem includes the Loxahatchee Wildlife Refuge, and two National Parks, Everglades National Park and Biscayne Bay National Park.

The State of Florida, in particular the State legislature has a long standing commitment to address the complex problems of the region and to restore this precious resource. Additionally, the agricultural industry south of Lake Okeechobee has committed up to $320 million for Everglades restoration as part of the 1993 Everglades Forever Act. While many would seek to find a single scapegoat for problems in the Everglades, I find this to be lacking in commitment to acting to preserve this precious resource. Therefore, today, it is important to remember that because South Florida is home to 7 of the 10 fastest-growing metropolitan areas in the country, restoration is clearly on a critical path.

It is clearly understood by all who are involved in the efforts to restore the Everglades that there is a significant gap in or scientific knowledge about ultimate ecological and water management needs of south Florida, and this necessitates continued detailed study. Yet, the framework for restoration and the design of major projects for land acquisition, water storage and restored hydrology is clear.

Restoration of one of the largest functioning ecosystems in the world is a massive undertaking, and success will depend upon the Federal Government, the State of Florida, and all local, regional, and tribal interests working in tandem. As the author of this language in the House, it is not my intent that these funds supplant any previous funds committed to south Florida for the purpose of Everglades restoration. However, it is my intent that the purchasing agents give the absolute highest priority to those lands owned by willing sellers but taxpayer dollars should not be wasted by paying more than fair market value for lands purchased with these funds. This underscores importance of the annual report to Congress by the Secretary of Interior describing all activities associated with the expenditure of these funds.

Mr. Speaker, this is a historic day for the House of Representatives, and a historic day for the Everglades. I'm proud to be the sponsor of this original language, and I now would encourage my colleague to support the final passage of this bill and urge the President to quickly sign this bill into law.

(Mr. BOEHLERT asked and was given permission to revise and extend his remarks.)

Mr. BOEHLERT. Mr. Speaker, I rise in support of this conference report.

Mr. Speaker, I rise in strong support of this farm bill—a bill that is good for farmers, good for consumers, good for taxpayers, and good for environmentalists—categories that, I hasten to add, are hardly mutually exclusive.

I want to focus on two aspects of the bill, in particular—first, the dairy provisions. This bill eliminates the assessments farmers pay, phases out price supports, funds export promotion, and consolidates milk marketing orders. The bill, in short, saves farmers and taxpayers money without imposing new burdens on consumers or creating chaos for Northeast dairy farmers. I want to thank the farmers in my district and throughout our region for their patience, their time, and most of all their critical guidance during this protracted debate. They worked closely with my colleagues and me in the Northeast ag caucus, which I am privileged to cochair, and together we fashioned responsible legislation.

Now, let me turn to the conservation title of this bill, which is another cause for celebration.

This week the Washington Post has run a series of spirited editorials critical of Republican environmental initiatives. I hope the Post
and others take notice of the revolutionary conservation measures included in the 1996 farm bill.

The 1996 farm bill is not only the greenest farm bill in the history of the Republic, it is the most significant environmental legislation passed in this Congress or the previous Congress, which by the way was Democrat controlled.

The over $3 billion provided in the farm bill for the Wetlands Reserve Program, the Conservation Reserve Program, the Environmental Quality Improvement Program, and the restoration of the Everglades will do more to improve water quality and wildlife habitat in this country than any bill proposed by the Clinton administration in the past 4 years. Millions of acres of environmentally sensitive lands across the nation will be protected.

Two weeks ago a conservation amendment to the farm bill, an amendment I authored, was adopted on the House floor by a vote of 372 to 37. A Republican amendment on the environment involving millions of acres of land and billions of dollars was approved with resounding bipartisan support.

Republicans have gotten the message on the environment, and unlike many in this town, we are responding with sensible, proenvironment, legislation like the 1996 farm bill.

The Republican Party is returning to its roots, as the party of conservation and sensible environmental protection. Teddy Roosevelt was proud of the conservation initiatives being advanced in the 1996 farm bill. I urge all my colleagues to support this proenvironment, profarmer legislation.

Mr. ROBERTS. Mr. Speaker, I yield such time as he may consume to the gentleman from Colorado [Mr. ALLARD], a valued member of the committee.

(Mr. ALLARD asked and was given permission to revise and extend his remarks.)

Mr. ALLARD. Mr. Speaker, I rise in support of H.R. 2854. This is the most market-oriented environmental friendly bill we have ever passed.

It balances the needs of producers and the needs of the environment, while providing significant regulatory relief to producers.

We reauthorize the Conservation Reserve Program which provides incentives to producers to idle environmentally sensitive land. The new CRP takes into account water quality needs important to midwestern states and soil erosion and wildlife habitat concerns of the Great Plains. The conference committee did a remarkable job of balancing the needs of different regions so we can all claim to be winners.

The conference report also provides money for the restoration of the Everglades. The provisions that we included will protect the Everglades and hopefully provide a model for restoration of other environmentally sensitive areas.

The conference report also establishes a new account that will provide mandatory money for cost share practices to reduce soil erosion and protect water quality. This program incorporates provisions from the legislation I introduced earlier this year, but expands it to include more money and more practices. It is an important program that will provide tremendous environmental benefits in rural and urban areas.

Also, the conference committee included language that will place a moratorium on actions by the Forest Service that have the effect of denying owners of water the use of that water through regulatory action. During the time this moratorium is in effect experts in the fields of public land law and Western water law will be developing a report on how to avoid the illegal taking of water from agricultural and municipal users. I am happy to have this provision in law, but want to make clear that it in no way recognizes the legality of recent Forest Service actions. The language in this provision is an attempt to stop the Forest Service from taking actions that run counter to law and allow them to find alternatives to imposing by-pass flows and avoid law suits they would surely lose.

Finally, this legislation incorporates other important reforms that we can be proud of, such as: making the USDA loan process more responsible and allowing the Department to more quickly release inventory property. Reform of Conservation Compliance that will allow the Department and the producer to work in a more cooperative manner while reducing regulatory burdens on the producer.

This is groundbreaking legislation that I hope all of my colleagues can support.

Mr. ROBERTS. Mr. Speaker, I yield 1 minute to the gentleman from Illinois [Mr. EWING], chairman of the Subcommittee on Risk Management and Specialty Crops.

(Mr. EWING asked and was given permission to revise and extend his remarks.)

Mr. EWING. Mr. Speaker, I thank the chairman for a job well done.

I would just like to say a couple things about the peanut and sugar program, which were under my subcommittee. First, these programs will not cost the taxpayer one dollar. Yes, without these programs, you might have a lot more cost to the consumers in this country. I would remind the gentlewoman from New York, who was so critical of these programs, that these programs were so bureaucratic after decades of being controlled on that side of the aisle in farm programs that it would have truly been unfair to the people who farm and grow peanuts and sugar in America, a lot of little people, had we cut their legs off at the knees and expected them to go out of these programs immediately. These are a good transition to the marketplace.

Mr. ROBERTS. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Vermont [Mr. SANDERS].

(Mr. SANDERS asked and was given permission to revise and extend his remarks.)

Mr. SANDERS. Mr. Speaker, all over this country, family farms have been disappearing in great numbers as a result of the failure of our current agricultural policy. In Vermont, in 1977, we had 3,300 farms. Today we have less than 2,000. All over the country this is happening. This is an American tragedy.

In 1989, some people in New England got together to figure out how we could save the family farm in our region, and they came up with a concept called the Northeast Dairy Compact. This compact could provide dairy farmers in New England finally with a fair price for their product, a fair price which they are not getting today. It is an opportunity to save the family farm. All six legislatures in New England overwhelmingly approved the compact; all six Governors, liberal and conservatives, approved the compact.

Mr. Speaker, originally when we voted on the bill, the compact was not in the farm bill, but today it is in the farm bill as a result of the work the conferees did. Mr. Speaker, the Northeast Dairy Compact could become a model for farms all over this country for regions all over this country. It is good for New England. It is good for America.

There is a lot in this bill that I do not support, but I certainly fervently support the Northeast Dairy Compact section.

Mr. ROBERTS. Mr. Speaker, I yield such time as he may consume to the gentleman from Iowa [Mr. GANSKE].

(Mr. GANSKE asked and was given permission to revise and extend his remarks.)

Mr. GANSKE. Mr. Speaker, I rise in support of this bill, the origins of which are partly in the Iowa plan.

Whether we call it the Fair Agriculture Improvement and Reform Act, the Agricultural Market Transition Act, or my favorite, the free farm to farm act, this is truly an evolutionary piece of legislation.

For the first time since the 1930’s when Federal farm policy took shape, we will begin to remove the inside-the-beltway, Washington bureaucrat from the backs of the American farmer.

Although we had to wait until 1996, nearly an entire lifetime, I am pleased that this body has come to the realizations that farmers, out in the fields, actually know more about farming than the bureaucrats in Washington do. In no small part do we owe our thanks to Chairman ROBERTS for bringing us to this enlightened stage.

This is a good bill. It saves taxpayers money. It provides long needed flexibility. It makes good free-market sense. It is proenvironment. And it stops paying farmers not to plant.

Under the freedom to farm approach in this bill, we provide flexibility and develop a true safety net for our farmers. That is why the Iowa Farm Bureau Federation, the Iowa Corn Growers Association, the Iowa Soybean Association, the Iowa Pork Producers, the Iowa Cattlemen Association, and the Iowa Agribusiness Association all support this bill.

Those in opposition to this legislation will say that it either ends the safety net for our farmers or is a free handout just like welfare. This is simply not true.

Opponents of this bill have a vested interest in maintaining the status quo. They want to continue to force the agricultural community to come to Washington, hat in hand. They want to continue the micromanagement of the farm. They want to continue to hamper development of the export markets with top-down we-know-best policies.

A vote for this bill is a rejection of those failed policies of the past. A vote for this bill...
Mr. HAMILTON and Mr. HALL on February 29.
I have worked on. Title 2 reflects the amendment that does that.
one-fifth belongs to the United States, and we have to protect ourselves. But our leadership in this dairy industry is under assault from all our competitors, whether it is Asia, Europe, wherever it might be. We must fight these unfair trade practices in agriculture and this bill does that.

This bill represents the first real reform in dairy policy in over a decade. This legislation is long overdue, and the reforms in here are long overdue, especially in the milk marketing order. The current milk marketing order is totally out of date. It is a relic of a by-gone era when raw milk had to be transported great distances for processing. Today our dairy industry is highly efficient.

Mr. Speaker, while I support the overall bill, I must register my serious concerns about the provisions which establish a special dairy system for the New England region. In essence, this is Government-mandated protectionism for one segment of our Nation’s dairy industry. When this bill is going to what a free market system, this particular provision takes us in the totally different direction.

Nevertheless, this is a good bill. Overall this bill makes good bill. It makes major reforms that will help our farmers and our exporters. It will contribute to a stronger, more competitive and expanding agricultural sector, and it will ensure that the United States remains the world’s leader in agriculture in the 1990’s and the 21st century. Remember, of the $210 billion export market in agriculture, one-fifth belongs to the United States, and we want to make sure we continue in that direction and this bill does that.

Mr. Speaker, taken as a whole, this farm bill is good legislation and should be passed. Let me address three provisions of the bill which I have worked on. Title 2 reflects the amendment which I offered along with Mr. Benezet, Mr. Hall, and Mr. Hall on February 29. This title reauthorizes and strengthens our agricultural trade programs.

These programs are essential to the competitive position of American agriculture in world markets.
Currently the United States has one-fifth of the $210 billion global trade in agricultural goods.

But our leadership is under assault, by our competitors in Europe, and Asia and Latin America.

In my Subcommittee on International Economic Policy and Trade, we carefully examined the competition in world agriculture.

The reality is, every major trading nation has programs to help their exporters take sales away from Americans.

We have to meet this competition. The amendment I offered, which is now part of this final bill, reflects the recommendations of every major farm group in the country.

This title extends our export credit programs for farm goods.

These programs support $3 billion in farm exports.

This title also improves our programs to combat unfair trading practices in agriculture. Without these programs, we would have no defenses against the predatory financial inducements that other countries use to undercut American farmers and exporters.

This title reauthorizes and renews our food assistance programs, which are vital to the relief of starvation and suffering around the globe.

In our domestic farm programs, this bill makes the first real reforms in U.S. dairy policy for more than a decade. In particular, this bill requires long-overdue reforms in the milk marketing order system.

The bill incorporates the approach I recommended in legislation which I have sponsored for a number of years. The current milk marketing order system is an outmoded and anachronistic fact of a by-gone era when raw milk had to be transported great distances for processing. Today, our dairy industry is highly efficient, but the old pricing system remains. Efficient dairy farmers in Wisconsin and other Great Lakes States are penalized under this unfair system.

This legislation is a major step toward reform.

While I support this bill overall, I must register my serious concern about the provisions which establish a special dairy system for New England region.

In essence, this is Government-mandated protectionism for one segment of the Nation’s dairy industry.

It goes against the rest of the bill, which moves American agriculture toward a more market-oriented system.

Nevertheless, this is a good bill overall. It makes major reforms that will help our farmers.

It contributes to a stronger, more competitive and expanding agriculture sector.

And it will help the United States remain the world’s leader in agriculture into the 21st century.

Therefore, I urge my colleagues to support this bill.

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In my Subcommittee on International Economic Policy and Trade, we carefully examined the competition in world agriculture.
Mr. Speaker, I am happy that this farm bill is a major step in building this new national agriculture policy. This bill begins to draw the line, the green line, to stop urban sprawl from paving over prime ag lands, and I am particularly happy that this bill makes the Federal Government a partner with the States in efforts to protect prime farm land from urban sprawl.

I am also glad that this bill allows the Secretary to provide seed money to farmers to help them purchase land from urban sprawl.

Mr. Speaker, let me say that in 1981, I managed my first farm bill. This is the fourth time that I have supported a farm bill.

Mr. Speaker, let me say that in 1981, I managed my first farm bill. This is the fourth time that I have supported a farm bill. It will be my last time that I do so. This will be my last farm bill that I will have managed, a farm bill, is the greatest number of anyone who has served in this House.

I ask you to support this legislation, because it addresses all of the areas of concern to rural America; from feeding the poor to making affordable improvements out in the rural areas.

Mr. Speaker, let me say that in 1981, I managed my first farm bill. This is the fourth time that I rise to support a farm bill and it will be my last time that I do so. This will be my last farm bill that I will have managed, a farm bill. It is with great pride now that I do so. This will be the time that I have managed a farm bill, this is the greatest number of anyone who has served in this House.

I ask you to support this legislation, not because of myself or what I have done, but because it is the art of the possible. Legislating is the art of the possible. What is possible now may not be possible 1 hour from now. It addresses human needs. It addresses the issues of the poor.

We are the best fed people in the world, in the history of the world, for the best amount of disposable income per family. We have the best quality food in the world. A lot of the costs that people complain about are for the many other areas in agriculture such as meat inspection and poultry inspection. That is not to say that agriculture programs are perfect. Now and then you have a fault, but the intent is to help farmers provide reasonable, safe, and affordable food. We have gone, I think, Mr. Speaker, a long, long way in helping ensure that we are the best fed people in the world in the history of the world.

Mr. Speaker, I would like to thank the chairman for his kindness to me; his working with me. This is not perfect legislation. I have never said that any bill that I brought to the floor was perfect legislation. If there are flaws in this bill, they may yet be corrected in the future. We have reduced the budget deficit. Agriculture has reduced the deficit by $2 billion in the past 10 years. If every committee in the House had done that, we would not be worried about a balanced budget. We have reduced that, but we have done it quietly.

When the Agriculture Committee started the legislative process on H.R. 2854 we were very much divided, not only along regional lines, as most farm legislation is, but also along partisan lines. I am glad to report that the partisan differences have disappeared and we were able to come together as a body to do what is best for agriculture.

When we started this process, I had three major areas of concern. First was the lack of recognition that agriculture has contributed more to deficit reduction than any other major entitlement program—and continues to do so. We were being asked to cut more than any other sector. This bill saves over $2 billion from the December baseline, and we are proud of the fact that agriculture is the only entitlement program to enact real budget deficit reduction this Congress.

Clearly, agriculture has more than met its responsibility to budget deficit reduction. Indeed, with this bill, agriculture—once again—continues to contribute more than its fair share to budget deficit reduction. Once again, agriculture leads the way to a balanced budget.

Second concern was the lack of a safety net for farmers and therefore for consumers. Let everyone understand, to the extent that there is volatility in commodity prices, consumers will pay. We tried to design agricultural programs in the past that would not allow wide fluctuations. Programs perfect? No. Is this program perfect? No. However, this bill does go a long way in addressing flexibility and commodity distortions. Still, I am concerned that the loan rates may be too rigid in times of low prices.

My third concern was that the House bill failed to address the total of circumstances in rural America. Gone is the time when we as policymakers could rely on farm programs alone to provide rural development. The country is much more complex than that today. People need telecommunications and business and industrial development in addition to our basic infrastructure development of water and waste water facilities.

The Fund for Rural America goes a long way to addressing the development needs. By providing additional money for research it provides resources for the future of agriculture. It is through research that we will maintain our status as the premier food production system in the world.

In addition, by reauthorizing the nutrition programs we ensure that our less fortunate neighbors are not left out. To those who want welfare reform, reauthorizing the programs for 2 years still allows us to do what we need to do to get people to self-sufficiency while at the same time providing certainty to the beneficiaries of the programs.

Once again, I support this bill. On the whole, it addresses my concerns regarding rural America, and I am hopeful that it will...
meet the needs of American agriculture and our Nation as we move into the 21st century. To the extent that problems arise during the next 7 years, I am confident that corrective action can be taken to address any such problems.

Mr. ROBERTS. Mr. Speaker, I yield back the balance of my time.

Mr. ROBERTS. Mr. Speaker, I yield myself such time as I may consume. I would like to entertain a colloquy with the distinguished chairman of the Committee on the Judiciary, the gentleman from Illinois [Mr. Hyde], whether the bill, if signed by the President this week will apply to the Department of Agriculture’s rules that will be promulgated under the Federal Agricultural Improvement and Reform Act.

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

Mr. ROBERTS. Mr. Speaker, I yield to the gentleman from Illinois.

Mr. HYDE. Mr. Speaker, yes, I will inform my colleagues that all Federal agency rules will be subject to congressional review upon enactment of the Congress Review Act.

Mr. ROBERTS. Mr. Speaker, obviously the rules implementing the Federal Agriculture Improvement and Reform Act will have a large economic impact on the agricultural community and farmers. I ask the distinguished chairman of the Committee on the Judiciary, if the Department of Agriculture were to issue major rules under the Federal Agriculture Improvement and Reform Act, will they be held up for 60 calendar days by the Congressional Review Act?

Mr. HYDE. Mr. Speaker, if the gentleman will continue to yield, yes, my colleague is correct. If any Federal agency issues what the Congressional Review Act defines as major rules, under the Federal Agriculture Improvement and Reform Act, those rules would not be allowed to go into effect for at least 60 calendar days. However, I advise my colleagues that the President, by executive order, may declare a health, safety or other emergency, and that particular major rule would be exempt from the 60-day delay.

I would add that the President’s determination of whether there is an emergency is not subject to judicial review.

Mr. ROBERTS. As the chairman of the Committee on the Judiciary may know, we in the conference on H.R. 2854 did not contemplate such prompt enactment of a congressional review bill. I would inform the chairman that H.R. 2854 requires that the Secretary of Agriculture, within 45 days of enactment, offer market transition contracts available to eligible producers. These contracts must not be further delayed, or they will not be effective for the 1996 planting season. Moreover, these contracts are worth billions of dollars, and they are certainly going to qualify as major rules under the Congressional Review Act.

Would the chairman agree that these major rules are the type that are contemplated by his committee as qualifying for the emergency exemption available under the Act?

Mr. HYDE. Yes, I agree with the chairman of the committee that the other emergency exception from the 60-day delay of major rules was included only for the President to determine by Executive order that the market transition contract rules promulgated this spring under the Federal Agriculture Improvement and Reform Act are emergency rules that would not be subject to the automatic 60-day delay.

Mr. ROBERTS. Mr. Speaker, I thank the gentleman from Illinois [Mr. Hyde]. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Ohio [Mr. BOEHNER], a valued member of the committee.

Mr. BOEHNER. Mr. Speaker, we are here, and over the last year I think all of us and the public have weaned us away from any time thought we would ever get here, but I want to congratulate the chairman of the committee, Mr. ROBERTS, for the work that he has done to guide this bill throughout the last year. He has done a marvelous job, and I am looking forward to working with the members of our committee.

Let me also say to the gentleman from Texas [Mr. DE LA GARZA] and to the gentleman from Texas [Mr. STENWICK] and Mr. EMERSON, and Mr. ERNST, for the work that he has done to put the way, sometimes difficult moments, but they were a great help to us in the conference. This is an effort that was a team effort, and all of us are to be congratulated for the job we have done on behalf of American agriculture.

Mr. ROBERTS. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Missouri [Mr. EMERSON].

(Mr. EMERSON asked and was given permission to revise and extend his remarks.)

Mr. EMERSON. Mr. Speaker, I thank the distinguished chairman of the committee for yielding this time to me, and I first want to commend him for the outstanding job of leadership that he has provided us during this most difficult year as we have undertaken agricultural restructuring in a legislative sense. He is to be highly commended for his patience and his many enduring qualities including his patience with me.

I finally want to say hail and farewell in just this momentary sense to our dear friend, the gentleman from Texas [Mr. DE LA GARZA], I would like to associate my remarks here this evening. Our chairman emeritus has always spoken with the most deeply felt passion about America’s No. 1 industry, agriculture, and his voice will continue to be heard, I am sure, even though for this year he will no longer be speaking from this Chamber.

So, I say to the gentleman, “Kika, God bless you, and thank you for all the great efforts that you have made over the years. You have been truly an inspiration.”

Finally, Mr. Speaker, I rise in support of the measure before the House.

Mr. ROBERTS. Mr. Speaker, I yield myself such time as I may consume. And to Mr. PO MEROY and Mr. TAYLOR and Mr. VOLKMER, good friends of mine all, I have a lengthy, lengthy refutation as to why freedom to farm is not
March 28, 1996

CONGRESSIONAL RECORD – HOUSE

The Market Transition Payment and the Welfare Myth

The political rhetoric: Currently within the agricultural community there are some who seem to be concerned with the appropriate payments or so-called “market transition payments” under the Agricultural Market Transition Act—for farmers during periods of high prices. Some even liken market transition payments to welfare payments, according to Agriculture Secretary Dan Glickman, in recommending a Presidential veto of the Balanced Budget Act, restated this position:

As we move to balance the budget, farmers should not receive windfall payments when market conditions are good. They should receive assistance when in greatest need—when prices are low, as provided for by the current structure of programs.

I have highlighted “market conditions” and “low prices.” This statement may reflect the Secretary’s thinking, but is the statement accurate in the real world of agriculture? Programs are not welfare and partisan statements equating farm programs with welfare do a disservice to farmers and ranchers.

Chester’s—Agriculture doesn’t fit the definition of welfare: One of the most unfair arguments against farmers is to say that agriculture payments—of any kind—are welfare payments. Under current law, to receive “welfare,” whether it’s food stamps or Aid to Families with Dependent Children (AFDC), an individual must meet the definition of “disadvantaged” to receive government assistance. In total contrast, farmers work on their land, and receive a payment for agreeing to certain conditions. Farmers must adhere to environmental mandates—conservation compliance and wetlands requirements—in return for a federal payment. There is a clear exchange of benefits environmental practices for benefits received by farmers in the program. Second, the federal payment helps to offset unfair trading practices under which farmers live. This means that farmers are at the mercy of many trade restrictions. Major markets in the Middle East such as wheat and rice are under export bounties. Threats to continued trade with China also pose significant concern in American agriculture. And finally, due to federal assistance, they can ensure their own land and affordable food supply for American consumers. A federal payment is a small price for a national food supply that guarantees the basic staples of bread, meat and milk at the lowest prices in the world.

What about “high and low prices” and farm income: Those who call a market transition payment “welfare” follow the basic proposition that Congress cannot justify paying farmers when prices are high because they are simply making a profit. For this scenario to work, farmers must be selling above average quantities of commodities at very high prices. But, does that often happen?

Here’s how it really works: Think of the basics of supply and demand: When supplies are tight, prices go up; when supplies are excessive, prices go down. The difference—or price—usually determines a windfall profit. Farmers receiving a windfall through a market transition payment during periods of high commodity prices, as Secretary Glickman indicates, depends upon whether farmers actually have a commodity to sell.

The Market Transition Payment allows farmers to manage their own destinies: A market transition payment gives the farmer responsibility for his own economic life. Just as farmers will need to look to the market for production and market signals, the Agricultural Market Transition Program will require farmers to manage their own finances to meet market swings. Government is out of the business of running the farm.

Don’t believe the hoopla with the economists: The economic consulting firm of Abel, Daft, Earley and Ward looked at the calculations and agreed. They said, “variations in production and market variations in market price, usually in the opposite direction. While market prices typically are lower with a larger crop, the positive impact of an increase in crop size more than offsets the negative impact of a lower market price. And, the reverse is true as well. The increase in market price associated with a smaller crop is typically not sufficient to offset the negative effect a small crop has on crop value.”

How to avoid a $2 billion payday disaster: The facts prove that the market transition payment is NOT welfare for farmers. Indeed, it actually corrects a major flaw in the present target price system. High prices, but no crop, means farmers have to pay back their advance deficiency payments. Without a crop or federal payment, farmers have repeatedly called for disaster assistance in the past—which costs billions of dollars. That’s why the market transition payment is a sound basis for the transition out of a 60-year-old formula. The key in looking at the policy options is to consider farm income, not high price.

What about “market conditions”: Market conditions can be defined price, or price. One “market condition” could be the circumstance of weather-related factors. The market transition contract will provide payments in lean years as well as in a year such as this when production is done in various regions of the county, but prices are strong.

One thing is very clear: The market transition payment is an essential part of the Farm Bill, NOT a welfare payment. The FEDERAL AGRICULTURAL IMPROVEMENT AND REFORM ACT IS RESPONSIBLE TO TAXPAYERS

1. Average expenditures for commodity and export programs in this farm bill are significantly less than previous farm bills. Average expenditures for commodity and export programs (fiscal years): 1985—$36.2 billion; 1986—$40.2 billion; 1987—$44 billion; 1988—$49 billion; 1989—$53 billion. The 1990 farm bill was composed to cost about $41 billion—instead it cost $56 billion. Under this bill, there is budget certainty—expiring programs valued at $47 billion on farm programs and ag. export promotion programs.

2. Budget Certainty. Expenditures are capped and their impact on commodity prices is no longer an open-ended entitlement.

CBH is the 1985 farm bill would cost $35 billion over 5 years—it cost nearly $90 billion. The 1990 farm bill was proposed to cost about $41 billion—instead it cost $56 billion. Under this bill, there is budget certainty—expiring programs valued at $47 billion on farm programs and ag. export promotion programs.

3. Payment limitation is reduced by 20 percent, to $40.000 from the current level of $50,000.

Part of the payments are really to compensate producers for the fact that deficiency payments have been capitalized in land values. The transition payments will bring it down to the low market values that may happen as we move to a more market-oriented agriculture.

4. Part of the payments are really to compensate farmers for the fact that deficiency payments have been capitalized in land values. The transition payments will bring it down to the low market values that may happen as we move to a more market-oriented agriculture.

5. The Market Transition Payment recognizes the fact that high prices do not translate into high income levels. Often the reason prices are high is because farmers didn’t have a crop and a high price times no crops delivers an equal high income.

6. Payments are based on 85 percent of each farm’s former base acres and program yield multiplied by the per bushel payment. The current average payment: 36 cents per bushel, wheat: 63 cents per bushel, upland cotton: 7.3 cents per pound and rice: $2.43 per cwt.


Hon. Pat Roberts, Chairman, Committee on Agriculture, Washington, D.C.

Dear Mr. Chairman: Although the Speaker directed me to name members of the Resources Committee as conferees on the House and Senate farm bills, both measures do contain provisions which fall within the Committee jurisdiction. I am sending this letter to confirm our continued jurisdiction in these provisions and hope that you will take our views into consideration during the conference on S. 1541 and H.R. 2854.

Senate bill (S. 1541)

Section 313, Wetlands Reserve Program. Section 313 of the Senate bill amends the wetlands reserve program of the Food Security Act. As the primary successor in interest to the Merchant Marine and Fisheries Committee, the Resources Committee received its jurisdiction over “fisheries and wildlife, including restoration and conservation”. The Merchant Marine and Fisheries Committee has successfully argued that the crucial role that wetlands serve as habitat for migratory waterfowl, their contribution to the nutrient base and habitat for many species of fish and wildlife, and the endangers species at critical stages in their development and their function in shoreline protection and flood protection and gave that committee strong protection in a provision in legislation affecting wetlands. The Merchant Marine Committee’s jurisdiction over bills affecting wetlands, including those amending or affecting the Food Security Act, have long been recognized, with the Committee receiving sequential referrals on the wetlands provisions of the farm bills in both 1985 and 1990. The 1990 Food Security Act report (H. Rep. 99-272, Part II) states “the Merchant Marine and Fisheries Committee’s jurisdiction over fisheries and wildlife, including habitat, provides the basis for Committee jurisdiction over legislation affecting wetlands”. Most recently, the Merchant Marine Committee was also represented on the 1990 conference on the Food, Agriculture, Conservation and Trade Act. Finally, the Resources Committee itself has received referrals of wetlands bills in the past (see H.R. 1203, a bill to promote the conservation of migratory waterfowl and to offset or prevent the serious loss of wetlands by banning the destruction of wetland habitat, referred to the Committee on Interior and Insular Affairs in the 99th Congress).

The changes proposed to the wetlands reserve program in section 313 of the Senate bill will enhance benefits for fish and wildlife.
while also recognizing landowner rights. We have no objection to including the measure in the conference report as long as our jurisdictional interests in this matter continue to be respected.

Section 545. Cooperative Work for Protection, Management, and Improvement of the National Forest System. The Committee on Resources recognizes that the National Forest System serves . . . created from the public domain". This provision would affect the operation of these forests. With this understanding of our jurisdiction, we have no objection to having the provision included in the conference report.

Section 814, Everglades Habitat Incentives Program. This section establishes a $50 million Wildlife Habitat Incentives Program overseen by the Secretary of Agriculture. The provision pays payments to owners to develop "upland wildlife, wetland wildlife, threatened and endangered species, fisheries and other types of wildlife habitat approved by the Secretary." We are sympathetic to the policy underlying this measure, which is similar to provisions included in H.R. 2275, reauthorizing the Endangered Species Act of 1972. However, we also believe that, based on the arguments outlined above, the Committee on Resources would be the primary committee of jurisdiction for these laws. We do not believe, therefore, that there is any reason why the laboratory should not be transferred between the departments.

Therefore, I would support the inclusion of this Everglades acquisition provision in the final conference report IF the provision is acceptable to Congressman Pombo.

I appreciate your consideration of these recommendations (which affect what I hope is a non-controversial provision of the historic Agricultural Market Transition Act) and ask that you include this letter in the conference report on the bills. You and your staff should be congratulated on the reforms you are trying to accomplish in the text of these bills.

Sincerely,

DON YOUNG, Chairman.

U.S. HOUSE OF REPRESENTATIVES, Committee on Science, Washington, DC, March 27, 1996.

Hon. Pat Roberts, Chairman, Committee on Agriculture, Washington, DC.

DEAR CHAIRMAN ROBERTS: I am writing to clarify the legislative history associated with the termination of the Agricultural Weather Service which you reference in your Joint Explanatory Statement of the Committee on Conference on H.R. 2854, the Federal Agricultural Improvement and Reform Act of 1996. As you are aware, under Rule X (n)(11) of the House of Representatives, the National Weather Service (NWS) and all its programs are within the jurisdiction of the Science Committee.

Last year, during consideration of the fiscal year (FY) 1996 authorization of the NWS' programs, the Science Committee amended the NWS Organic Act to forbid the NWS from continuing specialized weather services that can be provided by the private sector including the Agricultural Weather Service. The Committee also included report language which specifically addressed the issue of the Agricultural Weather Service. Report 104-1, Part I, 

P. 162 reads:

"** The Committee supports terminat ing the National Weather Service Agricult ural and Fruit Frost specialized weather service programs in 1996. The Committee notes that concerns have been raised about terminating the programs on
October 1, 1995. The Committee believes that the Secretary of Commerce should have flexibility to continue the programs beyond October 1, 1995 if he finds that the private sector is unable to provide replacement services. Under no circumstances should such an extension last beyond April 1, 1996.

The Committee’s NWS authorization passed the House on October 12, 1995 as part of H.R. 2405, the Omnibus Civilian Science Authorization Act of 1995. On March 4, 1996, the NOAA and Atmospheric Administration (NOAA) printed notice of its intent to terminate specialized weather services including the Agricultural Weather Service on April 1, 1996 in the Federal Register.

The Science Committee continues to support the privatization of specialized weather services such as the Agricultural Weather Service. The Committee expects the service to be terminated on April 1, 1996. Further, the Committee has authorized appropriations for Agricultural Weather Service for FY 1996 or FY 1997, and no money should be appropriated for its continuation.

I hope you will help clarify the legislative history associated with the Agricultural Weather Service. Please let me know if I can provide you with any additional information on the subject.

Cordially,

Robert S. Walker, Chairman.

Hon. Robert S. Walker, Chairman, Committee on Science, Washington, D.C.

Mr. Chairman: Thank you for your letter. As you indicate, under Rule X of the House of Representatives, the National Weather Service and all its programs fall under the primary jurisdiction of the Committee on Science. The statement of the Joint Committee of Conference on H.R. 2854, the “Federal Agriculture Improvement and Reform Act of 1996”, was intended as an expression of support for the programs within the Committee’s jurisdiction and this Committee’s concern that weather service be provided to rural areas and that those involved in agriculture and other governments have adequate collection and dissemination of weather data.

Thank you for providing me with the historical context under which the Department of Commerce has recommended terminating the agricultural weather service.

Sincerely,

Pat Roberts, Chairman.

Ms. KAPUR. Mr. Speaker, I rise in support of this bill which will move the Federal Government out of planting decisions while providing some support during the shift to a market driven agricultural economy. However, I must express my strong opposition to language inserted in the bill during the conference which will severely impact our ability to move to a modern science-based meat and poultry inspection system.

Section 918 was never subject to public hearings and was not included in the Senate or House passed bills. This advisory committee would review every decision made by the Food Safety Inspection Service, including inspection procedures, labeling regulations, food safety practices in meat and poultry plants and approval of new technologies. This could delay the implementation of the new Hazard Analysis and Critical Control Points (HACCP) inspection system, a science-based system endorsed by both industry and consumers.

Further, this panel will be able to meet in secret and conduct its deliberations outside of public scrutiny because it is specifically exempt from the requirements of Federal Advisory Committee Act.

Mr. Speaker, last year there were five million foodborne illnesses and 4,000 deaths in our Nation. Section 918 has no place in this bill and we should take no actions which will decrease public confidence in the healthfulness and safety of our meat and poultry products. We have learned nothing from the recent British experience.

Mrs. MORELLA. Mr. Speaker, the conference report on the farm bill, which is before us today, will benefit farmers, rural communities, and taxpayers. I congratulate the members of the conference committee for their diligence in crafting an innovative bill that will continue to provide Americans with an affordable food supply.

I am particularly pleased that the final report contains a provision that will provide Federal funding for State farmland protection efforts. This provision will make the Federal Government a partner in gaining long-term protection of important agricultural resources. The measure will help to counter the loss of millions of acres of productive farmland to urbanization.

It has come to my attention, however, that a provision has been added to the bill in conference that threatens consumer confidence in the safety of meat and poultry in the United States. Constituents have advised me that language has been included in the conference report that is not included in the Food Safety and Inspection Service (FSIS) panel to review every decision made by the Food Safety and Inspection Service (FSIS). This panel could delay the implementation of the new Hazard Analysis and Critical Control Points (HACCP) inspection system and undermine the confidence of the FSIS.

The language calls for two new Federal Register publication steps in the decision process which would add delays to the existing decision-making process. Moreover, the provision was not subject to public debate, and it has been my experience over the years that meat and poultry inspection issues have been considered separately, not as part of past farm bills.

It is my understanding that FSIS is underfunded, and that both meat and poultry producers have complained about the shortage of inspectors. The agency simply cannot afford to pay for another advisory panel.

The Secretary of Agriculture and the Department of Agriculture point out that contaminated meat and poultry cause five million illnesses and four thousand deaths every year. The purpose of the meat and poultry inspection program is to protect human health. If this inspection system is weakened, public confidence in the safety of meat and poultry products could erode, which will not be beneficial to either consumers or the industry.

I appreciate the opportunity to add my comments regarding this innovative and important farm bill.

Mr. LATHAM. Mr. Speaker, I am pleased that the conference agreed to include a provision in the bill that I originally sponsored in the House regarding revenue insurance. I believe, as do farmers in Iowa, that revenue-based risk management tools and a vital resource for today’s and tomorrow’s American farmer as the weather, market, and global trading patterns continue to fluctuate and pose often unpredictable risks for farmers worldwide.

The FAIR Act would require the Federal Crop Insurance Corporation to offer pilot revenue insurance programs for a number of crops for crop years 1997 through 2000 so that by 2002—when the production flexibility contracts expire—we will have well-tested revenue based risk management products available for farmers.

It is very important to note, however, that it was never my intent to restrict the authority of the Federal Crop Insurance Corporation as it currently exists under law to conduct pilot programs. There are two revenue insurance pilot programs currently underway for the crop year 1996. I don’t, and I don’t believe the Conferences, intend for this new language in any way to interfere with the operation or expansion of these existing programs to other crops under the same terms and conditions under which they are currently operating—for example, on a whole state basis. Rather, my intent was to encourage the Corporation to expand current efforts to other crops and speed the development of such products for the American farmer.

I strongly urge the Corporation to further experiment with revenue-based insurance products and to do so under similar terms and conditions represented by the 1996 crop year revenue insurance programs.

I wish to state for the RECORD that I fully agree with Representative LATHAM that the FAIR Act is not intended to restrict the existing authority of the FCIC to approve pilot programs under similar terms as the 1996 revenue pilot programs. The language agreed to by the Conferences is intended to be liberating, not restricting, in terms of FCIC authority.

Mr. BUYER. Mr. Speaker, the Federal Agricultural Improvement and Reform Act (FAIR) is truly an historic opportunity for farmers and for rural communities. This legislation seeks to reform Federal agriculture programs that begin to wean farmers off government subsidies and move them toward more market oriented principles. In addition, it consolidates existing grant and loan authorities and places primary administrative responsibility with the states and is the most environmentally friendly farm bill in 60 years. This legislation is a giant step in the right direction and I enthusiastically support it.

Hoosier farmers will be the beneficiary of such incremental steps to move the farmer into the next century and be able to plant for the market. Washington bureaucrats have told farmers for far too long what to plant, when to plant, and where to plant. The result has been inefficient farm policy.

The weaning of farmers off government subsidies is important to our country’s financial health. Government should not be in the business of subsidizing inefficient operations.
Technology is ever so important to farmers. If Indiana farmers are to successfully move into the next century and compete in the world marketplace, we must continue the public/private research initiatives. This legislation will aid in the transition into the market-oriented farm policy that has been started.

Furthermore, this legislation reduces the regulatory burden on farmers. Every time I meet with Hoosier farmers, the discussion quickly turns to regulatory relief. The regulatory demands on time and resources upon the family farmer is too great. This bill is the beginning of the end of needless, overbearing regulations.

The FAIR Act continues our commitment to rural communities. Indiana, and particularly the Fifth District, have benefited tremendously over the years from rural development programs. Many rural communities throughout Indiana need assistance to meet needs which include rural housing, rural water supply and wastewater infrastructure, and rural economic development.

There are several Federal programs to assist rural communities in meeting their needs through a combination of loan and grant funds. It is this position that streamlines and consolidates a variety of existing rural development programs, in order to provide a more focused federal effort and encourage additional support at the state level.

It is important that we address rural programs that: First, provide assistance to attain basic human amenities; second, alleviate health hazards; third, promote stability of rural areas by meeting the need for new and improved rural water and waste disposal systems; fourth, meet national safe drinking water and clean water standards. Most very small systems have no credit history and have never raised capital in financial markets. Increasingly, many small communities are being forced to install or remodel water and wastewater systems in order to meet state and federal water quality standards. It is these smaller, mostly rural communities that have the most difficulty in complying with drinking water regulations and securing the financial resources to meet their needs.

This legislation seeks to authorize a new delivery system for rural development programs called the Rural Community Advance Program. It would consolidate existing grant and loan authorities and place primary administrative responsibility with the state directors of USDA’s RECS offices. Existing rural housing, development, and research programs would receive $300 million in mandatory funding.

The demand by local communities in Indiana’s 5th Congressional District facing these funding concerns during my three years in office have included, Medaryville, Francesville, Goodland, Bass Lake, Lake of the Woods, Monticello, Buffalo, New London, Lowell, Cedar Lake, Cayuga, Wheatfield, DeMotte, Kewanna and Fowler. All of these communities are small towns with limited resources. Municipal water supplies and wastewater treatment facilities not only help protect the environmental resources of these communities, but they also form the infrastructure framework necessary to attract economic development.

Rural development is an integral part of the farm bill. Rural America must have access to the economic infrastructure to enable it to compete, including clean water, adequate housing, and good/low cost sewage infrastructure; all of which are prominent issues to Hoosiers in rural America.

The FAIR Act marks the most environmentally friendly farm bill in 60 years. It lifts the restrictions that tied farmers to the same crop year after year, which will allow them to maintain soil health and fertility through crop rotation. Thus, farmers will rely less on chemical fertilizers, herbicides and pesticides to maintain yields.

The FAIR Act promotes soil conservation and wetlands protection by requiring all regulations of such, to be met in order for farmers to qualify for payments. Additionally, it authorizes for seven years two successful programs, the Conservation Reserve Program and the Wetlands Reserve Programs, creates the Quality Incentives Program, and protects wetlands, water quality, and fights erosion.

Hoosiers will be the beneficiary of this legislation. Weaning farmers off government subsidies and lessening government involvement will provide America’s agri-businesses the opportunity to be the most productive and the most cost effective in the world.

Mr. Speaker, the Federal Agricultural Improvement and Reform Act is an historic opportunity for farmers and for rural communities. The FAIR Act reforms programs dealing with things that are at the state and local level and moves them into the next century. This bill gives Hoosier farmers the opportunity to do what they do best—farm the land with minimal government interference and provide the resources to improve the quality of life in rural communities.

I strongly support the FAIR Act.

Mr. RICHARDSON. Mr. Speaker, farmers in my district are in desperate need of some type of farm legislation now. Although I am not totally sold on the free market concept, I fully support this conference report which will provide our nation’s producers with some direction immediately.

I think the House and Senate Agriculture Committees have done a good job of shaping a bill with peanut program reforms that will make it no-net costs.

I believe the conservation programs contained in this bill are the strongest that we have ever reported out in a farm bill. This bill retains our commitment to help farmers as the stewards of America’s land.

I am also pleased to see that the conference committee chose to include the fund for rural America. This fund will give small towns in rural America the tools through research and economic development activities to provide their citizens with wastewater and sewer systems and the basic infrastructure to survive.

When we talk about reforming agriculture policies we must also talk about the needs of rural communities whose economies rely heavily on agriculture production.

Mr. Speaker, it is time to send the President this agreement on farm policy.

Mr. SKAGGS. Mr. Speaker, I want to focus briefly on one section of this conference report that’s particularly important for Colorado and other western States where municipal water supply facilities are located on or above National Forest lands.

During its consideration of this bill, the Senate adopted an amendment by Colorado’s senior Senator that would have amended existing laws applicable to the National Forest System. The amendment was explained as a response to Forest Service proposals that renewal of permits for water facilities serving several Colorado municipalities be accompanied by changes in the management of those facilities that would result in smaller diversions from streams on National Forest lands.

In arid States like Colorado, Mr. Speaker, no issues are more sensitive and important than those relating to water. So, even though I had very serious concerns about how this amendment would affect management of the National Forests, I understood why Senator BROWN attached such importance to this matter.

But I was disappointed to note that in his explanation of the amendment, the Senator referred to Boulder, a city located in my congressional district. It seems to me that this could have lead some to mistakenly think there’s a need for new legislation to resolve a dispute between that city and the Forest Service. In fact, however, that is not the case. It’s true that the city of Boulder wants to replace a water supply pipeline that now brings water across National Forest lands. But the city and the Forest Service are not in deadlock. Rather, they are both acting in accordance with agreements, worked out previously, to maintain the terms and conditions of an easement for the pipeline and the procedure to be followed in determining its route. Furthermore, Boulder has reached an agreement with the State of Colorado regarding continued in-stream flows, and the Forest Service has determined that this meets relevant requirements, so that there is no need for the city to take further steps to maintain bypass flows.

So, in addition to other serious reservations about Senator Brown’s amendment, I was concerned that its enactment might undermine the progress that Boulder and the Forest Service had made in connection with the pipeline project.

I was also concerned that a letter from Boulder’s city manager to Senator Brown regarding the amendment might have the inadvertent effect of creating confusion about the Boulder pipeline project. To clarify matters, I’ve both met and corresponded with the city manager, who confirmed that they are working toward a successful outcome to the pipeline project. For reference, I am attaching my letter to the city manager and his reply as part of this statement.

For all these reasons, I’m glad that the conference report drops the original language of the Brown amendment and instead provides for an 18-month moratorium on certain Forest Service decisions while a special task force develops recommendations for possible ways to address this subject. I am also very pleased to note that the conferences, in the statement of managers regarding section 389, make it clear that “the moratorium imposed by this section is not intended to interfere with the ability of the Forest Service to negotiate or enter into agreements or voluntary agreements concerning the use of National Forest land for water supply facilities.”

In other words, Mr. Speaker, enactment of section 389 of this conference report will neither rewrite the laws applicable to management of the National Forests nor interfere with continued progress in connection with Boulder’s pipeline. The Forest Service will be able...
to proceed with issuance of a draft environmental impact statement concerning possible routes, and the terms and conditions of an easement across National Forest lands will be as provided in the existing agreement between the Forest Service and the city of Boulder. Therefore, I can support this part of the conference report.

The letter repeats some of the city's previous expressed complaints about the U.S. Forest Service's approach to permitting renewal for the Lakewood Pipeline, and it provides a somewhat historical outline that includes description of more recent negotiations, agreements, and environmental reviews in which the city and the Forest Service are engaged.

Frankly, I was a little surprised by the letter's emphasis on problems the city feels it has had in the past with this process since I had heard that, through negotiations, I was pleased to sponsor, most of those problems had been resolved or set aside.

In particular, the city and the Forest Service agreed to language for a water conveyance facility easement for the pipeline. That language does not, as I understand it, negate the city's claim to a permanent right-of-way for the pipeline, but rather postpones an assertion of that right while the easement is in place.

I was also pleased that we were able to secure in the easement negotiated with the Forest Service its acknowledgement that the city's in-stream flow agreement with the State of Colorado is sufficient for forest management purposes.

Also, as you know, the city and the Forest Service have entered into a memorandum of understanding that is now guiding formal and public consideration and comparison, under the National Environmental Policy Act (NEPA) process, for locating and constructing the rebuilt pipeline. While these agreements are described in the background paper attached to the letter, the letter itself seems to suggest that there has been a lack of cooperation and effort on the part of the Forest Service toward fulfillment of these agreements.

The letter, for example, speaks of the city's difficulty with another provision in the easement language agreement, relating to compliance with Forest Management Plan standards and guidelines. Is there some failure of the Forest Service to proceed in an effort on the part of the Forest Service toward the letter, the letter itself seems to suggest that there has been a lack of cooperation and effort on the part of the Forest Service toward fulfillment of these agreements.

With regards to the city's in-stream flow agreement with the State of Colorado, I did not mean to imply that the Forest Service doesn't recognize and support this program. In fact, it is our understanding that the Forest Service has evaluated and determined that the in-stream flow program does meet the Forest Management Plan standards and guidelines and no additional bypass flows will be required, and I expect that the draft EIS will reflect this.

With respect to compliance with the Forest Management Plan, the MOU indicates that the EIS will analyze the information in compliance with the National Forest Management Act of 1976, as well as other applicable statutes, regulations and Forest Service Manual direction. In addition, the MOU states that the Forest Service will assure compliance with all existing water quality and environmental regulations. There is not specific statement about the Forest Management Plan standards and guidelines. At this point, we don't know if there will be any difficulty in complying with the Forest Management Plan until the draft EIS is released and the Forest Service's analysis is reviewed by the public. Between the time I signed the MOU and the decision is implemented, more than 2 years have passed, and some changes to the Forest Management Plan may have occurred. At this point, I just don't know what the impacts of these changes may mean.

My previous letter included a discussion about some of the alternatives to the failure of the January 26 letter to Senator Brown expressing support for his amendment to the farm bill dealing with water facilities on national forest land.
Two years ago, I sent a dear colleague to Members bringing their attention to an article I read in “equidave,” the National Horseman’s Inc. publication, that exposed the inhumane treatment of horses transported for slaughter. Two constituents in my district visited a horse auction in New Holland, PA and described the horrible conditions to which these horses are subjected. Imagine injured, pregnant, and ill horses crammed into cattle cars with combative stallions and other horses to be shipped on long journeys to slaughterhouses with no dividers separating them. Often, these horses travel for days without food. As a thoroughbred owner, I find this appalling.

While Americans traditionally view horses as pets or companions, the reality is that many of our beloved friends are sent to slaughterhouses for consumption in European, Asian, and Latin countries. Horses have a unique, trusting relationship with people and deserve to have a humane and dignified end to their lives as other household pets.

Fortunately, through the hard work of Senator MITCH MCCONNELL, Congressman GUN- DERSON and other Members of the House and Senate Agriculture Committee, the conference committee was able to come to a compromise on language that will ensure the safe transportation of horses for slaughter while protecting other livestock and poultry for slaughter from regulations. The language provides authority to the Secretary of Agriculture to authorize guidelines for the regulation of persons engaged in the commercial transportation of horses for slaughter. The Secretary shall consider in carrying out this section of the bill food, water, rest, and the segregation of stallions from other horses during transportation. I am hopeful these guidelines will be issued in a timely manner to protect the thousands of horses sent to slaughter each year. I would suggest the Secretary consider requiring horses be rested and provided food and water after traveling no longer than 10 hours, vehicles be required to be in sanitary condition and provide at least 7 feet, 6 inches of headroom, and provide for the separation of stallions from other horses.

This legislation has the full support of the horse industry and animal feed industry including the American Horse Council, the American Horse Protection Association, the Humane Society of the United States, the American Association of Equine Practitioners, American Horse Shows Association, American Veterinary Medical Association, Pennsylvania Horse Breeders Association, the American Feed Industry Association, and the National Pork Producers.

Once again, I would like to thank the Members of the House and Senate conference committee for their compassion and hardwork. I am sure this legislation will go a long way in protecting horses transported for slaughter and provide incentive for those in the industry to treat horses with greater care and respect.

Mr. ROBERTS. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the conference report.

The previous question was ordered. The SPEAKER pro tempore (Mr. OXLEY). The question is on the conference report. The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.
By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

The following Members (at the request of Mr. JEFFERSON) to revise and extend their remarks and include extraneous material:

Mr. SKEELTON, for 5 minutes, today.

Ms. KAPUTR, for 5 minutes, today.

Mr. PETE GEREN of Texas, for 5 minutes, today.

Mr. BROWDER, for 5 minutes, today.

**SPECIAL ORDERS GRANTED**

By unanimous consent, permission to revise and extend remarks was granted to:

(Mr. MOAKLEY, and to include extraneous material, after debate on the unfunded mandate motion to recommit H.R. 3136 today.)

(Mr. FAWELL and to include extraneous material notwithstanding the fact that it exceeds two pages of the RECORD and is estimated by the Public Printer to cost 1,742.)

(Mr. MCINNIS at the request of Mr. KOBLE, and to include extraneous material on the reconciliation rule of last year.)

(The following Members at the request of Mr. JEFFERSON and to include extraneous matter.)

Mr. TORRES.

Mr. STARK.

Mr. NEAL of Massachusetts.

Mr. POSHARD.

Mr. WARD.

Mr. MILLER of California.

Mr. FROST.

Mr. J. ACOLS.

Ms. ESHOO.

Ms. FURSE.

Ms. EDDIE BERNICE JOHNSON of Texas.

Mr. MONTGOMERY.

Mr. BROWDER.

Mrs. LOWEY.

Mr. SKAGGS.

(The following Members at the request of Mr. HAYWORTH and to include extraneous matter.)

Mr. BUNNING of Kentucky.

Mr. SHUSTER.

Mr. SOLOMON.

Mr. COMBEST.

Mr. FLANAGAN.

Mr. DAVIS.

Mr. FORBES.

Mr. CAMP.

Mr. ROGERS.

Mr. WELDON of Pennsylvania.

Mr. MOORE.

Mr. EWIN.

Mr. CUNNINGHAM.

Mr. RIGGS, in two instances.

Mr. SMITH of Michigan.

Mrs. KELLY.

Mr. OXLEY.

Mr. HORN.

Mr. M. MOLINARI.

Mr. CLINGER.

Mr. GILMAN.

Mr. BUYER.

Mr. PACKARD.

Mr. BUNN of Oregon.

Mrs. MYRICK.

**ENROLLED BILL AND JOINT RESOLUTION SIGNED**

Mr. THOMAS, from the Committee on House Oversight, reported that that committee had examined and found truly enrolled a bill and joint resolution of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 2966. An act to eliminate the Board of Tea Exports by repealing the Tea Importation Act of 1897.

**SENATE ENROLLED BILL SIGNED**

The SPEAKER announced his signature to enrolled bills of the Senate of the following titles:

S. 4. An act to give the President line item veto authority with respect to appropriations, new direct spending, and limited tax benefits.

**ADJOURNMENT**

Mr. HAYWORTH. Mr. Speaker, I move that the House do now adjourn. The motion was agreed to; accordingly (at 12 o'clock and 42 minutes a.m.), the House adjourned until today, Friday, March 29, 1996, at 10 a.m.

**EXECUTIVE COMMUNICATIONS, ETC.**

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

S. 2311. A letter from the Secretary of Defense, transmitting the Department's report entitled "Annual Report to the President and the Congress, March 1996;" pursuant to 10 U.S.C. 133 (c) and (e); to the Committee on National Security.

S. 2312. A letter from the Comptroller General of the United States, transmitting the list of all reports issued or released in February 1996, pursuant to 31 U.S.C. 733(h); to the Committee on Government Reform and Oversight.

of Public Law 104-8 to the Committee on Government Reform and Oversight.

231A. A letter from the Chairman, Nuclear Regulatory Commission, transmitting a copy of the prelicense permit to the Government in the Sunshine Act during the calendar year 1995, pursuant to 5 U.S.C. 552(b); to the Committee on Government Reform and Oversight.

231B. A letter from the Commissioner, Social Security Administration, transmitting a report on the activities under the Freedom of Information Act for the calendar year 1995, pursuant to 5 U.S.C. 552(d); to the Committee on Government Reform and Oversight.

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. GOODLING: Committee on Economic and Educational Opportunities. H.R. 3055. A bill to amend section 326 of the Higher Education Amendments Act of 1992, to permit continued participation by historically Black Graduate Professional Schools in the grant program authorized by that section (Rept. 104-504). Referred to the Committee of the Whole House on the State of the Union.

Mr. GOODLING: Committee on Economic and Educational Opportunities. H.R. 3048. A bill to amend title 26 of the Internal Revenue Code of 1986 to provide for increased taxpayer protections, with an amendment (Rept. 104-506). Referred to the Committee of the Whole House on the State of the Union.

Mr. ARCHER: Committee on Ways and Means. H.R. 2337. A bill to amend the Internal Revenue Code of 1986 to provide for increased examiner resources, with an amendment (Rept. 104-508). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 2502. A bill to extend the deadline under the Federal Power Act applicable to the construction of a hydroelectric project in the State of Kentucky, and for other purposes; with an amendment (Rept. 104-509). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 2502. A bill to extend the deadline under the Federal Power Act applicable to the construction of certain hydroelectric projects in the State of Pennsylvania, with an amendment (Rept. 104-509). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 2502. A bill to extend the deadline under the Federal Power Act, as amended by the Federal Power Regulatory Improvement Act of 1994, applicable to the construction of 2 hydroelectric projects in North Carolina, and for other purposes; with an amendment (Rept. 104-510). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 2502. A bill to extend the deadline under the Federal Power Act applicable to the construction of a hydroelectric project in Ohio, and for other purposes; with an amendment (Rept. 104-511). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 3189. A bill to extend the deadline for commencement of construction of a hydroelectric project in the State of Kentucky; with an amendment (Rept. 104-512). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 2869. A bill to extend the deadline for commencement of construction of a hydroelectric project in the State of Kentucky; with an amendment (Rept. 104-513). 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. FROST: H.R. 3090. A bill to extend the deadline for commencement of construction of a hydroelectric project in the State of Kentucky; with an amendment (Rept. 104-514). Referred to the Committee of the Whole House on the State of the Union.

By Mr. ESCH: H.R. 3182. A bill to prohibit providers of cellular and other mobile radio services from blocking access to 911 emergency services; to the Committee on Commerce.

By Mr. EWING (for himself, Mr. POSHARD, Mr. WELLER, Mr. LAHOD, and Mr. EMERSON): H.R. 3182. A bill to amend title 49, United States Code, relating to alcohol and controlled substances testing of operators of motor vehicles used to transport agricultural commodities and property for small local governments; to the Committee on Transportation and Infrastructure.

By Mr. MONTGOMERY: H.R. 3182. A bill to amend title 38, United States Code, to limit the amount of recoupment from veterans’ disability compensation that is required in the case of veterans who have received certain separation payments, with an amendment (Rept. 104-516). Referred to the Committee of the Whole House on the State of the Union.

By Mr. HORN (for himself, Mr. CLINGER, Mr. DAVIS, Mrs. MALONEY, Mr. BREWER (of Connecticut), and Mr. LARGENT): H.R. 3184. A bill to streamline and improve the effectiveness of chapter 75 of title 31, United States Code—commonly referred to as the Single Audit Act; to the Committee on Government Reform and Oversight.

By Mr. DINGELL (for himself, Mr. BENSEN, and Mr. SPROTT): H.R. 3185. A bill to increase access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, and to increase the deduction for health insurance costs of self-employed individuals, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Commerce, and the Committee on Economic and Educational Opportunities, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as may fall within the jurisdiction of the committee concerned.

By Mr. CLAY: H.R. 3185. A bill to designate the Federal building located at 1655 Woodson Road in Overland, MO, as the “Sammy L. Davis Federal Building”; to the Committee on Transportation and Infrastructure.

By Mr. CLYBURN: H.R. 3187. A bill to amend title 49, United States Code, to provide protection for airline employees who provide certain airport safety information; to the Committee on Transportation and Infrastructure.

By Mr. KLEIST: H.R. 3188. A bill to amend title 49, United States Code, to limit the applicability of hazardous material transportation requirements for persons who offer crude oil and condensate for transport in commerce, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. DAVIS (for himself, Mr. ENGLISH of Pennsylvania, and Mr. ROBBINS): H.R. 3189. A bill to delay the privatization of the Office of Federal Investigations of the Office of Personnel Management in order to allow sufficient time for a thorough review to be conducted as to the feasibility and desirability of any such privatization, and for other purposes; to the Committee on Government Reform and Oversight.

By Mr. FRANKS of Connecticut: H.R. 3190. A bill to prohibit Federal agencies to require or encourage preferences on race, sex, or other personal characteristics, in connection with Federal contracts; to the Committee on Government Reform and Oversight.

By Mr. KLING: H.R. 3191. A bill to authorize a program of grants to improve the quality of technical education in manufacturing and other vocational technologies; to the Committee on Economic and Educational Opportunities.

By Mr. MOOREHEAD: H.R. 3192. A bill to make amendments to section 119 of title 17 of the United States Code; to the Committee on the Judiciary.

By Ms. PELOSI: H.R. 3193. A bill to recognize the significance of the AIDS Memorial Grove, located in Golden Gate Park in San Francisco, CA, and to direct the Secretary of the Interior to designate the AIDS Memorial Grove as a national memorial; to the Committee on Resources.

By Mr. PUCKETT: H.R. 3194. A bill to provide that the property of innocent owners is not subject to forfeiture under the laws of the United States; to the Committee on the Judiciary.

By Mr. SANFORD (for himself, Mr. BENTSEN, Mr. BRADY of Pennsylvania, Mr. BREWER, and Mr. McGOWAN): H.R. 3195. A bill to amend title 23, United States Code, to modify the minimum allocation formula under the Federal-aid highway program, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. SHAYES: H.R. 3196. A bill to increase the penalty for trafficking in powdered cocaine to the same level as the penalty for trafficking in crack cocaine; to the Committee on the Judiciary.

By Mr. SANFORD (for himself, Mr. PETE GOREN of Texas, Mr. ARCHER, Mr. SHADEGG, and Mr. HALL of Texas): H.J. Res. 168. Joint resolution proposing an amendment to the Constitution of the United States relating to taxes; to the Committee on the Judiciary.

PRIVATE BILLS AND RESOLUTIONS

Under clause I of rule XXII, Mr. PUCKETT introduced a bill (H.R. 3197) for the relief of Emma W. Todd; which was referred to the Committee on the Judiciary.

ADDITIONAL SPONSORS

Under clause 4 of rule XXII, sponsors were added to public bills and resolutions as follows:

H.R. 244: Mr. HOKE.
H.R. 452: Mr. Inglis of South Carolina.
H.R. 500: Mr. Cox.
H.R. 894: Mr. Ackerman.
H.R. 895: Mr. Bonilla, Mr. Gene Green of Texas, Mr. Duncan, Mr. Hoekstra, Mr. Neal of Massachusetts, Mr. Bono, Mr. Cunningham, Mr. Stupak, Ms. Pryce, Mr. DeFazio, Mr. Thornberry, and Mr. Visclosky.
H.R. 1044: Mrs. Myrick.
H.R. 1363: Mr. Bryant of Tennessee and Mr. Heineken.
H.R. 1406: Mr. Saxton.
H.R. 1619: Mr. Torres.
H.R. 1625: Mr. Quillen.
H.R. 1627: Mrs. Roukema.
H.R. 1755: Mr. Camp and Mr. Barcia of Michigan.
H.R. 1893: Mr. Rahall, Mr. Evans, Mr. Ehrlich, and Ms. DeLauré.
H.R. 1963: Mr. Hilliard.
H.R. 2099: Mr. White, Mr. McDermott, Mr. Dicks, and Mr. Peterson of Minnesota.
H.R. 2240: Mr. Reed.
H.R. 2320: Mr. Martini, Mr. McKeon, Mr. English of Pennsylvania, Mr. Nussle, Mr. Matsui, Mr. Thomas, and Mr. Manton.
H.R. 2471: Mr. Barrett of Wisconsin.
H.R. 2508: Mr. Kildee, Mr. Livingston, Mr. Barr, Mr. Callahan, Mr. Canady, and Mr. Wise.
H.R. 2531: Mr. Schaefer.
H.R. 2566: Mr. Klecza.
H.R. 2579: Mr. Sawyer, Mr. Burr, Mr. White, Mr. Collins of Georgia, Mr. Laughlin, Mr. Talent, and Mr. McCrery.
H.R. 2651: Mr. Bilirakis, Mr. Mchale, and Mr. Solomon.
H.R. 2697: Mr. Gutierrez and Mr. Abercrombie.
H.R. 2745: Mr. Kasich.
H.R. 2820: Mr. Collins of Georgia, Mr. Laughlin, Mr. Talent, and Mr. McCrery.
H.R. 2864: Mr. Vento.
H.R. 2992: Mr. Clement, Mr. Calvert, Mr. Olver, Mr. Abercrombie, Mr. Baker of Louisiana, and Mr. Lipinski.
H.R. 2912: Mr. Klecza, Mr. Hilliard, Mr. Rahall, Mrs. Thurman, and Mr. Kildee.
H.R. 2925: Mr. Bonilla.
H.R. 2928: Mr. Metcalf, Mr. Weller, and Mr. Coburn.
H.R. 2930: Mr. Watts of Oklahoma.
H.R. 2938: Mr. Durbin, Mr. Ehlers, Mr. Smith of New Jersey, Mrs. Johnson of Connecticut, and Mr. Bilbray.
H.R. 2959: Mr. Leach.
H.R. 3011: Mr. Tate and Mr. McIntosh.
H.R. 3067: Mr. Condit, Mr. Manton, Mrs. Thurman, and Ms. Danner.
H.R. 3095: Mr. Kolbe.
H.R. 3142: Mr. Stearns, Mrs. Seastrand, Mr. Sawyer, Mr. Gordon, Mr. Cox, Mr. Dormann, Mr. Farr, Mr. Oberstar, and Mrs. Smith of Washington.
H.J. Res. 70: Mr. Tejeda, Mr. Berman, and Mr. Sanders.
H. Con. Res. 47: Mr. Hunter.
H. Con. Res. 152: Mr. Nethercutt, Mr. Ortiz, Mr. McHugh, Mr. Bonilla, and Mr. Stupak.
H. Con. Res. 155: Mr. Payne of New Jersey, Mrs. Clayton, and Mr. Gilman.
H. Res. 123: Mr. Rahall, Mr. Packard, and Mr. Dornan.
H. Res. 285: Mr. Bonior.
H. Res. 359: Mr. Frazer, Ms. Molinari, Mr. Andrews, Mrs. Kennelly, Mrs. Meek of Florida, Mr. Vento, and Mr. McCinnes.
H. Res. 381: Mr. DeFazio, Mr. Kennedy of Rhode Island, Mr. Underwood, Mrs. Seastrand, Mr. Horn, and Mr. Stockman.
H. Res. 385: Mrs. Morella, Mr. Rangel, and Mr. Orton.