United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 104th CONGRESS, SECOND SESSION

Vol. 142 WASHINGTON, THURSDAY, MARCH 28, 1996 No. 45

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.

THE JOURNAL

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

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

PLEDGE OF ALLEGIANCE

The SPEAKER. 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.

MESSAGE FROM THE SENATE

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 spent six years in the Maine House of Representatives, becoming minority leader;

Whereas, in 1954, 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 1958 to become the first popularly elected Democratic Senator in Maine's history;

Whereas, Edmund S. Muskie in 1968, 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 adjourn 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

H. Con. Res. 147. Concurrent resolution authorizing the use of the Capitol grounds for the fifteenth annual National Peace Officers' Memorial Service.

The message also announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 4) ''An act to grant the power to the President to reduce budget authority.''

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.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will recognize 15 Members on each side for 1–minutes.

UNION BOSSES ATTACKING THE PREFERRED REPUBLICAN VISION OF THE FUTURE

(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.

HEALTH REFORM DOES NOT HELP THE JOBLESS

(Mr. TRAFICANT asked and was given permission to address the House

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

Printed on recycled paper containing 100% post consumer waste

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, averaging 14 points per game.

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.

HOUSE LEADERSHIP HAS SURRENDERED TO THEIR EXTREMISTS

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

Ms. MCCARTHY. Mr. Speaker, today we have an opportunity to give the American people something they want and something they need, a guarantee that if they change jobs they will not lose their health insurance.

It is that simple. We know how to do it. The President, the Republican Senate and House Democrats all agree.

So I ask what is the problem? the problem is that the House leadership has surrendered to their extremists and loaded up a truly bipartisan bill with special interest provisions that would cost the American taxpayer millions of dollars.

My constituents are not asking for something for nothing. They are willing to pay for health insurance.

Let us push those special interests aside, work together, and give American families basic security.

Mr. Speaker, I urge the Republican leadership to put politics aside, clean up this bill so we can give Americans this important first step toward health care reform. It is the right thing to do.

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 immeasurably, and once again, Mr. Speaker, it comes down to this basic question:

Why should we be afraid to let the American people have control of their own money, have control of their own future, and again, Mr. Speaker, it comes down to this question:

Who do we trust; the people of the United States or the Washington bureaucrats?

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. We can pass legislation which 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 they get sick, they can stll 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 Congres 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 give terminally ill patients 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 timeable 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 actually 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 if they do that, it'll die.''

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.

□ 1015

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 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 Tillett, 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 to our tribute.

I want to thank the LaSalle Lancers and congratulate them for winning the State championship this year. Way to go, Lancers.

PRESERVE BIPARTISANSHIP IN SUPPORT FOR HEALTH CARE REFORM

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

Mr. WYNN. Mr. Speaker, as Members well know, bipartisanship are those rare occasions on which the Democrats and the Republicans agree. We have found some agreement. We agree we need health care reform that provides portability so people can change jobs and keep their health insurance. We agree that we need to prevent people from being barred from insurance because of preexisting conditions. The question becomes, why do we not pass the bill that we both agree on. I will tell Members why: because the Republicans want to ruin this bill, kill this bill with extraneous material to benefit their wealthy friends.

Once again, they ruined 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, those who are poor, those 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.

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 their constituents 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 out, you know, ''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 this morning 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 bipartisanship support. The Kennedy-Kassebaum bill simply says we want to give people the ability to have health care if they lose their job. If, tragically, they have a preexisting disease, lung disease, cancer, or heart disease, then we still care about them, and they can have insurance and be able to survivie.

But Robin Hood and the seven thieves, the House Republican leadership, wants to say, ''We want to give the money to the rich. We want to make sure we have a medical savings plans,'' which allows people to hoard money away, and those who are working and the working poor and those who are sick will not have the ability to have good health insurance because the medical savings plan is applicable only to the wealthy and the healthy. We will find out that under this Republican medical savings plan, working people will be left out in the cold. They would leave less healthy people to buy ordinary medical insurance at elevated prices because of this proposed medical savings plan. People who in fact lost their jobs would not have insurance.

Let us not kill this bill. Let us support good health reform. Let us pass the Kennedy-Kassebaum bill in a truly bipartisan manner for all Americans to have portability in health insurance coverage and coverage if you have a preexisting condition.

SUPPORT H.R. 3103, THE HEALTH CARE COVERAGE AVAILABILITY AND AFFORDABILITY ACT

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

Mr. NORWOOD. Mr. Speaker, today we will make a great step forward, in my opinion, in making health care available to all Americans. The Health Care Coverage Availability and Affordability Act will give Americans the two things they need most: increased access to health care and decreased cost. We will give hardworking Americans increased access by addressing the issues of preexisting conditions and portability. We will decrease the cost by

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 pages of new regulations.

Mr. Speaker, we are increasing access while lowering costs. Should that not be the goal of any health care legislation? We are doing it with as little government influence as possible, or interference. I urge my colleagues to support 3103, and I would remind them that when we talk in this body about rich and wealthy, the liberal Democrats define that as anybody with a job.

DO NOT LET THE REPUBLICAN PARTY OBSTRUCT HEALTH CARE REFORM TODAY

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

Mr. DOGGETT. Mr. Speaker, among the greatest failures of this failed Republican Congress is the failure to address the real health care needs of the American people. Mr. Speaker, the failed Contract on America was essentially silent on this question. Last year Speaker GINGRICH's entire program on health care was, to use his words, let Medicare wither on the vine for the health care security of our seniors.

This year the strategy is a little different. It has been spelled out here in black and white in the House Republican national strategic plan for 1996. The health care plan they outline is, and I quote: ''We will pursue a targeted inoculation strategy on Medicare''; not to inoculate against illness among the American people, but to inoculate against one of the most highly contagious illnesses politically in this country, and that is that the American people are beginning to understand the neglect and the failure of this Congress brought on by this Republican Party that cares more about special interests than the true national interests of the American people. Do not let them obstruct health care reform today. Let us do something for the 42 million American people who lack health insurance, health insurance coverage.

THE TRUTH ABOUT THE SPEAKER'S REMARKS ON HCFA AND MEDICAL SAVINGS ACCOUNTS

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

Mr. WELDON of Florida. Mr. Speaker, I rise to correct the RECORD. The Speaker of the House stated that he would like to see the Health Care Financing Administration, which is the big bureaucracy created by liberal Democrats in Washington that processes all the claims, he would like to see that wither on the vine, and the gentleman from Texas has misquoted the Speaker.

I would also like to rise in support of medical savings accounts. One of the biggest reasons why we have terrible health care inflation in American is because the providers and the consumers, both the doctor and the patient, are not the ones picking up the tab, and in medical savings accounts, the patients suddenly become wise and discriminating consumers. Where medical savings accounts have been implemented, cost savings average 17 percent. A 17-percent reduction in our health care costs 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.

THE HEALTH CARE REFORM BILL

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

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.

RECOGNIZING A GOOD IDEA: MEDICAL SAVINGS ACCOUNTS

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

Mr. MICA. Mr. Speaker, I was going to speak on another subject, but I have to comment on the lack of information that the other side has on medical savings accounts. I, in fact, as chair of the Subcommittee on Civil Service of the Committee on Government Reform and Oversight, held hearings on this. We found that in every instance, for almost every State and local government that testified on these, we found lower costs, lower premiums, expanded coverage.

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 think if we had a new idea and it came up and bit them on the leg, they would not even recognize it. Mr. Speaker, this is a new idea. It saves costs. It saves premiums. It is a good idea. It is time for it.

REPUBLICAN ADD-ONS MAY DERAIL BIPARTISAN HEALTH REFORM TRAIN

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

Mrs. SCHROEDER. Mr. Speaker, health insurance has really not been insurance for a very long time, because we have allowed those companies to refuse coverage to anybody who needs it. So today we have a great chance to do something about this. We have a chance to free people up who have been locked in their jobs because they do not dare lose their health insurance, and we have the ability of people to be able to port around their insurance coverage. And the Republican extremists in the House are about to derail this bipartisan train, this bipartisan train that came speeding out of the Senate, and this bipartisan train that the New York Times is talking about today, as they say, ''The House Republicans have added amendments that are not only bad health policy, but could delay passage of this useful health care reform.''

Mr. Speaker, I think it is time we stand up and say to the extremists, ''Please, stop this. America has been waiting much too long for this portability and for having some price constraints, and ending the denying of these preexisting conditions as a way to shut you out of your health care. Stand up to the extremists, finally. Please, let us get some health care reform.''

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

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

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. Many Americans wrongly assumed that Government programs or their general insurance 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. OLVER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. OLVER. Mr. Speaker, American families are losing their health insurance every day because of corporate 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.

□ 1030

But the House Republican leadership is turning straightforward reform into a goodie 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 500,000 jobs since 1972, closed half of their 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 can 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. The President agrees. He said, I will sign Kennedy-Kassebaum, it is a good first beginning in health care reform. The other body agrees. They have passed a bipartisan piece of legislation. The House Democrats agree. We will offer a substitute today that contains the Kennedy-Kassebaum bill. It is a clean, a good bill. Even some House Republicans agree. The substitute that we will introduce today was introduced originally by a Republican.

Mr. Speaker, there is one problem. Some people are not satisfied with fixing this problem. They want to add 10 new provisions in health care reform, 10 new insurance provisions that are too complicated. Pass the Kennedy-Kassebaum bill, begin health care reform.

NOT IF BUT WHEN

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

Mr. ISTOOK. Mr. Speaker, no nation can be secure if it depends on another nation for its economic lifeblood. Five years ago, we sent 500,000 American troops to the Persian Gulf to fight for oil. In 1991 we imported 45 percent of our oil. Today, we import 52 percent, 9 million barrels per day, annually $60 billion going out of the country to buy oil.

The number of producing wells in this country has declined by 11 percent since the gulf war. Instead of becoming less dependent on foreign oil, we are more so. 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 preserve America's independent producers of petroleum.

HEALTH CARE REFORM

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

Ms. DELAURO. Mr. Speaker, 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 have had an illness which they have managed to survive, that in fact insurance companies will deny them insurance because of a preexisting 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 incompleteness, that there was still work to be done.

We need a constitutional amendment to require a balanced budget, said Ronald Reagan. He went on to say: And the 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 will have 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 Americans will stay 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 everything on both sides really 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 it on a big one.

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 adopted. The previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto to final passage without intervening motion except: (1) one hour 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 without intervention 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 considered as read, and shall be separately debatable for 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 to accompany 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 that conference report.

□ 1045

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from New York [Mr. SOLOMON] is recognized for 1 hour.

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

(Mr. SOLOMON asked and was given permission to include extraneous material.)

AMENDMENT OFFERED BY MR. SOLOMON

Mr. SOLOMON. Mr. Speaker, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. SOLOMON:

Page 2, line 9, strike ''one hour'' and all that follows through ''Means'' on line 12, and insert in lieu thereof the following:

''80 minutes of debate on the bill, as amended, with 60 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means and 20 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Government Reform and Oversight or their designees''.

Mr. SOLOMON. Mr. Speaker, I ask unanimous consent that the amendment be agreed to.

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

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from New York.

Mr. SOLOMON. Mr. Speaker, I thank the gentleman from California [Mr. BEILENSON]. He is one of the most understanding Members of this body. He is going to be leaving us at the end of this year and we are going to miss him. We do not always agree, but he is one fine gentleman.

Mr. Speaker, House Resolution 391 provides for consideration of the bill H.R. 3136, the Contract With America Advancement Act of 1996. That is important. This bill contains the Senior Citizens Right to Work Act of 1996. It contains the Line-Item Veto Act, the Small Business Growth and Fairness Act of 1996, and a permanent increase in the public debt limit.

Believe me, if it were not for these other issues I just read off, I would not be standing up here supporting the increase in the debt limit for this Government. Not only does this bill represent the completion of three major contract promises, but it represents the product of bipartisan, bicameral and dual-branch negotiations. Think about that, ladies and gentlemen. That is cooperation. The bill before us today addresses concerns of both houses of Congress and the Clinton administration as well.

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. The rule provides for the adoption of 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 amendments address specific concerns of the administration and 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 waives 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 20 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 occurred last night after 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 the Senate 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 on S. 4, 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, three to one; you have 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.

It 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 allows them to expand employment in the marketplace and to grow our Nation's economy and grow jobs for high school students graduating and college students, as well.

Now, while this regulatory reform does not go as far as I would like to see it, it still represents a dramatic shift in the direction of regulatory relief that was promised in the contract for America. Mr. Speaker, this was another promise Republicans made, and this is another promise Republicans are going to keep here today.

Mr. Speaker, title II of the bill represents legislation that is near and dear to my personal heart, legislation that I have worked to pass for more than 18 years here in this Congress. Title II is the Line-Item Veto Act. It represents fundamental budget process reform, and I never thought it would happen. After many hearings, three committee markups, 2 days of floor consideration in the House, 1 week of floor consideration in the Senate, and more than a year of debate in a committee on conference, a thoroughly researched, extensively debated and well drafted bill has finally been produced.

The conferees, 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 that takes up almost all of the budget, these entitlement programs.

This delegated authority will allow the President to cancel any new expansions of direct spending.

Now, with regard to tax benefits, the President is permitted to cancel any limited tax benefits identified by the nonpartisan Joint Committee on Taxation in any revenue or reconciliation law. In an effort to limit this delegated cancellation authority, the line-item veto requires that the cancellations may be made if the President can determine that such cancellation would reduce the Federal budget deficit.

Most importantly, Mr. Speaker, in order to ensure reductions the deficit, a lot of people ought to listen to this because this is something we have been fighting for years, the bill has established a lock bloc 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 overriden 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 disapprove 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 determinations regarding the constitutionality of the bill be applied severably 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 was stated in the Committee on Rules yesterday, this effective date has been agreed to by the signers of the conference report 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:

THE AMENDMENT PROCESS UNDER SPECIAL RULES REPORTED BY THE RULES COMMITTEE,[1] 103D CONGRESS V. 104TH CONGRESS

[As of March 27, 1996]

Rule type	103d Congress		104th Congress	
	Number of rules	Percent of total	Number of rules	Percent of total
Open/Modified-open [2]	46	44	59	59
Modified Closed [3]	49	47	25	25
Closed [4]	9	9	16	16
Total	104	100	100	100

[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/or a requirement that the amendment be preprinted 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 to accompany 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).

SPECIAL RULES REPORTED BY THE RULES COMMITTEE, 104TH CONGRESS

[As of March 27, 1996]

H. Res. No. (Date rept.)	Rule type	Bill No.	Subject	Disposition of rule
H. Res. 38 (1/18/95)	O	H.R. 5	Unfunded Mandate Reform	A: 350–71 (1/19/95).
H. Res. 44 (1/24/95)	MC	H. Con. Res. 17	Social Security	A: 255–172 (1/25/95).
		H.J. Res. 1	Balanced Budget Amdt	
H. Res. 51 (1/31/95)	O	H.R. 101	Land Transfer, Taos Pueblo Indians	A: voice vote (2/1/95).
H. Res. 52 (1/31/95)	O	H.R. 400	Land Exchange, Arctic Nat'l. Park and Preserve	A: voice vote (2/1/95).
H. Res. 53 (1/31/95)	O	H.R. 440	Land Conveyance, Butte County, Calif	A: voice vote (2/1/95).
H. Res. 55 (2/1/95)	O	H.R. 2	Line Item Veto	A: voice vote (2/2/95).
H. Res. 60 (2/6/95)	O	H.R. 665	Victim Restitution	A: voice vote (2/7/95).
H. Res. 61 (2/6/95)	O	H.R. 666	Exclusionary Rule Reform	A: voice vote (2/7/95).
H. Res. 63 (2/8/95)	MO	H.R. 667	Violent Criminal Incarceration	A: voice vote (2/9/95).
H. Res. 69 (2/9/95)	O	H.R. 668	Criminal Alien Deportation	A: voice vote (2/10/95).
H. Res. 79 (2/10/95)	MO	H.R. 728	Law Enforcement Block Grants	A: voice vote (2/13/95).
H. Res. 83 (2/13/95)	MO	H.R. 7	National Security Revitalization	PQ: 229–100; A: 227–127 (2/15/95).
H. Res. 88 (2/16/95)	MC	H.R. 831	Health Insurance Deductibility	PQ: 230–191; A: 229–188 (2/21/95).
H. Res. 91 (2/21/95)	O	H.R. 830	Paperwork Reduction Act	A: voice vote (2/22/95).
H. Res. 92 (2/21/95)	MC	H.R. 889	Defense Supplemental	A: 282–144 (2/22/95).

SPECIAL RULES REPORTED BY THE RULES COMMITTEE, 104TH CONGRESS—Continued

[As of March 27, 1996]

H. Res. No. (Date rept.)	Rule type	Bill No.	Subject	Disposition of rule
H. Res. 93 (2/22/95)	MO	H.R. 450	Regulatory Transition Act	A: 252–175 (2/23/95).
H. Res. 96 (2/24/95)	MO	H.R. 1022	Risk Assessment	A: 253–165 (2/27/95).
H. Res. 100 (2/27/95)	O	H.R. 926	Regulatory Reform and Relief Act	A: voice vote (2/28/95).
H. Res. 101 (2/28/95)	MO	H.R. 925	Private Property Protection Act	A: 271–151 (3/2/95).
H. Res. 103 (3/3/95)	MO	H.R. 1058	Securities Litigation Reform	
H. Res. 104 (3/3/95)	MO	H.R. 988	Attorney Accountability Act	A: voice vote (3/6/95).
H. Res. 105 (3/6/95)	MO			A: 257–155 (3/7/95).
H. Res. 108 (3/7/95)	Debate	H.R. 956	Product Liability Reform	A: voice vote (3/8/95).
H. Res. 109 (3/8/95)	MC			PQ: 234–191 A: 247–181 (3/9/95).
H. Res. 115 (3/14/95)	MO	H.R. 1159	Making Emergency Supp. Approps	A: 242–190 (3/15/95).
H. Res. 116 (3/15/95)	MC	H.J. Res. 73	Term Limits Const. Amdt	A: voice vote (3/28/95).
H. Res. 117 (3/16/95)	Debate	H.R. 4	Personal Responsibility Act of 1995	A: voice vote (3/21/95).
H. Res. 119 (3/21/95)	MC			A: 217–211 (3/22/95).
H. Res. 125 (4/3/95)	O	H.R. 1271	Family Privacy Protection Act	A: 423–1 (4/4/95).
H. Res. 126 (4/3/95)	O	H.R. 660	Older Persons Housing Act	A: voice vote (4/6/95).
H. Res. 128 (4/4/95)	MC	H.R. 1215	Contract With America Tax Relief Act of 1995	A: 228–204 (4/5/95).
H. Res. 130 (4/5/95)	MC	H.R. 483	Medicare Select Expansion	A: 253–172 (4/6/95).
H. Res. 136 (5/1/95)	O	H.R. 655	Hydrogen Future Act of 1995	A: voice vote (5/2/95).
H. Res. 139 (5/3/95)	O	H.R. 1361	Coast Guard Auth. FY 1996	A: voice vote (5/9/95).
H. Res. 140 (5/9/95)	O	H.R. 961	Clean Water Amendments	A: 414–4 (5/10/95).
H. Res. 144 (5/11/95)	O	H.R. 535	Fish Hatchery—Arkansas	A: voice vote (5/15/95).
H. Res. 145 (5/11/95)	O	H.R. 584	Fish Hatchery—Iowa	A: voice vote (5/15/95).
H. Res. 146 (5/11/95)	O	H.R. 614	Fish Hatchery—Minnesota	A: voice vote (5/15/95).
H. Res. 149 (5/16/95)	MC	H. Con. Res. 67	Budget Resolution FY 1996	PQ: 252–170 A: 255–168 (5/17/95).
H. Res. 155 (5/22/95)	MO	H.R. 1561	American Overseas Interests Act	A: 233–176 (5/23/95).
H. Res. 164 (6/8/95)	MC	H.R. 1530	Nat. Defense Auth. FY 1996	PQ: 225–191 A: 233–183 (6/13/95).
H. Res. 167 (6/15/95)	O	H.R. 1817	MilCon Appropriations FY 1996	PQ: 223–180 A: 245–155 (6/16/95).
H. Res. 169 (6/19/95)	MC	H.R. 1854	Leg. Branch Approps. FY 1996	PQ: 232–196 A: 236–191 (6/20/95).
H. Res. 170 (6/20/95)	O	H.R. 1868	For. Ops. Approps. FY 1996	PQ: 221–178 A: 217–175 (6/22/95).
H. Res. 171 (6/22/95)	O	H.R. 1905	Energy & Water Approps. FY 1996	A: voice vote (7/12/95).
H. Res. 173 (6/27/95)	C	H.J. Res. 79	Flag Constitutional Amendment	PQ: 258–170 A: 271–152 (6/28/95).
H. Res. 176 (6/28/95)	MC	H.R. 1944	Emer. Supp. Approps	PQ: 236–194 A: 234–192 (6/29/95).
H. Res. 185 (7/11/95)	O	H.R. 1977	Interior Approps. FY 1996	PQ: 235–193 D: 192–238 (7/12/95).
H. Res. 187 (7/12/95)	O	H.R. 1977	Interior Approps. FY 1996 #2	PQ: 230–194 A: 229–195 (7/13/95).
H. Res. 188 (7/12/95)	O	H.R. 1976	Agriculture Approps. FY 1996	PQ: 242–185 A: voice vote (7/18/95).
H. Res. 190 (7/17/95)	O	H.R. 2020	Treasury/Postal Approps. FY 1996	PQ: 232–192 A: voice vote (7/18/95).
H. Res. 193 (7/19/95)	C	H.J. Res. 96	Disapproval of MFN to China	A: voice vote (7/20/95).
H. Res. 194 (7/19/95)	O	H.R. 2002	Transportation Approps. FY 1996	PQ: 217–202 (7/21/95).
H. Res. 197 (7/21/95)	O	H.R. 70	Exports of Alaskan Crude Oil	A: voice vote (7/24/95).
H. Res. 198 (7/21/95)	O	H.R. 2076	Commerce, State Approps. FY 1996	A: voice vote (7/25/95).
H. Res. 201 (7/25/95)	O	H.R. 2099	VA/HUD Approps. FY 1996	A: 230–189 (7/25/95).
H. Res. 204 (7/28/95)	MC	S. 21	Terminating U.S. Arms Embargo on Bosnia	A: voice vote (8/1/95).
H. Res. 205 (7/28/95)	O	H.R. 2126	Defense Approps. FY 1996	A: 409–1 (7/31/95).
H. Res. 207 (8/1/95)	MC	H.R. 1555	Communications Act of 1995	A: 255–156 (8/2/95).
H. Res. 208 (8/1/95)	O	H.R. 2127	Labor, HHS Approps. FY 1996	A: 323–104 (8/2/95).
H. Res. 215 (9/7/95)	O	H.R. 1594	Economically Targeted Investments	A: voice vote (9/12/95).
H. Res. 216 (9/7/95)	MO	H.R. 1655	Intelligence Authorization FY 1996	A: voice vote (9/12/95).
H. Res. 218 (9/12/95)	O	H.R. 1162	Deficit Reduction Lockbox	A: voice vote (9/13/95).
H. Res. 219 (9/12/95)	O	H.R. 1670	Federal Acquisition Reform Act	A: 414–0 (9/13/95).
H. Res. 222 (9/18/95)	O	H.R. 1617	CAREERS Act	A: 388–2 (9/19/95).
H. Res. 224 (9/19/95)	O	H.R. 2274	Natl. Highway System	PQ: 241–173 A: 375–39–1 (9/20/95).
H. Res. 225 (9/19/95)	MC	H.R. 927	Cuban Liberty & Dem. Solidarity	A: 304–118 (9/20/95).
H. Res. 226 (9/21/95)	O	H.R. 743	Team Act	A: 344–66–1 (9/27/95).
H. Res. 227 (9/21/95)	O	H.R. 1170	3-Judge Court	A: voice vote (9/28/95).
H. Res. 228 (9/21/95)	O	H.R. 1601	Internatl. Space Station	A: voice vote (9/27/95).
H. Res. 230 (9/27/95)	C	H.J. Res. 108	Continuing Resolution FY 1996	A: voice vote (9/28/95).
H. Res. 234 (9/29/95)	O	H.R. 2405	Omnibus Science Auth	A: voice vote (10/11/95).
H. Res. 237 (10/17/95)	MC	H.R. 2259	Disapprove Sentencing Guidelines	A: voice vote (10/18/95).
H. Res. 238 (10/18/95)	MC	H.R. 2425	Medicare Preservation Act	PQ: 231–194 A: 227–192 (10/19/95).
H. Res. 239 (10/19/95)	C	H.R. 2492	Leg. Branch Approps	PQ: 235–184 A: voice vote (10/31/95).
H. Res. 245 (10/25/95)	MC	H. Con. Res. 109	Social Security Earnings Reform	PQ: 228–191 A: 235–185 (10/26/95).
		H.R. 2491	Seven-Year Balanced Budget	
H. Res. 251 (10/31/95)	C	H.R. 1833	Partial Birth Abortion Ban	A: 237–190 (11/1/95).
H. Res. 252 (10/31/95)	MO	H.R. 2546	D.C. Approps.	A: 241–181 (11/1/95).
H. Res. 257 (11/7/95)	C	H.J. Res. 115	Cont. Res. FY 1996	A: 216–210 (11/8/95).
H. Res. 258 (11/8/95)	MC	H.R. 2586	Debt Limit	A: 220–200 (11/10/95).
H. Res. 259 (11/9/95)	O	H.R. 2539	ICC Termination Act	A: voice vote (11/14/95).
H. Res. 261 (11/9/95)	C	H.J. Res. 115	Cont. Resolution	A: 223–182 (11/10/95).
H. Res. 262 (11/9/95)	C	H.R. 2586	Increase Debt Limit	A: 220–185 (11/10/95).
H. Res. 269 (11/15/95)	O	H.R. 2564	Lobbying Reform	A: voice vote (11/16/95).
H. Res. 270 (11/15/95)	C	H.J. Res. 122	Further Cont. Resolution	A: 229–176 (11/15/95).
H. Res. 273 (11/16/95)	MC	H.R. 2606	Prohibition on Funds for Bosnia	A: 239–181 (11/17/95).
H. Res. 284 (11/29/95)	O	H.R. 1788	Amtrak Reform	A: voice vote (11/30/95).
H. Res. 287 (11/30/95)	O	H.R. 1350	Maritime Security Act	A: voice vote (12/6/95).
H. Res. 293 (12/7/95)	C	H.R. 2621	Protect Federal Trust Funds	PQ: 223–183 A: 228–184 (12/14/95).
H. Res. 303 (12/13/95)	O	H.R. 1745	Utah Public Lands.	
H. Res. 309 (12/18/95)	C	H. Con. Res. 122	Budget Res. W/President	PQ: 230–188 A: 229–189 (12/19/95).
H. Res. 313 (12/19/95)	O	H.R. 558	Texas Low-Level Radioactive	A: voice vote (12/20/95).
H. Res. 323 (12/21/95)	C	H.R. 2677	Natl. Parks & Wildlife Refuge	Tabled (2/28/96).
H. Res. 366 (2/27/96)	MC	H.R. 2854	Farm Bill	PQ: 228–182 A: 244–168 (2/28/96).
H. Res. 368 (2/28/96)	O	H.R. 994	Small Business Growth	
H. Res. 371 (3/6/96)	C	H.R. 3021	Debt Limit Increase	A: voice vote (3/7/96).
H. Res. 372 (3/6/96)	MC	H.R. 3019	Cont. Approps. FY 1996	PQ: voice vote A: 235–175 (3/7/96).
H. Res. 380 (3/12/96)	MC	H.R. 2703	Effective Death Penalty	A: 251–157 (3/13/96).
H. Res. 384 (3/14/96)	MC	H.R. 2202	Immigration	PQ: 233–152 A: voice vote (3/21/96).
H. Res. 386 (3/20/96)	C	H.J. Res. 165	Further Cont. Approps	PQ: 234–187 A: 237–183 (3/21/96).
H. Res. 388 (3/20/96)	C	H.R. 125	Gun Crime Enforcement	A: 244–166 (3/22/96).
H. Res. 391 (3/27/96)	C	H.R. 3136	Contract w/America Advancement	
H. Res. 392 (3/27/96)	MC	H.R. 3103	Health Coverage Affordability	

Codes: O-open rule; MO-modified open rule; MC-modified closed rule; C-closed rule; A-adoption vote; D-defeated; PQ-previous question vote. Source: Notices of Action Taken, Committee on Rules, 104th Congress.

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

Mr. BEILENSON. 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: a bill increasing the Social Security earnings limit, a conference report on the so-called Line Item Veto Act, and a new version of regulatory reform legislation entitled the Small Business Growth and Fairness Act.

The rule before us continues the disturbing trend under the Republican majority of disregarding normal legislative procedures and unreasonably restricting debate. This is a closed rule. No amendments are in order except one that the gentleman from Texas [Mr. ARCHER] is permitted to offer. When the Committee on Rules met last night on this matter, the committee allowed this amendment without knowing what

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 Line Item Veto Act. 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 free-standing legislation and without reference to action by 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.

□ 1100

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 of the Congress, 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. We have to do it very soon to prevent a Government default. 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 from Congress to the President and enhance the power of a minority in Congress to override the will of a majority on matters of spending priorities. Under this legislation, 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 passes a resolution disapproving the cancellation. If Congress overturns the President's action, the President could then veto the disapproval, which, in turn, would have to be overridden by two-thirds of both Houses. Thus the President would be empowered to cancel any such item with the support of only a minority of Members of either House. A one-third plus 1 minority, working with the President, would control spending.

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 Members 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. It will continue 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 $59 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 benefits, already our Nation's most expensive entitlement program by far, 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 some of 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 ought to consider very 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 one legislative priority from 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, Mr. Speaker, to defeat 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 would say to my good friend, first of all, this line-item veto does not apply to just the small portion of the budget dealing with discretionary spending. The conference final report expanded that to include all entitlement programs, including food stamps. It includes the entire budget.

Second, the gentleman complains that there are extraneous matters in this bill other than the debt ceiling; namely, Social Security, repeal of penalties and the line-item veto and regulatory relief. And yet, in their trying to defeat the previous question, they will add further extraneous material. That I do not understand.

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 for business at 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. An offer of extended credit is a false favor to someone who is having trouble paying the bills. And the same holds true for the national budget—higher debt limits simply postpone and exacerbate the inevitable pain of paying the bill. We have a moral obligation to break the cycle of debt. Of course we know that decades of neglect cannot be reversed overnight. But that does not mean we should not spend every day moving in that direction. Although President Clinton torpedoed our effort to lock in this year a glidepath to balance in 7 years, the drive toward a balanced budget is continuing. Our new majority has already saved billions of dollars in this year's spending cycle alone. We've crafted positive reforms to preserve and strengthen our national safety net—while shrinking the size and reach of the Federal bureaucracy. We've made tough choices to secure our children's future—and we are not going to be sidetracked by President Clinton's overactive veto pen. We all know the pen is filled with red ink, just like his budget pen. Mr. Speaker, I will vote for this debt ceiling increase—but only because we are finally on the right track toward a balanced budget and fiscal sanity. I hope next time we vote on the debt limit we will be voting to lower the ceiling, nor raise it. Thankfully, there is good news in this bill—items that represent promises kept to America. With this bill we will be implementing the line-item veto, a major deficit cutting tool that we are delegating to the President in the interest of saving the taxpayers money. After more than a year of hard work, the conference has completed an agreement to grant the President real, effective and carefully defined line-item veto authority over spending and tax bills.

This historic delegation of power will be a significant new weapon in our arsenal as we fight for deficit reduction. It is not a matter of the President pitted against the Congress. It is a matter of the two branches of government working together to ensure wise management of the Nation's finances. For the first time, the bias will shift away from spending and toward saving. Americans understand that big spending and tax bills often get signed into law, carrying with them provisions of questionable national merit that might not stand on their own. The line-item veto allows the President to zero in on these items and bring them to the light of day. That is just the kind of accountability we so desperately need in the Federal budget process 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 a long-overdue 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 knows that if it came to a vote, it would be next to impossible for Members of this House to deny the fact that the 10 million minimum wage earners in this country deserve a raise.

Mr. Speaker, in light of the fact that April 1 will mark the 5-year anniversary of the last time this House approved an increase in the minimum wage, the truth is the minimum wage has significantly lost its value and it keeps families in poverty.

Mr. Speaker, it is time for this body 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.

Mr. BEILENSON. Mr. Speaker, I yield 1 minute to the gentlewoman from Connecticut [Ms. DELAURO].

Ms. DELAURO. Mr. Speaker, I rise in opposition to the rule because it denies a long-overdue opportunity to raise 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.

□ 1115

Mr. SOLOMON. 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 all of these regulations, we certainly wouldn't object to a raise in the minimum wage.

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 me and is the chairman of the Committee on Government Reform and Oversight. He was the chairman of our conference for over a year on the line-item veto. If you want to

know why his hair is a little grayer, it is because of that, I assure you. He did yeoman work. We could not be here today without BILL CLINGER.

Mr. CLINGER. Mr. Speaker, I thank the chairman for yielding time to me.

Mr. Speaker, I rise in strong support of this rule.

Mr. Speaker, we often engage in this body in hyperbole, some would say hot air. But I have got to say today we really are entitled to say this is a historic time we are engaged in. This bill we are going to be considering today is indeed a historic bill.

For years a lot of us have talked the talk about the line-item veto. But, unfortunately, we have been unable to bring it to the floor to get a vote. Today we are going to be able to walk the walk. So I am very delighted as chairman of the conference on the line-item veto to bring our product to this floor as part of the increase in the debt limit. I think it is absolutely appropriate that it should be considered as part of this increase in the debt limit.

Mr. Speaker, we are about to consider a bill that will increase the Federal debt limit to $5.5 trillion. That is $22,000 for every man, woman, and child in this country. We have got to find a better way to get control of this spending. What this bill will do is give the President a scalpel instead of a hacksaw to really deal with the enormous debt that we keep building up year after year after year and the deficits we run year after year. This is an enormous burden we have been imposing on the American people. This is the first serious effort to really provide an effective means to address this enormous problem.

I have to say we would not be here without the hard work of a lot of people. BOB DOLE, our nominee for President, was an inspiration and really was the driving force in getting us to resolve this conference and get an agreement with the White House on what could pass and be signed by the President. The gentleman from New York [Mr. SOLOMON] has been a tireless worker for this legislation for, as he said, 10 years and longer. The gentleman from Florida [Mr. GOSS], the gentleman from Massachusetts [Mr. BLUTE], the gentleman from Kentucky [Mr. BUNNING], all of whom served over this whole year on this conference, have just been invaluable in bringing us to this day. At times we did not think we would get an agreement because of determined opposition. Despite that tough opposition from people on both sides of the aisle and both sides of the Capitol, we have gotten an agreement.

Mr. Speaker, this is a good bill. I urge support for the line-item veto and for this bill.

Mr. BEILENSON. 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, 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 line-item veto 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, dealing with the President's responsibility with regard to legislation, the Constitution states as follows: ''If he approves, 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 the friends that we have across the ocean in Britain are having second thoughts these days about their monarchy, this line-item veto provision and its effect will be to start the gradual accretion of power in an American monarchy.

If we recall 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 live to 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 Chadha case, making it absolutely clear that the powers of neither branch with respect to the division and responsibility on legislation can be 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 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-day cancellation right after signing a bill? That is absolutely absurd. This defies any 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 to what would have happened during the Reagan administration, with a President who, for his own reasons, sent budgets to this body zeroing out 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.

Even more pernicious, and 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 gotten, let us say, 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 my 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. SOLOMON. 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 what 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 today, especially for what he has done today on this line-item veto.

(Mr. BUNNING of Kentucky asked and was given permission to revise and extend his remarks.)

Mr. BUNNING of Kentucky. Mr. Speaker, the first bill I signed on when I came to Congress 9 years ago was the line-item veto, and, thank God, we are finally going to get it passed today. It has been a long time coming, but we have taken another major step in restoring fiscal responsibility to the budget process. Of course, I am talking about the line-item veto.

The line-item veto will allow the President to end, once and for all, that notion that Federal spending cannot be

controlled. As President Truman said, the buck will truly stop with the President. If he does not use that power that we give him, shame on him. I have been for this bill, by the way, when a Republican was in office, and now I am for it while a Democrat is in office.

Mr. Speaker, we are going to give the President the opportunity to restore the fiscal integrity of this Government and to end the era of pork-barrel spending. We all have spending needs in our States and districts, but we have a duty to the country not to bankrupt the Treasury. All spending is not the same. Alpine Ski slides in tropical locations and ice hockey warming huts are not of the same importance as people with adequate needs for post offices and courthouses.

Mr. Speaker, the bill before us is not perfect. We have worked hard to make something work that everyone can use, that is good for the American people. It was crafted in an effort to accommodate the concerns of the broadest cross-section of the Members of this House and the Senate.

I wish we had not gone down the road of applying the line-item veto to tax issues, but even on that issue we have tried to meet the concerns with the majority of this Congress. I hope and pray that everyone realizes that this line-item veto is in the best interest of the United States of America, and if in fact the courts look at this bill, as one of the prior speakers has talked about, that they will find how much the need is there for this and it will be ruled constitutional by the courts. We will let them decide. Let us just do our work and pass this bill today.

Mr. Speaker, it's been a long time in coming but we are about to take another major step toward restoring fiscal responsibility to the budget process. I am, of course, talking about finally giving the President the line-item veto.

The line-item veto will allow the President to end, once and for all, the notion that federal spending cannot be controlled. As President Truman said, the buck will truly stop with the President.

If he doesn't use the power that we give him, shame on him.

We are going to give him the opportunity to restore the fiscal integrity of this Government and end the era of the pork barrel.

We all have spending needs in our States and districts but we also have a duty to the country not to bankrupt the Treasury.

All spending is not the same. Alpine Ski slides in tropical locations and ice hockey warming huts are not of the same importance to the people as adequate post offices and courthouses.

The bill before us is not perfect but we have worked hard to make it something that will work for the American people.

It was crafted in an effort to accommodate the concerns of the broadest cross-section of the Members of the House and Senate.

I wish we had not gone done the road of applying the line-item veto to taxes. But, even on that issue we have tried to meet the concerns of the majority of our Members.

The line-item veto before us today will be criticized by some who think that it goes too far. Others will say that we did not do enough. That satisfies me that we did the right thing.

To those who wanted us to include more on taxes, I would simply remind them that our financial problems have not been caused by too few revenues but by too much spending.

In 1981, the year before the Reagan tax cut took effect, revenues were $599 billion and by 1993 revenues had grown to nearly $1.15 trillion., Even though revenues nearly doubled spending grew at an even faster pace.

To paraphrase President Reagan, the American people are not taxed too little, their Government spends too much.

Nonetheless, we recognized that there is the potential for abuse in the tax laws and we have taken adequate steps to address that problem.

The limited tax provisions which appear from time to time in a large tax bill and which under the Democrats were often targeted to a specific taxpayer are now going to be subject to the line-item veto.

That means that Congress will now specifically point out to the President what these provisions of limited benefit are and he can use the line-item veto on them.

The nonpartisan Joint Tax Committee will identify these limited tax provisions for the tax writing committees based on the definition in this bill. And we will clearly point to them in what we send to the President for his signature.

I feel confident that the President will see the good policy behind some of these very narrow tax breaks such as the orphan drug tax credit which provides a tax incentive for research into drugs for rare diseases.

But he can use his veto pen to make sure that no unfair tax breaks are given to one or just a few taxpayers as has happened from time to time.

I would also remind those who think that we should have gone farther on allowing the President to item veto tax provisions to remember that tax breaks allow people to keep their own money.

Spending provisions take money from one person's pocket to be used for someone else's benefit.

If that distinction isn't clear to you, I imagine that your constituents can help you see the light. They know whose money we are spending.

This is a good bill and by passing it we can keep one of our most important promises from the Contract With America. I urge my colleagues to support line-item veto.

Mr. BEILENSON. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Missouri [Mr. CLAY].

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

Mr. Speaker, I rise in opposition to this rule and urge the House to defeat the previous question. My opposition to the rule is very simple: This rule denies that House an opportunity to consider an amendment to increase the minimum wage that was offered before the Rules Committee by my colleague, Representative DELAURO.

Some on the other side of the aisle will argue that a minimum wage increase is not germane to a bill increasing the debt limit. I remind my colleagues that the Republican leadership 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 disparity 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 1989, for example, the minimum wage increase passed this body by a vote of 382 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.

□ 1130

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes and 45 seconds to the distinguished gentleman from Maryland [Mr. HOYER].

Mr. SOLOMON. Mr. Speaker, I yield 15 seconds to the gentleman from Maryland [Mr. HOYER].

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Maryland [Mr. HOYER] is recognized for 3 minutes.

Mr. HOYER. Mr. Speaker, let me say that the debt limit part of this bill should have been passed last year. It is another indication of the inability of the leadership of this House to get issues of fiscal importance to the floor in a timely fashion. The debt has been confronting us since September of last year and has placed at risk the good credit of the United States of America,

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.

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 BYRD and I would hope with at least some 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, I support an 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 be passed. 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 have one-third plus 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, of course, but the fact of 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. BUNNING, 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 almost 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 irritates me 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 veto, which is going to put a crimp in every one of these big spenders. There are not many left around here. Most of them got beat, 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 he is on it.

Mr. Speaker, I yield 3 minutes to the gentleman from Massachusetts [Mr. BLUTE], someone I have great respect for, from Shewsbury, MA. He has only been here now for about 3½ years. But let me tell my colleagues, he 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. CASTLE] and many others, the gentleman from Tennessee [Mr. DUNCAN], 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 others have 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, but it took this Republican Congress to give it to a Democratic President in a true showing of bipartisanship.

Bipartisanship is exactly what has characterized this legislation from its inception. It passed the House on February 6, 1995, by the overwhelming vote of 294 to 134. All along, Members from both sides of the aisle have pushed this legislation toward this ultimate destination. In a process that took more than a year, the House and Senate conferees worked out the differences in two bills which could not have been more different. The product of that work is an extremely workable procedure that mirrors what the House has passed.

Congress has delegated to the President the very serious power to cancel individual spending items that are normally buried in appropriations bills. However, we did not stop there. This conference report expands the line-item veto to include direct spending and limited tax benefits that cost the American taxpayers more in some cases than appropriations bills. Unlike other attempts at rescissions legislation, the emphasis in this conference report is on deficit reduction and not spending.

Mr. Speaker, the President will be able to cancel individual spending items, increases in direct spending and limited tax benefits. Congress must then pass a bill to disapprove of those cancellations and affirm it wants to spend the money. The President can veto the disapproval legislation and Congress must override by a two-thirds majority. Make no mistake about it, this is a powerful tool of fiscal accountability.

When the Congress cannot muster the two-thirds to override the President, the total of the cancellations must be deposited in a lockbox. 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.

This line-item veto, Mr. Speaker, has been field tested in 43 States with very impressive results. It is common sensical. It works, It is what the American people want.

Let us continue the revolution of fiscal sanity begun by the 104th Congress and give the President this fiscal tool.

Mr. Speaker, on a personal note, I would like to commend and thank the gentleman from Pennsylvania [Mr. CLINGER], the gentleman from New York [Mr. SOLOMON], the gentleman from Florida [Mr. GOSS], and the gentleman from Kentucky [Mr. BUNNING], 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. DOGGETT].

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

The Contract With America Advancement 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 tell 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 seniors would have 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.

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, 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?

Well, 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 quote: ''You 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 conferees 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 hard. They 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. But once again, we are here and the majority will not, the majority will not even allow us a vote on an issue to put more money in the pockets of Americans. That is what we are talking about, putting more money in the pockets of working people and families in this country.

Now, the minimum wage has not been raised since 1989. Back then two people who supported the raise were NEWT GINGRICH and BOB DOLE. But they are standing in the way today of helping working families. Mr. Speaker, when are my friends on this side of the aisle going to learn they cannot talk about family values if they are not going to value the family and they cannot move from welfare to work if they do not make work pay.

The minimum wage is not enough. It is less than $9,000 a year for a full-time worker. One cannot raise a family on that amount of money. There are literally millions of single parents in this country who are trying to do just that. Think about it. Could we raise a child or two children on that? It is a disgrace that people who make that choice to choose work over welfare, who work hard every single day, they try to set a good example for their kids, for their neighborhood, cannot lift themselves above the poverty line.

□ 1145

Now these are not kids we are talking about. We are talking about 60 percent of the people on the minimum wage are working women 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 the studies that were done in 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, everybody benefits. 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 buying 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 in general.

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, it 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 having this made in order so we could vote on this important question and put money in the pockets of Americans today.

I urge my colleagues to vote ''no'' on the previous question so we can have 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 has led the fight 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. DUNCAN asked and was given permission to revise and extend his remarks.)

Mr. DUNCAN. Mr. Speaker, I rise in strong support of this bill which includes a very important provision—the line-item veto.

Mr. Speaker, I first want to thank my good friend, the gentleman from New York [Mr. SOLOMON], with whom I have worked so closely on this issue in the past, for yielding me this time.

Mr. Speaker, when we pass this legislation, I think there is no one in this House who will deserve more credit for it than the gentleman from New York, JERRY SOLOMON. I congratulate him for his work on this very important piece of legislation.

Mr. Speaker, on the first day of every Congress since I was elected in 1988, I have introduced a line-item veto bill that is almost identical to the provision that we are considering now.

While past Congresses have been unwilling to pass a line-item veto with real teeth in it, and in fact we passed one that the Wall Street Journal in 1993 called a voodoo line-item veto bill, I am pleased that today we are on the verge of approving a line-item veto that will truly be effective in reducing pork barrel spending.

In fact, the other body overwhelmingly passed this provision yesterday by a vote of 69 to 31.

Mr. Speaker, this is not a partisan issue. Forty-three of our Nation's Governors, both Democratic and Republican, already have the line-item veto and are using it to cut spending in their States and balance their budgets.

It is time for Congress to give this same tool to the President, so that he can eliminate the most outrageous examples of wasteful and unnecessary spending without vetoing entire appropriation bills.

The General Accounting Office estimated in 1992 that more than $70 billion of pork-barrel spending could have been cut between 1984 and 1989 if Presidents Reagan and Bush had had a line-item veto.

The Cato Institute estimates that $5 to $10 billion a year could be saved with a line-item veto.

In last year's State of the Union Address, President Clinton highlighted some of the most absurd examples of pork-barrel spending approved by the 103d Congress, and said ''If you give me the line-item veto, I will remove some of that unnecessary spending.''

Mr. Speaker, I wish we did not need such things as a balanced-budget amendment and a line-item veto to bring our Federal spending under control.

Unfortunately, however, Mr. Speaker, Congress has proven time and again that it does not have the will to cut spending on its own.

That is why this legislation is so very necessary today. If the Congress does not really want to cut spending, it will have to say so, and say so publicly.

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 months ago, said that if present 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.

This will not 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 this time to me.

Mr. Speaker, when I first ran for the Congress 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 to advance 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 such time as I may consume.

Let me simply advise Members that if the previous question is defeated, we will offer an amendment to the rule which would make in order the floor amendment to incrementally increase the minimum wage from its current $4.25 an hour to $5.15 an hour beginning on the Fourth of July 1997.

Mr. Speaker, I yield the balance of my time to the gentleman from Missouri [Mr. GEPHARDT], our distinguished minority leader.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Missouri is recognized for 1¾ minutes.

Mr. GEPHARDT. Mr. Speaker, Members of the House, I urge my colleagues to vote against the previous question so that we can add an amendment to this bill that will increase the minimum wage. I simply want to say that wages, decent wages, are a family value. People who earn the minimum wage today earn a little over $8,000 a year. The minimum wage has not been increased in 5 years. It is a 40-year low. One-third of the people on the minimum wage are the sole wage earner in their family. It will not cost jobs, as some have asserted.

I met a woman in my district the other day, a single mother with 2 minimum wage jobs. She told me she was worried that her kids would not be a victim of a crime; she was worried they would perpetrate crimes. People cannot spend time with their family if they do not earn a decent wage.

I urge Members to vote against this previous question, and I say to my friends on the other side, ''You've not heard the last of the minimum wage. I suspect we won't prevail on this vote. But we are going to bring it back and back and back and back until we finally prevail for America's families and workers.''

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

The SPEAKER pro tempore. The gentleman from New York is recognized for 3 minutes.

Mr. SOLOMON. Mr. Speaker, let me say to my good friend, the minority leader, who I have great respect for, I just cannot help but feel that there are some political games being played here. As my colleagues know, written into this rule was a little provision that said during the time after the Committee on Rules finished meeting last night, and while Mr. Panetta or the President were meeting with our Republican leadership, they could have negotiated to add anything into this bill, anything. That was not even mentioned once, this business of the increasing the minimum wage. Where this has come from I do not know, but I just suspect it is political games.

So let us just do away with that, and let me just in closing give my colleagues a little bit of history because it is kind of interesting, especially when we consider the word BYRD from West Virginia, something to do with the other body. As my colleagues know, in 1876; that was 120 years ago, Representative Charles Falken of West Virginia—remember him, George; was the gentleman here then?—came to the floor of this House and introduced a bill granting the President the authority to veto individual items in spending measures. Can my colleagues imagine that 120 years ago, a Representative from West Virginia? Boy, how times change over 120 years.

When I first came to this Congress 17 years ago, one of the first bills I introduced was the line-item veto. We have been waiting 17 years. In 1980, when Ronald Reagan entered the White House and asked Congress to grant him line-item veto authority, that was 16 years ago. In 1994 the Republican candidates for the House of Representatives all across this great country campaigned on a promise in the Contract With America that, if elected, they would pass a bill giving the President line-item veto, no matter who that President was, Republican, Democrat.

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, most of the Democrats on that side of the aisle will vote to deliver a promise to the American people.

As a conferee 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 Pennsylvania [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 law, shall be referred to each committee 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 section 601 and the pay-as-go balances under section 252 of the Balanced 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 are established 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. The time clock for 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 of 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 in both Houses. However, upon 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 conferees intend to 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 conferees. The conferees 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. Each such disapproval bill must include in the first blank space a list of the reference numbers for all of the cancellations made by the President in that special message.

Any disapproval bill introduced in the Senate may disapprove all or part 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 notion 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 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 motion to reconsider the vote 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 for failure to comply with the one day layover, against the bill and against 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 first reading of the bill 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 read for amendment under the 5-minute rule. 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 Member if supported by 49 other Members, a quorum being present, may offer an 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 thereto 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 already rejected 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.

In the event of disagreement between the two Houses over the content of a disapproval bill passed by both Houses, conferees should be promptly appointed and a conference on 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.

Debate in the House of Representatives on the conference report and any amendments in disagreement on any disapproval bill shall be limited to not more than 1 hour equally divided and controlled by a proponent and an opponent. A motion to further limit debate shall not be debatable. A motion to recommit the conference report shall not be in order and it shall not be in order to reconsider the vote by which the conference report is agreed to or disagreed to.

Mr. SOLOMON. 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 had 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 out 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 self-executes into this debt limit 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 of the SEC outlining the problems with the small business bill.

I urge my colleagues to defeat this rule.

SECURITIES AND EXCHANGE COMMISSION,
Washington, DC, March 27, 1996.

Hon. JOHN D. DINGELL,
House of Representatives, Committee on Commerce, Rayburn House Office Building, Washington, DC.

DEAR CONGRESSMAN 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 a negative 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 Commission, even in cases where 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 abuse, the SEC often must act with swift, decisive enforcement action against fraud or other misconduct. The requirements of S. 942 could serve to hamper the Commission's enforcement efforts as it seeks penalties or other 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 address the merits of proposed SEC enforcement actions before they are instituted by the Commission. In addition, pursuant to The Securities Enforcement Remedies and Penny Stock Reform 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 also has sought to expand the category of small businesses that are exempt from the registration and full disclosure requirements of the Exchange Act. Most recently, the Commission's internal Task Force on Disclosure Simplification released a report recommending the elimination of numerous 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 possible to streamline disclosure requirements for small business issuers without impairing market fairness, there is much less room to dilute or alter the regulatory and enforcement framework 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'' or ''Commission'') has traditionally supported efforts to facilitate the capital formation process for small business. However, SEC staff is concerned that S. 942's proposals for small business regulatory reform 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.[1] 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 for the waiver, of 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 and self-vigilance by *all* market participants, regardless of size.[2]

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 that could qualify as ''small entities'' under S. 942. In addition, this enforcement philosophy would also be applied to non-scienter 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 matter 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 requirement of Section 202 suggests that 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

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 SEC than the relief the SEC requested. 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 the full relief it initially sought. For example, in enforcement actions, the Commission frequently seeks to obtain an injunction against securities law violations. While the court could find 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 loses central issues of fact or law, regardless of the reasonableness of the Commission's position. The Commission faces some litigation risk every time it brings an enforcement action. 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 awards. Even the most settled interpretations of the securities laws are subject to dissenting approaches of judicial or adjudicatory decisionmakers. In a recent case, for example, the U.S. Court of Appeals for the Fourth Circuit refused to follow several other circuit courts that had long recognized a claim for fraudulent insider trading based on the misappropriation of material 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.[3]

Finally, the Commission often must act with swift, decisive enforcement action against fraud, particularly in cases where money may be moved quickly outside of the jurisdiction of a U.S. Court. The requirements 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 wrongdoers.

Because the Commission could be liable for EAJA awards even when it prevails in a lawsuit, or when its position is reasonable,[4] 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 regulatory 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 faithfully prepares the requisite analyses for every rulemaking action it takes. Nevertheless, the Act requires the Commission to predict future events—that is, the effects that new and untested rules will have on small businesses operating in ever-changing markets. Such predictions are intrinsically imprecise; the Commission cannot 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, even rules that reduce burdens or provide exemptions for businesses—large or small—could be subject to attack under the Reg. Flex. Act amendments on the grounds that 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 and relating to market integrity issues should apply equally to all firms, large as well as small.

CONGRESSIONAL REVIEW OF COMMISSION RULEMAKING

Title V of S. 942 permits Congress to override an agency's adoption of any rules. This legislative veto authority does not extend, however, to rules that concern monetary policy proposed or implemented 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 securities markets, and are often closely tied to the stability of such markets, we believe that it is appropriate to accord the same exemption 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 continues to pose significant issues with respect to the Commission's enforcement and regulatory programs. This analysis outlines those concerns for the Commerce Committee.

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

[3] Although the proposed EAJA amendments provide an exception from fee awards if the ''party or small entity has committed a willful violation of law or otherwise acted in bad faith, or special circumstances made an award of attorney's fees unjust,'' a court or administrative law judge probably could not make a finding of ''willful violation'' or bad faith action by the defendant 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 Commission.

[4] Under existing law, EAJA fees have not been imposed 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, because of reasonable basis for Commission's enforcement action).

[5] Even though the Commission by law forwards the civil penalties it obtains in enforcement actions to the U.S. Treasury, the Commission must pay EAJA fees directly out of its annual appropriation. Amendments to EAJA under S. 942 would further increase the burden on the Commission by increasing the fee rate for attorney's fees from $75 per hour to $125 per hour.

[6] Similar concerns arise regarding H.R. 994, a separate regulatory reform bill that is currently under consideration in the House. That bill would require the Commission to engage in a lengthy, costly and onerous review of all of its rules (even those involving market integrity), despite the substantial efforts the Commission has made in the past to tailor its rules to the changing conditions of the securities industry. A similar exception in H.R. 994 for the rules of the federal banking agencies should be extended to include the Commission.

Mr. SOLOMON. 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 ''ayes'' appeared to have it.

Mr. BEILENSON. 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, as amended.

The vote was taken by electronic device and there were—yeas 232, nays 180, not voting 19, as follows:

[Roll No. 97]

YEAS—232

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bilbray
Bilirakis
Bliley
Boehlert
Boehner
Bonilla
Bono
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Geren
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Montgomery
Moorhead
Morella
Myers
Myrick
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pombo
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Riggs
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Souder
Spence
Stearns
Stenholm
Stockman
Stump
Talent
Tate
Tauzin
Taylor (NC)
Thomas
Thornberry
Tiahrt
Torkildsen
Torricelli
Upton
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NAYS—180

Abercrombie
Ackerman
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Beilenson
Bentsen
Bereuter
Berman
Bevill
Bishop
Bonior
Boucher
Brewster
Browder

Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Clay
Clayton
Clement
Clyburn
Coleman
Collins (MI)
Condit
Conyers
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Durbin
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Gibbons
Gonzalez
Gordon
Green
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kennedy (MA)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
McNulty
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pomeroy
Poshard
Rahall
Rangel
Reed
Richardson
Rivers
Roemer
Rose
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Skaggs
Skelton
Slaughter
Spratt
Stark
Studds
Stupak
Tanner
Taylor (MS)
Tejeda
Thompson
Thornton
Thurman
Torres
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Ward
Waters
Watt (NC)
Waxman
Williams
Wilson
Wise
Woolsey
Wynn
Yates

NOT VOTING—19

Blute
Borski
Bryant (TX)
Chapman
Collins (IL)
Fields (LA)
Filner
Forbes
Fowler
Gutierrez
Jefferson
Kaptur
Kennedy (RI)
Lazio
Nethercutt
Sisisky
Smith (WA)
Stokes
Weldon (PA)

☐ 1214

The Clerk announced the following pairs:

On this vote:

Mrs. Fowler for, with Mrs. Collins of Illinois against.

Mr. Lazio of New York for, with Mr. Stokes against.

Mr. GIBBONS and Mr. DEUTSCH changed their vote from ''yea'' to ''nay.''

Mr. SHAYS changed his vote from ''nay'' to ''yea.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The question is on the resolution, as amended.

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

RECORDED VOTE

Mr. BEILENSON. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 232, noes 177, not voting 22, as follows:

[Roll No. 98]

AYES—232

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Bilbray
Bilirakis
Bliley
Boehlert
Boehner
Bonilla
Bono
Brewster
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clement
Clinger
Coble
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Deutsch
Diaz-Balart
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Kleczka
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Montgomery
Moorhead
Morella
Myers
Myrick
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pombo
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Riggs
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shuster
Sisisky
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Souder
Spence
Stearns
Stockman
Stump
Talent
Tate
Taylor (NC)
Thomas
Thornberry
Tiahrt
Torkildsen
Upton
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOES—177

Abercrombie
Ackerman
Andrews
Baesler
Baldacci
Barcia
Becerra
Beilenson
Bentsen
Bereuter
Berman
Bevill
Bishop
Bonior
Boucher
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Clay
Clayton
Clyburn
Coburn
Coleman
Collins (MI)
Condit
Conyers
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Durbin
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gephardt
Geren
Gibbons
Gonzalez
Gordon
Green
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kennedy (MA)
Kennelly
Kildee
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
McNulty
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pomeroy
Poshard
Rahall
Rangel
Reed
Richardson
Rivers
Rose
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Shays
Skaggs
Skelton
Slaughter
Spratt
Stark
Stenholm
Studds
Stupak
Tanner
Taylor (MS)
Tejeda
Thompson
Thornton
Thurman
Torres
Torricelli
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Ward
Waters
Watt (NC)
Waxman
Williams
Wilson
Wise
Woolsey
Wynn
Yates

NOT VOTING—22

Blute
Borski
Bryant (TX)
Chapman
Collins (IL)
Dickey
Fields (LA)
Filner
Fowler
Gejdenson
Gutierrez
Hayes
Kaptur
Kennedy (RI)
Lazio
Longley
Nethercutt
Roth
Smith (WA)
Stokes
Tauzin
Weldon (PA)

☐ 1224

The Clerk announced the following pairs:

On this vote:

Mrs. Fowler for, with Mrs. Collins of Illinois against.

Mr. Lazio of New York for, with Mr. Stokes against.

Mr. BARCIA changed his vote from ''aye'' to ''no.''

So the resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. BLUTE. 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 ''yes.''

(For text of conference report deemed adopted pursuant to Resolution 391, see proceedings of the House of March 21, 1996, at page H2640.)

CONTRACT WITH AMERICA 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, and the Small Business Growth 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.

This Act may be cited as the ''Contract with America Advancement Act of 1996''.

TITLE I—SOCIAL SECURITY EARNINGS LIMITATION AMENDMENTS

SEC. 101. SHORT TITLE OF TITLE.

This title may be cited as the ''Senior Citizens' Right to Work Act of 1996''.

SEC. 102. 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 provision of this subsection, the exempt amount which is applicable to an individual who has attained retirement age (as defined in section 216(l)) before the close of the taxable year involved shall be—

''(i) for each month of any taxable year ending after 1995 and before 1997, $1,041.66⅔,

''(ii) for each month of any taxable year ending after 1996 and before 1998, $1,125.00,

''(iii) for each month of any taxable year ending after 1997 and before 1999, $1,208.33⅓,

''(iv) for each month of any taxable year ending after 1998 and before 2000, $1,291.66⅔,

''(v) for each month of any taxable year ending after 1999 and before 2001, $1,416.66⅔,

''(vi) for each month of any taxable year ending after 2000 and before 2002, $2,083.33⅓, and

''(vii) for each month of any taxable year ending after 2001 and before 2003, $2,500.00.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 203(f)(8)(B)(ii) of such Act (42 U.S.C. 403(f)(8)(B)(ii)) is amended—

(A) by striking ''the taxable year ending after 1993 and before 1995'' and inserting ''the taxable year ending after 2001 and before 2003 (with respect to individuals described in subparagraph (D)) or the taxable year ending after 1993 and before 1995 (with respect to other individuals)''; and

(B) in subclause (II), by striking ''for 1992'' and inserting ''for 2000 (with respect to individuals described in subparagraph (D)) or 1992 (with respect to other individuals)''.

(2) The second sentence of section 223(d)(4)(A) of such Act (42 U.S.C. 423(d)(4)(A)) is amended by striking ''the exempt amount under section 203(f)(8) which is applicable to individuals described in subparagraph (D) thereof'' and inserting the following: ''an amount equal to the exempt amount which would be applicable under section 203(f)(8), to individuals described in subparagraph (D) thereof, if section 102 of the Senior Citizens' Right to Work Act of 1996 had not been enacted''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years ending after 1995.

SEC. 103. CONTINUING DISABILITY REVIEWS.

(a) AUTHORIZATION FOR APPROPRIATIONS FOR CONTINUING DISABILITY REVIEWS.—Section 201(g)(1)(A) of the Social Security Act (42 U.S.C. 401(g)(1)(A)) is amended by adding at the end the following: ''Of the amounts authorized to be made available out of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under the preceding sentence, there are hereby authorized to be made available from either or both of such Trust Funds for continuing disability reviews—

''(i) for fiscal year 1996, $260,000,000;

''(ii) for fiscal year 1997, $360,000,000;

''(iii) for fiscal year 1998, $570,000,000;

''(iv) for fiscal year 1999, $720,000,000;

''(v) for fiscal year 2000, $720,000,000;

''(vi) for fiscal year 2001, $720,000,000; and

''(viii) for fiscal year 2002, $720,000,000.

For purposes of this subparagraph, the term 'continuing disability review' means a review conducted pursuant to section 221(i) and a review or disability eligibility redetermination conducted to determine the continuing disability and eligibility of a recipient of benefits under the supplemental security income program under title XVI, including any review or redetermination conducted pursuant to section 207 or 208 of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103-296).''.

(b) ADJUSTMENT TO DISCRETIONARY SPENDING LIMITS.—Section 251(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding the following new subparagraph:

''(H) CONTINUING DISABILITY REVIEWS.—(i) Whenever a bill or joint resolution making appropriations for fiscal year 1996, 1997, 1998, 1999, 2000, 2001, or 2002 is enacted that specifies an amount for continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration, the adjustments for that fiscal year shall be the additional new budget authority provided in that Act for such reviews for that fiscal year and the additional outlays flowing from such amounts, but shall not exceed—

''(I) for fiscal year 1996, $15,000,000 in additional new budget authority and $60,000,000 in additional outlays;

''(II) for fiscal year 1997, $25,000,000 in additional new budget authority and $160,000,000 in additional outlays;

''(III) for fiscal year 1998, $145,000,000 in additional new budget authority and $370,000,000 in additional outlays;

''(IV) for fiscal year 1999, $280,000,000 in additional new budget authority and $520,000,000 in additional outlays;

''(V) for fiscal year 2000, $317,500,000 in additional new budget authority and $520,000,000 in additional outlays;

''(VI) for fiscal year 2001, $317,500,000 in additional new budget authority and $520,000,000 in additional outlays; and

''(VII) for fiscal year 2002, $317,500,000 in additional new budget authority and $520,000,000 in additional outlays.

''(ii) As used in this subparagraph—

''(I) the term 'continuing disability reviews' has the meaning given such term by section 201(g)(1)(A) of the Social Security Act;

''(II) the term 'additional new budget authority' means new budget authority provided for a fiscal year, in excess of $100,000,000, for the Supplemental Security Income program and specified to pay for the costs of continuing disability reviews attributable to the Supplemental Security Income program; and

''(III) the term 'additional outlays' means outlays, in excess of $200,000,000 in a fiscal year, flowing from the amounts specified for continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration, including outlays in that fiscal year flowing from amounts specified in Acts enacted for prior fiscal years (but not before 1996).''.

(c) BUDGET ALLOCATION ADJUSTMENT BY BUDGET COMMITTEE.—Section 606 of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding the following new subsection:

''(e) CONTINUING DISABILITY REVIEW ADJUSTMENT.—

''(1) IN GENERAL.—(A) For fiscal year 1996, upon the enactment of the Contract with America Advancement Act of 1996, the Chairmen of the Committees on the Budget of the Senate and House of Representatives shall make the adjustments referred to in subparagraph (C) to reflect $15,000,000 in additional new budget authority and $60,000,000 in additional outlays for continuing disability reviews (as defined in section 201(g)(1)(A) of the Social Security Act).

''(B) When the Committee on Appropriations reports an appropriations measure for fiscal year 1997, 1998, 1999, 2000, 2001, or 2002 that specifies an amount for continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration, or when a conference committee submits a conference report thereon, the Chairman of the Committee on the Budget of the Senate or House of Representatives (whichever is appropriate) shall make the adjustments referred to in subparagraph (C) to reflect the additional new budget authority for continuing disability reviews provided in that measure or conference report and the additional outlays flowing from such amounts for continuing disability reviews.

''(C) The adjustments referred to in this subparagraph consist of adjustments to—

''(i) the discretionary spending limits for that fiscal year as set forth in the most recently adopted concurrent resolution on the budget;

''(ii) the allocations to the Committees on Appropriations of the Senate and the House of Representatives for that fiscal year under sections 302(a) and 602(a); and

''(iii) the appropriate budgetary aggregates for that fiscal year in the most recently adopted concurrent resolution on the budget.

''(D) The adjustments under this paragraph for any fiscal year shall not exceed the levels set forth in section 251(b)(2)(H) of the Balanced Budget and Emergency Deficit Control Act of 1985 for that fiscal year. The adjusted discretionary spending limits, allocations, and aggregates under this paragraph shall be considered the appropriate limits, allocations, and aggregates for purposes of congressional enforcement of this Act and concurrent budget resolutions under this Act.

''(2) REPORTING REVISED SUBALLOCATIONS.—Following the adjustments made under paragraph (1), the Committees on Appropriations of the Senate and the House of Representatives may report appropriately revised suballocations pursuant to sections 302(b) and 602(b) of this Act to carry out this subsection.

''(3) DEFINITIONS.—As used in this section, the terms 'continuing disability reviews', 'additional new budget authority', and 'additional outlays' shall have the same meanings as provided in section 251(b)(2)(H)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(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) are used, to the greatest extent practicable, to maximize the combined savings in the old-age, survivors, and disability insurance, supplemental security income, medicare, and medicaid 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 in 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 which result in cessations of benefits and the estimated present value of such savings.

(e) 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 redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(B) by inserting after subsection (b) the following new subsection:

''Chief Actuary

''(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 as the chief actuarial officer of the Administration, and shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence. The Chief Actuary may be removed only for cause.

''(2) The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.''.

(2) EFFECTIVE DATE OF SUBSECTION.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

SEC. 104. 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 or''.

(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) TERMINATION OF CHILD'S INSURANCE BENEFITS BASED ON WORK RECORD OF STEPPARENT UPON NATURAL PARENT'S DIVORCE FROM STEPPARENT.—

(1) IN GENERAL.—Section 202(d)(1) of the Social Security Act (42 U.S.C. 402(d)(1)) is amended—

(A) by striking ''or'' at the end of subparagraph (F);

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

(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 a stepparent who is subsequently divorced from such child's natural parent, the month after the month in which such divorce becomes final.''.

(2) NOTIFICATION.—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 stepparent shall notify the Commissioner of Social Security of any divorce upon such divorce becoming final; and

''(B) the Commissioner shall annually notify any stepparent of the rule for termination described in paragraph (1)(H) and of the requirement described in subparagraph (A).''.

(3) EFFECTIVE DATES.—

(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. DENIAL OF DISABILITY BENEFITS TO DRUG ADDICTS AND ALCOHOLICS.

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

(1) IN GENERAL.—Section 223(d)(2) of the Social Security Act (42 U.S.C. 423(d)(2)) is amended by adding at the end the following:

''(C) 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 Commissioner's determination that the individual is disabled.''.

(2) REPRESENTATIVE PAYEE REQUIREMENTS.—

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

''(B) In the case of an individual entitled to benefits based on 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 205(j)(2)(C)(v) of such Act (42 U.S.C. 405(j)(2)(C)(v)) is amended by striking ''entitled to benefits'' and all that follows through ''under a disability'' and inserting ''described in paragraph (1)(B)''.

(C) Section 205(j)(2)(D)(ii)(II) of such Act (42 U.S.C. 405(j)(2)(D)(ii)(II)) is amended by striking all that follows ''15 years, or'' and inserting ''described in paragraph (1)(B).''.

(D) Section 205(j)(4)(A)(i)(II) of such Act (42 U.S.C. 405(j)(4)(A)(ii)(II)) is amended by striking ''entitled to benefits'' and all that follows through ''under a disability'' and inserting ''described in paragraph (1)(B)''.

(3) TREATMENT REFERRALS FOR INDIVIDUALS WITH AN ALCOHOLISM OR DRUG ADDICTION CONDITION.—Section 222 of such Act (42 U.S.C. 422) is amended by adding at the end the following new subsection:

''Treatment Referrals for Individuals with an Alcoholism or Drug Addiction Condition

''(e) In the case of any individual whose benefits under this title are paid to a representative payee pursuant to section 205(j)(1)(B), the Commissioner of Social Security shall refer such individual to the appropriate State agency administering the State plan for substance abuse treatment services approved under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).''.

(4) CONFORMING AMENDMENT.—Subsection (c) of section 225 of such Act (42 U.S.C. 425(c)) is repealed.

(5) EFFECTIVE DATES.—

(A) 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 with respect to, benefits under 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 has applied for, and whose claim has been finally adjudicated by the Commissioner with respect to, such benefits before such date of enactment, such amendments shall apply only with respect to such benefits for months beginning on or after January 1, 1997.

(B) The amendments made by paragraphs (2) and (3) shall apply with respect to benefits for which applications are filed after the third month following the month in which this Act is enacted.

(C) Within 90 days after the date of the enactment of this Act, the Commissioner of Social Security shall notify each individual who is entitled to monthly insurance benefits under title II of the Social Security Act based on disability for the month in which this Act is enacted and whose entitlement to such benefits would terminate by reason of the amendments made by this subsection. If such an individual reapplies for 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 of Social Security shall, not later than January 1, 1997, complete the entitlement redetermination (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:

''(I) 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 Commissioner's determination that the individual is disabled.''.

(2) REPRESENTATIVE PAYEE REQUIREMENTS.—

(A) Section 1631(a)(2)(A)(ii)(II) of such Act (42 U.S.C. 1383(a)(2)(A)(ii)(II)) is amended to read as follows:

''(II) In the case of an individual 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 ''is disabled'' and inserting ''described in subparagraph (A)(ii)(II)''.

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

(D) Section 1631(a)(2)(D)(i)(II) of such Act (42 U.S.C. 1383(a)(2)(D)(i)(II)) is amended by striking ''eligible for benefits'' and all that follows through ''is disabled'' and inserting ''described in subparagraph (A)(ii)(II)''.

(3) TREATMENT REFERRALS FOR INDIVIDUALS WITH AN ALCOHOLISM OR DRUG ADDICTION CONDITION.—Title XVI of such Act (42 U.S.C. 1381

et seq.) is amended by adding at the end the following new section:

''TREATMENT REFERRALS FOR INDIVIDUALS WITH AN ALCOHOLISM OR DRUG ADDICTION CONDITION

''SEC. 1636. In the case of any individual whose benefits under this title are paid to a representative payee pursuant to section 1631(a)(2)(A)(ii)(II), the Commissioner of Social Security shall refer such individual to the appropriate State agency administering the State plan for substance abuse treatment services approved under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).''.

(4) CONFORMING AMENDMENTS.—

(A) Section 1611(e) of such Act (42 U.S.C. 1382(e)) is amended by striking paragraph (3).

(B) Section 1634 of such Act (42 U.S.C. 1383c) is amended by striking subsection (e).

(5) EFFECTIVE DATES.—

(A) 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 with respect to, supplemental security income benefits under title XVI 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 has applied for, and whose claim has been finally adjudicated by the Commissioner with respect to, such benefits before such date of enactment, such amendments shall apply only with respect to such benefits for months beginning on or after January 1, 1997.

(B) The amendments made by paragraphs (2) and (3) shall apply with respect to supplemental security income benefits under title XVI of the Social Security Act for which applications are filed after the third month following the month in which this Act is enacted.

(C) Within 90 days after the date of the enactment of this Act, the Commissioner of Social Security shall notify each individual who is eligible for supplemental security income benefits under title XVI of the Social Security Act for the month in which this Act is enacted and whose eligibility for such benefits would terminate by reason of the amendments made by this subsection. If such an individual reapplies for supplemental security income benefits under title XVI of such Act (as amended by this Act) within 120 days after the date of the enactment of this Act, the Commissioner of Social Security shall, not later than January 1, 1997, complete the eligibility redetermination (including a new medical determination) with respect to such individual pursuant to the procedures of such title.

(D) For purposes of this paragraph, the phrase ''supplemental security income benefits under title XVI of the Social Security Act'' includes supplementary payments pursuant to an agreement for Federal administration under section 1616(a) of the Social Security Act and payments pursuant to an agreement entered into under section 212(b) of Public Law 93–66.

(c) CONFORMING AMENDMENT.—Section 201(c) of the Social Security Independence and Program Improvements Act of 1994 (42 U.S.C. 425 note) is repealed.

(d) SUPPLEMENTAL FUNDING FOR ALCOHOL AND SUBSTANCE ABUSE TREATMENT PROGRAMS.—

(1) IN GENERAL.—Out of any money in the Treasury not otherwise appropriated, there are hereby appropriated to supplement State and Tribal programs funded under section 1933 of the Public Health Service Act (42 U.S.C. 300x–33), $50,000,000 for each of the fiscal years 1997 and 1998.

(2) ADDITIONAL FUNDS.—Amounts appropriated under paragraph (1) shall be in addition to any funds otherwise appropriated for allotments under section 1933 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 INSURANCE BENEFITS.

(a) 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 in or after 1984 and who have remained entitled to such benefits for a continuous period of not less than 5 years. The number of such recipients involved in the study shall be of sufficient size to generate a statistically valid sample for purposes of the study, but shall not exceed 600,000 beneficiaries.

(b) ANNUALIZED STATEMENTS.—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 information:

(1) an estimate of the 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;

(2) an estimate of the aggregate of the employee and self-employment contributions, and the aggregate of the employer contributions (separately identified), made with respect to the wages and self-employment income on which the benefit is based, as shown on the records of the Commissioner as of the end of the calendar year preceding the beneficiary's first month of entitlement; and

(3) an estimate of the total amount paid as benefits under section 202 of the Social Security Act based on such wages and self-employment income, 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 reports provided pursuant to this section are, to the maximum extent practicable, included with other reports currently provided to beneficiaries on an annual basis.

(d) REPORT TO THE CONGRESS.—The Commissioner shall report to each House of the Congress regarding the results of the pilot study conducted pursuant to this section not later than 60 days after the completion of such study.

SEC. 107. PROTECTION OF SOCIAL SECURITY AND MEDICARE TRUST FUNDS.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

''PROTECTION OF SOCIAL SECURITY AND MEDICARE TRUST FUNDS

''SEC. 1145. (a) IN GENERAL.—No officer or employee of the United States shall—

''(1) delay the deposit of any amount into (or delay the credit of any amount to) any Federal fund or otherwise vary from the normal terms, procedures, or timing for making such deposits or credits,

''(2) refrain from the investment in public debt obligations of amounts in any Federal fund, or

''(3) redeem prior to maturity amounts in any Federal fund which are invested in public debt obligations for any purpose other than the payment of benefits or administrative expenses from such Federal fund.

''(b) PUBLIC DEBT OBLIGATION.—For purposes of this section, the term 'public debt obligation' means any obligation subject to the public debt limit established under section 3101 of title 31, United States Code.

''(c) FEDERAL FUND.—For purposes of this section, the term 'Federal fund' means—

''(1) the Federal Old-Age and Survivors Insurance Trust Fund;

''(2) the Federal Disability Insurance Trust Fund;

''(3) the Federal Hospital Insurance Trust Fund; and

''(4) the Federal Supplementary Medical Insurance Trust Fund.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of the enactment of this Act.

SEC. 108. PROFESSIONAL STAFF FOR THE SOCIAL SECURITY ADVISORY BOARD.

Section 703(i) of the Social Security Act (42 U.S.C. 903(i)) is amended in the first sentence by inserting after ''Staff Director'' the following: '', and three professional staff members one of whom shall be appointed from among individuals approved by the members of the Board who are not members of the political party represented by the majority of the Board,''.

TITLE II—LINE ITEM VETO

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. 681 et seq.) is amended by adding at the end the following new part:

''PART C—LINE ITEM VETO

''LINE ITEM VETO AUTHORITY

''SEC. 1021. (a) IN GENERAL.—Notwithstanding the provisions of parts A and B, and subject to the provisions of this part, the President may, with respect to any bill or joint resolution that has been signed into law pursuant to Article I, section 7, of the Constitution of the United States, cancel in whole—

''(1) any dollar amount of discretionary budget authority;

''(2) any item of new direct spending; or

''(3) 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.

''(b) 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, construction, 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) use the definitions 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 cancellation has been made under this part, the President shall transmit 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 1021(a), together with any supporting material;

''(C) the reasons for the cancellation;

''(D) to the maximum extent practicable, the estimated fiscal, economic, and budgetary effect 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 upon the sequestration procedures of section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985.

''(2) In the case of a cancellation of any dollar amount of discretionary budget authority or item of new direct spending, the special message shall also include, if applicable-

''(A) any account, department, or establishment of the Government for which such budget authority was to have been available for obligation and the specific project or governmental functions involved;

''(B) the specific States and congressional districts, if any, affected by the cancellation; and

''(C) the total number of cancellations imposed during the current session of Congress on States and congressional districts identified in subparagraph (B).

''(c) TRANSMISSION OF SPECIAL MESSAGES TO HOUSE AND SENATE.—

''(1) The President shall transmit to the Congress each special message under this part within five calendar days (excluding Sundays) after enactment of the law to which the cancellation applies. Each special message shall be transmitted to the House of Representatives and the Senate on the same calendar day. Such special message shall be delivered to the Clerk of the House of Representatives if the House is not in session, and to the Secretary of the Senate if the Senate is not in session.

''(2) Any special message transmitted under this part shall be printed in the first issue of the Federal Register published after such transmittal.

''CANCELLATION EFFECTIVE UNLESS DISAPPROVED

''SEC. 1023. (a) IN GENERAL.—The cancellation 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 for such special message 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) COMMENSURATE REDUCTIONS IN DISCRETIONARY BUDGET AUTHORITY.—Upon the cancellation of a dollar amount of discretionary budget authority under subsection (a), the total appropriation for each relevant account of which that dollar amount is a part shall be simultaneously reduced by the dollar amount of that cancellation.

''DEFICIT REDUCTION

''SEC. 1024. (a) IN GENERAL.—

''(1) DISCRETIONARY BUDGET AUTHORITY.—OMB shall, for each dollar amount of discretionary budget authority and for each item of new direct spending canceled from an appropriation law under section 1021(a)—

''(A) reflect the reduction that results from such cancellation in the estimates required by section 251(a)(7) of the Balanced Budget and Emergency Deficit Control Act of 1985 in accordance with that Act, including an estimate of the reduction of the budget authority and the reduction in outlays flowing from such reduction of budget authority for each outyear; and

''(B) include a reduction to the discretionary spending limits for 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 section 601(a)(2) by amounts equal to the amounts for each fiscal year estimated pursuant to subparagraph (A).

''(2) DIRECT SPENDING AND LIMITED TAX BENEFITS.—(A) OMB shall, for each item of new direct spending or limited tax benefit canceled from a law under section 1021(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.

''(b) ADJUSTMENTS TO SPENDING LIMITS.—After ten calendar days (excluding Sundays) after the expiration of the time period in section 1025(b)(1) for expedited congressional consideration of a disapproval bill for a special message containing a cancellation of discretionary budget authority, OMB shall make the reduction included in subsection (a)(1)(B) as part of the next sequester report required by section 254 of the Balanced Budget and Emergency Deficit Control Act of 1985.

''(c) EXCEPTION.—Subsection (b) shall not apply to a cancellation if a disapproval bill or other law that disapproves that cancellation is enacted into law prior to 10 calendar days (excluding Sundays) after the expiration of the time period set forth in section 1025(b)(1).

''(d) CONGRESSIONAL BUDGET OFFICE ESTIMATES.—As soon as practicable after the President makes a cancellation from a law under section 1021(a), the Director of the Congressional Budget Office shall provide the Committees on the Budget of the House of Representatives and the Senate with an estimate of the reduction of the budget authority and the reduction in outlays flowing from such reduction of budget authority for each outyear.

''EXPEDITED CONGRESSIONAL CONSIDERATION OF DISAPPROVAL BILLS

''SEC. 1025. (a) RECEIPT AND REFERRAL OF SPECIAL MESSAGE.—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 at the end of a Congress prior to the expiration of the period described in paragraph (1) and a disapproval bill was then pending in either House of 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) INTRODUCTION OF DISAPPROVAL BILLS.—(1) In order for a disapproval bill to be considered under the procedures set forth in this section, the bill must meet the definition of a disapproval bill and must be introduced no later than the fifth calendar day of session following the beginning of the period described in subsection (b)(1).

''(2) In the case of a disapproval bill introduced in the House of Representatives, such bill shall include in the first blank space referred to in section 1026(6)(C) a list of the reference numbers for all cancellations made by the President in the special message to which such disapproval bill relates.

''(d) 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 session after the date of its introduction. If any committee fails to report the bill within that period, it is in order to move that the House discharge the committee from further consideration of the bill, except that such a motion may not be made after the committee has reported a disapproval bill with respect to the same special message. A motion to discharge may be 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 after the calendar day on which the Member offering the motion announces to the House his intention to do so and the form of the motion). The motion is highly privileged. Debate thereon shall be limited to not more than one hour, the time to be divided in the House equally between a proponent

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 has been discharged from 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. If reported and the report has been available for at least one calendar day, all points of order against the bill and against consideration of the bill are waived. If discharged, 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 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 bill shall be considered as read for amendment under the five-minute rule. Only one motion to rise shall be in order, except if offered by the manager. 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 the reference number or numbers of 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 this subsection more than one disapproval bill for the same special message except for consideration of a similar Senate bill (unless the House has already rejected a disapproval bill for the same special message) or more than one motion to discharge described in paragraph (1) with respect to a disapproval bill for that special message.

''(e) CONSIDERATION IN THE SENATE.—

''(1) REFERRAL AND REPORTING.—Any disapproval bill introduced in the Senate shall be referred to the appropriate committee or committees. A committee to which a 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 the bill and the bill shall be placed on the Calendar.

''(2) DISAPPROVAL BILL FROM HOUSE.—When the Senate receives from the House of Representatives a disapproval bill, such bill shall not be referred to committee and shall be placed on the Calendar.

''(3) CONSIDERATION OF SINGLE DISAPPROVAL BILL.—After the Senate has proceeded to the consideration of a disapproval bill for a 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.

''(4) AMENDMENTS.—

''(A) AMENDMENTS IN ORDER.—The only amendments in order to a disapproval bill are—

''(i) an amendment that strikes the reference number of a cancellation from the disapproval bill; and

''(ii) an amendment that only inserts the reference number of a cancellation included in the special message to which the disapproval bill relates that is not already contained in such bill.

''(B) WAIVER OR APPEAL.—An affirmative vote of three-fifths of the Senators, duly chosen and sworn, shall be required in the Senate—

''(i) to waive or suspend this paragraph; or

''(ii) to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

''(5) MOTION NONDEBATABLE.—A motion to proceed to consideration of a disapproval bill under this subsection shall not be debatable. It shall not be in order to move to reconsider the vote by which the motion to proceed was adopted or rejected, although subsequent motions to proceed may be made under this paragraph.

''(6) LIMIT ON CONSIDERATION.— (A) After no more than 10 hours of consideration of a disapproval bill, the Senate shall proceed, without intervening action or debate (except as permitted under paragraph (9)), to vote on the final disposition thereof to the exclusion of all amendments not then pending and to the exclusion of all motions, except a motion to reconsider or to table.

''(B) A single motion to extend the time for consideration under subparagraph (A) for no more than an additional five hours is in order prior to the expiration of such time and shall be decided without debate.

''(C) The time for debate on the disapproval bill shall be equally divided between the Majority Leader and the Minority Leader or their designees.

''(7) DEBATE ON AMENDMENTS.—Debate on any amendment to a disapproval bill shall be limited to one hour, equally divided and controlled by the Senator proposing the amendment and the majority manager, unless the majority manager is in favor of the amendment, in which case the minority manager shall be in control of the time in opposition.

''(8) NO MOTION TO RECOMMIT.—A motion to recommit a disapproval bill shall not be in order.

''(9) DISPOSITION OF SENATE DISAPPROVAL BILL.—If the Senate has read for the third time a disapproval bill that originated 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 received from 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 disapproval 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 on a disapproval bill shall be limited to not more than four hours. Debate on each motion or amendment shall be limited to 30 minutes. Debate on any appeal or point of order that is submitted in connection with the disposition of the House message shall be limited to 20 minutes. Any time for debate shall be equally divided and controlled by the proponent and the majority manager, unless the majority manager is a proponent of the motion, amendment, appeal, or point of order, in which case the minority manager shall be in control of the time in opposition.

''(f) CONSIDERATION IN CONFERENCE—

''(1) CONVENING OF CONFERENCE.—In the case of disagreement between the two Houses of Congress with respect to a disapproval bill passed by both Houses, conferees should be promptly appointed and a conference promptly convened, if necessary.

''(2) HOUSE CONSIDERATION.—(A) Notwithstanding any other rule of the House of Representatives, it shall be in order to consider the report of a committee of conference relating to a disapproval bill provided such report has been available for one calendar day (excluding Saturdays, Sundays, or legal holidays, unless the House is in session on such a day) and the accompanying statement shall have been filed in the House.

''(B) Debate in the House of Representatives on the conference report and any amendments in disagreement on any disapproval bill shall each be limited to not more than one hour equally divided and controlled by a proponent and an opponent. A motion to further limit debate is not debatable. A motion to recommit the conference report is not in order, and it is not in order to move to reconsider the vote by which the conference report is agreed to or disagreed to.

''(3) SENATE CONSIDERATION.—Consideration in the Senate of the conference report and any amendments in disagreement on a disapproval bill shall be limited to not more than four hours equally divided and controlled by the Majority Leader and the Minority Leader or their designees. A motion to recommit the conference report is not in order.

''(4) LIMITS ON SCOPE.—(A) When a disagreement to an amendment in the nature of a substitute has been referred to a conference, the conferees shall report those cancellations that were included in both the bill and the amendment, and may report a cancellation included in either the bill or the amendment, but shall not include any other matter.

''(B) When a disagreement on an amendment or amendments of one House to the disapproval bill of the other House has been referred to a committee of conference, the conferees shall report those cancellations upon which both Houses agree and may report any or all of those cancellations upon which there is 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—

''(A) with respect to any dollar amount of discretionary budget authority, to rescind;

''(B) with respect to any item of new direct spending—

''(i) that is budget authority provided by law (other than an appropriation law), to prevent such budget authority from having legal force or effect;

''(ii) that is entitlement authority, to prevent the specific legal obligation of the United States from having legal force or effect; or

''(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; and

''(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 on _____', the blank space being filled in with the date of transmission of the relevant special message and the public law number to which the message relates;

''(B) which does not have a preamble; and

''(C) which provides only the following after the enacting clause: 'That Congress disapproves of cancellations _____', the blank space being filled in with a list by reference number of one or more cancellations contained in the President's special message, 'as transmitted by the President in a special message on _____', the blank space being filled in with the appropriate date, 'regarding _____.', the blank space being filled in with the public law number to which the special message relates.

''(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 entire dollar 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) represented separately in any table, chart, or explanatory text included in the statement of managers or the governing committee report accompanying such law;

''(iii) required to be allocated for a specific program, project, or activity in a law (other than an appropriation law) that mandates the expenditure of budget authority from accounts, programs, projects, or activities for which budget authority is provided in an appropriation law;

''(iv) 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

''(v) 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 mandates 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) budget authority in an appropriation law which funds direct spending provided for in other law;

''(iii) any existing budget authority rescinded or canceled in an appropriation law; or

''(iv) any restriction, condition, or limitation in an appropriation law or the 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 any specific provision of 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 257 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 for 10 or fewer beneficiaries in any fiscal year from a change to the Internal Revenue Code of 1986.

''(B) 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 or form of the business or association involved;

''(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.

''(C) A provision shall not be treated as described in subparagraph (A)(ii) if—

''(i) it provides for the retention of prior law with respect to all binding contracts or other legally enforceable obligations in existence on a date contemporaneous with congressional action specifying such date; or

''(ii) it is a technical 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 a single beneficiary; 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.

''(E) For purposes of this paragraph, the term 'revenue-losing provision' means any provision which results in a reduction in Federal tax revenues for any one of the two following periods—

''(i) the first fiscal year for which the provision is effective; or

''(ii) the period of the 5 fiscal years beginning with the first fiscal year for which the provision is effective.

''(F) The terms used in this paragraph shall have the same meaning as those terms have generally in the Internal Revenue Code of 1986, unless otherwise expressly provided.

''(10) OMB.—The term 'OMB' means the Director of the Office of Management and Budget.

''IDENTIFICATION OF LIMITED TAX BENEFITS

''SEC. 1027. (a) STATEMENT BY JOINT TAX COMMITTEE.—The Joint Committee on Taxation shall review any revenue or reconciliation bill or joint resolution which includes any amendment to the Internal Revenue Code of 1986 that is being prepared for filing by a committee of conference of the two Houses, and shall identify whether such bill or joint resolution contains any limited tax benefits. The Joint Committee on Taxation shall provide to the committee of conference a statement identifying any such limited tax benefits or declaring that the bill or joint resolution does not contain any limited tax benefits. Any such statement shall be made available to any Member of Congress by the Joint Committee on Taxation immediately upon request.

''(b) STATEMENT INCLUDED IN LEGISLATION.—(1) Notwithstanding any other rule of the House of Representatives or any rule or precedent of the Senate, any revenue or reconciliation bill or joint resolution which includes any amendment to the Internal Revenue Code of 1986 reported by a committee of conference of the two Houses may include, as a separate section of such bill or joint resolution, the information contained in the statement of the Joint Committee on Taxation, but only in the manner set forth in paragraph (2).

''(2) The separate section permitted under paragraph (1) shall read as follows: 'Section 1021(a)(3) of the Congressional Budget and Impoundment Control Act of 1974 shall _____ apply to _____.', with the blank spaces being filled in with —

''(A) in any case in which the Joint Committee on Taxation identifies limited tax benefits in the statement required under subsection (a), the word 'only' in the first blank space and a list of all of the specific provisions of the bill or joint resolution identified by the Joint Committee on Taxation in such statement in the second blank space; or

''(B) in any case in which the Joint Committee on Taxation declares that there are no limited tax benefits in the statement required under subsection (a), the word 'not' in the first blank space and the phrase 'any provision of this Act' in the second blank space.

''(c) PRESIDENT'S AUTHORITY.—If any revenue or reconciliation bill or joint resolution is signed into law pursuant to Article I, section 7, of the Constitution of the United States—

''(1) with a separate section described in subsection (b)(2), then the President may use the authority granted in section 1021(a)(3) only to cancel any limited tax benefit in that law, if any, identified in such separate section; or

''(2) without a separate section described in subsection (b)(2), then the President may use the authority granted in section 1021(a)(3) to cancel any limited tax benefit in that law that meets the definition in section 1026.

''(d) CONGRESSIONAL IDENTIFICATIONS OF LIMITED TAX BENEFITS.—There shall be no judicial review of the congressional identification under subsections (a) and (b) of a limited tax benefit in a conference report.''.

SEC. 203. JUDICIAL REVIEW.

(a) EXPEDITED REVIEW.—

(1) Any Member of Congress or any individual adversely affected by part C of title X of

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) 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 10 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 1(a) of the Congressional Budget and Impoundment Control Act of 1974 is amended by—

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

(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 'Line Item Veto 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) EXERCISE OF RULEMAKING POWERS.—Section 904(a) of the Congressional Budget Act of 1974 is amended by striking ''and 1017'' and inserting '', 1017, 1025, and 1027''.

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, 1997;

and shall 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. 302. FINDINGS.

Congress finds that—

(1) a vibrant and growing small business sector is critical to creating jobs in a dynamic economy;

(2) small businesses bear a disproportionate share of regulatory costs and burdens;

(3) fundamental changes that are needed in the regulatory and enforcement culture of Federal agencies to make agencies more responsive to small business can be made without compromising the statutory missions of the agencies;

(4) three of the top recommendations of the 1995 White House Conference on Small Business involve reforms to the way government regulations are developed and enforced, and reductions in government paperwork requirements;

(5) the requirements of chapter 6 of title 5, United States Code, have too often been ignored by government agencies, resulting in greater regulatory burdens on small entities than necessitated by statute; and

(6) small entities should be given the opportunity to seek judicial review of agency actions required by chapter 6 of title 5, United States Code.

SEC. 303. PURPOSES.

The purposes of this title are—

(1) to implement certain recommendations of the 1995 White House Conference on Small Business regarding the development and enforcement of Federal regulations;

(2) to provide for judicial review of chapter 6 of title 5, United States Code;

(3) to encourage the effective participation of small businesses in the Federal regulatory process;

(4) to simplify the language of Federal regulations affecting small businesses;

(5) to develop more accessible sources of information on regulatory and reporting requirements for small businesses;

(6) to create a more cooperative regulatory environment among agencies and small businesses that is less punitive and more solution-oriented; and

(7) to make Federal regulators more accountable for their enforcement actions by providing small entities with a meaningful opportunity for redress of excessive enforcement activities.

Subtitle A—Regulatory Compliance Simplification

SEC. 311. 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. 312. COMPLIANCE GUIDES.

(a) COMPLIANCE GUIDE.—For each rule or group of related rules for which an agency is required to prepare a final regulatory flexibility analysis under section 604 of title 5, United States Code, the agency shall publish one or more guides to assist small entities in complying with the rule, and shall designate such publications as ''small entity compliance guides''. The guides shall explain the actions a small entity is required to take to comply with a rule or group of rules. The agency shall, in its sole discretion, taking into account the subject matter of the rule and the language of relevant statutes, ensure that the guide is written using sufficiently plain language likely to be understood by affected small entities. Agencies may prepare separate guides covering groups or classes of similarly affected small entities, and may cooperate with associations of small entities to develop and distribute such guides.

(b) COMPREHENSIVE SOURCE OF INFORMATION.—Agencies shall cooperate to make available to small entities through comprehensive sources of information, the small entity compliance guides and all other available information on statutory and regulatory requirements affecting small entities.

(c) LIMITATION ON JUDICIAL REVIEW.—An agency's small entity compliance guide shall not be subject to judicial review, except that in any civil or administrative action against a small entity for a violation occurring after the effective date of this section, the content of the small entity compliance guide may be considered as evidence of the reasonableness or appropriateness of any proposed fines, penalties or damages.

SEC. 313. INFORMAL SMALL ENTITY GUIDANCE.

(a) GENERAL.—Whenever appropriate in the interest of administering statutes and regulations within the jurisdiction of an agency which regulates small entities, it shall be the practice of the agency to answer inquiries by small entities concerning information on, and advice about, compliance with such statutes and regulations, interpreting and applying the law to specific sets of facts supplied by the small entity. In any civil or administrative action against a small entity, guidance given by an agency applying the law to facts provided by the small entity may be considered as evidence of the reasonableness or appropriateness of any proposed fines, penalties or damages sought against such small entity.

(b) PROGRAM.—Each agency regulating the activities of small entities shall establish a program for responding to such inquiries no later than 1 year after enactment of this section, utilizing existing functions and personnel of the agency to the extent practicable.

(c) REPORTING.—Each agency regulating the activities of small business 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 the Judiciary of the House of Representatives no later than 2 years after the date of the enactment of this section on the scope of the agency's program, the number of small entities using the program, and the achievements of the program to assist small entity compliance with agency regulations.

SEC. 314. SERVICES OF SMALL BUSINESS DEVELOPMENT CENTERS.

(a) Section 21(c)(3) of the Small Business Act (15 U.S.C. 648(c)(3)) is amended—

(1) in subparagraph (O), by striking ''and'' at the end;

(2) in subparagraph (P), by striking the period at the end and inserting a semicolon; and

(3) by inserting after subparagraph (P) the following new subparagraphs:

''(Q) providing information to small business concerns regarding compliance with regulatory requirements; and

''(R) developing informational publications, establishing resource centers of reference materials, and distributing compliance guides published under section 312(a) of the Small Business Regulatory Enforcement Fairness Act of 1996.''.

(b) Nothing in this Act in any way affects or limits the ability of other technical assistance or extension programs to perform or continue to perform services related to compliance assistance.

SEC. 315. COOPERATION ON GUIDANCE.

Agencies may, to the extent resources are available and where appropriate, in cooperation with the states, develop guides that fully integrate 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 guides 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, the term—

''(1) 'Board' means a Regional Small Business Regulatory Fairness Board established under subsection (c); 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. Other agencies shall assist 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, compliance assistance effort, or other enforcement related communication or contact by agency personnel are provided with a means to comment on the enforcement activity conducted by such personnel;

''(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 circumstances, and otherwise seek to maintain the identity of the person and small business concern making such comments on a confidential basis to the same extent as employee identities are 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 activities of agency personnel including a rating of the responsiveness to small business of the various regional and program offices of each agency;

''(D) coordinate and report annually on the activities, findings and recommendations of the Boards to the Administrator and to the heads of affected agencies; and

''(E) provide the affected agency with an opportunity to comment on draft reports prepared under subparagraph (C), 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.

''(c) REGIONAL SMALL BUSINESS REGULATORY FAIRNESS BOARDS.—

''(1) Not later than 180 days after the date of enactment of this section, the Administrator shall establish a 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 any findings or recommendations of the Board as to agency enforcement policy or practice; and

''(C) prior to publication, provide comment on the annual report of 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 more 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 branch or the Congress.

''(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 1 year 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 same manner and 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, while away from 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 for the waiver, of civil penalties for violations of a statutory or regulatory requirement by a small entity. Under appropriate circumstances, an agency may consider ability to pay in determining penalty assessments on small entities.

(b) CONDITIONS AND EXCLUSIONS.—Subject to the requirements or limitations 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 or failed to qualify 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. Fees and expenses awarded under this paragraph shall be paid only as a consequence of appropriations provided in advance.''.

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

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

(2) at the end of paragraph (1)(B), by inserting before the semicolon ''or for purposes of subsection (a)(4), a small entity as defined in section 601'';

(3) at the end of paragraph (1)(D), by striking ''and'';

(4) at the end of paragraph (1)(E), by striking the period and inserting ''; 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, but does not 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 the following new subparagraph:

''(D) If, in a civil action brought by the United States, or a proceeding for judicial review of an adversary 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 and is unreasonable when compared 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 appropriations provided in advance.''.

(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)(1)(D), 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) 'demand' means 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, or (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 the enactment of this subtitle.

Subtitle D—Regulatory Flexibility Act Amendments

SEC. 341. REGULATORY FLEXIBILITY ANALYSES.

(a) INITIAL REGULATORY FLEXIBILITY ANALYSIS.—

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

(A) by inserting after ''proposed rule'', the phrase '', or publishes a notice of proposed rulemaking for an interpretative rule involving the internal revenue laws of the United States''; and

(B) by inserting at the end of the subsection, the following new sentence: ''In the case of an interpretative rule involving the internal revenue laws of the United States, this chapter applies to interpretative rules published in the Federal Register for codification in the Code of Federal Regulations, but only to the extent that such interpretative rules impose on small entities a collection of information requirement.''.

(2) SECTION 601.—Section 601 of title 5, United States Code, is amended by striking ''and'' at the end of paragraph (5), by striking the period at the end of paragraph (6) and inserting ''; and'', and by adding at the end the following:

''(7) the term 'collection of information'—

''(A) means the obtaining, causing to be obtained, soliciting, or requiring the disclosure to third parties or the public, of facts or opinions by or for an agency, regardless of form or format, calling for either—

''(i) answers to identical questions posed to, or identical reporting or recordkeeping requirements imposed on, 10 or more persons, other than agencies, instrumentalities, or employees of the United States; or

''(ii) answers to questions posed to agencies, instrumentalities, or employees of the United States which are to be used for general statistical purposes; and

''(B) shall not include a collection of information described under section 3518(c)(1) of title 44, United States Code.

''(8) RECORDKEEPING REQUIREMENT.—The term 'recordkeeping requirement' means a requirement imposed by an agency on persons to maintain specified records.

(b) FINAL REGULATORY FLEXIBILITY ANALYSIS.—Section 604 of title 5, United States Code, is amended—

(1) in subsection (a) to read as follows:

''(a) When an agency promulgates a final rule under section 553 of this title, after being required by that section or any other law to publish a general notice of proposed rulemaking, or promulgates a final interpretative rule involving the internal revenue laws of the United States as described in section 603(a), the agency shall prepare a final regulatory flexibility analysis. Each final regulatory flexibility analysis shall contain—

''(1) a succinct statement of the need for, and objectives of, the rule;

''(2) a summary of the significant issues raised by the public comments in response to the initial regulatory flexibility analysis, a summary of the assessment of the agency of such issues, and a statement of any changes made in the proposed rule as a result of such comments;

''(3) a description of and an estimate of the number of small entities to which the rule will apply or an explanation of why no such estimate is available;

''(4) a description of the projected reporting, record keeping and other compliance requirements of the rule, including an estimate of the classes of small entities which will be subject to the requirement and the type of professional skills necessary for preparation of the report or record; and

''(5) a description of the steps the agency has taken to minimize the significant economic impact on small entities consistent with the stated objectives of applicable statutes, including a statement of the factual, policy, and legal reasons for selecting the alternative adopted in the final rule and why each one of the other significant alternatives to the rule considered by the agency which affect the impact on small entities was rejected.''; and

(2) in subsection (b), by striking ''at the time'' and all that follows and inserting ''such analysis or a summary thereof.''.

SEC. 342. JUDICIAL REVIEW.

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

''§ 611. Judicial review

''(a)(1) For any rule 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 requirements of sections 601, 604, 605(b), 608(b), and 610 in accordance with chapter 7. Agency compliance with sections 607 and 609(a) shall be judicially reviewable in connection with judicial review of section 604.

''(2) Each court having jurisdiction to review such rule for compliance with section 553, or under any other provision of law, shall have jurisdiction to review any claims of noncompliance with sections 601, 604, 605(b), 608(b), and 610 in accordance with chapter 7. Agency compliance with sections 607 and 609(a) shall be judicially reviewable in connection with judicial review of section 604.

''(3)(A) A small entity may seek such review during the period beginning on the date of final agency action and ending one year later, except that where a provision of law requires that an action challenging a final agency action be commenced before the expiration of one year, such lesser period shall apply to an action for judicial review under this section.

''(B) In the case where an agency delays the issuance of a final regulatory flexibility analysis pursuant to section 608(b) of 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 1-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.

''(4) In 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 unless the court finds that continued enforcement of the rule is in the public interest.

''(5) Nothing in this subsection shall be construed to limit the authority of any court to stay the effective date of any rule or provision thereof under any other provision of law or to grant any other relief in addition to the requirements of this section.

''(b) In an action for the judicial review of a rule, the regulatory flexibility analysis for such rule, including an analysis prepared or corrected pursuant to paragraph (a)(4), shall constitute part of the entire record of agency action in connection with such review.

''(c) Compliance or noncompliance by an agency with the provisions of this chapter shall be subject to judicial review only in accordance with this section.

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

SEC. 343. TECHNICAL AND CONFORMING AMENDMENTS.

(a) Section 605(b) of title 5, United States Code, is amended to read as follows:

''(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 publish such certification in the Federal Register at the time of publication of general notice of proposed rulemaking for the rule or at the time of publication of the final rule, along with a statement providing the factual basis for such certification. The agency shall provide such certification and statement to the Chief Counsel for Advocacy of the Small Business Administration.''.

(b) Section 612 of title 5, United States Code is amended—

(1) in subsection (a), by striking ''the committees on the Judiciary of the Senate and the House of Representatives, the Select Committee on Small Business of the Senate, and the Committee on Small Business of the House of Representatives'' and inserting ''the Committees on the Judiciary and Small

Business of the Senate and House of Representatives''.

(2) in subsection (b), by striking ''his views with respect to the'' and inserting in lieu thereof, ''his or her views with respect to compliance with this chapter, the adequacy of the rulemaking record with respect to small entities and the''.

SEC. 344. SMALL BUSINESS ADVOCACY REVIEW PANELS.

(a) SMALL BUSINESS OUTREACH AND INTERAGENCY COORDINATION.— Section 609 of title 5, United States Code is amended—

(1) before ''techniques,'' by inserting ''the reasonable use of'';

(2) in paragraph (4), after ''entities'' by inserting ''including soliciting and receiving comments over computer networks'';

(3) by designating the current text as subsection (a); and

(4) by adding the following:

''(b) Prior to publication of an initial 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 and provide 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 responsible for carrying out the proposed rule, the Office of Information and Regulatory Affairs within the Office of Management and Budget, and the Chief Counsel;

''(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 603(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 on the comments of 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.

''(c) An agency may 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.

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

''(e) The Chief Counsel for Advocacy, in consultation with the individuals identified in subsection (b)(2), and with the Administrator of the Office of Information and Regulatory Affairs within the Office of Management and Budget, may waive the requirements of subsections (b)(3), (b)(4), and (b)(5) 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 covered 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) would provide the individuals identified in subsection (b)(2) with a competitive advantage relative to other small entities.''.

(b) SMALL BUSINESS ADVOCACY CHAIRPERSONS.—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 shall designate a small business advocacy chairperson using existing personnel to the extent possible, to be responsible for implementing this section and to act as permanent chair of the agency's review panels established pursuant to this section.

SEC. 345. EFFECTIVE DATE.

This subtitle shall become effective on the expiration of 90 days after the date of enactment of this subtitle, except that such amendments shall not apply to interpretative rules for which a notice of proposed rulemaking was published prior to the date of enactment.

Subtitle E—Congressional Review

SEC. 351. CONGRESSIONAL REVIEW OF AGENCY RULEMAKING.

Title 5, United States Code, is amended by inserting immediately after chapter 7 the following new chapter:

''CHAPTER 8—CONGRESSIONAL REVIEW OF AGENCY RULEMAKING

''Sec.
''801. Congressional review.
''802. Congressional disapproval procedure.
''803. Special rule on statutory, regulatory, and judicial deadlines.
''804. Definitions.
''805. Judicial review.
''806. Applicability; severability.
''807. Exemption for monetary policy.
''808. Effective date of certain rules.

''§ 801. Congressional review

''(a)(1)(A) Before a rule can take effect, the Federal agency promulgating such rule shall submit to each House of the Congress and to the Comptroller General a report containing—

''(i) a copy of the rule;

''(ii) a concise general statement relating to the rule, including whether it is a major rule; and

''(iii) the proposed effective date of the rule.

''(B) On the date of the submission of the report under subparagraph (A), the Federal agency promulgating the rule shall submit to the Comptroller General and make available to each House of Congress—

''(i) a complete copy of the cost-benefit analysis of the rule, if any;

''(ii) the agency's actions relevant to sections 603, 604, 605, 607, and 609;

''(iii) the agency's actions relevant to sections 202, 203, 204, and 205 of the Unfunded Mandates Reform Act of 1995; and

''(iv) any other relevant information or requirements under any other Act and any relevant Executive Orders.

''(C) Upon receipt of a report submitted under subparagraph (A), each House shall provide copies of the report to the Chairman and Ranking Member of each standing committee with jurisdiction under the rules of the House of Representatives or the Senate to report a bill to amend the provision of law under which the rule is issued.

''(2)(A) The Comptroller General shall provide a report on each major rule to the committees of jurisdiction in each House of the Congress by the end of 15 calendar days after the submission or publication date as provided in section 802(b)(2). The report of the Comptroller General shall include an assessment of the agency's compliance with procedural steps required by paragraph (1)(B).

''(B) Federal agencies shall cooperate with the Comptroller General by providing information relevant to the Comptroller General's report under subparagraph (A).

''(3) A major rule relating to a report submitted under paragraph (1) shall take effect on the latest of—

''(A) the later of the date occurring 60 days after the date on which—

''(i) the Congress receives the report submitted under paragraph (1); or

''(ii) the rule is published in the Federal Register, if so published;

''(B) if the Congress passes a joint resolution of disapproval described in section 802 relating to the rule, and the President signs a veto of such resolution, the earlier date—

''(i) on which either House of Congress votes and fails to override the veto of the President; or

''(ii) occurring 30 session days after the date on which the Congress received the veto and objections of the President; or

''(C) the date the rule would have otherwise taken effect, if not for this section (unless a joint resolution of disapproval under section 802 is enacted).

''(4) Except for a major rule, a rule shall take effect as otherwise provided by law after submission to Congress under paragraph (1).

''(5) Notwithstanding paragraph (3), the effective date of a rule shall not be delayed by operation of this chapter beyond the date on which either House of Congress votes to reject a joint resolution of disapproval under section 802.

''(b)(1) A rule shall not take effect (or continue), if the Congress enacts a joint resolution of disapproval, described under section 802, of the rule.

''(2) A rule that does not take effect (or does not continue) under paragraph (1) may not be reissued in substantially the same form, and a new rule that is substantially the same as such a rule may not be issued, unless the reissued or new rule is specifically authorized by a law enacted after the date of the joint resolution disapproving the original rule.

''(c)(1) Notwithstanding any other provision of this section (except subject to paragraph (3)), a rule that would not take effect by reason of subsection (a)(3) may take effect, if the President makes a determination under paragraph (2) and submits written notice of such determination to the Congress.

''(2) Paragraph (1) applies to a determination made by the President by Executive Order that the rule should take effect because such rule is—

''(A) necessary because of an imminent threat to health or safety or other emergency;

''(B) necessary for the enforcement of criminal laws;

''(C) necessary for national security; or

''(D) issued pursuant to any statute implementing an international trade agreement.

''(3) An exercise by the President of the authority under this subsection shall have no effect on the procedures under section 802 or the effect of a joint resolution of disapproval under this section.

''(d)(1) In addition to the opportunity for review otherwise provided under this chapter, in the case of any rule for which a report was submitted in accordance with subsection (a)(1)(A) during 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)(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) a report 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, unless the rule is made of no force or effect under section 802.

''(f) 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.

''(g) If the Congress does not enact a joint resolution of disapproval under section 802 respecting a rule, no court or agency may infer any intent of the Congress from any action or inaction 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 ending 60 days thereafter (excluding days either House of Congress is adjourned for more than 3 days during a session of Congress), the matter after the resolving clause of which is as follows: 'That Congress disapproves the rule submitted by the ___ relating to ___, and such rule shall have no force or effect.' (The blank spaces being appropriately filled in).

''(b)(1) A joint resolution described in subsection (a) shall be referred to the committees in each House of Congress with jurisdiction.

''(2) For purposes of this section, the term 'submission or publication date' means the later of the date on which—

''(A) the Congress receives the report submitted under section 801(a)(1); or

''(B) the rule is published in the Federal Register, if so published.

''(c) In the Senate, if the committee to which is referred a joint resolution described in subsection (a) has not reported such joint resolution (or an identical joint resolution) at the end of 20 calendar days after the submission or publication date defined under subsection (b)(2), such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

''(d)(1) In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subsection (c)) from further consideration of a joint resolution described in subsection (a), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

''(2) In the Senate, debate on the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between those favoring and those opposing the joint resolution. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

''(3) In the Senate, immediately following the conclusion of the debate on a joint resolution described in subsection (a), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on final passage of the joint resolution shall occur.

''(4) Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in subsection (a) shall be decided without debate.

''(e) In the Senate the procedure specified in subsection (c) or (d) shall not apply to the consideration of a joint resolution respecting a rule—

''(1) after the expiration of the 60 session days beginning with the applicable submission or publication date, or

''(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) If, before the passage by one House of a joint resolution of that House 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 is enacted by Congress—

''(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 each 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 it supersedes other rules only to 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 take effect (or the effectiveness of 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 enactment of the joint resolution. Nothing in this subsection shall be construed to affect a deadline merely by reason of the postponement of a rule's effective date under section 801(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, innovation, or on 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 such term 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 nonagency parties.

"§ 805. Judicial review

''No determination, finding, action, or omission under this chapter shall be subject to judicial review.

"§ 806. Applicability; severability

''(a) This chapter shall apply notwithstanding any other provision of law.

''(b) If any provision of this chapter or the application of any provision of this chapter to any person or circumstance, is held invalid, the application of such provision to other persons or circumstances, and the remainder of this chapter, shall not be affected thereby.

"§ 807. Exemption for monetary policy

''Nothing in this chapter shall apply to rules that concern monetary policy proposed or implemented by the Board of Governors of the Federal Reserve System or the Federal Open Market Committee.

"§ 808. Effective date of certain rules

''Notwithstanding section 801—

''(1) any rule that establishes, modifies, opens, closes, or conducts a regulatory program for a commercial, recreational, or subsistence activity related to hunting, fishing, or camping, or

''(2) any rule which an agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rule issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest,

shall take effect at such time as the Federal agency promulgating the rule determines.''.

SEC. 352. EFFECTIVE DATE.

The amendment made by section 351 shall take effect on the date of enactment of this Act.

SEC. 353. TECHNICAL AMENDMENT.

The table of chapters for part I of title 5, United States Code, is amended by inserting immediately after the item relating to chapter 7 the following:

"8. Congressional Review of Agency Rulemaking ..... 801".

TITLE IV—PUBLIC DEBT LIMIT

SEC. 401. INCREASE IN PUBLIC DEBT LIMIT.

Subsection (b) of section 3101 of title 31, United States Code, is amended by striking the dollar limitation contained in such subsection and inserting ''$5,500,000,000,000''.

The SPEAKER pro tempore. Pursuant to House Resolution 391, as amended, the gentleman from Texas [Mr. ARCHER] will be recognized for 30 minutes, the gentleman from Florida [Mr. GIBBONS] will be recognized for 30 minutes, the gentleman from Pennsylvania [Mr. CLINGER] will be recognized for 10 minutes, and the gentlewoman from New York [Ms. SLAUGHTER], the designee of the ranking minority member, will be recognized for 10 minutes.

The Chair recognizes the gentleman from Texas [Mr. ARCHER].

GENERAL LEAVE

Mr. ARCHER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on and include extraneous material on the bill H.R. 3136.

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

There was no objection.

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

Mr. Speaker, I rise today in strong support of H.R. 3136, the Contract With 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 limit.

Let me first compliment Chairmen SOLOMON, CLINGER, and BUNNING, and the rest of the line-item-veto conferees for their hard work. As the original author of line-item-veto legislation at the request of 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 1970's. As you know the House has already approved this measure by a large bipartisan vote of 411 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 2002, 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 work force 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 almost 1 million senior citizens 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 business. 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 including in the Balanced Budget Act, and sought by the Treasury Department. We have receive correspondence from Treasury expressing their support for the provision.

This is a straightforward debt limit extension. As you know, we need to pass this legislation quickly as the current temporary limit expires tomorrow.

Section 107 of this legislation codifies Congress' understanding that the Secretary of Treasury and other Federal officials are not authorized to use Social Security and Medicare funds for debt management purposes under any circumstances. Specifically, the Secretary of the Treasury and other Federal officials are required not to delay or otherwise underinvest incoming receipts to the Social Security and Medicare trust funds. They are also required not to sell, redeem or otherwise disinvest securities, obligations or other assets of these trust funds except when necessary to provide for the payment of benefits and administrative expenses of these programs. The legislation applies to the following trust funds: Federal Old-Age and Survivors Insurance [OASI] Trust Fund; Federal Hospital Insurance [HI] Trust Fund; and Federal Supplementary Medical Insurance [SMI] Trust Fund.

Since late October, the total amount of public debt obligations has been very close to the public debt limit. This has given rise to concerns that the Social Security and Medicare trust funds might be underinvested or disinvested for debt management purposes. While the administration has stated that it would not take such action, it is desirable to make clear in law that these funds could not be used for debt management purposes. It is the purpose of this legislation to clarify that any limitation on the public debt shall not be used as an excuse to avoid the full and timely investment of the Social Security trust funds. The Secretary, by law, is the managing trustee of these trust funds, and also the chief financial officer of the U.S. Government charged with its day-to-day cash management. As such, he shall take all necessary steps to ensure the full and timely investment of the Social Security and Medicare trust funds.

This bill seeks to assure that the Secretary of the Treasury and other Federal officials shall invest and disinvest Social Security and Medicare trust funds solely for the purposes of accounting for the income and disbursements of these programs. There are no circumstances envisioned under which the investments of the trust funds will not be made in a timely fashion in accordance with the normal investment practices of the Treasury, or under which the trust funds are drawn down prematurely for the purpose of avoiding limitations on the public debt or to make room under the statutory debt limit for the Secretary of the Treasury to issue new debt obligations in order to cover the expenditures of the Government.

Mr. Speaker, this is an excellent bill, which advances many important elements of our Contract With America, keeping our promises to the American

people. I urge my colleagues on both sides of the aisle to support it today.

□ 1230

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 379; 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 hurts 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 extraneous 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 power of the purse to the people, which are represented in the 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 rule, is patterned after the provisions of S. 942, legislation sponsored by Senator CHRISTOPHER BOND of Missouri, which passed the Senate on March 19 by the vote of 100 to 0. It would provide important regulatory relief for America's small businesses.

This measure is vitally important to the small business community, which is particularly burdened by the effect of multiple, and many times conflicting, regulatory requirements. It should be viewed not as a total solution to all regulatory problems, but as a good first step of making rules more fair, more rational, and more carefully tailored to achieve the goal they are designed to accomplish.

First, title III proposes important changes in 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, farmers, 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 head of 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 reviews 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 prepared, small entities are 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 allows the President 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 gather information from 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 and no more than 500 employees. 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, if they have been subjected to excessive 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 a small entity to enforce a statutory or regulatory requirement. In these situations, the test for recovering attorneys' fees would become 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 from small businesses and will be more likely to make fair settlement offers prior to proceeding with a formal regulatory enforcement action or before going to court to collect the civil fine or penalty.

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 the Senate, there is no formal legislative history available to explain its terms. To cure this deficiency, I will be inserting in the CONGRESSIONAL RECORD at a later date a document which will serve as the equivalent of a statement of managers. The same document will be submitted to the RECORD in the Senate. It is the committee's intent that that document carry the weight of legislative history regarding title III of H.R. 3136.

Mr. Speaker, this legislation represents an important and significant step toward removing unnecessary and unduly burdensome regulations from the backs of small businesses. I urge my colleagues to support H.R. 3136 and look forward to its prompt passage and it being signed into law.

Mr. GIBBONS. Mr. Speaker, I yield 3 minutes to the gentleman from Hawaii [Mr. ABERCROMBIE].

Mr. ABERCROMBIE. 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 4, a proposition I supported with my vote in favor of H.R. 2684 last December.

Rather, my objection, Mr. Speaker, is to the measure before us, which rests on my adamant opposition to the line-item veto provisions of 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 branch, compared to the legislature, 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 deprives the 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 be among the few votes that 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 asked and was given permission to revise and extend his remarks.)

Mr. BUNNING of Kentucky. Mr. Speaker, I thank the chairman for yielding me time.

Mr. Speaker, hopefully 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 100th Congress class, because this has been a class project for over 8 years.

Mr. Speaker, the House has twice passed legislation to increase this onerous earnings limit in 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.

By 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 continue contributing 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 harsh 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

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.

□ 1245

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 when we pass the bill. It 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 the Republicans 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 park-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 conferees. 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 chairman and other people on the floor 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 reelection.

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 President. 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 revise 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 able, 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, to be available then, and 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 asked for it consistently to be 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 use her 10 minutes.

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 economic security 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.

We are 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, was 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, whomever he or she 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 in the Senate. He would call in 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 under New York that has 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 simply to line 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 a President 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 on to 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 until this time. To put, again, a 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 Democrats in the House or Senate were a part of that conference, and indeed the Democrats only 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 example, it includes Medicare, Medicaid, Social Security, and all other entitlement programs. We are now going to say to the President, ''If you do not like the increases that we have given in Social Security, get rid of them.'' We have put 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 these decision 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 about the fact that in many cases it is just as serious a drain on 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 tax policy, giving benefits to certain groups, 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-break friends are safe.

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 sacred.

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, and, frankly, I think 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 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.

□ 1300

It has been demonstrated now that also 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 provision 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 spending 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. BARRETT].

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Wisconsin is recognized for 1½ 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.

This bill does a good job of taking care of the pork barrel spending, but it does a lousy job of taking care of special interest tax breaks. Why is that? It is because the people on the Republican side of the aisle like special interest tax breaks.

We hear on the floor day after day proponents of tax reform from the Republican side say, ''Let's have a flat tax. Let's get rid of all these deductions. Let's get rid of all these loopholes.''

Well, this was the opportunity to get rid of those. This bill was the opportunity to say we do not believe in special interest tax loopholes.

But when they came up to bat, they swung and missed. They had no desire to give the President of the United States the ability to get rid of special interest tax loopholes. Why not? Because they are the gift that just keeps on giving. You can tuck them away into a revenue bill. You do not have to go through the appropriations process. It just keeps giving and giving and giving.

The other irony of this entire debate is something that has happened to me over the last year and a half when I have gone back to my district and talked at Rotary lunches or Kiwanis lunches. They always talk about the Presidential line-item veto. I say, ''Mark my words: We will get it, but the Republican leadership will find a way to make sure that President Clinton does not have the authority to get rid of their pork barrel spending or their special interest tax loopholes in the 104th Congress.''

The provisions we are passing today do not give the President the ability to do it in this Congress.

Mr. CLINGER. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. GOSS].

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

Mr. GOSS. Mr. Speaker, I rise in very strong support of this legislation, noting that 43 Governors have the line-item veto. Governor John Engler of Michigan has spoken out strongly that it does restrain unwise spending.

Mr. Speaker, there are some supporters of line-item veto who may have despaired of ever getting it done. I must admit that there were days over the past 13 months when I had my doubts. Well, in the spirit of Sean Connery I am reminded ''never to say never.'' Today we fulfill a major plank in the Contract With America and implement a powerful budget-cutting tool. Title II of the bill before us is the text of our conference agreement on the line-item veto. It reflects countless hours of meetings and discussions—and an enormously good faith effort by all the conferees to ensure that this significant delegation of power from the Congress to the President is effective, workable and clearly defined. The conferees understood the magnitude of a delegation of authority of this kind. Quite simply, it is historic. Although some of our colleagues are fundamentally opposed to transferring such power to the President—any President—I firmly believe that this is a legitimate and necessary 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 authority. 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 majority to override the President and 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 taxpayers money. That is a change that more than 70 percent of Americans have been asking for. Americans know that when huge spending and tax bills go to the President for his signature or veto, often individual items of less or even questionable national merit get carried into law by the greater good in the bill. That costs money—lots of money—and that's what this tool is designed to control. Our conference built upon the House enhanced rescission model and, I believe, made it stronger by expanding the authority beyond appropriation measures to include new entitlements. As everyone knows, 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 use his line-item veto 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 us an opportunity 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. This is a practical 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 an enormously 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. CLINGER. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. DELAY], the distinguished majority whip and tireless leader in the battle to achieve 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 Advancement 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 provisions 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 congressional accountability to the regulatory process. No Congress before this one has been willing to take responsibility for the way laws are implemented after they are signed.

I believe it is both appropriate and necessary for Congress to conduct oversight over agencies' promulgation of regulations, and 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 Maryland [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 administration worked together to bring this bill forward. 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 limitation. 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 appropriations. We pass these omnibus bills where none of us really 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 be to take 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 honor our obligations.

But it is interesting, why have we delayed for 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 is 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 Democrats and Republicans to 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 her 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. I support the increase in 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 flexibility has strong 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 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, edicts and 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 have made a lifetime career 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 time, and thank him for his leadership on this bill.

Mr. Speaker, I rise in strong support of the line-item veto provision, 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 write new regulations and create redtape.

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 SOLOMON, 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.

Our 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 redtape 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, 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 redtape.

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 struggle against the regulatory bureaucracy 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 Federal agencies issuing new 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 prepare 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 Transition Act of 1995, which was reported out of my Subcommittee on National Economic Growth, Natural Resources, and Regulatory Affairs. Although 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 rulemaking proceedings before they waste more agency and private resources.

As the principal House sponsor of the Congressional 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 November. Before it becomes law, this bill will have passed the Senate at least four times and passed the House at least twice. In discussions with the Senate and House co-sponsors 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 equivalent of a floor managers' statement. But because this bill will not likely have a conference report or managers' statement prior to passage, 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 Reagan's Executive Order 12291. Although President Clinton's Executive Order 12866 contains a definition of a significant rule that is purportedly as broad, several of the administration's significant rule determinations under Executive Order 12866 have been questionable. 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 nonnumerical factors contained in the new subsection 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 notice and comment requirements of the Administrative Procedure Act by trying to give legal effect to general policy statements, guidelines, and agency policy and procedure manuals. Although agency interpretive rules, general statements of policy, guideline documents, and agency policy and procedure 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 congressional 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. Interpretive 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 affect the rights or obligations of nonagency parties.'' The focus of the test is not on the type of rule but on its effect on the rights or obligations of nonagency parties. 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 a substantial effect within the meaning of the exception. Thus, this exception should be read narrowly and resolved in favor of nonagency parties who can demonstrate that the rule will have a nontrivial effect on their rights or obligations.

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 effective 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 was selected to provide a more meaningful time within which Congress could act to pass a joint resolution before a major rule went into effect. Even though the expedited 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 outside parties are forced to comply with the rule.

The subtitle provides an emergency exception 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. Sections 801(c) and 808(2) should be narrowly construed, for any other reading of these exceptions would defeat the purpose of the delay period. The emergency exception in section 801(c) is only available pursuant to Executive order and after congressional notification that a specified situation exists. The good cause exception in section 808(2) is borrowed from the chapter 5 of the Administrative Procedure Act and applies only to rules which are exempt from notice and comment under section 553. Even in such cases, the agency should provide for the 60-day delay in the effective date unless such delay is clearly contrary to the public interest. This is because a determination under section 801(c) and 808(2) shall have no effect on the procedures under 802 to enact joint resolutions of disapproval respecting such rule, and it is contrary to the policy of this legislation that major rules take effect before Congress has had a meaningful opportunity to act on such joint resolutions.

ALL EXECUTIVE AGENCIES AND SO-CALLED INDEPENDENT AGENCIES ARE COVERED BY THE BILL

Congress intends this legislation to be comprehensive. It covers any agency or other entity that fits the ''Federal agency'' definition borrowed from 5 U.S.C. 551(1). That definition includes ''each authority of the government'' that is not expressly excluded by section 551(1)(A)–(H). The objective is to cover each and every entity in the executive branch, whether it is a department, independent agency, independent establishment, or Government corporation, whether or not it conducts its rulemaking under section 553(c), and whether or not it is even 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 congressional review legislation, in large part, as an exercise of its oversight and legislative responsibility over the executive branch. Regardless of the justification for excluding or granting independence for certain entities from the coverage of certain laws, that justification does not apply in this legislation, where Congress has an interest in exercising its constitutional oversight and legislative responsibility over all executive branch agencies and entities 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 is necessary, a few special adjustments have been made, such as the exclusion for the monetary policy activities of the Board of Governors of the Federal Reserve System, rules of particular applicability, and rules of agency management and personnel. Where it is not necessary, no exemption is provided and the rule is that the entity's regulations are covered by this act. This is made clear by the provisions of the new section 806 which states that the act applies notwithstanding any other provision of law.

□ 1315

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 urgently needed to avoid financial chaos. This is a compromise bill. In exchange for extending the debt limit, it provides a much needed procedure for reducing unnecessary pork barrel spending. That procedure is the line-item

veto. As cochairman of the congressional pork busters coalition, I strongly support the line-item veto as an essential tool to eliminate pork from appropriations bills. We have been battling pork for 6 years on the floor of this House, but not always successfully.

This legislation provides much needed back up power to the Executive, allowing him to surgically slice out those items which do not deserve funding. Governors in 43 States, including California, already have this power and it has worked well. In our State of California, it has allowed our Governors to balance the budget. The House voted for a line-item veto over a year ago, and it has been bottled up in the Senate ever since. This is a golden opportunity to finally achieve our goal.

Mr. GIBBONS. Mr. Speaker, I yield 4 minutes to the gentleman from Mississippi [Mr. TAYLOR].

Mr. TAYLOR of Mississippi. Mr. Speaker, I want to thank one of the heroes of D-day for the opportunity, the gentleman from Florida [Mr. GIBBONS].

When the new majority came to power 1 year ago, they promised the American people that Congress would change its ways, that we would live by all the laws of the land. Obviously one of the laws that we are not going to live by is the law of regulating false advertising. The very name of this bill is false advertising. It has nothing to do with the Contract With America. It has everything to do with raising the debt limit by $600 billion.

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, 10 times 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 some 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 since 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 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 back, and H.R. 5838 permanently 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 4.9 to 5.5 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 Pascagoula, 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 and then turn around and borrow $600 billion more. Let us draw the line today. Let us quit fooling the American people. Let us do what is right for this country.

I thank the chairman and the great hero of D-Day. This gentleman, in case Members do not know, paratrooped into Normandy the night before the D-Day invasion. He is going to end his congressional career this year. He is a great American, and we are going to miss him.

Mr. ARCHER. Mr. Speaker, I yield 30 seconds to the gentleman from California [Mr. DREIER].

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

Mr. DREIER. Mr. Speaker, I thank my friend, the gentleman from Texas [Mr. ARCHER] for yielding time to me. I want to congratulate the gentleman from Pennsylvania [Mr. CLINGER] and, of course, congratulate the gentleman from Florida [Mr. GIBBONS]. We are going to miss him greatly.

Mr. Speaker, it saddens me that we have gotten to the point where we have to rely on the line-item veto to turn the corner on the profligate spending that we have seen go on for decades. We have seen it successful in 38 States. I would simply like the RECORD to show that in our State of California, Governor Wilson has used the line-item veto 354 times, saving our State's taxpayers nearly $800 million.

I hope very much that we can proceed with passage of this very important measure.

Mr. GIBBONS. Mr. Speaker, I yield 4 minutes to the gentleman from Ohio [Mr. TRAFFICANT].

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

Mr. TRAFICANT. Mr. Speaker, let us see if this sounds right. Congress is frustrated with political pork. Congress has tried but Congress is fed up with pork-barrel spending.

Congress honestly and desperately wants to stop all of this political pork. So Congress today, in both desperation and frustration, has decided that the only way to stop political pork is by giving the top politician in America, the President, the power to control political pork. Beam me up here. Let me remind everybody herein assembled, this is not Rotary. This is the Super Bowl of politics. And as we speak, White House staffers are not only watching and listening to what we say but how we say it, and they will be individually scoring your voting records to determine who may need some discipline.

In America the people are supposed to govern. My problem with the line item veto is very simple. It is an awesome transfer of the people's power to one person who needs to get elected and then needs 34 Senators in his hip pocket to run America. I guarantee not one of those 34 Senators will ever worry about a line item veto.

Mr. Speaker, let me say this today in the little bit of time I have, watch what we say from here on out, bite our tongues, mind our votes, mind our votes. And consider our votes politically, folks, because the White House is watching, the White House is keeping score.

I think there is a better way to do this without transferring the power from the people to the White House. We are making the White House too powerful in the United States of America. I think we are endangering the freedom of our Nation and the power of our people.

With that, I appreciate the gentleman for giving me the time. I want to echo the remarks of the gentleman from Mississippi [Mr. TAYLOR].

I have been quite aggressive in some of my opposition at times to the Committee on Ways and Means, but never to the gentleman personally. I think the gentleman is an absolute great American. We are going to miss the gentleman from Florida [Mr. GIBBONS]. I thank him for putting up with me. A lot of Members love him; I certainly do.

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

Mr. TRAFICANT. I yield to the gentleman from North Carolina.

Mr. HEFNER. Mr. Speaker, as one who did not support the line item veto

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 early on over here, and I understand that this transaction will not go into place until 1997. Why would not 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 say the reason 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. CLINGER. 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 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 it is 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 to the deputy 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 I think for 13 Congresses has worked to make this thing 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 100th 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 that working 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 help put their grandchildren through college, so that they can maybe go on a vacation or somebody pay their property taxes or even buy a new car. These people are affected by this bill.

I am proud to be able to stand here today and say 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 glad we have been able to come up with a plan that the President will sign. The seniors need and deserve relief. They have waited patiently for too long. In fact, I think those people who have to work by the sweat of their brow, people who work at McDonald's and flower shops and drive school buses need a break today, and we are going to give it to them.

Mr. GIBBONS. 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 lot of years, everything that is in this bill that we are debating here today, as soon as the President signs 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. 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.

□ 1330

The gentleman is saying to the President, If you will do what we want to do, we'll give you the line-item veto this year, but everything else extending the debt limit and everything else will go into effect as soon as he signs it, with the exception of the line-item veto which we passed well over a year ago, in the first year of this new administration.

Why? I do not understand why the gentleman would object to giving the President the line-item veto when he has got all these bills that are coming up for all the appropriations for everything that we authorized this year. Why would the gentleman want to wait until 1997, because we can save a lot of money? Would it have been possible 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. 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——

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 a 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.

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 the Congress of the United States. For too long they have suffered the indignity of the Federal regulator, the agency head, who burdens the farmer and burdens the small business man with countless items of regulation that stifle 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 regulatee, if there be 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

and take whatever the agency says as a mandate, now for the first time we will have the farmer and the small business man say to himself and to the community, ''I'll be able to do something about this adverse regulation.''

Mr. ARCHER. Mr. Speaker, I yield 1½ 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 legislation 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. 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 discuss 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 circumstances 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 1½ minutes to the gentleman from New York [Mr. QUINN].

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

Mr. Speaker, I rise today in support of the entire bill which includes the most important line-item veto. This 104th Congress has been hailed as a reform-minded Congress. We have made historic attempts to cut wasteful Government spending, scale back a bloated bureaucracy and, most importantly, balance our Federal budget.

Although we have made great strides in these areas, our budgets still suffer from a deficit increasing plague which is known as pork barrel spending. In order to complete this goal of returning fiscal responsibility to the Federal Government, we must enact this measure.

With the line-item veto the President can literally draw a line through any item in the Federal budget without having to veto the entire budget. No longer will taxpayer dollars be spent on wasteful projects. Instead, the stroke of a pen from the President will eliminate millions of dollars of pork from each year's budget.

Furthermore, these savings will go into a lockbox, insuring that they be used for deficit reduction. In fact, the General Accounting Office, during the course of our discussion on this matter these last 2 years, has reported that they would have saved or been able to save over $70 billion had the line-item veto been in effect.

Mr. Speaker, we are 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 this 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 conference. We appreciate his work and 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. 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 guidelines, without some actual legislative change, at the very least some direction, to cut the spending of this overbloated Government. Borrowing has obscured the true siege of Government. Ultimately we must reach a balanced budget. This bill does not do that, 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. I thank the gentleman for yielding me the time.

Mr. Speaker, let me rise in opposition to H.R. 3136 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 term of the current President, Bill Clinton, has expired, and I think that 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 does is it provides, in this particular piece of legislation, through an amendment which I must say just came to us last night, which amends this 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 know what something that they 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 customary practice allowed to sit in, in an open and fair process on the record, on what should be done with regard to regulatory reform.

This legislation says no, we do not need to do that any more. Let us go ahead 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.

Finally, the environment is at stake. 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 we find in 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 close look for all the reasons I stated on why we should oppose H.R. 3136.

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 figured-out way, no agreed-to plan, to solve that debt, and we are going back to the bank to borrow more money?

□ 1345

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 within 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, and vote not 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 gentlewoman 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 in the debt limit. My colleagues know that I have long advocated decisive action on the debt limit and feel this step is long overdue. In addition, I have supported the increase in 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.

[From the New York Times, Mar. 28, 1996]

LINE-ITEM LUNACY

(By David Samuels)

It's a scene from a paranoid thriller by Oliver Stone: A mercurial billionaire, elected President with 35 percent of the vote, holds America hostage to his minority agenda by vetoing item after item in the Federal budget, in open breach of the separation of powers doctrine enshrined in the Constitution. Impossible? Not anymore.

With the announcement by Republican leaders that they plan to pass the line-item veto this spring, the specter of a Napoleonic Presidency has moved from the far reaches of poli-sci fiction, where it belongs, to the brink of political possibility.

At the moment, of course, a Presidential dictatorship is far from the minds of the G.O.P. leadership and White House Democrats, who hope that the line-item veto would encourage the President to eliminate pork-barrel giveaways and corporate tax breaks. But to see the measure as a simple procedural reform is to ignore the forces that have reconfigured the political landscape since it was first proposed.

Back in the 1980's, President Ronald Reagan ritually invoked the line-item veto while shifting blame onto a Democratic Congress for ballooning deficits. Part Republican chestnut, part good-government gimmick, the line-item veto became part of the Contract With America in 1994, and this month rose to the top of the political agenda.

What the calculations of Democrats and Republicans leave out, however, is that the unsettled politics of the 1990's bear little relation to the political order of the Reagan years.

In poll after poll, a majority of voters express a raging disaffection with both major parties. With Ross Perot poised to run in November, we could again elect our President with a minority of the popular vote (in 1992, Mr. Clinton won with 43 percent). 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 a Presidential veto of Federal arts 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 reflect on 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 zigs 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 law states that power-hungry billionaires 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 model of Ciceronian rectitude.

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 separation of powers 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 ourselves at a time when the certainties of two-party politics are dissolving before our eyes.

He's absolutely right! A pure line-item veto—and the version included in this 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 legislature more susceptible than ever to obstructionists . . .''

This line-item veto could easily take legislative horse-trading to a new level. While many President's have held out the prospect of pork in order to enlist votes for legislation they wanted—that is, the vote trading that occurred during the NAFTA 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 all 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 ruling the Nation. So they wrote the Constitution based on a delicate system of checks and balances and the separation of powers doctrine.

I have supported a so-called expedited rescissions process which will maintain the delicate balance of powers by allowing the President to reject spending and tax changes with a majority vote of Congress.

I am convinced, however, that the Supreme Court of the United States will save this Congress from itself. This proposed violates the foundation of our Constitution and will be overturned at its first judicial challenge.

Mr. Speaker, I regret that inclusion of this line-item veto will force me to vote ''no'' on this vital legislation.

Many of my colleagues know that I have been a strong voice urging quick passage of a long-term debt limit extension. I spoke out on this issue as early as November 15 in a letter to Speaker GINGRICH and again in letters in late January, in late February, and early March.

And today—finally, finally—we are doing the right thing.

For too long, many in this Congress threatened to use this long-term debt limit extension bill as leverage in the effort to enact entitlement reform or other legislation.

That was playing with fire.

When it comes to our financial obligations, the stakes are simply too high. In its 219-year history, the United States has never defaulted on its financial obligations. The full faith and credit of the United States must not be jeopardized.

Default could set off a chain reaction of economic events, at home and abroad, that could be both uncontrollable and catastrophic. Even talking about a default carries costs that are being borne by the taxpayers and private businesses.

As Members dedicated to fiscal responsibility and protecting the economic future of our country, I am pleased that we are finally taking responsible action to increase the debt ceiling and, in doing so, avoid default.

Mr. Speaker, I also support enactment of a phased increase in the Social Security earnings limit and the provisions of the small business regulatory flexibility act.

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

Mr. Speaker, 75 percent of the American people support the line-item veto, and have supported the line-item veto for a long time. I am sorry the gentleman from North Carolina did not stay on the floor. He asked me the question, could we not have made this effective now? I would return the question and say why did not the majority, the then-majority party, provide a line-item veto for the 40 years in which they controlled this body?

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 to be 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 transfer of power. I 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 supercede or conflict with the Inspector General Act of 1978, as amended, or to otherwise 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 inspectors 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:

CONGRESS OF THE UNITED STATES,
JOINT COMMITTEE ON TAXATION,
Washington, DC, March 26, 1996.

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 prescribing tax consequences under the Internal Revenue Code that is either (1) a revenue-losing provision that provides a Federal tax deduction, credit, exclusion, or preference to 100 or 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. The Joint Committee on Taxation is responsible for identifying limited tax benefits.

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 exceptions 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, the item is not 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 is for provisions that have the effect of providing the same treatment to all persons owning the same type of property or issuing the same type of investment instrument. Finally, a provision is not a limited tax benefit if the only reason the provision affects different persons differently is because of: (1) the size or form of the business or association involved; (2) general demographic conditions affecting individuals, such as their income level, marital status, number of dependents, or tax return filing status; (3) the amount involved; or (4) a generally available election provided under the Internal Revenue Code.

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 January 1, 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. An exception provides that a transfer from a grandparent to a grandchild is not subject to the generation-skipping tax if the grandchild's parent (who is the grandparent's child) is deceased at the time of the transfer. 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. 11114)

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 all persons engaged in the activity of drug testing are not treated the same. Only certain types of drug testing would qualify for the credit.

3. Extension of binding contract date for biomass and coal facilities (sec. 11142)

Under present law, a tax credit is provided for fuel produced from certain ''nonconventional sources.'' In the case of synthetic fuel produced from coal and gas produced from biomass, the credit is available only for fuel from facilities placed in service before January 1, 1997, pursuant to a binding contract entered into before January 1, 1996. The BBA provision would extend the credit to facilities placed in service before January 1, 1998, pursuant to a binding contract entered into before July 1, 1996.

This provision is a ''limited tax benefit'' because it loses revenue, it is expected to affect fewer than 100 fuel producers, and all persons engaged in the production of fuel from nonconventional sources are not treated the same. Persons producing fuel from nonconventional sources in facilities placed in service after July 1, 1996 would not be eligible for the credit.

4. Exemption from diesel fuel dyeing requirements with respect to certain States (sec. 11143)

Under present law, an excise tax is imposed on all diesel fuel removed from a terminal facility unless the fuel is destined for a nontaxable use and is indelibly dyed pursuant to Treasury Department regulations. A similar dyeing regime exists for diesel fuel under the Clean Air Act, but the State of Alaska is partially exempt from the dyeing regime of the Clean Air Act. The BBA provision would exempt diesel fuel sold in the State of Alaska from the excise tax dyeing requirement during the period when that State is exempt from the Clean Air Act dyeing requirement.

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. The provision does not treat all persons engaged in the same activity the same way, because persons removing diesel fuel from terminals in Alaska would be treated differently than those removing diesel fuel from terminals in other areas of the United States.

5. Common investment fund for private foundations (sec. 11276)

The BBA provision would grant tax-exempt status to any cooperative service organization comprised solely of members that are tax-exempt private foundations and community foundations, if the organization meets certain requirements and is organized and operated solely to hold, commingle, and collectively invest and reinvest funds contributed by 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. The provision does not treat all persons engaged in the same activity the same way, because mutual funds that are engaged in the same type of activity, i.e., collectively investing funds in stocks and securities, would not receive the benefit of the provision.

6. Transition relief from repeal of section 936 credit (sec. 11305)

Under present law, certain domestic corporations with business operations in the U.S. possessions may elect the section 936 credit which significantly reduces the U.S. tax on certain income related to their operations in the possessions. The BBA generally would repeal section 936 for taxable years beginning after December 31, 1995. However, transition rules would be provided under which corporations that are existing claimants under section 936 would be eligible to claim credits for a transition period. One of these transition rules would allow a corporation that is an existing claimant with respect to operations in Guam, American Samoa, or the Commonwealth of the Northern Mariana Islands to continue to determine its section 936 credit with respect to its operations in such possessions under present law for its taxable years beginning before January 1, 2006.

This transition rule for corporations operating in Guam, American Samoa, or the Commonwealth of the Northern Mariana Islands is a ''limited tax benefit'' because it is expected to provide transitional relief from a change to the Internal Revenue Code to 10 or fewer beneficiaries in at least one fiscal year in which the provision would be in effect, and it does not meet the binding contract exception.

7. Modification to excise tax on ozone-depleting chemicals (sec. 11332)

Under present law, an excise tax is imposed on the sale or use by the manufacturer or importer of certain ozone-depleting chemicals. Taxable chemicals that are recovered and recycled within the United States are exempt from tax. The BBA provision would extend the exemption to imported recycled halons.

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, others engaged in the manufacture or import of ozone-depleting chemicals would not qualify for the exemption.

8. Modification to tax-exempt bond penalties for local furnishers of electricity and 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 bond-financed loans becomes nondeductible. The BBA provision would allow private businesses engaged in the local 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 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. All persons engaged in the activity of generating electricity or gas would not be treated the same.

9. Tax-exempt bonds for sale of Alaska Power Administration Facility (sec. 11334)

Under present law, tax-exempt bonds may be issued for the benefit of certain private electric utilities. If the bonds are used to finance acquisition of existing property by these utilities, a minimum amount of rehabilitation must be performed on the property as a condition of receiving the tax-exempt bond financing. The BBA provision would waive the rehabilitation requirement in the case of bonds to be issued as part of the sale of the Snettisham facility by the Alaska Power Administration.

This provision is a ''limited tax benefit'' because it loses revenue, it is expected to benefit only one 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.

10. Transitional rule under section 2056A (sec. 11614)

Under present law, a marital deduction generally is allowed for estate and gift tax purposes for the value of property passing to a spouse. The marital deduction is not available for property passing to a non-U.S.-citizen spouse outside a qualified domestic trust

(''QDT''). 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 before the 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 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. The provision would benefit a closed group of taxpayers. Trusts created before the enactment of OBRA 1990 would be treated differently than trusts created after the enactment of OBRA 1990.

11. Organizations subject to section 833 (sec. 11703)

Present-law section 833 (created in the Tax Reform Act of 1986) provides special tax benefits to Blue Cross or Blue Shield organizations existing on August 16, 1986, which have not experienced a material change in structure or operations since that date. The BBA provision would extend this special rule to other similarly-structured organizations that were in existence on August 16, 1986, and have not materially changed in structure or operations since that date.

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 all persons engaged in the same activity would not be entitled to take the benefit. The benefit would be available only to a closed group of taxpayers that were in existence in 1986, and would not be available to any newly formed entities.

EXAMPLES OF ''LIMITED TAX BENEFITS'' FROM OTHER STATUTES

1. The original income tax, as enacted in 1913, exempted the sitting President

The 1913 Act imposing the first income tax provided an exemption for the sitting President of the United States for the remainder of his term. If the Line Item Veto Act had been applicable at the time, the President would have had the option of canceling this ''limited tax benefit.''

2. Financial institution transition rule to interest allocation rules

A provision in the Tax Reform Act of 1986 changed the rules relating to how multinational corporations allocate interest expense for foreign tax credit purposes. The provision included a favorable rule for banks, and also included a special exception allowing ''certain'' nonbanks to use the favorable bank rule. The special exception applied to any corporation if ''(A) such corporation is a Delaware corporation incorporated on August 20, 1959, and (B) such corporation was primarily engaged in the financing of dealer inventory or consumer purchases on May 29, 1985, and at all times thereafter before the close of the taxable year.'' P.L. 99–514, 100 Stat. 2548, sec. 1215(c)(5).

This transition rule would have been a ''limited tax benefit'' if it were expected to provide transitional relief from a change to the Internal Revenue Code 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 actually received the benefit of this provision.)

3. Community development corporations

The Omnibus Budget Reconciliation Act of 1993 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'' if it were expected to provide a benefit to 100 or fewer contributors in at least one fiscal year in which the provision would be in effect. (In retrospect, it is believed that 100 or fewer contributors received the benefit of this provision.) All persons who engage in the activity of making contributions to CDCs are not treated the same, and the difference is not based upon size, filing status, or any of the other enumerated factors.

4. Exemptions from cutbacks in meal and entertainment expense deductions

Prior to 1986, a 100-percent deduction was provided for certain meal and entertainment expenses. In 1986, the deduction was reduced to an 80-percent deduction. 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 drilling rig. A separate exemption was 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 54 degrees north latitude (i.e., in Alaska).

These exemptions both would have been ''limited tax benefits'' in 1986 if they had been expected to provide transitional relief from a change to the Internal Revenue Code to 10 or fewer beneficiaries in at least one fiscal year in which the provision would be in effect.

5. Transition relief from private activity bond requirements

The Omnibus Budget Reconciliation Act of 1987 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 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, 1986 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.

6. Various Tax Reform Act of 1986 provisions

The Tax Reform Act of 1986 contains a number of provisions that are clearly targeted to only one taxpayer (in some cases, even referring to the taxpayer by name). For example:

''* * * indebtedness (which was outstanding on May 29, 1985) of a corporation incorporated on June 13, 1917, which has its principal place of business in Bartlesville, Oklahoma.'' (sec. 1215(c)(2)(D))

''In the case of an affiliated group of domestic corporations the common parent of which has its principal office in New Brunswick, New Jersey, and has a certificate of organization which was filed with the Secretary of the State of New Jersey on November 10, 1887 * * *'' (sec. 1215(c)(6)(A))

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 report dated May 30, 1984, prepared for a State urban development corporation, and (iii) such facility is eligible for real property tax (and power and energy) benefits pursuant to State legislation approved and effective as of July 7, 1982.'' (sec. 1317(3)(S))

''A project is described in this subparagraph if such project is consistent with an urban renewal plan adopted or ordered prepared before August 28, 1986, by the city council of the most populous city in a state which entered the Union on February 14, 1859.'' (sec. 1317(6)(U))

A facility if ''(i) such facility is to be used for an annual civic festival, (ii) a referendum was held in the spring of 1985 in which voters permitted the city council to lease 130 acres of dedicated parkland to such festival, and (iii) the city council passed an inducement resolution on June 19, 1986.'' (sec. 1317(7)(J))

A residential rental property if ''(i) it is a new residential development with approximately 98 dwelling units located in census tract No. 4701, and (ii) there was an inducement ordinance for such project adopted by a city council on August 14, 1984.'' (sec. 1317(13)(M))

''A facility is described in this subparagraph if it consists of the rehabilitation of the Andover Town Hall in Andover, Massachusetts.'' (sec. 1317(27)(I))

Proceeds of an issue if ''(i) such issue is issued on behalf of a university established by Charter granted by King George II of England on October 31, 1754, to accomplish a refunding (including an advance refunding) of bonds issued to finance 1 or more projects, and (ii) the application or other request for the issuance of the issue to the appropriate State issuer was made by or on behalf of such university before February 26, 1986.'' (sec. 1317(33)(C))

Mr. GIBBONS. Mr. Speaker, I yield back the balance of my time.

Mr. ARCHER. Mr. Speaker, I yield the balance of my time to the gentleman from Texas [Mr. ARMEY].

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Texas [Mr. ARMEY] is recognized for 12 minutes.

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

Mr. Speaker, when we wrote the Contract With America, we promised the American people a new deal, a change, a real change which would be meaningful in their real lives. We promised innovation and responsiveness.

Today we bring forward the Contract With America Advancement Act, and it includes the line-item veto. The line-item veto is something the American people have called for for years. The chairman of the committee, the gentleman from Texas [Mr. ARCHER], who first came to Congress with Richard Nixon was in the White House, introduced the line-item veto at that time.

Through the end of the Nixon Presidency and through the Ford Presidency, through the Carter Presidency, the Reagan Presidency, the Bush Presidency, and thus far through the Clinton Presidency, the chairman has fought for a line-item veto, and through all that time the other party, while in the majority, were unwilling to give this authority to the President

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 promised and we are delivering 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 business in America and has been 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 years 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 in getting done what it is they 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 status quo.

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 a new 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 disallowed 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, sat on 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 Democrat chairmen. 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 do-nothing majority 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 every Member 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 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 monarchical power in the American presidency. The Founders would surely be appalled.

Incredibly, under this proposal, after an appropriations bill has been passed by the Congress and signed it 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.

Recall those grand 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.

Thank God the courts 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 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 has a 5 day cancellation right, after signing a bill? That is absolutely absurd. This defies any logical reading of the clear meaning to the provisions of the Constitution that 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, sadly, 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 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.'' 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

this way, to get their version of spending adopted. As one former Governor recently stated, the real use of the line-item veto power he had as Governor was not to control a bloated budget but to persuade legislators to change their votes on important issues. Ironically, this may actually result in more spending; in most cases, certainly no reduction.

Last year, the majority in this body rejected the expedited rescissions proposal that represented a constitutionally acceptable approach to this issue, requiring each Member of Congress to be accountable with a specific vote on any items a President might find objectionable enough to rescind. Without that mechanism for requiring congressional reconsideration, the line-item veto proposal before us is clearly unconstitutional.

The language in the Constitution clearly gives Congress the responsibility for crafting legislation, while the President is limited to simple approval or disapproval of bills presented to him. Article I, section 7 refers to the President returning a bill, not pieces of a bill. Yes, the Constitution allows the President to state his objections to a bill upon returning it, but the objections merely serve as guidelines for Congress should it choose to redraft the legislation.

We have no legitimate power to pass a statute to the contrary. The Constitution does not allow the President to repeal a provision of law by striking a spending level approved by Congress. We have no legitimate power to pass a statute to the contrary.

As the Supreme Court noted in its decision I.N.S. versus Chadha, ''Explicit and unambiguous provisions of the Constitution prescribe and define the respective functions of the Congress and of the Executive in the legislative process.''

The Court continues, ''These provisions of Article 1 are integral parts of the constitutional design for the separation of powers.'' The line-item veto proposal in the bill before us would impermissibly alter the ''constitutional design for the separation of powers'' between the executive and legislative branches by allowing the President singlehandedly to repeal or amend legislation which Congress has approved, and the President has already signed into law.

The Framers were deliberate and precise in dividing legislative powers. In the Federalist papers, Hamilton and Madison both expressed the view that the legislature would be the most powerful branch of government. Thus, they also recognized the need for some checks on its powers. So, the Constitution provides for a bicameral legislature, with each body elected under different terms and districts. And it affords the President a veto power. Other constraints are also imposed, such as requirements for origination of certain legislation in the House.

The President's veto power, as a check on Congress, was recognized to be a blunt instrument. As Hamilton explains in Federalist 73, the Framers acknowledged that with the veto power ''the power of preventing bad laws includes that of preventing good ones.'' It was their sense, however, that ''the negative would be employed with great caution.''

The line-item veto being considered today, by providing the President 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 legislative 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 outcome that flies in the face of 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 include funding for education, environmental, health, and other governmental programs—because it also includes tax provisions among the items the President can ''cancel.''

But, the only tax provisions that can be cancelled are ''limited tax benefits,'' defined as revenue-losing provisions that provide a benefit to ''100 or fewer beneficiaries under the Internal Revenue Code of 1986.'' A tax break for a particular industry that takes millions of dollars out of the Federal treasury can't be cancelled by the President. And even a so-called limited tax break can be easily finessed—that is, immunized from veto—if the conference report 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 particular industries. So, under this bill, a member who wants to include funding in an appropriations bill for a national park in her Congressional District must worry about the President cancelling a benefit to her District, but a member who wants to provide funding to his favorite 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 appropriation expenditures while ignoring most tax expenditures. I urge my colleagues to reject it before it is rejected by the courts. Regrettably, this provision so taints this entire bill, otherwise needed to extend the debt limit, that the bill itself should be defeated.

Mr. STEARNS. Mr. Speaker. I rise in support of this legislation to raise the debt ceiling because I do not believe we can allow our Government to go into default. To do otherwise 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 billion in spending over the past year. This is a very good start on the road to achieving a balanced budget.

There are two provisions in particular that are included in this measure that allow me to vote 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 wouldn't have these huge debts which, if not reduced, threaten to crush the next generation with huge taxes and a diminished quality of life.

Today we have been given a rare opportunity to enact legislation that will accomplish this.

My other chief reason for voting for this bill is that it contains an increase in the earnings limit for those age 65 to 69 to $30,000 by the year 2002. Currently, a working senior who reaches $11,280 in earned income loses $1 in Social Security for each $3 earned thereafter. That's a marginal tax rate of 33 percent. That's a high price for merely wanting to work.

The earnings test limit is unjust. It treats Social Security benefits less like a pension and more like welfare. It represents a Social Security bias in favor of unearned income over earned income.

It is effectively a mandatory retirement mechanism our country no longer accepts or needs. It precludes greater flexibility for the elderly worker and also prevents America's full use of eager, experienced and educated elderly workers. Finally, it deprives the U.S. economy of the additional income tax which would be generated by the elderly workers.

Let's pass this bill today so that we can get America back on the right track.

Mr. VENTO. Mr. Speaker, I reluctantly support 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 risk of default. For over 200 years through civil and world wars, recession and depression, the United States has honored our debt.

Certainly it is deplorable that the total U.S. debt has grown so dramatically in the past decades, but the 1993 Clinton budget measure passed by Congress has had a dramatic and positive impact. The deficit of 1996 is half of the 1993 projected 1996 deficit, lowering the amount of deficit by $150 billion this 1996 fiscal year, and at the same time our Nation's economy has performed positively, inflation is in check, unemployment remains low and productivity growth, G.D.P., and business profitability are strong.

This debt ceiling will act to accommodate the Federal budget needs until late 1997. It is past time to take this off the Republican political agenda. The threat of default and intimidation won't work, to sell GOP budget programs that lack merit.

Included in this package of legislative measures is a constitutionally questionable line item veto power for the President. President Clinton, of course, wants this power, but this sloppy rearrangement of the fundamental separation of powers proviso won't pass muster. Furthermore, the line item veto power in this promises much but delivers little. First, it doesn't apply to authorization and appropriation riders.

Therefore, the environmental riders so controversial this fiscal year would be beyond the line item veto reach of this measure. Second, it only applies to categories of spending, making it impossible to single out the specific bad apple in the basket. Finally it doesn't apply to bad tax policy, only specific narrow tax provisions of specific small groups as certified by the Joint Tax Committee.

Yet another dubious congressional limit in the constitutional separation of powers and unique congressional authority which cannot be delegated to the nonelected apparently is the rush to give away congressional powers held by the previous Democratic Congress. The Republicans have today sold symbolism,

not substance, to the Executive Office, and they bought it. To add further limits, the measure has a short life—1997 to 2005. This line item veto is weak, not likely to be effective and will be rendered inoperable by the courts and/or its limited scope.

Everyone can record it on their political campaign literature as an accomplishment, that's probably its best use; other issues added to the debt ceiling measure apparently are popular and the further price of the 2-year debt ceiling which the President agreed to. I'm concerned that the expanded Social Security earning limit, the retirement test ceiling may undermine support for the Social Security Retirement System. The basic predicate of Social Security retirement is that the beneficiary is no longer working. This means a job and slot is available to a less senior worker.

For many, this elevated ceiling means they will receive Social Security retirement benefits but remain on the same job, in essence claiming a retirement income and the wages of a worker. The idea regarding the Social Security retirement is that workers are not able to continue working and that the Social Security income provides for that person and family during that phase of one's life. At least this measure maintains a ceiling and earlier versions lifted it even further.

The income group that benefits from this provision is healthy and generally better off financially. It would be regrettable if the upshot of this policy change would undermine Social Security retirement for those unable to work.

Finally, this overall bill contains some regulatory relief for smaller enterprises. Candidly, I've had serious reservations about the broad ranging measures that try to pass as regulatory relief. Too many have been put forth and passed by the 104th Congress whose intent was to render inoperable important health, safety, and environmental laws.

Rules and regulations are the wheels which carry laws into implementation. Usually the Administrative Procedures Act [APA] provides sufficient assurance of participation and monitoring of the executive department or agency rule and regulatory process. The features of this provision seems reasonable—ironically expanding the potential for lawsuits and litigation—after the Republican majority in this House and Congress have beat the drum and attempted to enact ill considered punitive measures on the legal process and limiting the peoples right to seek redress.

Mr. Speaker, legislation is the art of compromise and as we can note from this document a big dose of symbolism. I'm voting for this measure with little enthusiasm, but with a pragmatic eye.

The Republicans have finally arrived at a point of talking with a Democratic President and have convinced themselves to move forward on the debt ceiling, the main vehicle and single most important engine which necessitates this legislation before the House.

Mr. CONYERS. Mr. Speaker, I am opposed to the regulatory reform 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—continues the Republican record of disdain 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 nature of regulatory enforcement. 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 ex parte contacts with the agencies 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—this bill takes the concept to the extreme. For it allows the waiver of some of our most important environmental penalties 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 source of the hazards.

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 put hundreds of environmental rules at risk, and subject them to endless 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 the regulatory 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's own 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 timing conveniently exempts the fiscal year 1997 appropriations cycle from Presidential line-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 takes 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 breached its own contract in defining that term very narrowly to mean only those tax giveaways 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 checks should be allowed to work without paying an effective marginal tax rate higher than that of millionaires.

In addition, this legislation also 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 hundred so 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 limit an unfair 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 to end the days where the legislatively-spawned Government pork and largesse would cause our deficit to grow like an unkempt bush in one's front yard and the President would not have the hedge clippers to trim it.

However, during those two Congresses, I and other fervent supporters of the line-item veto had been frustrated and thwarted by the then-Democratic majority. The Democrats would say that a line-item veto would render Congress impotent or that Congress does not need to use such a draconian measure as a line-item veto and that we can solve our Nation's fiscal problems by just saying no to pork. Mr. Speaker, I did not accept the Democrats' empty assurances about spending then, and my instincts were proved current when that supposed discipline was nowhere to be found.

Thankfully, Mr. Speaker, times have changed. With the passage of H.R. 3136, the President of the United States, be he Republican or Democrat, will be able to eliminate specific spending and target tax provision in legislation passed by the Congress. This is important, for now the President will have the ability to veto out pork barrel spending in a bill which he may view in an otherwise favorable light. Mr. Speaker, this is a mechanism that 43 of our Governors now possess, and we should extend it to the President of the United States.

Mr. Speaker, I also want to take note of other provisions in H.R. 3136 that I support. I feel that the bill's provisions which raise the limit of income senior citizens may earn while still receiving full Social Security benefits would be beneficial to those concerned.

Presently, senior citizens between the ages of 65 and 69 lose $1 in Social Security benefits for every $3 they earn above $11,520 while the earnings test amounts to an additional 33 percent marginal tax rate on top of existing income taxes. Because of this, seniors who want to work past the age 64 would not have the ability to remain productive, and thus, they are unfairly treated. H.R. 3136 would gradually raise the earnings limit for seniors between the ages of 65 and 90 from the current level of $11,520 to $30,000 by the year 2002.

I have spoken with many seniors around my district, and they, Mr. Speaker, have indicated to me that this measure sounds like a pretty good idea. Many of the seniors in my district still want to work full time or part time. They want to be productive members of society and by raising the limit on income, they can achieve this desired lifestyle. We should definitely support this initiative.

Finally, I rise in full support of the measures in H.R. 3136 which would provide regulatory relief to our Nation's small businesses. Presently, Federal regulations cost our Nation's small businesses an astronomical $430 billion per year while spending a ludicrous 1.9 billions hours per year completing Federal regulatory forms.

Included in these relief provisions are reforms providing for regulatory compliance simplification, regulatory flexibility, procedures for Congress to disapprove new regulations, and small business legal fees associated with fighting excessive proposed penalties.

Mr. Speaker, small businesses are the true lifeblood of our Nation's economy. By helping our small businesses by providing regulatory fairness, we will truly help our workers, our families, our towns and our cities.

Mr. Speaker, I support H.R. 3136, and I urge my colleagues to do likewise when it comes time to vote.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today to speak about H.R. 3136, the Contract With America Advancement Act. I will vote for this bill because it raises the debt limit, however, I must state that I would have preferred a clean debt limit bill. I support the increase in the earnings limit for social security beneficiaries, however, I would like to have had more debate about the small business regulatory flexibility provisions.

I am a strong supporter of small business, which is the foundation of America's economic base. I support regulatory flexibility for small business and having clear guidelines so that small businesses can more easily comply with Government standards. However, I have concerns about bogging down Government agencies in frivolous lawsuits that would draw their attention away from maintaining Government standards for the environment and ensuring workplace safety.

Mr. Speaker, I would also like to discuss this bill in the context of the current ongoing budget debate, and I would urge that we as a body do more for the American people than pass a debt limit increase. Although we will be discussing other important issues the Health Coverage Availability Act, I would like to remind this House of the glaring fact that we do not yet have a balanced budget for the United States, when this fiscal year is half over, and we have not provided funding for all of the Government agencies that serve the American public. This outrageous fact is not forgotten by the American people, and I would urge the leadership on both sides to not forget their duty to the citizens of this country.

The summer is fast approaching and teens that participate in the Summer Jobs Program are wondering if the budget will leave their program intact, or if it will be eliminated. Students and families across the country are wondering what is going on in this House.

Mr. Speaker, I will vote for this debt limit increase bill, but I would urge my colleagues to remember that we are not finished with the budget and that the American people are watching and that they know what the real issues are. Thank you, Mr. Speaker, and I reserve the balance of my time.

Mr. EWING of Illinois. Mr. Speaker, I rise in strong support of this legislation which contains judicial review of the Regulatory Flexibility Act [RFA].

This is an issue which I have been heavily involved in for nearly 5 years, when I was first elected to Congress in 1991. At that time, one of the top concerns I heard about from my constituents was the burden of excessive Federal regulations. Small businesses in particular felt that the money and time they spent complying with rules and regulations handed down from the Federal Government were crippling their ability to complete and invest in productive activity. In the 4½ years since I was elected, these concerns have only increased.

When I was elected, I looked for ways to reduce unnecessary regulation. I found that way back in 1980 Congress passed, and President Carter signed into law, the RFA. Simply put, the RFA required Federal regulators to conduct an analysis of the impact of any proposed new regulation could have on small businesses and small governmental entities. The RFA required the regulators to seek corrective ways to minimize the impact of those proposed rules before they are finalized.

Despite the good intentions of the RFA, the act has been almost totally ignored by Federal regulators for the 16 years its has been on the books. When I looked further into this issue, I found that Federal agencies were routinely using a loophole in the law which allows then to publish a statement in the Federal Register certifying that their regulation does not affect a significant number of small entities, and therefore allowing the agency to avoid conducing the analyses required by the RFA. In fact, I found that RFA analyses are rarely conducted, even when a regulation clearly would have a major impact on the small entities being regulated.

Herein lies the achilles heel of the RFA. When an agency certifies that a regulation will not significantly affect small entities, that certification cannot be challenged in court. A small business owner is prohibited from asking the courts to review whether the Federal agency has complied with the RFA. It is because the agencies know their decision to ignore the RFA cannot be challenged that they almost always do ignore the act. This fact has been confirmed to me as I have met with dozens of small business organizations and hundreds of small business owners over the past 4 years to discuss this issue. A number of hearings have been held in both the Small Business Committee and the Judiciary Committee and scores of witnesses have convinced me and many others in Congress that without judicial review, the Federal regulators will continue to ignore the RFA.

Many of us talk about reducing the cost which Government regulations impost on the American economy, but with passage of this

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 this 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 come together in support of providing 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 RFA 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 also provided great institutional knowledge about the RFA, and the Chamber has lent considerable clout to this legislation. The National Federation of Independent Business, and their employees Nelson Litterst and Kent Knutson, have worked endlessly to mobilize hundreds of thousands of small businesses in support of this legislation. Both the NFIB and the Chamber of Commerce have included Reg Flex votes in their ''Key Vote'' programs which have been extremely important in informing Members of Congress about how important this issue is to their small business constituents. Craig Brightup and the National Roofing Contractors Association 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 Halicki 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 Katrichis 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 strong remedies 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.

Thank you for your leadership on this important issue to small business.

Sincerely,

PHILIP LADER,
Administrator-Designate.

THE WHITE HOUSE,
Washington, October 7, 1994.

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 business, states, and other entities are reduced.

Ironically, Phil Lader, our nominee for Administrator of the Small Business Administration (whose nomination was voted favorably today by a 22–0 vote of the Senate Small Business Committee) has been a principal champion of judicial review of ''Reg Flex.'' In his capacity as Chairman of the Policy Committee on the National Performance Review, Phil vigorously advocated this position. I know that, if confirmed, as SBA Administrator, he would join us in continued efforts to win Congressional support for such judicial review.

Sincerely,

LEON E. PANETTA,
Chief of Staff.

THE VICE PRESIDENT,
Washington, November 1, 1994.

Hon. THOMAS W. EWING,
House of Representatives,
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 (and continues to be) sought by the small business community—i.e., an amendment that furthers the intent of the Act and reduces the paperwork burdens 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,
Washington, October 8, 1994.

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, my 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 next year 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 business, 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, and in the Senior Citizens Right to Work Act. Support of this legislation is my commitment to the senior citizens of my district to remove the disincentive to continue working after they begin receiving their Social Security benefits.

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 encourage seniors between the ages of 65 to 69 to work by eliminating 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 past abuses in the SSI and SSDI programs, we must be alert to the likelihood that many of these drug addicts and alcoholics currently on Federal disability rolls will attempt to requalify 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 find a way around the major accomplishments we are achieving today.

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; even when they are all putting forth their best efforts, there may not be 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 where the MEP provided help to 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 Nelson implement 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 prosthesis company, to replace a curing process using ozone-depleting chemicals with a low-cost, solvent-free process that led to reductions both in hazardous wastes and air emissions.

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 complying fully with environmental and other important regulations. I thank the conferees on this Title for avoiding a legislative turf fight and for allowing the MEP to continue one of its most important missions.

Mr. REED. Mr. Speaker, it is with reluctance that I will vote in favor of this bill before us today.

For almost 6 months, this Nation's good faith and credit has been questioned due to the failure of the Republican majority to complete its budgetary responsibilities.

Apparently, my Republican colleagues have come to their senses and will end their last minute, stop gap extensions of the Government's ability to meet its obligations to bond holders and Social Security recipients.

However, while my colleagues are acting to prevent default they have attached a number of controversial provisions to this must-pass legislation—namely, some of the bill's regulatory reform language as well as line-item veto authority for the President.

Let me be clear, while I am concerned with some of the regulatory reform provisions included in this bill, I support regulatory reform.

I am pleased that legislation to provide judicial review of the Regulatory Flexibility Act is finally on its way to becoming law.

Small businesses have been working to pass this legislation for years, and it will give real teeth to the small business protections in the Regulatory Flexibility Act. My subcommittee marked up this legislation last year, and this will be the second time a version of this legislation has passed the House.

However, there are other regulatory reform-related provisions in the debt ceiling bill that were never considered by the Judiciary Committee, nor any other House committee.

These provisions were not in H.R. 3136 as introduced. Instead, these items were slipped into a manager's amendment that was adopted by passage of the rule. Moreover, they are not identical to the provisions that passed the Senate as part of Senator Bond's bill, S. 942.

For example, one of the non-Senate provisions requires the chief counsel of the SBA to select individuals representative of affected small entities who would review a proposed rule before it is available to the public at large and lobby for changes. These individuals could be campaign contributors of special interest representatives. This provision has been limited to OSHA and EPA rules, since apparently the majority realized what havoc it would wreak if certain politically connected individuals were able to preview IRS, SEC, and other rules—and were thus able to restructure their financial transactions, for example.

Many of the regulatory reform provisions in the bill are meritorious and are based on S. 942. However, that is no reason to circumvent 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 implications 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 motor.

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, and 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.

The question is on the engrossment and third reading of the bill.

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

MOTION TO RECOMMIT OFFERED BY MR. BONIOR

Mr. BONIOR. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

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 331(b) the following:

The amendment made by subsection (a) shall only apply during periods when the minimum wage under section 6(a)(1) of the Fair Labor Standards Act is not less than $4.70 an hour during the year beginning on July 4, 1996 and not less than $5.15 an hour after July 3, 1997.

POINT OF ORDER

Mr. ARCHER. Mr. Speaker, I make a point of order.

The SPEAKER pro tempore. The gentleman will 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 intergovernmental mandate under section 425 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. Does the gentleman from Michigan [Mr. BONIOR] desire to be heard on the point of order?

Mr. BONIOR. I do, Mr. Speaker.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Michigan [Mr. BONIOR] 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 that 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 what is pending.

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 for——

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 to confine his remarks to the germaneness of the point of order as raised by the gentleman from Texas [Mr. ARCHER].

□ 1400

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 admonition, 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

that the Department of Labor certify. And I would tell my friend from Texas, the Department of Labor has to certify whether any of its rules, including rules governing the minimum wage. And that, it seems to me, is the direct connection in this bill with the needs of working people in this country who are working for a minimum wage and deserve to have the opportunity to have that wage increase.

Mr. ARCHER. Mr. Speaker, may I be heard on my point of order?

The SPEAKER pro tempore. The gentleman from Texas is recognized.

Mr. ARCHER. Mr. Speaker, I would like to be heard on the point of order on germaneness first and, subsequent to the ruling on that point of order, be heard on the second point of order on intergovernmental mandates.

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 is recognized.

Mr. ENGEL. Mr. Speaker, I must say that I think it is disingenuous and outrageous to say that the minority leader's point of order is not in order here.

The SPEAKER pro tempore. The gentleman will suspend.

Mr. ARCHER. Mr. Speaker, the gentlemen 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. ENGEL. Mr. Speaker, it would seem to me, if we are debating this bill on raising the debt ceiling limit, that something to do with the minimum wage is about as germane to 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 playing by fair rules. I think we 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 amendment proposed in a motion to recommit offered by the gentleman from Michigan is not germane to the bill. The text of germaneness in the case of a motion to recommit with instructions is a relationship of those instructions to the bill as a whole.

The pending bill permanently increases the debt limit. It also comprehensively addresses several other unrelated programs, specifically, the Senior Citizens' Right to Work Act, which amends the Social Security Act, the Line-Item Veto Act, which amends the Congressional Budget and Impoundment Control Act, and the Small Business Growth and Fairness Act of 1996, which amends the Regulatory Flexibility Act and the Small Business Act, and it establishes congressional review of agency rulemaking.

The motion does not amend the Fair Labor Standards Act. The motion does not directly amend the laws that go directly to the jurisdiction of the Committee on Economic and Educational Opportunities.

The Chair would cite to page 600 of the Manual the following: An amendment that conditions the availability of funds covered by a bill by adopting as a measure of their availability the monthly increases in the debt limit may be germane so long as the amendment does not directly affect other provisions of law or impose unrelated contingencies.

Therefore, the Chair rules that this motion is germane and overrules that point of order.

UNFUNDED MANDATE POINT OF ORDER

Mr. ARCHER. Mr. Speaker, I urge my second point of order that the motion to recommit with instructions constitutes an unfunded governmental mandate under section 425 of the Congressional Budget Act. Section 425 prohibits consideration of a measure containing unfunded intergovernmental mandates whose total unfunded direct costs exceeds $50 million annually. The precise 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 provision 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 met his threshold burden to identify 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. Speaker, it is indeed ironic 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 which 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 businesses, would not cost jobs, it would

add jobs. That is what some of these studies have said. Over 100 economists, three Nobel laureates, have suggested it is way past the time that we raise the minimum wage for these folks who have chosen work over welfare, 70 percent of them who are adults, many of them single women with children who need to have more money in their pockets so that they can survive and so they can live in dignity and teach their children that work indeed does pay in this country.

That is what we are all about here, making work pay. Five years ago we passed a similar bill, 90 cents over 2 years, which President Bush supported. Some of my friends on this side of the aisle support it. And here we are again, 5 years later, people struggling to make ends meet, having to work because they are getting paid the minimum wage and in various parts of this country having to work overtime in some jobs, having to work two or three jobs; fathers who cannot come home at night and be with their kids for athletic events, who are not there for PTA meetings; mothers who have to work overtime who are not there reading them bedtime stories, teaching their kids right from wrong.

Mr. Speaker, that is what this is all about. This issue is more than about wages. This is about community. This is about family.

Mr. Speaker, there is nothing more important than increasing the wages of the 80 percent of Americans in this society today who have not seen an increase since 1979.

□ 1415

Since 1979, 98 percent of all income growth in America has gone to the top 20 percent. The other 80 percent got 2 percent of that growth. So the minimum wage, while it will not help all of those 80 percent, will help some of them and it will help the people who are above the minimum wage a little bit. But it more importantly will circulate money throughout the economy, and the more money people have, the more they spend at the hardware store, the more they spend at the grocery store.

This indeed is necessary for us to do justice to those who are working in this society today and who have been denied economic justice for too long. So I do not believe, Mr. Speaker, that this is a violation of the unfunded mandates bill. This is a funding of the mandates of people to take care of their families. That is what this is about, Mr. Speaker.

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

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

Mr. Speaker, this clearly is an unfunded mandate on State and local government. It is the very thing that this Congress overwhelmingly passed a law to prevent last year. It will significantly increase the cost of State and local government. If the Federal Government is to do that by its own legislation, it has an obligation to reimburse the State and local governments. That is not mandatory that we do that, but we took the position that it was inappropriate for us to do that. That is why we are having this debate today, because of the unfunded mandate legislation that was passed and signed into law by the President last year.

In addition, it places an unfunded mandate of unquantified amount on employers, which was also part of the law that we passed on a bipartisan basis and signed by the President of the United States last year. Here already the provisions of that law are to be tested. Did we really mean it? Well, if this motion to recommit passes, it will say to the American people we did not really mean it.

I do not think that is an appropriate thing for this Congress to do. CBO estimates that the potential loss of jobs will range, will reduce the employment level of teenagers and a smaller percentage reduction of young adults, reducing by a half a percent to 2 percent in the employment level of those types of individuals. They would produce employment losses of 90 cents per hour, increasing the minimum wage. From roughly 100,000 to 500,000 jobs, that 90-cent-per-hour increase will cost employment that much.

I urge a positive vote on the point of order on unfunded mandates, Mr. Speaker.

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

Mr. BONIOR. Mr. Speaker, I yield 2 minutes to the gentleman from New York [Mr. ENGEL].

Mr. ENGEL. Mr. Speaker, I thank the minority whip for yielding me the time.

Mr. Speaker, let us say what this really is. This is an attempt by the Republican majority not to allow the whole issue of minimum wage, of raising the minimum wage for American workers to come to the floor. I serve on the Committee on Economic and Educational Opportunities. We cannot get that bill to come to committee. The Republican leadership has blocked it. We cannot get that bill to come to the floor. The Republican leadership has blocked it.

They could care less about raising the minimum wage. They expect people to work at a $4.25 an hour standard, which is less than people who are on welfare are getting. So much for welfare reform. They claim they are for welfare reform, but they do not want to pay someone who wants to work for a living a decent wage. Apparently they think coolie wages is what we should do, $4.25 an hour. This would simply raise it to $5.15.

The last raise was 5 years ago. Workers' moneys in terms of what they make on minimum wage are at a 40-year low. Is there no decency? Do we not care about what people who are trying to work for a living do?

The Republican majority does not want this to come to a vote. I may ask my colleagues on the other side of the aisle, what are they afraid of? All we are saying is that the minimum wage ought to be raised from $4.25 to $5.15. We owe it to America's workers to do this. This is simple decency. What are you afraid of? Are you afraid that the vote will pass and that people on your side of the aisle, some of them, may even vote for it?

There has been an attempt to block this bill from being in the committee and from being on the floor. We cannot get a vote. All we are saying is let us vote up or down whether or not the minimum wage should be raised. That is all we are asking and that is all we want here this afternoon.

PARLIAMENTARY INQUIRY

Mr. ARCHER. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman will state it.

Mr. ARCHER. Would the Speaker please explain to the House how this vote will be framed and what a ''yes'' or ''no'' vote will mean, because this is the first time that we have had a test of the unfunded mandate legislation?

The SPEAKER pro tempore. The question will be put by the Chair, to wit, will the House now consider the motion to recommit? So an ''aye'' vote would mean that the House should indeed consider the motion to recommit. A ''no'' vote would mean that the House would not consider the motion to recommit.

Mr. ARCHER. Mr. Speaker, would it be fair to say that a ''no'' vote then would sustain the point of order?

The SPEAKER pro tempore. Yes.

Mr. BONIOR. Mr. Speaker, that is not a point of order. Mr. Speaker, may I be heard?

The SPEAKER pro tempore. The statute provides that on this point of order the House shall decide that question and not a ruling from the Chair on whether to consider the motion. It would not be a prerogative of the Chair to make that judgment.

Mr. CLINGER. Mr. Speaker, I would indicate that I think a ''yes'' vote on this matter would in effect be saying that we would allow an unfunded mandate to be passed through, or open the door to passing through, an unfunded mandate to the States.

Those who would want to sustain the unfunded mandate legislation, and this is our first look at this thing, the first time we have had to consider this procedure, those who want to sustain that should vote ''no'' on this measure.

Mr. ARCHER. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. DELAY], the majority whip.

Mr. DELAY. Mr. Speaker, 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.

The gentleman from New York who just spoke before I did said in his speech that we owe the American workers this vote and we owe the American workers to raise the minimum wage. Where did he get that? I submit he got that from the convention that was just held in this town by the AFL–CIO who said that they would raise over $35 million to take this majority out.

That is what this vote is all about. This group over here on this side of the aisle has been screaming and yelling for the last many weeks.

Mr. BONIOR. Mr. Speaker, I move that the gentleman's words be taken down. He used the word ''hypocrisy.''

□ 1425

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Clerk will report the last words by the gentleman from Texas [Mr. DELAY].

The Clerk read as follows:

The gentleman from New York, who just spoke before I did, said in his speech that we owe the American workers this vote and we owe the American workers to raise the minimum wage. I submit he got that from the convention that was just held in this town by the AFL–CIO, who said that they would raise over $35 million to take this majority out. That is what this vote is all about. This group over here on this side of the aisle has been screaming and yelling for the last many weeks.

The SPEAKER pro tempore. The Chair does not believe that anything in those remarks constitutes any personal reference to any other Member of this body.

Mr. BONIOR. Mr. Speaker, may I be heard?

The SPEAKER pro tempore. The gentleman from Michigan.

Mr. BONIOR. Mr. Speaker, the Clerk needs to go back farther, because there was reference and the use of the word ''hypocrite,'' and the Clerk has not gone back far enough to pick up the words that I objected to. The word ''hypocrisy'' was used, excuse me, Mr. Speaker.

The SPEAKER pro tempore. The Chair would remind the gentleman that on points such as that, the point of order from the gentleman making the point of order has to be timely. The Clerk has gone back several sentences to transcribe what the gentleman had said, and the gentleman's demand certainly was not timely in this instance.

The gentleman from Texas may proceed with his remarks.

POINT OF ORDER

Mr. BONIOR. Point of order, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his point of order.

Mr. BONIOR. Mr. Speaker, that dialog that I am referring to could not have taken more than 30 seconds, and it seems to me that I was indeed timely when I rose to my feet as the gentleman was completing his idea, which included referring to the gentleman from New York [Mr. ENGEL] with the term ''hypocrisy.''

The SPEAKER pro tempore. Under the precedents set, those points of order raised by the gentleman have to be on a timely basis. This is precedent that has been set in this body for a number of years where there are intervening remarks that you are alluding to. So the Chair rules that the gentleman from Texas may proceed.

Mr. BONIOR. Mr. Speaker, I appeal the ruling of the Chair.

The SPEAKER pro tempore. The question is: Shall the decision of the Chair stand as the judgment of the House?

MOTION TO TABLE OFFERED BY MR. ARCHER

Mr. ARCHER. Mr. Speaker, I move to table the appeal of the ruling of the Chair.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas [Mr. ARCHER] to lay on the table the appeal of the ruling of the Chair.

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

RECORDED VOTE

Mr. BONIOR. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 232, noes 185, not voting 14, as follows:

[Roll No. 99]

AYES—232

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hancock
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Jacobs
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pombo
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Riggs
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Souder
Spence
Stearns
Stockman
Stump
Talent
Tate
Tauzin
Taylor (NC)
Thomas
Thornberry
Tiahrt
Torkildsen
Upton
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOES—185

Abercrombie
Ackerman
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Beilenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Brewster
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (MI)
Condit
Conyers
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Durbin
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Flake
Foglietta
Ford
Frank (MA)
Furse
Gejdenson
Gephardt
Geren
Gibbons
Gonzalez
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pomeroy
Poshard
Rahall
Rangel
Reed
Richardson
Rivers
Roemer
Rose
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Sisisky
Skaggs
Skelton
Slaughter
Spratt
Stark
Stenholm
Studds
Stupak
Tanner
Taylor (MS)
Thompson
Thornton
Thurman
Torres
Torricelli
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Ward
Waters
Watt (NC)
Waxman
Wilson
Wise
Woolsey
Wynn
Yates

NOT VOTING—14

Bryant (TX)
Collins (IL)
Fields (LA)
Filner
Fowler
Frost
Hayes
Martinez
McNulty
Smith (WA)
Stokes
Tejeda
Weldon (PA)
Williams

□ 1453

So the motion to lay on the table the appeal of the ruling of the Chair was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. TEJEDA. Mr. Speaker, I was at the White House on official business and missed vote No. 99. Had I been present, I would have voted ''no.''

I ask that my statement appear in the RECORD immediately after the vote.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Under the order of business, the debate is on a point of order by the gentleman from Texas [Mr. ARCHER].

The gentleman from Texas [Mr. DELAY], the majority whip, has 1 minute remaining.

The Chair recognizes the gentleman from Texas [Mr. DELAY].

Mr. DELAY. Mr. Speaker, all I was trying to say was is it not interesting that we are having a motion on the floor, 3 days after the AFL–CIO had a convention calling for an increase in the minimum wage and promising to raise $35 million by assessing their membership more of their hard-earned wages, to take out the majority that is trying to allow working families to keep more of their hard-earned wages?

I hope everyone that was outraged by the gun vote last week will vote ''no'' on this, because we were accused of the same thing.

Is it not also interesting that we have heard time and time again that we have not had enough hearings in this body; that we have to look at these issues, hold hearings on these issues. yet we have the Democrats bringing a motion to the floor that wants to do away with the unfunded mandate legislation that was passed by the Senate and debated in less than 20 minutes.

The SPEAKER pro tempore. The gentleman from Texas [Mr. ARCHER] has 5½ minutes remaining, and the gentleman from Michigan [Mr. BONIOR] has 4 minutes remaining.

Mr. ARCHER. Mr. Speaker, I yield 1½ minutes to the gentleman from Pennsylvania [Mr. GOODLING], the chairman of the Committee on Economic and Educational Opportunities.

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

Mr. GOODLING. Mr. Speaker, I think the first thing I would like to do is remind all Members that our balanced budget provides an instant raise for workers in the form of lower taxes, reduced interest rates, and greater economic growth.

PARLIAMENTARY INQUIRY

Mr. VOLKMER. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state 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?

□ 1500

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, stagnate the economy even more. We cannot afford to grow at 1 percent or less, or we will never get out of this stagnated economy that we are presently in.

Mr. BONIOR. Mr. Speaker, I yield 1 minute to the gentleman from New York [Mr. HINCHEY].

Mr. HINCHEY. 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 1989. 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 be 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 this is a motion to proceed on a vote 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 and preached to us just a few minutes ago about the AFL–CIO wanting this vote. Those people do not make the minimum wage. They do not make it because they got together. They banded together in unity for a decent wage for themselves. They are working for other folks. They are trying to get them a decent wage.

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 here again 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 gentlewoman 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, 90 cents, when they make over $130,000 a year.

That is not justice. It is wrong to happen to working families in this country. Shame. Stop the excuses. Let us vote on a minimum wage in this House and let us past minimum wage for working families in this country.

PARLIAMENTARY INQUIRIES

Mr. VOLKMER. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. VOLKMER. Mr. Speaker, as a result of my previous parliamentary inquiry to the Chair and to others, that the debate was on the motion to recommit to determine whether or not it is an unfunded mandate; is that correct or incorrect?

The SPEAKER pro tempore. The Chair will read from section 426(b) of the Budget Act as to what the House is debating: question of consideration, ''as disposition of points of order under section 425 or subsection (a) of this section, the Chair shall put the question of consideration with respect to the proposition that is the subject of the points of order.''

Mr. VOLKMER. The point of order is the motion to recommit is an unfunded mandate; is that correct?

The SPEAKER pro tempore. That is correct.

Mr. VOLKMER. That is the point of order.

Now, the Parliamentarian does not rule on this and we are to vote and make an individual decision as to whether or not we believe that this is an unfunded mandate if the point of order is proper; is that correct, as an individual?

The SPEAKER pro tempore. The question is simply on whether this body wants to consider the motion to recommit, notwithstanding the point of order.

Mr. VOLKMER. Notwithstanding the point of order. Therefore, any Member can raise a point of order not on the motion to recommit or an amendment or anything under this rule, correct?

The SPEAKER pro tempore. Only against this motion at this time.

Mr. VOLKMER. Only against the motion.

Now, should the Members not make a decision based on recommendations like the Congressional Budget Office which says this is not an unfunded mandate?

The SPEAKER pro tempore. The Chair would remind Members that the reason the House is having this debate is so the Members can make up their minds on which way they want to vote on this question.

Mr. VOLKMER. Without listening to the Congressional Budget Office.

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

The SPEAKER pro tempore. The gentleman will state it.

Mr. FRANK of Massachusetts. Mr. Speaker, it has to do with the nature of the question we are voting on.

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.

The SPEAKER pro tempore. The gentleman will state it.

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?

The SPEAKER pro tempore. The gentleman is not stating a parliamentary inquiry.

The Chair would advise Members that the gentleman from Texas [Mr. ARCHER] has 3½ minutes remaining, the gentleman from Michigan [Mr. BONIOR] has 30 seconds remaining, and the gentleman from Texas [Mr. ARCHER] has the right to close.

Mr. BONOIR. 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.)

□ 1515

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. ARMEY], the majority leader.

Mr. ARMEY. 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.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 192, noes 228, not voting 11, as follows:

[Roll No. 100]

AYES—192

Abercrombie
Ackerman
Andrews
Baldacci
Barcia
Barrett (WI)
Becerra
Beilenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (MI)
Condit
Conyers
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Duncan
Durbin
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Gibbons
Gilman
Gonzalez
Gordon
Green
Gutierrez
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Leach
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pomeroy
Poshard
Rahall
Rangel
Reed
Richardson
Riggs
Rivers
Roemer
Rose
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Sisisky
Skaggs
Skelton
Slaughter
Smith (NJ)
Spratt
Stark
Stenholm
Stockman
Studds
Stupak
Tanner
Taylor (MS)
Tejeda
Thompson
Thornton
Thurman
Torkildsen
Torres
Torricelli
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Ward
Waters
Watt (NC)
Waxman
Williams
Wilson
Wise
Woolsey
Wynn
Yates

NOES—228

Allard
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brewster
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Dickey
Doolittle
Dornan
Dreier
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Geren
Gilchrest
Gillmor
Goodlatte
Goodling
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Montgomery
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pombo
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Roberts
Rogers
Rohrabacher
Roth
Roukema
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (TX)
Solomon
Souder
Spence
Stearns
Stump
Talent
Tate
Tauzin
Taylor (NC)
Thomas
Thornberry
Tiahrt
Upton
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—11

Bryant (TX)
Collins (IL)
Diaz-Balart
Fields (LA)
Filner
Fowler
McNulty
Ros-Lehtinen
Smith (WA)
Stokes
Weldon (PA)

□ 1537

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 a Member of the other body on another piece of legislation under consideration by that Chamber. That legislation contained specific language which would have directly increased the minimum wage. To equate that legislation with this modest motion is to compare apples and oranges—make that grapes and watermelons.

I want to place at this point in my statement, a letter from the Congressional Budget Office that states that this motion does not contain an unfunded mandate:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 28, 1996.

Hon. JOHN JOSEPH MOAKLEY,
Ranking Minority Member, Committee on Rules, House of Representatives, Washington, DC.

DEAR CONGRESSMAN: As you requested, we have reviewed the motion made by Mr. Bonior to determine whether it contains an intergovernmental mandate as defined by the Unfunded Mandates Reform Act of 1995 (Public Law 104–4). The motion would require H.R. 3136, the Contract with America Advancement Act of 1996, to be recommitted to the House Committee on Ways and Means, with instructions to add a new section to the bill. The new section would amend section 331 of Subtitle C to prohibit the administrative proceedings provisions of that subtitle from applying in any period during which the minimum wage was less than $4.70 per hour beginning on July 4, 1996, and $5.15 per hour after July 3, 1997.

The motion and the new section would not increase the minimum wage, but would make other provisions conditional on such an increase. Subsequent legislation would be necessary to increase the minimum wage. Public Law 104–4 defines an intergovernmental mandate as ''any provision in legislation . . . that would impose an enforceable duty upon state, local, or tribal governments.'' The motion contains no such enforceable duty and thus does not contain an intergovernmental mandate.

If you wish further details on this matter, we would be pleased to provide them. The CBO staff contact is Theresa Gullo.

Sincerely,

JUNE E. O'NEILL,
Director.

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 curb 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 that implemented 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 104–4—in any bill, joint resolution, motion, conference report, or amendment. Only a small handful of House 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

Member raising the point-of-order. It does not matter if the point-of-order is baseless, simply by raising the point-of-order, the House is required to vote on whether to consider the text that is challenged. A simple majority of the House, for any reason, regardless of whether there is any legitimate financial imposition or not, can deny the opportunity of a Member to proceed with an otherwise germane and viable legislative measure. I raised the concern at that time that this could be used both to stop legislation not containing unfunded mandates from being considered on the floor and as a dilatory tactic to disrupt the legislative process. I was always assured that this would not be used for this purpose. Even then, however, I did not anticipate that the very first use of this tactic would be to deny the minority the right to offer an entirely legitimate and germane motion to recommit.

One of the Republican leadership's first changes to the House rules on the 104th Congress guaranteed the minority the right to recommit with instructions. In fact, during the 102d and 103d Congresses in particular, we in the majority were crudely accused of ''raping the rights of the minority'' by, on rare occasion, denying them instructions on the motion to recommit. Now it appears they are grossly misusing the new unfunded mandates law and, on this first challenge out of the gate, we are being denied the very right that was so vital to the Republicans in previous Congresses.

I am deeply troubled that if this practice continues, it could simply become a backdoor approach used to gag legitimate debate, whether on the motion to recommit or on any other responsible and germane legislative initiatives. I urge the majority to carefully consider the ramifications of misusing the unfunded mandates point-of-order for purposes other than the legitimate intentions spelled out in Public Law 104–4. The unfunded mandates law should be used as tool to fix legislation that imposes unfair financial burdens on state and local governments and the private sector. It should not be used as a weapon to prevent the consideration of viable and responsible legislation initiatives.

MOTION TO RECOMMIT OFFERED BY MR. ORTON

Mr. ORTON. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Is the gentleman opposed to the bill?

Mr. ORTON. I am in its present form, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. ORTON moves to recommit the bill to the Committee on Ways and Means with instructions to report the bill forthwith with the following amendment:

On page 60, strike lines 5 through 15 and insert the following:

SEC. 205. EFFECTIVE DATES.

This title and the amendments made by it shall take effect and apply to measures enacted after the date of its enactment and shall have no force or effect on or after January 1, 2005.

PARLIAMENTARY INQUIRIES

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 President for his signature?

The SPEAKER pro tempore. The Chair would tell the gentleman that the answer to that is yes.

Mr. ORTON. Further parliamentary inquiry, Mr. Speaker. Is it correct that the rule provides that title II in this bill, which is the line-item veto title, would be stripped from this bill if unamended, and the bill would be sent without title II, but if amended, title II would remain in this bill and go 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. That is all it does.

Therefore, the President will already get the opportunity to sign the conference report making line-item veto effective the beginning of next year.

□ 1545

This amendment will give him the opportunity, if adopted, to make it effective immediately and give the President the authority to veto items of specific spending between the date of enactment and the next calendar year. That is the only difference.

Now, Mr. Speaker, let me just in explanation suggest that not only I but many of my colleagues on both sides of the aisle support this line-item veto. The line-item veto has not been partisan. It is supported by both Democrats and Republicans, by the Congress and the President. In fact, during floor debate in the other body on March 23, 1995, the majority leader said the following: ''During the 1980's, opponents of the line-item veto used to say that Republicans supported it only because the President happened to be a Republican at the time. Now, we are in the majority and we are prepared, nearly all of us on this side, to give this authority to a Democratic President.''

The Senate majority whip said the following: ''Why be afraid of allowing this current President to use his power? We on this side of the aisle, the Republicans, are ready to give this opportunity to President Clinton so he can have the opportunity to pare spending.''

In this body in February 1995 during debate on this line-item veto bill, the Chairman of the Committee on Rules, Mr. SOLOMON, said the following: ''Well, here we are. We get a Democrat President, and here is SOLOMON up here fighting for the same line-item veto for the Democrat President.''

Finally, the gentleman from Florida [Mr. GOSS] during the same debate said, ''Let us give it to the President whether the President is Democrat or Republican. Let us stop the games. Let us get into budget management.''

That is what this amendment is about. It is about budget management. It is about stopping the partisan games. It is about saying we are for line-item veto now, not next year or next decade; we want it to be effective upon enactment.

Mr. Speaker, that is all this amendment will do. If passed, it will send it to the other body for consideration and the President's signature, which would then give us all the opportunity to drop partisan rhetoric and actually have the opportunity to cut spending.

Now someone suggests we do not really need it because we are cutting spending. This is the 1996 congressional pig book put out by the Citizens Against Government Waste. They have identified over $12.5 billion in the eight appropriation bills that we have already passed for 1996 of questionable spending which, if the President had this authority right now, he could veto. That is for 1996. We have lost that opportunity. Let us not lose the opportunity for 1997. Let us give him the opportunity during the appropriation process of 1997.

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 this President has not only the opportunity, but the responsibility, to look at each item of spending and veto those items that he believes are inappropriate, send them back under new legislation. It is appropriate, it is responsible, it is the thing to do. I would urge adoption of the motion to recommit.

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 conferees have 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 here 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.

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 line-item veto on both sides 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 was only finally resolved 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 January 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 takes it out of the political spectrum. It gives the next President or the continuing President the ability to use this line-item veto.

So I would urge, and urge strongly, Members on both sides not to upset the apple cart here, because it really could do violence to what we had agreed to.

Our conference report is on its way to the President now. It was, in fact, passed as a result of the rule that passed. It was passed. Now, if we were to adopt this amendment, it would change a deal that has been made, an agreement that has been reached, bipartisan on both sides of the aisle and I think would possibly make it difficult for us actually to exercise the line-item veto.

So I would urge as strongly as I can, please, keep the effective date where it is, keep it out of the political and the Presidential campaign this year.

Mr. ARCHER. Mr. Speaker, to reiterate what was said in the earlier debate, that the President has within his power unilaterally to activate this authority immediately after his signature on the bill by signing and agreeing to a balanced budget for this country and does not have to wait until January 1, 1997.

Further, to say to the Members that the perfect can be the enemy of good movement for what has taken so very, very long, and I know it better than anybody else, because I initiated line-item veto as a proposal before the Congress. It is not agreed to, it can be signed into law. Let us not put it back into the maze of procedure that could further tie it up this year. I urge a vote against the motion to recommit.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

Mr. ORTON. Mr. Speaker, on that I demand the yeas and nays. The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 159, nays 256, not voting 16, as follows:

[Roll No. 101]

YEAS—159

Ackerman	Gejdenson	Olver
Andrews	Gephardt	Orton
Baesler	Geren	Owens
Baldacci	Gibbons	Pallone
Barcia	Gonzalez	Payne (NJ)
Barrett (WI)	Gordon	Payne (VA)
Becerra	Graham	Pelosi
Beilenson	Green	Peterson (FL)
Bentsen	Gutierrez	Peterson (MN)
Berman	Hall (OH)	Pomeroy
Bevill	Hamilton	Poshard
Bishop	Harman	Reed
Bonior	Hefner	Richardson
Boucher	Hilliard	Rivers
Browder	Hinchey	Roemer
Brown (CA)	Holden	Rose
Brown (FL)	Hoyer	Roybal-Allard
Brown (OH)	Jacobs	Royce
Campbell	Johnson (SD)	Rush
Cardin	Johnson, E. B.	Sabo
Chapman	Johnston	Salmon
Clay	Kanjorski	Sawyer
Clement	Kaptur	Schroeder
Clyburn	Kennedy (MA)	Schumer
Coburn	Kennedy (RI)	Shadegg
Coleman	Kennelly	Shays
Collins (MI)	Kleczka	Sisisky
Condit	LaFalce	Skaggs
Conyers	Levin	Skelton
Costello	Lewis (GA)	Slaughter
Coyne	Lincoln	Souder
Cramer	Lofgren	Stenholm
Danner	Lowey	Studds
de la Garza	Luther	Stupak
DeFazio	Maloney	Tanner
DeLauro	Manton	Taylor (MS)
Deutsch	Markey	Thompson
Dingell	Martinez	Thornton
Doggett	Mascara	Thurman
Dooley	Matsui	Torres
Doyle	McCarthy	Upton
Durbin	McDermott	Vento
Edwards	McHale	Visclosky
Ensign	Meehan	Volkmer
Eshoo	Menendez	Wamp
Farr	Miller (CA)	Ward
Fattah	Minge	Waters
Fazio	Mink	Waxman
Flake	Moakley	Wilson
Ford	Moran	Wise
Frank (MA)	Neal	Woolsey
Frost	Neumann	Wynn
Furse	Obey	Zimmer

NAYS—256

Abercrombie	Bachus	Barr
Allard	Baker (CA)	Barrett (NE)
Archer	Baker (LA)	Bartlett
Armey	Ballenger	Barton

Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Borski
Brewster
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clayton
Clinger
Coble
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Dellums
Diaz-Balart
Dickey
Dicks
Dixon
Doolittle
Dornan
Dreier
Dunn
Ehlers
Ehrlich
Emerson
Engel
English
Evans
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foglietta
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Goss
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kildee
Kim
King
Kingston
Klink
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Lipinski
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McKeon
McKinney
Meek
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Mollohan
Montgomery
Moorhead
Morella
Murtha
Myers
Myrick
Nadler
Nethercutt
Ney
Norwood
Nussle
Oberstar
Ortiz
Oxley
Packard
Parker
Pastor
Paxon
Petri
Pickett
Pombo
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Riggs
Roberts
Rogers
Rohrabacher
Roth
Roukema
Sanders
Sanford
Saxton
Scarborough
Schaefer
Schiff
Scott
Seastrand
Sensenbrenner
Serrano
Shaw
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Spence
Stark
Stearns
Stockman
Stump
Talent
Tauzin
Taylor (NC)
Tejeda
Thomas
Thornberry
Tiahrt
Torkildsen
Towns
Traficant
Velazquez
Vucanovich
Waldholtz
Walker
Walsh
Watt (NC)
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Williams
Wolf
Yates
Young (AK)
Young (FL)
Zeliff

NOT VOTING—16

Bryant (TX)
Collins (IL)
Duncan
Fields (LA)
Filner
Fowler
Lantos
McIntosh
McNulty
Ros-Lehtinen
Smith (WA)
Spratt
Stokes
Tate
Torricelli
Weldon (PA)

☐ 1614

The Clerk announced the following pair:

On this vote:

Mrs. Collins of Illinois for, with Mrs. Fowler against.

Mrs. MYRICK, Ms. 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, SHADEGG, 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 appeared 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—ayes 328, noes 91, not voting 12, as follows:

[Roll No. 102]

AYES—328

Ackerman
Allard
Andrews
Archer
Armey
Bachus
Baesler
Baker (LA)
Baldacci
Ballenger
Barcia
Barrett (NE)
Barrett (WI)
Bass
Bateman
Bentsen
Bereuter
Bevill
Bilbray
Bilirakis
Bishop
Bliley
Blute
Boehlert
Boehner
Bonilla
Bonior
Bono
Boucher
Brewster
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Brownback
Bryant (TN)
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Chapman
Christensen
Chrysler
Clayton
Clement
Clinger
Coble
Collins (GA)
Combest
Costello
Cox
Coyne
Cramer
Crane
Cremeans
Cubin
Cunningham
Danner
Davis
de la Garza
Deal
DeFazio
DeLauro
DeLay
Deutsch
Diaz-Balart
Dickey
Dicks
Dixon
Doggett
Dooley
Dornan
Doyle
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
Emerson
Engel
English
Ensign
Eshoo
Everett
Ewing
Farr
Fawell
Fazio
Fields (TX)
Flake
Flanagan
Foglietta
Foley
Ford
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Gordon
Goss
Graham
Green
Greenwood
Gunderson
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (WA)
Hayes
Hefley
Hefner
Heineman
Hilleary
Hinchey
Hobson
Hoke
Holden
Horn
Hostettler
Houghton
Hoyer
Hunter
Hutchinson
Hyde
Inglis
Istook
Jackson-Lee (TX)
Johnson (CT)
Johnson (SD)
Johnson, E. B.
Johnson, Sam
Jones
Kaptur
Kasich
Kelly
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kim
King
Kleczka
Klug
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Laughlin
Lazio
Leach
Levin
Lewis (GA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Lipinski
Livingston
LoBiondo
Longley
Lowey
Lucas
Luther
Maloney
Manton
Manzullo
Martini
Mascara
McCarthy
McCollum
McCrery
McDade
McHale
McHugh
McInnis
McIntosh
McKeon
Meehan
Menendez
Meyers
Mica
Miller (CA)
Miller (FL)
Minge
Moakley
Molinari
Montgomery
Moorhead
Moran
Morella
Myrick
Nadler
Nethercutt
Neumann
Ney
Norwood
Nussle
Obey
Ortiz
Orton
Oxley
Packard
Pallone
Parker
Pastor
Paxon
Payne (VA)
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pomeroy
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Ramstad
Reed
Regula
Richardson
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Rose
Roth
Royce
Rush
Sawyer
Saxton
Schaefer
Schiff
Schumer
Scott
Seastrand
Sensenbrenner
Shaw
Shuster
Sisisky
Skeen
Skelton
Slaughter
Smith (NJ)
Smith (TX)
Solomon
Souder
Spence
Spratt
Stearns
Stenholm
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (NC)
Tejeda
Thomas
Thornberry
Thornton
Thurman
Tiahrt
Torkildsen
Torres
Upton
Vento
Visclosky
Volkmer
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Ward
Watts (OK)
Weldon (FL)
Weller
Whitfield
Wicker
Williams
Wilson
Wise
Wolf
Woolsey
Wynn
Young (AK)
Young (FL)
Zeliff
Zimmer

NOES—91

Abercrombie
Baker (CA)
Barr
Bartlett
Barton
Becerra
Beilenson
Berman
Borski
Bunn
Chenoweth
Clay
Clyburn
Coburn
Coleman
Collins (MI)
Condit
Conyers
Cooley
Crapo
Dellums
Dingell
Doolittle
Evans
Fattah
Forbes
Frank (MA)
Gonzalez
Hastings (FL)
Hayworth
Herger
Hilliard
Hoekstra
Jackson (IL)
Jacobs
Jefferson
Johnston
Kanjorski
Kingston
Klink
LaFalce
Largent
Lewis (CA)
Lofgren
Markey
Martinez
Matsui
McDermott
McKinney
Meek
Metcalf
Mink
Mollohan
Murtha
Myers
Neal
Oberstar
Olver
Owens
Payne (NJ)
Pelosi
Pombo
Rahall
Rangel
Roukema
Roybal-Allard
Sabo
Salmon
Sanders
Sanford
Scarborough
Schroeder
Serrano
Shadegg
Shays
Skaggs
Smith (MI)
Stark
Stockman
Studds
Stump
Taylor (MS)
Thompson
Towns
Traficant
Velazquez
Waters
Watt (NC)
Waxman
White
Yates

NOT VOTING—12

Bryant (TX)
Collins (IL)
Fields (LA)
Filner
Fowler
Lantos
McNulty
Ros-Lehtinen
Smith (WA)
Stokes
Torricelli
Weldon (PA)

☐ 1632

The Clerk announced the following pairs:

On this vote:

Mrs. Fowler for, with Mrs. Collins of Illinois against.

Ms. Ros-Lehtinen for, with Mr. Filner against.

Mrs. Smith of Washington for, with Mr. Stokes against.

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 result of the vote 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. KOLBE) 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 our 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 whenever 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 and benefit.

WILLIAM J. CLINTON.

THE WHITE HOUSE, *March 28, 1996.*

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 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. 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 adopted. All points of order against the bill, as amended, and against its consideration are waived (except those arising under section 425(a) of the Congressional Budget Act of 1974). The previous question shall be considered as ordered on the bill, as amended, and on 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 and controlled by the chairman and ranking minority member of the Committee on Economic and Educational Opportunities; (2) the further amendment specified in part 2 of the Committee on Rules, if offered by the minority leader or his designee, 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) or demand for division of the question, shall be considered as read, and shall be separately debatable for one hour 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. The yeas and nays shall be considered as ordered on the question of passage of the bill and on any conference report thereon. Clause 5(c) of rule XXI shall not apply to the bill, amendments thereto, or conference reports thereon.

The SPEAKER pro tempore. The gentleman from Florida [Mr. GOSS] is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, for the purpose of debate only I yield the customary 30 minutes to the distinguished gentleman from Massachusetts [Mr. MOAKLEY], the ranking member of the Committee on Rules, pending which I yield myself such time as I may consume. During consideration of this resolution all time yielded is for the purpose of debate only.

Mr. Speaker, the Rules Committee has carefully crafted this rule to allow for ample debate on the major issues of health insurance reform without opening ourselves up to a free-for-all. The purpose is to pass a streamlined bill that accomplishes meaningful, results without getting bogged down in a replay of last Congress' frustrating and fruitless health reform debate.

Mr. Speaker, this rule is a modified closed rule that allows us to knit together the work product of five major committees. This rule makes in order as base text for the purpose of amendment the text of H.R. 3160, modified by a technical amendment printed in part 1 of the Rules Committee report. The rule waives all points of order against the bill as amended and against its consideration, except those arising under section 425(e) of the Congressional Budget Act of 1974, relating to unfunded mandates. The rule provides for a total of 2 hours of debate, with 45 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. The rule allows the minority to offer the amendment in the nature of a substitute, as referenced to the CONGRESSIONAL RECORD in part 2 of our Rules Committee report. That amendment shall not be subject to any point of order—except relating to section 425(e) of the budget act—or to any demand for a division of the question. The amendment shall be debatable for 1 hour, equally divided between a proponent and an opponent. The previous question shall be considered as ordered on the bill as amended and on any further amendment thereto, to final passage, without intervening motion, except as specified. The rule provides for the traditional right of the minority to offer 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 new House rule requiring 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. It closes the loophole 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 committees 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 fear of 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 purchase 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 fraud and abuse, 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 doctor you must see and what pills you must take. Well, 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 set of proposals for meaningful and doable health care reform now.

Support the rule; support the bill.

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

Mr. MOAKLEY. 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-fifth vote required for tax increases, which my Republican colleagues like so much, they wanted to make it an amendment to the Constitution. If the three-fifth 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.

□ 1645

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 previously 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 lot of hands-on 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 House is turning a blind 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.

I urge my colleagues to defeat the rule, defeat the previous question. It is time to put the American people and their health care before politics.

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

Mr. MCINNIS. 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.

Second, Mr. Speaker, I think 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:

> 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, 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 requesting 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 lien 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, establishing 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 a three-fifths vote on either the minority substitute or on the bill itself. However, as was mentioned in the opening statement on this rule, the waiver was provided out of an abundance of caution to avoid unnecessary points of order.

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 passage of H.R. 2491, or to the votes any amendment thereto or conference report thereon.

The suspension of clause 5(c) of rule XXI is not being done 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 constitute a Federal income tax rate 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 15, 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 13, 1995, regarding 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 the rules 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 and prohibit 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, respectively, 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 confined to the rates specified in 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. 2491 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, things that made eminent good sense.

Now this year of course the House has been working on Medicare and Medicaid, and insurance reform has 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 need to go 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, that we could 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 really 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 available. The problem is people do not drive them 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 people that do not have jobs.

So that is the issue. How do we take people who need 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 know this package goes a little bit 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 four 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 came out of the Committee on the Judiciary and put it together in the Rules Committee yesterday.

Now what is the difference between this bill, the House Republican bill sponsored by the chairmen of the four committees and subcommittee 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,'' and 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 life 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 account.

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 we do just that.

Now 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 expense so 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 marketplace 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 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.

□ 1700

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.

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 yielding.

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, ends up doing one thing; that is, 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. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Speaker, I thank my friend, the gentleman from Massachusetts, for yielding me this time.

Mr. Speaker, this is a bad 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 makes it less 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 it very difficult for our States to 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 had 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 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 is small. 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, named 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 under this rule.

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Connecticut [Ms. DELAURO].

Ms. DELAURO. 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 was 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 that we are here to help working families.

The bipartisan Kennedy-Kassebaum-Roukema bill expands access to health

insurance. It increases portability, it limits a health insurance company's ability to deny coverage because of preexisting medical conditions. Rather than helping these hardworking families, the Republican leadership has hijacked the bill to make a payoff to their special interest cronies. The bill provides a big windfall to the Golden Rule Insurance Company by including a provision for medical savings accounts. The Wall Street Journal said today that Golden Rule was the third biggest corporate giver to the Republican party in the last election. The Washington Times, not a liberal newspaper, says, ''Riders imperil health reform.''

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 and therefore eliminates consumer protections existing in State law for employers and employees insuring 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 before the House.

The consequence of allowing insuring 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 as a State insurance commissioner. I know full well people 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 wipes 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 some 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 why 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 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 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 to have health insurance. The American people want to know that if there is a preexisting condition used as a excuse not to give them or a loved one health insurance, that that cannot be used as an excuse anymore. It has bipartisan support in the Senate, 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 for 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 a newly emerging and very important aspect of health insurance reform, that is genetic information and the potential for insurance discrimination. Last December, I introduced H.R. 2748, the Genetic Information Non-discrimination 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 with 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 family history of breast cancer 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 to 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; 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 insurance policies and to prohibit disclosure of genetic information.

As therapies are developed to cure genetic diseases, and potentially to save lives, the women and men affected must be assured access to genetic testing and therapy without concern that they will be discriminated against. As legislators, I believe it is our responsibility to ensure that protection against genetic discrimination is guaranteed. Today, we will take the first step in that direction. I invite my colleagues to join me in making the commitment to ensuring the passage of comprehensive protections against genetic discrimination.

Mr. Speaker, I urge a ''no'' vote on this rule.

Mr. GOSS. Mr. Speaker, I yield myself 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?

□ 1715

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 beginning 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. Those, along with 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? Twenty-five million. Today, we have that chance. We can help them stay healthy. We can help them end their fear. 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, many Republicans agree, the President agrees. Do not gum up the works, do not support special interests over our interests. Twenty-five million people are waiting. Do not let them down. Vote against this rule.

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 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.

It astounds me the arguments that the other side has used against medical savings accounts saying that only healthy people would flock to them. Why? When you have a high deductible health care policy that kicks in when your medical savings account ends, you are going to 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 redtape and the paperwork 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 $3,500 for the delivery. Two months later my sister-in-law 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. 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 of Texas. I thank the gentleman from Massachusetts, and I would simply say that every time we address this health reform question, the American people see us collapse. We do not have to collapse today, Mr. Speaker. We can support the Kassebaum-Kennedy-Roukema bill in the Democratic substitute, which allows for portability, and it protects those with preexisting conditions.

In addition, it recognizes the small businessperson who has been working an striving. It allows them an 80-percent deduction for their small business health insurance by the year 2002.

Mr. Speaker, let us stop the game. We know that the medical savings plans are simply for those who are healthy and wealthy. Let us face it. Whenever we hear from our seniors and those that are least able to take care of themselves, they are in these HMO plans and they cap them out, the doctors say I cannot see you because I have limits.

We need real health reform. Let us provide the American worker with portability and the opportunity to be covered for a preexisting condition.

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 assists the American worker who changes jobs and needs health insurance. I also support increasing the tax deduction to 80 percent because it would grant to the self-employed the tax favored status for approximately the same portion of their health insurance costs as 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 will defeat the bill. Contrary to what supporters of MSA's claim, medical savings accounts are not equitable. Medical savings accounts will be used primarily by upper income healthy individuals who can afford the high deductible.

I do not support MSA's, because medical savings accounts would appeal mainly to healthy people, and this would leave less healthy people to buy medical coverage at increased cost. This will obviously make health insurance more expensive. This so-called reform measure goes against the goal of real health care reform, which is to create a more standardized health package for everyone and equalize the less healthy and the poorer with those more able. The bill generally prohibits punitive damages in cases involving drug and medical device manufacturers or sellers whose products had been approved by the Food and Drug Administration. Prohibiting punitive damages for pharmaceutical and manufacturers of medical devices takes away their ongoing responsibility to public health after they have received FDA approval.

The Republican bill allows small employers to band together to purchase coverage for their workers but then exempts them from State taxation. I support such associations, however, this bill would take these co-ops out of State administration, and thus makes State level health reform more difficult.

The substitute amendment like the Republican bill assures group to group and group to individual portability. It limits the exclusion for preexisting conditions to 12 months and provides that the exclusion would be reduced by the period of time the person was covered in his or her previous job.

The substitute prohibits insurance carriers and HMO's from denying coverage to employers with two or more employees and prohibits employment-based health plans from excluding any employee from coverage based on health status. This substitute amendment also requires health plans to renew coverage for groups and individuals as long as the premiums are paid. All of these measures help to assure some significant health reform for Americans.

If we are truly committed to health care reform, then I urge my colleagues to pass the substitute amendment. Thank you, Mr. Speaker, and I reserve the balance of my time.

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

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

Mr. LIPINSKI. Mr. Speaker, I thank the gentleman from Florida for yielding me this time.

Mr. Speaker, I rise today in support of Medical Savings Accounts. Unfortunately, MSAs have become a polarizing and partisan issue in this House. By giving MSAs tax treatment that is equal to other types of employer-provided health insurance plans, we will be giving the American people what they desperately need in their health care: Portability, lower costs, and more choices.

MSAs should not be a partisan issue. In fact, Democrats were the initial sponsors of MSAs, and MSAs unanimously passed the House Ways and Means Committee in 1994 during the debate on the Clinton health care plan. While I understand that many of my colleagues do not want to weigh down or destroy any health insurance reform with any extraneous and unnecessary provisions, I believe that MSAs are an essential part of insurance reforms that will benefit all Americans. It goes without saying that the health care of the American people should always hold priority over partisan politics.

Those opposed to MSAs claim that they will lead to adverse risk selection. But of the over 2,000 MSA plans that employers have in place, there are no actual examples of adverse risk selection. And the very sick will save money in most cases because their out of—pocket—costs will be less under MSAs.

I also support basic health insurance provisions included in the Democratic substitute that allow for portability, limits on the exclusion for pre-existing conditions, and increases in the health insurance tax deductions for the self-employed. These provisions would allow employees who get laid off to keep their health insurance, and gives an individual the peace of mind to change jobs or 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 MSA's, an ideal 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. MSA's do lead 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 employers and employees without sacrificing service and care.

Lastly, MSA's give the consumer unlimited choices. Patients are allowed to shop around to choose their personal doctors based on their own unique needs.

Mr. Speaker, we should subdue our partisan politics 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 1½ 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 the problem is a lot of people do not have health care coverage and the cost of health insurance keeps going on.

So when we talk about the Kennedy-Kassebaum-Roukema bill, it accomplishes the goal of expanding coverage because a lot more people that have the problem with preexisting conditions or problems with portability should be able to get health insurance now who were not able to get it before. 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 the people who are going to take advantage of MSAs 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. People who are sicker and need to go to the doctor or the hospital more often are not going to be able to afford a medical savings account, because they will have to constantly shell out money to pay for the health care coverage that they are receiving.

So what is essentially going to happen is that this risk pool is going to be

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. MICA. 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. PALLONE] just bash MSA's.

Let me say what Mayor Schundler testified to, the mayor of Jersey City, NJ, who came before our subcommittee. He said MSA's were offered and 60 percent of eligible employees chose MSA's over 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 1,000 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.

□ 1730

Mr. MOAKLEY. Mr. Speaker, I yield 1½ 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 govern all of our actions that said 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 to waive it, 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 it is inconvenient to let it apply 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, putting it in the Constitution and then 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 handicapped 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 would have an incentive to spend their money wisely. That is a marked contrast to the use-it-or-lose-it approach fostered by third-payer 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 propositions: 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 job for any 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 health 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.

The malpractice changes are all slanted to help the wrongdoer at the expense of the victim. They only preempt State laws to the extent that they hurt the victim. Incredibly, the bill provides if the victim is hurt worse under State law, then the State law prevails.

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 gentleman from Missouri [Mr. VOLKMER].

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

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 Coverage 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 not 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. WELDON].

(Mr. WELDON of Florida asked and was given permission to revise and extend his remarks.)

Mr. WELDON of Florida. Mr. Speaker, I would like to talk about what the American people want and the facts about the bill before us. They want medical insurance that is available, affordable, and portable. Most Americans without health insurance work for small business. Most small businesses also want to provide health insurance to their employees but find it too expensive to do so. Large corporations, on the other hand, are able to buy health insurance in bulk for their thousands of employees at more affordable rates.

Current law does not give small businesses the same opportunities to join together with other small businesses and purchase insurance in bulk. The end result is that insurance is not affordable.

Our bill makes health insurance affordable and available for small businesses by allowing them to pool together and buy insurance for their employees in bulk at affordable rates. This change will make medical insurance available and affordable for tens of millions of Americans who work for small businesses and have no insurance today. This is supported by small business associations across the board and deserves the full support of Congress.

We also make insurance more portable. We make it easier for employees to take their health insurance with them when they change jobs. For too long employees have resisted changing jobs and advancing in their careers because of fear of losing their health insurance. By making health insurance more portable, we open new job opportunities for millions of Americans. This is a good bill. Let us pass the bill. Let us pass the rule. If there is anything blatant about this, it is blatant democracy at work.

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; those Americans who 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 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 makes absolutely no sense.

So let us 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 cost, 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.

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

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.

That is why they are against this. It is a tort reform issue. It is a trial lawyers' issue. They are also against small businesses. I like the idea of pet shops, clothes stores, bicycle shops, combining together to get economies of scale that large corporations can. My small businesses are in favor of that, as are all 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:

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 1994 elections. It donated more than $2.2 million to congressional campaigns, with Democrats receiving 94 percent of the funds. In 1995, despite Republican majorities in the House and Senate, the association gave 79 percent of its $700,000 in campaign contributions to Democrats.

The political and financial clout of the trial lawyers has been credited with President Clinton's threat to veto the product liability law, and the group has come under fire from congressional Republicans.

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 further ''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 these contributions 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.

Josh Goldstein of the Center for Responsive Politics said he thought the ATLA plan would provide ''a way for trial lawyers to distinguish themselves from other lawyers when giving to campaigns,'' and therefore ''give them more bang for their buck on Capitol Hill.''

ATLA's program encouraged Democrats about their chances in the fall elections. ''I think it could impact a number of races because it will probably benefit Democrats more than Republicans,'' said Don Sweizer, a Democratic consultant and former finance director at the Democratic National Committee. ''It's good news for our team.''

Republicans seemed to agree. ''In general, I think Republicans should be concerned,'' said Dawn Sciarrino, a vice president at Brockmeyer, Allen and Associates, a Republican consulting firm. ''This helps them funnel a great deal of money to the candidates of their choice.''

Pam Liapakis, president of ATLA, said that she was inspired by a similar program at EMILY's List, an association whose contributors give money to Democratic prochoice women candidates. Liapakis expects to have the program ''up and running'' well before the November elections.

But if campaign reformers have their way, this could be the only election in which ATLA, EMILY's List, or any other organization can engage in what is sometimes referred to as ''bundling'' contributions. Bipartisan campaign finance reform bills submitted in the House and Senate would ban this kind of activity.

Liapakis, however, said she believed ATLA's program was within the law. ''There is a right under the First Amendment to communicate and to participate in elections,'' she said.

□ 1745

Mr. MOAKLEY. Mr. Speaker, I yield 1½ minutes to the gentleman from Washington [Mr. MCDERMOTT].

Mr. MCDERMOTT. Mr. Speaker, as a physician, I am particularly concerned with the section of this bill that many may not have had a chance to study. Buried within the 300-plus pages of this bill is a 29-page section called ''Administrative simplification.''

Now, ''administrative simplification'' has a nice right to it, but let me tell you why everyone concerned with the future of health care in this country should oppose the inclusion of this section in any health care reform bill.

First of all, section 1173 on page 222 forces a physician to reveal confidential patient information for billing purposes. The bill says ''The Secretary shall adopt standards for transactions and data elements for such transactions to enable health information to be exchange electronically.'' This bill sets up electronic elearinghouses for all the health care administration information in this country.

Now, among the transactions that doctors will be forced to make, on page 223, it says ''Claims or equivalent encounter information.'' This will require doctors to submit not just general information, but personal, private information that patients need to disclose to their doctors.

Next, this bill fails to adequately protect the privacy of patient health information, which is vital if you are going to have good quality care in this country. Instead of actual privacy protections, the administrative simplification section provided vague promises to develop privacy standards in the future.

The bottom of page 226, part E of section 1173, it says ''Privacy standards for health information.'' It reads, ''The Secretary shall adopt standards with respect to the privacy of individually identifiable health information.''

Now, we do not know what those protections are going to look like, yet 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.

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 not been cleared with the groups. They understand that this is an invasion of privacy.

I cannot understand how Republicans can be putting a bill out here that invades the public privacy for people who say they want privacy, and they want the Government out of their lives, to suddenly say to the insurance industry in a 29-page section buried in this bill, you can gather all the information you want and have a electronic transfer, so any insurance company can type in a name and here it will come printed out somewhere in a computer somewhere.

That is what is being set up in this bill, and it is for the insurance industry, and everybody ought to understand it. You are going to come to rue the day that you pass this bill without talking about it.

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.

Yesterday several of these members appeared before the Committee on Rules and spoke eloquently on the importance of a 24-hour emergency care antitrust relief to small rural hospitals and expanded telemedicine services in rural areas. It is important when we consider health care reform to ensure that Americans who live in small towns and rural communities are able to enjoy the same access to health care as those in urban areas.

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 93)'' and insert the following:

''(3) the amendment printed in Section 2 of the resolution by Representatives Gunderson, Poshard, Roberts and Gutknecht or their designee, 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) or 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:

''Sec. 2. At the end of the bill, add the following new title (and conform the table of contents accordingly):

TITLE V—PROMOTING ACCESS AND AVAILABILITY OF HEALTH COVERAGE IN RURAL AREAS

Subtitle A—Medicare Program

SEC. 501. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 of the Social Security Act (42 U.S.C. 1395i–4) is amended to read as follows:

''MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

''SEC. 1820. (a) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

''(b) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

''(1) assurances that the State—

''(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 (d)) 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 subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

''(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

''(3) such other information and assurances as the Secretary may require.

''(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

''(A) the State shall develop at least one rural health network (as defined in subsection (d)) in the State; and

''(B) at least one facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

''(2) STATE DESIGNATION OF FACILITIES.—

''(A) IN GENERAL.—A State may designate one or more facilities as a critical access hospital in accordance with subparagraph (B).

''(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

''(i) is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

''(I) is located more than a 35-mile drive from a hospital, or another facility described in this subsection, or

''(II) is certified by the State as being a necessary provider of health care services to residents in the area;

''(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

''(iii) provides not more than 6 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 72-hour restriction on a case-by-case basis;

''(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present,

''(II) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off-site basis under arrangements as defined in section 1861(w)(1), and

''(III) the inpatient care described in clause (iii) may be provided by a physician's assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

''(v) meets the requirements of subparagraph (I) of paragraph (2) of section 1861(aa).

''(d) RURAL HEALTH NETWORK DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'rural health network' means, with respect to a State, an organization consisting of—

''(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital, and

''(B) at least 1 hospital that furnishes acute care services.

''(2) AGREEMENTS.—

''(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

''(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

''(i) Patient referral and transfer.

''(ii) The development and use of communications systems including (where feasible)—

''(I) telemetry systems, and

''(II) systems for electronic sharing of patient data.

''(iii) The provision of emergency and nonemergency transportation among the facility and the hospital.

''(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least 1—

''(i) hospital that is a member of the network;

''(ii) peer review organization or equivalent entity; or

''(iii) other appropriate and qualified entity identified in the State rural health care plan.

''(e) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

''(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

''(2) is designated as a critical access hospital by the State in which it is located; and

''(3) meets such other criteria as the Secretary may require.

''(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as 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 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed 12 beds (minus the number of inpatient beds used for providing inpatient care in the facility pursuant to subsection (c)(2)(B)(iii)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital.

''(g) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to conduct the program established under this section.''.

(b) PART A AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) DEFINITIONS.—Section 1861(mm) of such Act (42 U.S.C. 1395x(mm)) is amended to read as follows:

''Critical Access Hospital; Critical Access Hospital Services

''(mm)(1) The term 'critical access hospital' means a facility certified by the Secretary as a critical access hospital under section 1820(e).

''(2) 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.''.

(2) COVERAGE AND PAYMENT.—(A) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended by striking ''or inpatient rural primary care hospital services'' and inserting ''or inpatient critical access hospital services''.

(B) Sections 1813(a) and section 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking ''inpatient rural primary care hospital services'' each place it appears, and inserting ''inpatient critical access hospital services''.

(C) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by striking ''inpatient rural primary care hospital services'' and inserting ''inpatient critical access hospital services''.

(D) Section 1814 of such Act (42 U.S.C. 1395f) is amended—

(i) in subsection (a)(8) by striking ''rural primary care hospital'' each place it appears and inserting ''critical access hospital''; and

(ii) in subsection (b), by striking ''other than a rural primary care hospital providing inpatient rural primary care hospital services,'' and inserting ''other than a critical access hospital providing inpatient critical access hospital services,''; and

(iii) by amending subsection (l) to read as follows:

''(l) PAYMENT FOR INPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for inpatient critical access hospital services is the reasonable

costs of the critical access hospital in providing such services.''.

(3) TREATMENT OF CRITICAL ACCESS HOSPITALS AS PROVIDERS OF SERVICES.—(A) Section 1861(u) of such Act (42 U.S.C. 1395x(u)) is amended by striking ''rural primary care hospital'' and inserting ''critical access hospital''.

(B) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by striking ''a rural primary care hospital'' and inserting ''a critical access hospital''.

(4) CONFORMING AMENDMENTS.—(A) Section 1128A(b)(1) of such Act (42 U.S.C. 1320a–7a(b)(1)) is amended by striking ''rural primary care hospital'' each place it appears and inserting ''critical access hospital''.

(B) Section 1128B(c) of such Act (42 U.S.C. 1320a–7b(c)) is amended by striking ''rural primary care hospital'' and inserting ''critical access hospital''.

(C) Section 1134 of such Act (42 U.S.C. 1320b–4) is amended by striking ''rural primary care hospitals'' each place it appears and inserting ''critical access hospitals''.

(D) Section 1138(a)(1) of such Act (42 U.S.C. 1320b–8(a)(1)) is amended—

(i) in the matter preceding subparagraph (A), by striking ''rural primary care hospital'' and inserting ''critical access hospital''; and

(ii) in the matter preceding clause (i) of subparagraph (A), by striking ''rural primary care hospital'' and inserting ''critical access hospital''.

(E) Section 1816(c)(2)(C) of such Act (42 U.S.C. 1395h(c)(2)(C)) is amended by striking ''rural primary care hospital'' and inserting ''critical access hospital''.

(F) Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(i) in subsection (h)(5)(A)(iii), by striking ''rural primary care hospital'' and inserting ''critical access hospital'';

(ii) in subsection (i)(1)(A), by striking ''rural primary care hospital'' and inserting ''critical access hospital'';

(iii) in subsection (i)(3)(A), by striking ''rural primary care hospital services'' and inserting ''critical access hospital services'';

(iv) in subsection (l)(5)(A), by striking ''rural primary care hospital'' each place it appears and inserting ''critical access hospital''; and

(v) in subsection (l)(5)(B), by striking ''rural primary care hospital'' each place it appears and inserting ''critical access hospital''.

(G) Section 1835(c) of such Act (42 U.S.C. 1395n(c)) is amended by striking ''rural primary care hospital'' each place it appears and inserting ''critical access hospital''.

(H) Section 1842(b)(6)(A)(ii) of such Act (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by striking ''rural primary care hospital'' and inserting ''critical access hospital''.

(I) Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(i) in subsection (a)—

(I) in paragraph (1), by striking ''inpatient rural primary care hospital services'' and inserting ''inpatient critical access hospital services''; and

(II) in paragraph (2), by striking ''rural primary care hospital'' and inserting ''critical access hospital'';

(ii) in the last sentence of subsection (e), by striking ''rural primary care hospital'' and inserting ''critical access hospital'';

(iii) in subsection (v)(1)(S)(ii)(III), by striking ''rural primary care hospital'' and inserting ''critical access hospital'';

(iv) in subsection (w)(1), by striking ''rural primary care hospital'' and inserting ''critical access hospital''; and

(v) in subsection (w)(2), by striking ''rural primary care hospital'' each place it appears and inserting ''critical access hospital''.

(J) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking ''rural primary care hospital'' each place it appears and inserting ''critical access hospital''.

(K) Section 1866(a)(1) of such Act (42 U.S.C 1395cc(a)(1)) is amended—

(i) in subparagraph (F)(ii), by striking ''rural primary care hospitals'' and inserting ''critical access hospitals'';

(ii) in subparagraph (H), in the matter preceding clause (i), by striking ''rural primary care hospitals'' and ''rural primary care hospital services'' and inserting ''critical access hospitals'' and ''critical access hospital services'', respectively;

(iii) in subparagraph (I), in the matter preceding clause (i), by striking ''rural primary care hospital'' and inserting ''critical access hospital''; and

(iv) in subparagraph (N)—

(I) in the matter preceding clause (i), by striking ''rural primary care hospitals'' and inserting ''critical access hospitals'', and

(II) in clause (i), by striking ''rural primary care 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) in subparagraph (C)(ii)(II), by striking ''rural primary care hospitals'' each place it appears and inserting ''critical access hospitals''.

(M) Section 1867(e)(5) of such Act (42 U.S.C. 1395dd(e)(5)) is amended by striking ''rural primary care hospital'' and inserting ''critical access hospital''.

(c) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(1) in clause (iii)(III), by inserting ''as in effect on September 30, 1995'' before the period at the end; and

(2) in clause (v)—

(A) by inserting ''as in effect on September 30, 1995'' after ''1820 (i)(1)''; and

(B) by striking ''1820(g)'' and inserting ''1820(e)''.

(d) PART B AMENDMENTS RELATING TO CRITICAL ACCESS HOSPITALS.—

(1) COVERAGE.—(A) Section 1861(mm) of such Act (42 U.S.C. 1395x(mm)) as amended by subsection (d)(1), is amended by adding at the end the following new paragraph:

''(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis.''.

(B) Section 1832(a)(2)(H) of such Act (42 U.S.C. 1395k(a)(2)(H)) is amended by striking ''rural primary care hospital services'' and inserting ''critical access hospital services''.

(2) PAYMENT.—(A) Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended in paragraph (6), by striking ''outpatient rural primary care hospital services'' and inserting ''outpatient critical access hospital services''.

(B) Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended to read as follows:

''(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1996.

SEC. 502. ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) 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 title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and operating losses, and the closure of the facility would limit the access to emergency services of individuals residing in the facility's service area.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), 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 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 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING

REQUIREMENTS.—Section 1867(e)(5) of such Act (42 U.S.C. 1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))''.

(c) COVERAGE AND PAYMENT FOR SERVICES.—

(1) COVERAGE.—Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (I);

(B) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(2) PAYMENT BASED ON PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(A) IN GENERAL.—Section 1833(a)(6) of such Act (42 U.S.C. 1395l(a)(6)), as amended by section 501(f)(2), is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(B) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)), as amended by section 501(f)(2)(B), is amended—

(i) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES''; and

(ii) by adding at the end the following new sentence: ''The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1996.

SEC. 503. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

(B) by inserting after clause (ii) the following new clause:

''(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.''.

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(ii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) of such Act (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(ii) of such Act.

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1994 shall be classified as such a rural referral center 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—

(1) the merger of, or the attempt to merge, 2 or more hospitals,

(2) a contract entered into solely by 2 or more hospitals to allocate hospital services, or

(3) 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 of 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) In 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 allocate the hospital services specified in such request, as the case may be.

SEC. 513. DEFINITION.

For purposes of this title, the term ''antitrust laws'' has the meaning given such term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies with respect to unfair methods of competition.

Subtitle C—Miscellaneous Provisions

SEC. 521. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. 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 338B(g) of the Public Health Service Act.''.

(b) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act is amended by striking ''Federal, State, or local'' and inserting ''State or local''.

(c) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 137 and inserting the following:

''Sec. 137. National Health Service Corps loan repayments.

''Sec. 138. Cross references to other Acts.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of the enactment of this Act.

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 professional shortage area (under section 332(a) of the Public Health Service Act).

Mr. Speaker, every single rule the House has adopted this session has been a restrictive rule. You heard that 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 unreported. Mr. Speaker, I include the following material for the RECORD:

FLOOR PROCEDURE IN THE 104TH CONGRESS; COMPILED BY THE RULES COMMITTEE DEMOCRATS

Bill No.	Title	Resolution No.	Process used for floor consideration	Amendments in order
H.R. 1*	Compliance	H. Res. 6	Closed	None.
H. Res. 6	Opening Day Rules Package	H. Res. 5	Closed; contained a closed rule on H.R. 1 within the closed rule	None.
H.R. 5*	Unfunded Mandates	H. Res. 38	Restrictive; Motion adopted over Democratic objection in the Committee of the Whole to limit debate on section 4; Pre-printing gets preference.	N/A.
H.J. Res. 2*	Balanced Budget	H. Res. 44	Restrictive; only certain substitutes	2R; 4D.
H. Res. 43	Committee Hearings Scheduling	H. Res. 43 (OJ)	Restrictive; considered in House no amendments	N/A.
H.R. 101	To transfer a parcel of land to the Taos Pueblo Indians of New Mexico.	H. Res. 51	Open	N/A.
H.R. 400	To provide for the exchange of lands within Gates of the Arctic National Park Preserve.	H. Res. 52	Open	N/A.
H.R. 440	To provide for the conveyance of lands to certain individuals in Butte County, California.	H. Res. 53	Open	N/A.
H.R. 2*	Line Item Veto	H. Res. 55	Open; Pre-printing gets preference	N/A.
H.R. 665*	Victim Restitution Act of 1995	H. Res. 61	Open; Pre-printing gets preference	N/A.
H.R. 666*	Exclusionary Rule Reform Act of 1995	H. Res. 60	Open; Pre-printing gets preference	N/A.
H.R. 667*	Violent Criminal Incarceration Act of 1995	H. Res. 63	Restrictive; 10 hr. Time Cap on amendments	N/A.

FLOOR PROCEDURE IN THE 104TH CONGRESS; COMPILED BY THE RULES COMMITTEE DEMOCRATS—Continued

Bill No.	Title	Resolution No.	Process used for floor consideration	Amendments in order
H.R. 668*	The Criminal Alien Deportation Improvement Act	H. Res. 69	Open; Pre-printing gets preference; Contains self-executing provision	N/A.
H.R. 728*	Local Government Law Enforcement Block Grants	H. Res. 79	Restrictive; 10 hr. Time Cap on amendments; Pre-printing gets preference	N/A.
H.R. 7*	National Security Revitalization Act	H. Res. 83	Restrictive; 10 hr. Time Cap on amendments; Pre-printing gets preference	N/A.
H.R. 729*	Death Penalty/Habeas	N/A	Restrictive; brought up under UC with a 6 hr. time cap on amendments	N/A.
S. 2	Senate Compliance	N/A	Closed; Put on Suspension Calendar over Democratic objection	None.
H.R. 831	To Permanently Extend the Health Insurance Deduction for the Self-Employed.	H. Res. 88	Restrictive; makes in order only the Gibbons amendment; Waives all points of order; Contains self-executing provision.	1D.
H.R. 830*	The Paperwork Reduction Act	H. Res. 91	Open	N/A.
H.R. 889	Emergency Supplemental/Rescinding Certain Budget Authority	H. Res. 92	Restrictive; makes in order only the Obey substitute	1D.
H.R. 450*	Regulatory Moratorium	H. Res. 93	Restrictive; 10 hr. Time Cap on amendments; Pre-printing gets preference	N/A.
H.R. 1022*	Risk Assessment	H. Res. 96	Restrictive; 10 hr. Time Cap on amendments	N/A.
H.R. 926*	Regulatory Flexibility	H. Res. 100	Open	N/A.
H.R. 925*	Private Property Protection Act	H. Res. 101	Restrictive; 12 hr. time cap on amendments; Requires Members to pre-print their amendments in the Record prior to the bill's consideration for amendment, waives germaneness and budget act points of order as well as points of order concerning appropriating on a legislative bill against the committee substitute used as base text.	1D.
H.R. 1058*	Securities Litigation Reform Act	H. Res. 105	Restrictive; 8 hr. time cap on amendments; Pre-printing gets preference; Makes in order the Wyden amendment and waives germaneness against it.	1D.
H.R. 988*	The Attorney Accountability Act of 1995	H. Res. 104	Restrictive; 7 hr. time cap on amendments; Pre-printing gets preference	N/A.
H.R. 956*	Product Liability and Legal Reform Act	H. Res. 109	Restrictive; makes in order only 15 germane amendments and denies 64 germane amendments from being considered.	8D; 7R.
H.R. 1158	Making Emergency Supplemental Appropriations and Rescissions	H. Res. 115	Restrictive; Combines emergency H.R. 1158 & nonemergency 1159 and strikes the abortion provision; makes in order only pre-printed amendments that include offsets within the same chapter (deeper cuts in programs already cut); waives points of order against three amendments; waives cl 2 of rule XXI against the bill, cl 2, XXI and cl 7 of rule XVI against the substitute; waives cl 2(e) od rule XXI against the amendments in the Record; 10 hr time cap on amendments. 30 minutes debate on each amendment.	N/A.
H.J. Res. 73*	Term Limits	H. Res. 116	Restrictive; Makes in order only 4 amendments considered under a ''Queen of the Hill'' procedure and denies 21 germane amendments from being considered.	1D; 3R
H.R. 4*	Welfare Reform	H. Res. 119	Restrictive; Makes in order only 31 perfecting amendments and two substitutes; Denies 130 germane amendments from being considered; The substitutes are to be considered under a ''Queen of the Hill'' procedure; All points of order are waived against the amendments.	5D; 26R.
H.R. 1271*	Family Privacy Act	H. Res. 125	Open	N/A.
H.R. 660*	Housing for Older Persons Act	H. Res. 126	Open	N/A.
H.R. 1215*	The Contract With America Tax Relief Act of 1995	H. Res. 129	Restrictive; Self Executes language that makes tax cuts contingent on the adoption of a balanced budget plan and strikes section 3006. Makes in order only one substitute. Waives all points of order against the bill, substitute made in order as original text and Gephardt substitute.	1D.
H.R. 483	Medicare Select Extension	H. Res. 130	Restrictive; waives cl 2(1)(6) of rule XI against the bill; makes H.R. 1391 in order as original text; makes in order only the Dingell substitute; allows Commerce Committee to file a report on the bill at any time.	1D.
H.R. 655	Hydrogen Future Act	H. Res. 136	Open	N/A.
H.R. 1361	Coast Guard Authorization	H. Res. 139	Open; waives sections 302(f) and 308(a) of the Congressional Budget Act against the bill's consideration and the committee substitute; waives cl 5(a) of rule XXI against the committee substitute.	N/A.
H.R. 961	Clean Water Act	H. Res. 140	Open; pre-printing gets preference; waives sections 302(f) and 602(b) of the Budget Act against the bill's consideration; waives cl 7 of rule XVI, cl 5(a) of rule XXI and section 302(f) of the Budget Act against the committee substitute. Makes in order Shuster substitute as first order of business.	N/A.
H.R. 535	Corning National Fish Hatchery Conveyance Act	H. Res. 144	Open	N/A.
H.R. 584	Conveyance of the Fairport National Fish Hatchery to the State of Iowa.	H. Res. 145	Open	N/A.
H.R. 614	Conveyance of the New London National Fish Hatchery Production Facility.	H. Res. 146	Open	N/A.
H. Con. Res. 67	Budget Resolution	H. Res. 149	Restrictive; Makes in order 4 substitutes under regular order; Gephardt, Neumann/Solomon, Payne/Owens, President's Budget if printed in Record on 5/17/95; waives all points of order against substitutes and concurrent resolution; suspends application of Rule XLIX with respect to the resolution; self-executes Agriculture language.	3D; 1R.
H.R. 1561	American Overseas Interests Act of 1995	H. Res. 155	Restrictive; Requires amendments to be printed in the Record prior to their consideration; 10 hr. time cap; waives cl 2(1)(6) of rule XI against the bill's consideration; Also waives sections 302(f), 303(a), 308(a) and 402(a) against the bill's consideration and the committee amendment in order as original text; waives cl 5(a) of rule XXI against the amendment; amendment consideration is closed at 2:30 p.m. on May 25, 1995. Self-executes provision which removes section 2210 from the bill. This was done at the request of the Budget Committee.	N/A.
H.R. 1530	National Defense Authorization Act FY 1996	H. Res. 164	Restrictive; Makes in order only the amendments printed in the report; waives all points of order against the bill, substitute and amendments printed in the report. Gives the Chairman en bloc authority. Self-executes 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 with the concurrence of Ms. Collins.	36R; 18D; 2 Bipartisan.
H.R. 1817	Military Construction Appropriations; FY 1996	H. Res. 167	Open; waives cl. 2 and cl. 6 of rule XXI against the bill; 1 hr. general debate; Uses House passed budget numbers as threshold for spending amounts pending passage of Budget.	N/A.
H.R. 1854	Legislative Branch Appropriations	H. Res. 169	Restrictive; Makes in order only 11 amendments; waives sections 302(f) and 308(a) of the Budget Act against the bill and cl. 2 and cl. 6 of rule XXI against the bill. All points of order are waived against the amendments.	5R; 4D; 2 Bipartisan.
H.R. 1868	Foreign Operations Appropriations	H. Res. 170	Open; waives cl. 2, cl. 5(b), and cl. 6 of rule XXI against the bill; makes in order the Gilman amendments as first order of business; waives all points of order against the amendments; if adopted they will be considered as original text; waives cl. 2 of rule XXI against the amendments printed in the report. Pre-printing gets priority (Hall) (Menendez) (Goss) (Smith, NJ).	N/A.
H.R. 1905	Energy & Water Appropriations	H. Res. 171	Open; waives cl. 2 and cl. 6 of rule XXI against the bill; makes in order the Shuster amendment as the first order of business; waives all points of order against the amendment; if adopted it will be considered as original text. Pre-printing gets priority.	N/A.
H.J. Res. 79	Constitutional Amendment to Permit Congress and States to Prohibit the Physical Desecration of the American Flag.	H. Res. 173	Closed; provides one hour of general debate and one motion to recommit with or without instructions; if there are instructions, the MO is debatable for 1 hr.	N/A.
H.R. 1944	Recissions Bill	H. Res. 175	Restrictive; Provides for consideration of the bill in the House; Permits the Chairman of the Appropriations Committee to offer one amendment which is unamendable; waives all points of order against the amendment.	N/A.
H.R. 1868 (2nd rule)	Foreign Operations Appropriations	H. Res. 177	Restrictive; Provides for further consideration of the bill; makes in order only the four amendments printed in the rules report (20 min. each). Waives all points of order against the amendments; Prohibits intervening motions in the Committee of the Whole; Provides for an automatic rise and report following the disposition of the amendments.	N/A.
H.R. 1977 *Rule Defeated*	Interior Appropriations	H. Res. 185	Open; waives sections 302(f) and 308(a) of the Budget Act and cl 2 and cl 6 of rule XXI; provides that the bill be read by title; waives all points of order against the Tauzin amendment; self-executes Budget Committee amendment; waives cl 2(e) of rule XXI against amendments to the bill; Pre-printing gets priority.	N/A.
H.R. 1977	Interior Appropriations	H.Res. 187	Open; waives sections 302(f), 306 and 308(a) of the Budget Act; waives clauses 2 and 6 of rule XXI against provisions in the bill; waives all points of order against the Tauzin amendment; provides that the bill be read by title; self-executes Budget Committee amendment and makes NEA funding subject to House passed authorization; waives cl 2(e) of rule XXI against the amendments to the bill; Pre-printing gets priority.	N/A.
H.R. 1976	Agriculture Appropriations	H. Res. 188	Open; waives clauses 2 and 6 of rule XXI against provisions in the bill; provides that the bill be read by title; Makes Skeen amendment first order of business, if adopted the amendment will be considered as base text (10 min.); Pre-printing gets priority.	N/A.
H.R. 1977 (3rd rule)	Interior Appropriations	H. Res. 189	Restrictive; provides for the further consideration of the bill; allows only amendments pre-printed before July 14th to be considered; limits motions to rise.	N/A.
H.R. 2020	Treasury Postal Appropriations	H. Res. 190	Open; waives cl. 2 and cl. 6 of rule XXI against provisions in the bill; provides the bill be read by title; Pre-printing gets priority.	N/A.
H.J. Res. 96	Disapproving MFN for China	H. Res. 193	Restrictive; provides for consideration in the House of H.R. 2058 (90 min.) And H.J. Res. 96 (1 hr). Waives certain provisions of the Trade Act.	N/A.

FLOOR PROCEDURE IN THE 104TH CONGRESS; COMPILED BY THE RULES COMMITTEE DEMOCRATS—Continued

Bill No.	Title	Resolution No.	Process used for floor consideration	Amendments in order
H.R. 2002	Transportation Appropriations	H. Res. 194	Open; waives cl. 3 0f rule XIII and section 401 (a) of the CBA against consideration of the bill; waives cl. 6 and cl. 2 of rule XXI against provisions in the bill; Makes in order the Clinger/Solomon amendment waives all points of order against the amendment (Line Item Veto); provides the bill be read by title; Pre-printing gets priority. *RULE AMENDED*.	N/A.
H.R. 70	Exports of Alaskan North Slope Oil	H. Res. 197	Open; Makes in order the Resources Committee amendment in the nature of a substitute as original text; Pre-printing gets priority; Provides a Senate hook-up with S. 395.	N/A.
H.R. 2076	Commerce, Justice Appropriations	H. Res. 198	Open; waives cl. 2 and cl. 6 of rule XXI against provisions in the bill; Pre-printing gets priority; provides the bill be read by title..	N/A.
H.R. 2099	VA/HUD Appropriations	H. Res. 201	Open; waives cl. 2 and cl. 6 of rule XXI 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 Klug and Davis amendments; Pre-printing gets priority; Provides that the bill be read by title.	N/A.
S. 21	Termination of U.S. Arms Embargo on Bosnia	H. Res. 204	Restrictive; 3 hours of general debate; Makes in order 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 a designee.	ID.
H.R. 2126	Defense Appropriations	H. Res. 205	Open; waives cl. 2(l)(6) of rule XI and section 306 of the Congressional Budget Act against consideration of the bill; waives cl. 2 and cl. 6 of rule XXI against provisions in the bill; self-executes a strike of sections 8021 and 8024 of the bill as requested by the Budget Committee; Pre-printing gets priority; Provides the bill be read by title.	N/A.
H.R. 1555	Communications Act of 1995	H. Res. 207	Restrictive; waives sec. 302(f) of the Budget Act against consideration of the bill; Makes in order the Commerce Committee amendment as original text and waives sec. 302(f) of the Budget Act and cl. 5(a) of rule XXI against the amendment; Makes in order the Bliely amendment (30 min.) as the first order of business, if adopted it will be original text; makes in order only the amendments printed in the report and waives all points of order against the amendments; provides a Senate hook-up with S. 652.	2R/3D/3 Bipartisan.
H.R. 2127	Labor/HHS Appropriations Act	H. Res. 208	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 XXI 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.	N/A.
H.R. 1594	Economically Targeted Investments	H. Res. 215	Open; 2 hr of gen. debate. makes in order the committee substitute as original text	N/A.
H.R. 1655	Intelligence Authorization	H. Res. 216	Restrictive; waives sections 302(f), 308(a) and 401(b) of the Budget Act. Makes in order the committee substitute as modified by Govt. Reform amend (striking sec. 505) and an amendment striking title VII. Cl 7 of rule XVI and cl 5(a) of rule XXI are waived against the substitute. Sections 302(f) and 401(b) of the CBA are also waived against the substitute. Amendments must also be pre-printed in the Congressional record.	N/A.
H.R. 1162	Deficit Reduction Lock Box	H. Res. 218	Open; waives cl 7 of rule XVI against the committee substitute made in order as original text; Pre-printing gets priority.	N/A.
H.R. 1670	Federal Acquisition Reform Act of 1995	H. Res. 219	Open; waives sections 302(f) and 308(a) of the Budget Act against consideration of the bill; bill will be read by title; waives cl 5(a) of rule XXI and section 302(f) of the Budget Act against the committee substitute. Pre-printing gets priority.	N/A.
H.R. 1617	To Consolidate and Reform Workforce Development and Literacy Programs Act (CAREERS).	H. Res. 222	Open; waives section 302(f) and 401(b) of the Budget Act against the substitute made in order as original text (H.R. 2332), cl. 5(a) of rule XXI is also waived against the substitute. provides for consideration of the managers amendment (10 min.) If adopted, it is considered as base text.	N/A.
H.R. 2274	National Highway System Designation Act of 1995	H. Res. 224	Open; waives section 302(f) of the Budget Act against consideration of the bill; Makes H.R. 2349 in order as original text; waives section 302(f) of the Budget Act against the substitute; provides for the consideration of a managers amendment (10 min.) If adopted, it is considered as base text; Pre-printing gets priority.	N/A.
H.R. 927	Cuban Liberty and Democratic Solidarity Act of 1995	H. Res. 225	Restrictive; waives cl 2(L)(2)(B) of rule XI against consideration of the bill; makes in order H.R. 2347 as base text; waives cl 7 of rule XVI against the substitute; Makes Hamilton amendment the first amendment to be considered (1 hr). Makes in order only amendments printed in the report.	2R/2D
H.R. 743	The Teamwork for Employees and managers Act of 1995	H. Res. 226	Open; waives cl 2(l)(2)(b) of rule XI against consideration of the bill; makes in order the committee amendment as original text; Pre-printing get priority.	N/A.
H.R. 1170	3-Judge Court for Certain Injunctions	H. Res. 227	Open; makes in order a committee amendment as original text; Pre-printing gets priority	N/A.
H.R. 1601	International Space Station Authorization Act of 1995	H. Res. 228	Open; makes in order a committee amendment as original text; pre-printing gets priority	N/A.
H.J. Res. 108	Making Continuing Appropriations for FY 1996	H. Res. 230	Closed; Provides for the immediate consideration of the CR; one motion to recommit which may have instructions only if offered by the Minority Leader or a designee.	.....
H.R. 2405	Omnibus Civilian Science Authorization Act of 1995	H. Res. 234	Open; self-executes a provision striking section 304(b)(3) of the bill (Commerce Committee request); Pre-printing gets priority.	N/A.
H.R. 2259	To Disapprove Certain Sentencing Guideline Amendments	H. Res. 237	Restrictive; waives cl 2(l)(2)(B) of rule XI against the bill's consideration; makes in order the text of the Senate bill S. 1254 as original text; Makes in order only a Conyers substitute; provides a senate hook-up after adoption.	1D
H.R. 2425	Medicare Preservation Act	H. Res. 238	Restrictive; waives all points of order against the bill's consideration; makes in order the text of H.R. 2485 as original text; waives all points of order against H.R. 2485; makes in order only an amendment offered by the Minority Leader or a designee; waives all points of order against the amendment; waives cl 5© of rule XXI (⅗ requirement on votes raising taxes).	1D
H.R. 2492	Legislative Branch Appropriations Bill	H. Res. 239	Restrictive; provides for consideration of the bill in the House	N/A.
H.R. 2491 H. Con. Res. 109	7 Year Balanced Budget Reconciliation Social Security Earnings Test Reform.	H. Res. 245	Restrictive; makes in order H.R. 2517 as original text; waives all pints of order against the bill; Makes in order only H.R. 2530 as an amendment only if offered by the Minority Leader or a designee; waives all points of order against the amendment; waives cl 5© of rule XXI (⅗ requirement on votes raising taxes).	1D
H.R. 1833	Partial Birth Abortion Ban Act of 1995	H. Res. 251	Closed	N/A.
H.R. 2546	D.C. Appropriations FY 1996	H. Res. 252	Restrictive; waives all points of order against the bill's consideration; Makes in order the Walsh amendment as the first order of business (10 min.); if adopted it is considered as base text; waives cl 2 and 6 of rule XXI against the bill; makes in order the Bonilla, Gunderson and Hostettler amendments (30 min.); waives all points of order against the amendments; debate on any further amendments is limited to 30 min. each.	N/A
H.J. Res. 115	Further Continuing Appropriations for FY 1996	H. Res. 257	Closed; Provides for the immediate consideration of the CR; one motion to recommit which may have instructions only if offered by the Minority Leader or a designee.	N/A
H.R. 2586	Temporary Increase in the Statutory Debt Limit	H. Res. 258	Restrictive; Provides for the immediate consideration of the CR; one motion to recommit which may have instructions only if offered by the Minority Leader or a designee; self-executes 4 amendments in the rule; Solomon, Medicare Coverage of Certain Anti-Cancer Drug Treatments, Habeas Corpus Reform, Chrysler (MI); makes in order the Walker amend (40 min.) on regulatory reform.	5R
H.R. 2539	ICC Termination	H. Res. 259	Open; waives section 302(f) and section 308(a)	.....
H.J. Res. 115	Further Continuing Appropriations for FY 1996	H. Res. 261	Closed; provides for the immediate consideration of a motion by the Majority Leader or his designees to dispose of the Senate amendments (1hr).	N/A.
H.R. 2586	Temporary Increase in the Statutory Limit on the Public Debt	H. Res. 262	Closed; provides for the immediate consideration of a motion by the Majority Leader or his designees to dispose of the Senate amendments (1hr).	N/A.
H. Res. 250	House Gift Rule Reform	H. Res. 268	Closed; provides for consideration of the bill in the House; 30 min. of debate; makes in order the Burton amendment and the Gingrich en bloc amendment (30 min. each); waives all points of order against the amendments; Gingrich is only in order if Burton fails or is not offered.	2R
H.R. 2564	Lobbying Disclosure Act of 1995	H. Res. 269	Open; waives cl. 2(l)(6) of rule XI against the bill's consideration; waives all points of order against the Istook and McIntosh amendments.	N/A.
H.R. 2606	Prohibition on Funds for Bosnia Deployment	H. Res. 273	Restrictive; waives all points of order against the bill's consideration; provides one motion to amend if offered by the Minority Leader or designee (1 hr non-amendable); motion to recommit which may have instructions only if offered by Minority Leader or his designee; if Minority Leader motion is not offered debate time will be extended by 1 hr.	N/A.
H.R. 1788	Amtrak Reform and Privatization Act of 1995	H. Res. 289	Open; waives all points of order against the bill's consideration; makes in order the Transportation substitute modified by the amend in the report; Bill read by title; waives all points of order against the substitute; makes in order a managers amend as the first order of business, if adopted it is considered base text (10 min.); waives all points of order against the amendment; Pre-printing gets priority.	N/A.
H.R. 1350	Maritime Security Act of 1995	H. Res. 287	Open; makes in order the committee substitute as original text; makes in order a managers amendment which if adopted is considered as original text (20 min.) unamendable; pre-printing gets priority.	N/A.
H.R. 2621	To Protect Federal Trust Funds	H. Res.	Closed; provides for the adoption of the Ways & Means amendment printed in the report. 1 hr. of general debate.	N/A.

FLOOR PROCEDURE IN THE 104TH CONGRESS; COMPILED BY THE RULES COMMITTEE DEMOCRATS—Continued

Bill No.	Title	Resolution No.	Process used for floor consideration	Amendments in order
H.R. 1745	Utah Public Lands Management Act of 1995	H.Res. 303	Open; waives cl 2(l)(6) of rule XI and sections 302(f) and 311(a) of the Budget Act against the bill's consideration. Makes in order the Resources substitute as base text and waives cl 7 of rule XVI and sections 302(f) and 308(a) of the Budget Act; makes in order a managers' amend as the first order of business, if adopted it is considered base text (10 min)..	N/A.
H.Res. 304	Providing for Debate and Consideration of Three Measures Relating to U.S. Troop Deployments in Bosnia.	N/A	Closed; makes in order three resolutions; H.R. 2770 (Dorman), H.Res. 302 (Buyer), and H.Res. 306 (Gephardt); 1 hour of debate on each..	1D; 2R
H.Res. 309	Revised Budget Resolution	H.Res. 309	Closed; provides 2 hours of general debate in the House.	N/A.
H.R. 558	Texas Low-Level Radioactive Waste Disposal Compact Consent Act	H.Res. 313	Open; pre-printing gets priority	N/A.
H.R. 2677	The National Parks and National Wildlife Refuge Systems Freedom Act of 1995.	H. Res. 323	Closed; consideration in the House; self-executes Young amendment	N/A.
		PROCEDURE IN THE 104TH CONGRESS 2D SESSION		
H.R. 1643	To authorize the extension of nondiscriminatory treatment (MFN) to the products of Bulgaria.	H. Res. 334	Closed; provides to take the bill from the Speaker's table with the Senate amendment, and consider in the House the motion printed in the Rules Committee report; 1 hr. of general debate; previous question is considered as ordered. ** NR.	N/A.
H.J. Res. 134 H. Con. Res. 131	Making continuing appropriations/establishing procedures making the transmission of the continuing resolution H.J. Res. 134.	H. Res. 336	Closed; provides to take from the Speaker's table H.J. Res. 134 with the Senate amendment and concur with the Senate amendment with an amendment (H. Con. Res. 131) which is self-executed in the rule. The rule provides further that the bill shall not be sent back to the Senate until the Senate agrees to the provisions of H. Con. Res. 131. ** NR.	N/A.
H. R. 1358	Conveyance of National Marine Fisheries Service Laboratory at Gloucester, Massachusetts.	H. Res. 338	Closed; provides to take the bill from the Speakers table with the Senate amendment, and consider in the house the motion printed in the Rules Committee report; 1 hr. of general debate; previous quesetion is considered as ordered. ** NR.	N/A.
H.R. 2924	Social Security Guarantee Act	H. Res. 355	Closed; ** NR	N/A.
H.R. 2854	The Agricultural Market Transition Program	H. Res. 366	Restrictive; waives all points of order against the bill; 2 hrs of general debate; makes in order a committee substitute as original text and waives all points of order against the substitute; makes in order only the 16 amends printed in the report and waives all points of order against the amendments; circumvents unfunded mandates law; Chairman has en bloc authority for amends in report (20 min.) on each en bloc..	5D; 9R; 2 Bipartisan.
H.R. 994	Regulatory Sunset & Review Act of 1995	H.Res 368	Open rule; makes in order the Hyde substitute printed in the Record as original text; waives cl 7 of rule XVI against the substitute; Pre-printing gets priority; vacates the House action on S. 219 and provides to take the bill from the Speakers table and consider the Senate bill; allows Chrmn. Clinger a motion to strike all after the enacting clause of the Senate bill and insert the text of H.R. 994 as passed by the House (1 hr) debate; waives germaneness against the motion; provides if the motion is adopted that it is in order for the House to insist on its amendments and request a conference.	N/A.
H.R. 3021	To Guarantee the Continuing Full Investment of Social security and Other Federal Funds in Obligations of the United States.	H.Res 371	Closed rule; gives one motion to recommit, which if it contains instructions, may only if offered by the Minority Leader or his designee. ** NR.	N/A.
H.R. 3019	A Further Downpayment Toward a Balanced Budget	H.Res. 372	Restrictive; self-executes CBO language regarding contingency funds in section 2 of the rule; makes in order only the amendments printed in the report; Lowey (20 min), Istook (20 min), Crapo (20 min), Obey (1 hr); waives all points of order against the amendments; give one motion to recommit, which if contains instructions, may only if offered by the Minority Leader or his designee. ** NR.	2D/2R.
H.R. 2703	The Effective Death Penalty and Public Safety Act of 1996	H. Res. 380	Restrictive; makes in order only the amendments printed in the report; waives all points of orer against the amendments; gives Judiciary Chairman en bloc authority (20 min.) on enblocs; provides a Senate hook-up with S. 735. ** NR.	6D; 7R; 4 Bipartisan.
H.R. 2202	The Immigration and National Interest Act of 1995	H. Res. 384	Restrictive; waives all points of order against the bill and amendments in the report except for those arising under sec. 425(a) of the Budget Act (unfunded mandates); 2 hrs. of general debate on the bill; makes in order the committee substitute as base text; makes in order only the amends in the report; gives the Judiciary Chairman en bloc authority (20 min.) of debate on the en blocs; self-executes the Smith (TX) amendment re: employee verification program..	12D; 19R; 1 Bipartisan.
H.J. Res. 165	Making further continuing appropriations for FY 1996	H. Res. 386	Closed; provides for the consideration of the CR in the House and gives one motion to recommit which may contain instructions only if offered by the Minority Leader; the rule also waives cl 4(b) of rule XI against the following: an omnibus appropriations bill, another CR, a bill extending the debt limit. ** NR.	N/A.
H.R. 125	The Gun Crime Enforcement and Second Amendment Restoration Act of 1996.	H. Res. 388	Closed; self-executes an amendment; provides one motion to recommit which may contain instructions only if offered by the Minority Leader or his designee. ** NR.	N/A
H.R. 3136	The Contract With America Advancement Act of 1996	H. Res. 391	Closed; provides for the consideration of the bill in the House; self-executes an amendment in the Rules report; waives all points of order, except sec. 425(a)(unfunded mandates) of the CBA, against the bill's consideration; orders the PQ except 1 hr. of general debate between the Chairman and Ranking Member of Ways and Means; one Archer amendment (10 min.); one motion to recommit which may contain instructions only if offered by the Minority Leader or his designee; Provides a Senate hookup if the Senate passes S. 4 by March 30, 1996. **NR.	N/A
H.R. 3103	The Health Coverage Availability and Affordability Act of 1996	H. Res. 392	Restrictive: 2 hrs. of general debate (45 min. split by Ways and Means) (45 split by Commerce) (30 split by Economic and Educational Opportunities); self-executes H.R. 3160 as modified by the amendment in the Rules report as original text; waives all points of order, except sec. 425(a) (unfunded mandates) of the CBA; makes in order a Democratic substitute (1 hr.) waives all points of order, except sec. 425(a) (unfunded mandates) of the CBA, against the amendment; one motion to recommit which may contain instructions only if offered by the Minority Leader or his designee; waives cl 5(c) of Rule XXI (requiring 3/5 vote on any tax increase) on votes on the bill, amendments or conference reports.	N/A

* Contract Bills, 67% restrictive; 33% open. ** All legislation 1st Session, 53% restrictive; 47% open. *** All legislation 2d 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 circumvented standard procedure and was never reported from any House committee. ****** Restrictive rules are those which limit the number of amendments which can be offered, and include so-called modified open and modified closed rules as well as completely closed rules and rules providing for consideration in the House 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 103d 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 recommit, 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 engineer 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 229, nays 186, not voting 16, as follows:

[Roll No. 103]

YEAS—229

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Goss
Graham
Greenwood
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pombo
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Riggs
Roberts
Rogers
Rohrabacher
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Solomon
Souder
Spence
Stearns
Stockman
Stump
Talent
Tate
Tauzin
Taylor (NC)
Thomas
Thornberry
Tiahrt
Torkildsen
Upton
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NAYS—186

Abercrombie
Ackerman
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Beilenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Brewster
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (MI)
Condit
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Durbin
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Gonzalez
Gordon
Green
Gunderson
Gutierrez
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Murtha
Nadler
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pomeroy
Poshard
Rahall
Rangel
Reed
Richardson
Rivers
Roemer
Rose
Roukema
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Sisisky
Skaggs
Skelton
Slaughter
Spratt
Stark
Stenholm
Studds
Stupak
Tanner
Taylor (MS)
Tejeda
Thompson
Thornton
Thurman
Torres
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Ward
Waters
Watt (NC)
Waxman
Williams
Wise
Woolsey
Wynn
Yates

NOT VOTING—16

Becerra
Bryant (TX)
Collins (IL)
Conyers
Fields (LA)
Fowler
Lantos
McNulty
Neal
Ros-Lehtinen
Smith (TX)
Smith (WA)
Stokes
Torricelli
Weldon (PA)
Wilson

□ 1809

Ms. FURSE and Mr. BALDACCI changed their vote from ''yea'' to ''nay.''

Mr. COBURN and Mr. THOMAS of California changed their vote from ''nay'' to ''yea.''

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.

FURTHER MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, 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. 3136. 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. 168. 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.''

□ 1815

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. 3160 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:

Sec. 1. Short title; table of contents.

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 pregnancy.

Sec. 103. Prohibiting exclusions based on health status and providing for enrollment periods.

Sec. 104. Enforcement.

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.

Sec. 132. Guaranteed renewability of group coverage.

PART 2—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 3—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, and 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. Findings relating 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.
Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.
Sec. 218. Effective date.

Subtitle C—Data Collection

Sec. 221. Establishment of the health care fraud and abuse data collection program.

Subtitle D—Civil Monetary Penalties

Sec. 231. Social security act civil monetary penalties.
Sec. 232. Clarification of level of intent required for imposition of sanctions.
Sec. 233. Penalty for false certification for home health services.

Subtitle E—Revisions to Criminal Law

Sec. 241. Definitions relating to Federal health care offense.
Sec. 242. Health care fraud.
Sec. 243. Theft or embezzlement.
Sec. 244. False statements.
Sec. 245. Obstruction of criminal investigations of health care offenses.
Sec. 246. Laundering of monetary instruments.
Sec. 247. Injunctive relief relating to health care offenses.
Sec. 248. Authorized investigative demand procedures.
Sec. 249. Forfeitures for Federal health care offenses.
Sec. 250. Relation to ERISA authority.

Subtitle F—Administrative Simplification

Sec. 251. Purpose.
Sec. 252. Administrative simplification.

''PART C—ADMINISTRATIVE SIMPLIFICATION

''Sec. 1171. Definitions.
''Sec. 1172. General requirements for adoption of standards.
''Sec. 1173. Standards for information transactions and data elements.
''Sec. 1174. Timetables for adoption of standards.
''Sec. 1175. Requirements.
''Sec. 1176. General penalty for failure to comply with requirements and standards.
''Sec. 1177. Wrongful disclosure of individually identifiable health information.
''Sec. 1178. Effect on State law.

Sec. 253. Changes in membership and duties of National Committee on Vital and Health Statistics.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

Sec. 261. Duplication and coordination of medicare-related plans.

Subtitle H—Medical Liability Reform

PART 1—GENERAL PROVISIONS

Sec. 271. Federal reform of health care liability actions.
Sec. 272. Definitions.
Sec. 273. Effective date.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

Sec. 281. Statute of limitations.
Sec. 282. Calculation and payment of damages.
Sec. 283. Alternative dispute resolution.

TITLE III—TAX-RELATED HEALTH PROVISIONS

Sec. 300. Amendment of 1986 code.

Subtitle A—Medical Savings Accounts

Sec. 301. Medical savings accounts.

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.

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

Sec. 321. Treatment of long-term care insurance.
Sec. 322. Qualified long-term care services treated as medical care.
Sec. 323. Reporting requirements.

PART II—CONSUMER PROTECTION PROVISIONS

Sec. 325. Policy requirements.
Sec. 326. Requirements for issuers of long-term care insurance policies.
Sec. 327. Coordination with State requirements.
Sec. 328. Effective dates.

Subtitle D—Treatment of Accelerated Death Benefits

Sec. 331. Treatment of accelerated death benefits by recipient.
Sec. 332. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle E—High-Risk Pools

Sec. 341. Exemption from income tax for State-sponsored organizations providing health coverage for high-risk individuals.

Subtitle F—Organizations Subject to Section 833

Sec. 351. Organizations subject to section 833.

TITLE IV—REVENUE OFFSETS

Sec. 400. Amendment of 1986 Code.

Subtitle A—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

Sec. 401. Repeal of bad debt reserve method for thrift savings associations.

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.

Subtitle C—Treatment of Individuals Who Lose United States Citizenship

Sec. 421. Revision of income, estate, and gift taxes on individuals who lose United States citizenship.
Sec. 422. Information on individuals losing United States citizenship.
Sec. 423. Report on tax compliance by United States citizens and residents living abroad.

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.

(a) CREDITING PERIODS OF PREVIOUS COVERAGE TOWARD PREEXISTING CONDITION RESTRICTIONS.—Subject to the succeeding provisions of this section, 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 qualified prior coverage (if any, as 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 recommended or 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 shall not be considered to be 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 under health insurance coverage, the period during which benefits with respect to treatment of a condition of such individual 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 commencement of 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 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 subsection (c), the term ''qualified coverage period'' means, with respect to an individual, any period of coverage of the individual under a group health plan, health insurance coverage, under title XVIII or XIX of the Social Security Act, coverage under the TRICARE program under chapter 55 of title 10, United States Code, a program of the Indian Health Service, and State health insurance coverage or risk pool, 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 occurring before any 60-day break in coverage described in subparagraph (A).

(C) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraphs (A) and (B), any 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) shall not be considered to be a break in coverage described in subparagraph (B)(ii).

(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.

(c) CERTIFICATIONS OF COVERAGE; CONFORMING COVERAGE.—

(1) 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 (or previously covered within the previous 18 months) under the plan or coverage, provide for a certification of the period of coverage of the individual under such plan or coverage and of the waiting period (if any) imposed with respect to the individual for any coverage under the plan.

(2) STANDARD METHOD.—Subject to paragraph (3), a group health plan, or insurer or HMO offering health insurance coverage in connection with a group health plan, shall determine qualified coverage periods under subsection (b)(3)(B) by including all periods described in such subsection, without regard to the specific benefits offered during such a period.

(3) 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—

(A) 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 the health 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

(B) upon the request of the plan, insurer, or HMO, the entity providing a certification under paragraph (1)—

(i) shall promptly disclose to the requesting plan, insurer, or HMO the plan statement (insofar as it relates to health benefits under the plan) or other detailed benefit information on the benefits available under the previous plan or coverage, 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 CHILDREN, AND PREGNANCY.

(a) LIMITATION OF PERIOD.—

(1) 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 defined in section 101(b)(2)) does not exceed 12 months, counting from the effective date of coverage.

(2) EXTENSION OF PERIOD IN THE CASE OF LATE ENROLLMENT.—In the case of a participant or beneficiary whose initial coverage commences after the date the participant or beneficiary first becomes eligible for coverage under the group health plan, the reference in paragraph (1) to ''12 months'' is deemed a reference to ''18 months''.

(b) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS AND CERTAIN ADOPTIONS.—

(1) 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, may not provide any limitation on benefits based on the existence of a preexisting condition in the case of—

(A) an individual who within the 30-day period beginning with the date of birth, or

(B) an adopted child or a child placed for 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,

becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or covered for medical assistance under title XIX of the Social Security Act).

(2) LOSS IF BREAK IN COVERAGE.—Paragraph (1) shall no longer apply to an individual if the individual does not have any coverage described in section 101(b)(3)(B)(i) for a continuous period of 60 days, not counting in such period any days that are in a waiting period for any coverage under a group health plan.

(3) PLACED FOR ADOPTION DEFINED.—In this subsection and section 103(e), the term ''placement'', or being ''placed'', for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(c) 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 which offers health insurance coverage in connection with a group health plan and which does not use the preexisting condition limitations allowed under this section and section 101 with respect to any particular coverage option may impose an eligibility period for such coverage option, but only if such period does not exceed—

(1) 60 days, in the case of a participant or beneficiary whose initial coverage commences at the time such participant or beneficiary first becomes eligible for coverage under the plan, or

(2) 90 days, in the case of a participant or beneficiary whose initial coverage commences after the date on which such participant or beneficiary first becomes eligible for coverage.

Such an HMO may use alternative methods, from those described in the previous sentence, to address adverse selection as approved by the applicable State authority. For purposes of this subsection, the term ''eligibility period'' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. Any such eligibility period shall be treated for purposes of this subtitle as a waiting period under the plan and shall run concurrently

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 exclude an employee or his or her beneficiary from being (or continuing to be) enrolled as 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 to pay a premium or contribution which is greater than such premium or contribution for a similarly situated participant or beneficiary solely on the basis of the health status of the participant or beneficiary.

(2) CONSTRUCTION.—Nothing in this subsection is intended—

(A) to effect the premium rates an insurer or HMO may charge an employer for health insurance coverage provided in connection a group health plan,

(B) to prevent a group health plan (or insurer or HMO in 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

(C) 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 area of residence, or wage levels) that are not directly related to health status.

(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 under 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 had health insurance coverage at the time coverage was previously offered to the employee or individual.

(2) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment.

(3) The employee or dependent lost 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 of employment).

(4) The employee requests such enrollment within 30 days after the date of termination of such coverage.

(d) DEPENDENT BENEFICIARIES.—

(1) 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 a 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 that participant.

(2) TIMELY ENROLLMENT.—

(A) IN GENERAL.—Enrollment of a participant's beneficiary described in paragraph (1) shall be considered to 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.

(B) COVERAGE.—If available coverage includes family coverage and enrollment is made under such coverage on a 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 group health plan which is a multi-employer plan, a multiple employer health plan (as defined in section 701(4) 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 employer whose employees 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,

(3) for noncompliance with material plan or arrangement provisions,

(4) because the plan or arrangement is ceasing to offer any coverage in a geographic area,

(5) for 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 a plan or arrangement to which subparagraph (C), (D), or (E) of section 3(40) of the Employee Retirement Income Security Act of 1974 applies, to the extent necessary to meet the requirements of such subparagraph, or

(7) in the case of a multiple employer health plan (as defined in section 701(4) of such Act), for failure to meet the requirements under part 7 of subtitle B of title I of such Act for exemption under section 514(b)(6)(B) of such Act.

SEC. 104. ENFORCEMENT.

(a) ENFORCEMENT THROUGH COBRA PROVISIONS IN INTERNAL REVENUE CODE.—

(1) APPLICATION OF COBRA SANCTIONS.—Subsection (a) of section 4980B of the Internal Revenue Code of 1986 is amended by striking ''the requirements of'' and all that follows and inserting ''the requirements of—

''(1) subsection (f) with respect to any qualified beneficiary, or

''(2) subject to subsection (h)—

''(A) section 101 or 102 of the Health Coverage Availability and Affordability Act of 1996 with respect to any individual covered under the group health plan, or

''(B) section 103 (other than subsection (e)) of such Act with respect to any individual.''.

(2) NOTICE REQUIREMENT.—Section 4980B(f)(6)(A) of such Code is amended by inserting before the period the following: ''and subtitle A of title I of the Health Coverage Availability and Affordability Act of 1996''.

(3) SPECIAL RULES.—Section 4980B of such Code is amended by adding at the end the following:

''(h) SPECIAL RULES.—For purposes of applying this section in the case of requirements described in subsection (a)(2) relating to section 101, section 102, or section 103 (other than subsection (e)) of the Health Coverage Availability and Affordability Act of 1996—

''(1) IN GENERAL.—

''(A) DEFINITION OF GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 191(a) of the Health Coverage Availability and Affordability Act of 1996.

''(B) QUALIFIED BENEFICIARY.—Subsections (b), (c), and (e) shall be applied by substituting the term 'individual' for the term 'qualified beneficiary' each place it appears.

''(C) NONCOMPLIANCE PERIOD.—Clause (ii) of subsection (b)(2)(B) and the second sentence of subsection (b)(2) shall not apply.

''(D) LIMITATION ON TAX.—Subparagraph (B) of subsection (c)(3) shall not apply.

''(E) LIABILITY FOR TAX.—Paragraph (2) of subsection (e) shall not apply.

''(2) DEFERRAL TO STATE REGULATION.—No tax shall be imposed by this section on any failure to meet the requirements of such section by any entity which offers health insurance coverage and which is an insurer or health maintenance organization (as defined in section 191(c) of the Health Coverage Availability and Affordability Act of 1996) regulated by a State unless the Secretary of Health and Human Services has made the determination described in section 104(c)(2) of such Act with respect to such State, section, and entity.

''(3) LIMITATION FOR INSURED PLANS.—In the case of a group health plan of a small employer (as defined in section 191 of the Health Coverage Availability and Affordability Act of 1996) that provides health care benefits solely through a contract with an insurer or health maintenance organization (as defined in such section), no tax shall be imposed by this section upon the employer on a failure to meet such requirements if the failure is solely because of the product offered by the insurer or organization under such contract.

''(4) LIMITATION ON IMPOSITION OF TAX.—In no case shall a tax be imposed by this section for 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 under section 104(c) of the Health Coverage Availability and Affordability Act of 1996 with respect to such failure.''.

(b) ENFORCEMENT THROUGH ERISA SANCTIONS FOR CERTAIN GROUP HEALTH PLANS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, sections 101 through 103 of this subtitle (and subtitle D insofar as it is applicable to such sections) shall be deemed to be provisions of title I of the Employee Retirement Income Security

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 section 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) NO APPLICATION WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—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 under this subsection 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 under 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 subsection (c).

(c) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPOSITION.—

(A) IN GENERAL.—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 for liability for a tax imposed under section 4980B(a) of such Code shall apply to liability for a penalty imposed under subparagraph (A).

(C) AMOUNT 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.

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) 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.

(D) 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 after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 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 intent to modify 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 the judge. A final order which takes effect under this paragraph 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 of Columbia by filing 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 judgment of such district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(i) FAILURE TO PAY ASSESSMENT.—If any person fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(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 apply to enforcement of the requirements 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 subsection 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 for which a civil money penalty has been imposed under the authority provided under subsection (b).

(d) COORDINATION IN ADMINISTRATION.—The Secretaries 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 subsections 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 for enrollment under such coverage every eligible individual (as defined in paragraph (2)) who applies for enrollment during the initial period in which the individual first becomes eligible for coverage under the group health plan and may not place any restriction which is inconsistent with section 103(a) on an individual being a participant or beneficiary so long as such individual is an eligible individual.

(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, such an individual in relation to 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 connection with such a plan, the insurer or HMO may—

(A) limit the employers that may apply for such coverage to those with eligible individuals whose place of employment or residence is in the service area for such plan or HMO;

(B) limit the individuals who may be enrolled under such coverage to those whose place of residence or employment is within the service area for such plan or HMO; and

(C) within the service area of such plan or HMO, deny such coverage to such employers if the insurer or HMO demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to

existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(2) 180-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 not offer coverage in the small group market within such service area for a period of 180 days after such coverage is denied.

(c) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—

(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) 180-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 180 days after such coverage is denied.

(d) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES.—

(1) IN GENERAL.—Subsection (a) shall not apply in the case of any group health plan with respect to which—

(A) participation rules of an insurer or HMO which are described in paragraph (2) are not met, or

(B) contribution rules of an insurer or HMO which are described in paragraph (3) are not met.

(2) 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 a group health plan only if such rules are uniformly applicable and in accordance with applicable State law and the number or percentage of eligible individuals who, under the plan, are participants or beneficiaries equals or exceeds a level which is determined in accordance with such rules.

(3) 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, if 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 offered an employer based only on one or more of the following:

(1) NONPAYMENT OF PREMIUMS.—The employer has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the insurer or organization has not received timely premium payments.

(2) FRAUD.—The employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) VIOLATION WITH PARTICIPATION OR CONTRIBUTION RULES.—The employer has failed to comply with a material plan provision relating to participation or contribution rules in accordance with section 131(d).

(4) TERMINATION OF PLAN.—Subject to subsection (c), the insurer or organization is ceasing to offer coverage in the small or large group market in a State (or, in the case of a network plan or HMO, in a geographic area).

(5) MOVEMENT OUTSIDE SERVICE AREA.—The employer has changed the place of employment in such manner that employees and dependents reside and are employed outside the service area of the insurer or organization or outside the area for which the insurer or organization is authorized to do business.

Paragraph (5) 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.

(c) EXCEPTIONS FOR UNIFORM TERMINATION OF COVERAGE.—

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which a insurer or HMO decides to discontinue offering a particular type of health insurance coverage in the small or large group market, coverage of such type may be discontinued by the insurer or organization only if—

(A) the insurer or organization provides notice to each employer provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 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 replacement coverage, the insurer or organization acts uniformly without regard to the health status or insurability of participants or beneficiaries covered or new participants or beneficiaries who may become eligible for 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 offering all health insurance coverage in the small group market or the large group market, or both markets, in a State, health insurance coverage may be 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 180 days prior to the date of the expiration of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in one or both markets, the insurer or organization may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) 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 among group health plans with that type of coverage.

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

SEC. 141. 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 a manner 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 any such plan);

(B) who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of such Act (or any successor program), and does not have individual health insurance coverage;

(C) with respect to whom the most recent coverage within the coverage period described in subparagraph (A)(i) was not terminated based on a factor described in paragraph (1) or (2) of section 132(b);

(D) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(E) who, if the individual elected such continuation coverage, has exhausted such continuation coverage.

In applying subparagraph (A)(i), the reference in section 101(b)(3)(B)(ii) to a 60-day break in coverage is deemed a reference to a 60-day break in any coverage described in section 101(b)(3)(B)(i).

(2) QUALIFYING COVERAGE.—

(A) IN GENERAL.—The term ''qualifying coverage'' means, with respect to an insurer or HMO in relation to an qualifying individual, individual health insurance coverage for which the actuarial value of the benefits is not less than—

(i) the weighted average actuarial value of the benefits provided by all the individual health insurance coverage issued by the insurer or HMO in the State during the previous year (not including coverage issued under this section), or

(ii) the weighted average of the actuarial value of the benefits provided by all the individual health insurance coverage issued by all insurers and HMOs in the State during the previous year (not including coverage issued under this section),

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 under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(3) CREDITING FOR PREVIOUS COVERAGE.—Crediting 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 this subsection, 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). If 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 is qualifying coverage under 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 of 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 coverage.

(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 the legislature of which does not have a regular legislative session at any time between January 1, 1997, and June 30, 1997.

(C) CONSTRUCTION.—Nothing in this section shall be construed as preventing a State from—

(i) implementing guaranteed availability mechanisms before the deadline,

(ii) continuing in effect 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 on a timely basis under subsection (c), the Secretary shall notify the State that paragraph (3) will be applied in the State.

(2) PRELIMINARY DETERMINATION AFTER STATE ELECTION.—If—

(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, of 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) that is reasonably designed to meet the goals specified in subsection (a). The Secretary shall not make such a determination on any basis other than the basis described in subparagraph (B). If, after providing such notice and opportunity, the Secretary finds that the State has not implemented such a mechanism, the Secretary shall notify the State that paragraph (3) will be applied in the State.

(3) DESCRIPTION OF FALLBACK MECHANISM.—As provided under paragraphs (1) and (2) and subject to paragraph (5), each insurer or HMO in the State involved that issues individual health insurance coverage—

(A) shall offer qualifying 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 LIMITS.—Under regulations, the provisions of subsections (b) and (c) of section 131 shall apply to an individual in the individual health insurance market under this subsection in the same manner as 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 subsection (a), and until the Secretary finds that such mechanism is no longer being implemented.

(e) CONSTRUCTION.—

(1) PREMIUMS.—Nothing in this section shall be construed to affect the determination of an insurer or HMO as to the amount of the premium payable under an individual health insurance coverage under applicable state law.

(2) MARKET REQUIREMENTS.—

(A) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that an insurer or HMO offering health insurance coverage only in connection with a group health plan or an association offer individual health insurance coverage.

(B) CONVERSION POLICIES.—An insurer or HMO offering health insurance coverage in connection with a group health plan under subtitle A shall not be deemed to be an insurer or HMO offering an individual health insurance coverage solely because such insurer or HMO offers a conversion policy.

(3) DISREGARD OF ASSOCIATION COVERAGE.—An insurer or HMO that offers health insurance coverage only in connection with a group health plan or in connection with individuals based on affiliation with one or more bona fide associations is not considered, for purposes of this subtitle, to be offering individual health insurance coverage.

(4) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring insurer or HMOs offering individual health insurance coverage to actively market such coverage.

SEC. 142. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) 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.

(b) NONRENEWAL PERMITTED IN CERTAIN CASES.—An insurer or HMO may nonrenew or discontinue individual health insurance coverage of an individual only based on one or more of the following:

(1) NONPAYMENT.—The individual fails to pay payment of premiums or contributions in accordance with the terms of the coverage or the insurer or organization has not failed to receive timely premium payments.

(2) FRAUD.—The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) 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).

(4) 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.

Paragraph (4) 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.

(c) 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, respectively.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—The provisions of section 132(d) shall apply to individual health insurance coverage in the individual market under this section in the same manner as it applies to health insurance coverage offered in connection with a group health plan in the group market under such section.

PART 3—ENFORCEMENT

SEC. 151. INCORPORATION OF PROVISIONS FOR STATE ENFORCEMENT WITH FEDERAL FALLBACK AUTHORITY.

The provisions of paragraphs (1) and (2) of section 104(c) shall apply to enforcement of requirements in each section in 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 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 SECRETARY OF LABOR TO IMPLEMENT PROVISIONS OF CURRENT LAW PROVIDING FOR EXEMPTIONS AND SOLVENCY STANDARDS FOR MULTIPLE EMPLOYER HEALTH PLANS.

(a) RULES GOVERNING REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by the preceding provisions of this title) is amended by inserting after part 6 the following new part:

"PART 7—RULES GOVERNING REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS

"SEC. 701. DEFINITIONS.

''For purposes of this part—

''(1) FULLY INSURED.—A particular benefit under a group health plan or a multiple employer welfare arrangement is 'fully insured' if such benefit (irrespective of any recourse available against other parties) is provided by an insurer or a health maintenance organization in a manner so that such benefit constitutes insurance regulated by the law of a State (within the meaning of section 514(b)(2)(A)).

''(2) INSURER.—The term 'insurer' means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)(A)).

''(3) HEALTH MAINTENANCE ORGANIZATION.—The terms 'health maintenance organization' means—

''(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, or

''(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,

if it is subject to State law which regulates insurance (within the meaning of section 514(b)(2)(A)).

''(4) MULTIPLE EMPLOYER HEALTH PLAN.—The term 'multiple employer health plan' means a multiple employer welfare arrangement which provides medical care and which is or has been exempt under section 514(b)(6)(B).

''(5) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the individuals who are dependents (as defined under the terms of the arrangement) of its employees, are or were covered under such arrangement in connection with the employment of the employees.

''(6) SPONSOR.—The term 'sponsor' means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

''(7) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' means the insurance commissioner (or similar official) of a State.

"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.

''(a) TREATMENT 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 solely of medical care (disregarding such incidental 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 employee welfare benefit plan which is a group health plan if the arrangement is exempt under section 514(b)(6)(B) in accordance with this part.

''(2) EXCEPTION.—In the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii), paragraph (1) shall apply with respect to such arrangement, but only with respect to benefits provided thereunder which constitute medical care.

''(b) TREATMENT UNDER PREEMPTION RULES.—

''(1) IN GENERAL.—The Secretary shall prescribe regulations described in section 514(b)(6)(B)(i), applicable to multiple employer welfare arrangements described in subparagraphs (A) and (B) of subsection (a)(1), providing a procedure for granting exemptions from section 514(b)(6)(A)(ii) with respect to such arrangements. Under such regulations, any such arrangement treated under subsection (a) as an employee welfare benefit plan shall be deemed to be an arrangement described in section 514(b)(6)(B)(ii).

''(2) STANDARDS.—Under the procedure prescribed pursuant to paragraph (1), the Secretary shall grant an arrangement described in subsection (a) an exemption described in subsection (a) only if the Secretary finds that—

''(A) such exemption—

''(i) is administratively feasible,

''(ii) is not adverse to the interests of the individuals covered under the arrangement, and

''(iii) is protective of the rights and benefits of the individuals covered under the arrangement,

''(B) the application for the exemption meets the requirements of paragraph (3), and

''(C) the requirements of sections 703 and 704 are met with respect to the arrangement.

''(3) INFORMATION TO BE INCLUDED IN APPLICATION FOR EXEMPTION.—An application for an exemption described in subsection (a) meets the requirements of this paragraph only if it includes, in a manner and form prescribed in regulations of the Secretary, at least the following information:

''(A) IDENTIFYING INFORMATION.—The names and addresses of—

''(i) the sponsor, and

''(ii) the members of the board of trustees of the arrangement.

''(B) STATES IN WHICH ARRANGEMENT INTENDS TO DO BUSINESS.—The States in which individuals covered under the arrangement are to be located and the number of such individuals expected to be located in each such State.

''(C) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(D) PLAN DOCUMENTS.—A copy of the documents governing the arrangement (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits and coverage that will be provided to individuals covered under the arrangement.

''(E) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the arrangement and contract administrators and other service providers.

''(F) FUNDING REPORT.—A report setting forth information determined as of a date within the 120-day period ending with the date of the application, including the following:

''(i) RESERVES.—A statement, certified by the board of trustees of the arrangement, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 705 are or will be met in accordance with regulations which the Secretary shall prescribe.

''(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(iii) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the 12-month period referred to in clause (ii). The income statement shall identify separately the arrangement's administrative expenses and claims.

''(iv) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the arrangement.

''(v) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

''(4) FILING FEE.—Under the procedure prescribed pursuant to paragraph (1), a multiple employer welfare arrangement shall pay to the Secretary at the time of filing an application for an exemption referred to in subsection (a) a filing fee in the amount of $5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the exemption procedures applicable with respect to such arrangement.

''(5) CLASS EXEMPTION TREATMENT FOR EXISTING LARGE ARRANGEMENTS.—Under the procedure prescribed pursuant to paragraph (1), if—

''(A) at the time of application for an exemption under section 514(b)(6)(B) with respect to an arrangement which has been in existence as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996 for at least 3 years, either (A) the arrangement covers at least 1,000 participants and beneficiaries, or (B) with respect to the arrangement there are at least 2,000 employees of eligible participating employers,

''(B) a complete application for the exemption with respect to the arrangement has been filed and is pending, and

''(C) the application meets such requirements (if any) as the Secretary may provide with respect to class exemptions under this subsection,

the exemption shall be treated as having been granted with respect to the arrangement unless and until the Secretary provides appropriate notice that the exemption has been denied.

''(c) FILING NOTICE OF EXEMPTION WITH STATES.—An exemption granted under section 514(b)(6)(B) to a multiple employer welfare arrangement shall not be effective unless written notice of such exemption is filed with the State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any multiple employer welfare arrangement exempt under section 514(b)(6)(B), descriptions of material changes in any information which was required to be submitted with the application for the exemption under this part shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the exemption.

''(e) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102, 103, and 104 shall apply with respect to any multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such exemption continues in effect. The annual report required under section 103 for any plan year in the case of any such multiple employer welfare arrangement shall also include information described in subsection (b)(3)(F) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year.

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) shall engage, on behalf of all covered individuals, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the arrangement and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the arrangement.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 703. REQUIREMENTS RELATING TO SPONSORS, BOARDS OF TRUSTEES, AND PLAN OPERATIONS.

''(a) IN GENERAL.—A complete application for an 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) SPONSOR.—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, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members and collects dues or contributions from its members on a periodic basis, without conditioning such dues or contributions on the basis of the health status of the employees of such members or the dependents of such employees or on the basis of participation in a group health plan. Any sponsor consisting of an association of entities meeting the preceding requirements of this paragraph shall be treated as meeting the requirements of this paragraph.

''(2) BOARD OF TRUSTEES.—The arrangement is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the board of trustees 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 meet 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 member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members 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 participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

''(3) COVERED PERSONS.—The instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B)—

''(A) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer,

''(B) all individuals thereafter commencing coverage under the arrangement must be—

''(i) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

''(ii) the beneficiaries of individuals described in clause (i), and

''(C) no participating employer may provide health insurance coverage in the individual market for any employee not covered under the arrangement which is similar to the coverage contemporaneously provided to employees of the employer under the arrangement, if such exclusion of the employee from coverage under the arrangement is based in whole or in part on the health status of the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the arrangement.

''(4) INCLUSION OF ELIGIBLE EMPLOYERS AND EMPLOYEES.—No employer described in paragraph (3) is excluded as a participating employer (except to the extent that requirements of the type referred to in section 131(d)(2) of the Health Coverage Availability and Affordability Act of 1996 are not met) and the requirements of section 103 of such Act (as referred to in section 104(b)(1) of such Act) are met.

''(5) RESTRICTION ON VARIATIONS OF PREMIUM RATES.—Premium rates under the arrangement with respect to any particular employer do not vary on the basis of the claims experience of such employer alone.

''(b) TREATMENT OF FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement which is established and maintained by a franchisor for a franchise network consisting of its franchisees, the requirements of subsection (a)(1) shall not apply with respect to such network in any case in which such requirements would be met if the franchisor were deemed to be the sponsor referred to in subsection (a)(1), such network were deemed to be an association described in subsection (a)(1), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in subsection (a)(1).

''(c) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In the case of a multiple employer welfare arrangement in existence on March 6, 1996, which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii) or (to the extent provided in regulations of the Secretary) solely for the failure to meet the requirements of subparagraph (D) or (F) of section 3(40)—

''(1) subsection (a)(1) shall not apply, and

''(2) the joint board of trustees shall be considered the board of trustees required under subsection (a)(2).

''(d) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

''(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer—

''(A) subsection (a)(1) shall not apply if the sponsor of the arrangement is the person who would be the plan sponsor if the related employers were disregarded in determining whether the requirements of section 3(40)(B) are met, and

''(B) subsection (a)(2) shall be treated as satisfied if the board of trustees is the named fiduciary in connection with the arrangement.

''(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are 'related' if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

''SEC. 704. OTHER REQUIREMENTS FOR EXEMPTION.

''A multiple employer welfare arrangement exempt under section 514(b)(6)(B) shall meet the following requirements:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrangement include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(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 in section 3(16)(A)),

''(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) CONTRIBUTION RATES.—The contribution rates referred to in section 702(b)(3)(F)(ii) are adequate.

''(3) REGULATORY REQUIREMENTS.—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the purposes 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 satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities, and

''(3) a reserve, in an amount recommended by the qualified actuary, for any other obligations of the arrangement.

''(b) MINIMUM AMOUNT FOR 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) 25 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. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements.

''(e) ADJUSTMENTS 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, guarantee, hold-harmless arrangement, or other financial arrangement as the Secretary determines to be adequate to enable the arrangement 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 be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the arrangement in the form of assessments of participating employers, security, or other financial arrangement.

''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 participants 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 timely payment of all 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 met. In any case in which 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 and so notifies the committee, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the end of the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 705. Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee shall notify the Secretary (in such form and manner as the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the committee has taken or plans to take in response to such recommendations. The committee shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the committee, regarding corrective action taken by the committee until the requirements of section 705 are met.

''(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 restored 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, at the direction of the Secretary, terminate the arrangement and, in the course of the termination, take such actions as the Secretary may require, including recovering for the arrangement any liability under 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 UPON STATE'S CERTIFICATION OF GUARANTEED ACCESS TO HEALTH INSURANCE COVERAGE IN SUCH STATE.—

''(1) IN GENERAL.—If a State certifies to the Secretary that such State provides to its residents guaranteed access to health insurance coverage, during the period for which such certification is in effect, the law of such State may regulate any health care 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 this subsection, the certification by a State that such State provides 'guaranteed access' to health insurance coverage to the residents of such State means—

''(A) certification that the number of residents of such State who are covered by a group health plan or otherwise have health insurance coverage exceeds 90 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 for employees with respect to at least one option of health insurance coverage offered by insurers and health maintenance organizations in such market, and

''(ii) 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) EXCEPTIONS.—

''(1) CERTAIN MULTISTATE ASSOCIATIONS.—Subsection (a) shall not apply in the case of a multiple employer welfare arrangement operating in any State which has made a certification under subsection (a)(2)(B) if—

''(A) in the application for the exemption under section 514(b)(6)(B), the sponsor of such arrangement demonstrates to the Secretary (in such form and manner as shall be prescribed in regulations of the Secretary) that—

''(i) such sponsor operates in the majority of the 50 States and in at least 2 of the regions of the United States, and

''(ii) 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 arrangement does not have pending against it any enforcement action by the State.

''(2) EXISTING ARRANGEMENTS.—Subsection (a) shall not apply with respect to an arrangement operating in any State if—

''(A) such arrangement was operating in such State as of March 6, 1996, and

''(B) at the time of the application for the exemption under section 514(b)(6), the arrangement does not have pending against it any enforcement action by the State.

''(3) LIMITATIONS.—Paragraphs (1) and (2) shall not apply in the case of any State which has made a certification under subsection (a) and which, as of January 1, 1996, had enacted a law that either—

''(A) provided guaranteed issue of individual health insurance coverage offered by insurers and health maintenance organizations

in the individual market using pure community rating and did not provide for any transition period (after the effective date of the guaranteed issue requirement) in the implementation of pure community rating; or

''(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 are limited to a single industry.

''(c) ASSESSMENT AUTHORITY WITH RESPECT TO NEW ARRANGEMENTS.—

''(1) IN GENERAL.—Notwithstanding section 514, a State may impose by law a premium tax on multiple employer welfare arrangements which are otherwise exempt under section 514(b)(6)(B) and the sponsor of which is described in section 703(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 TAX.—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 under the arrangement) provided by such insurers or health maintenance organizations in such State to such arrangement.

''(d) DEFINITIONS.—For purposes of this section—

''(1) SMALL GROUP MARKET.—The term 'small group market' means the health insurance coverage market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer.

''(2) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a calandar 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, 2 or 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)).

''(3) REGION.—The term 'region' means any of the following regions:

''(A) The East Region, consisting of the States of Maine, New Hampshire, Vermont, New York, Massachusetts, Rhode Island, Connecticut, New Jersey, Pennsylvania, Delaware, Maryland, West Virginia, and Ohio, and the District of Columbia.

''(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.

''(D) The West Region, consisting of the States of Oregon, Washington, Idaho, Nevada, California, New Mexico, Arizona, Nebraska, Wyoming, Hawaii, Alaska, Colorado, and Utah.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6)(A)(i) of such Act (29 U.S.C. 1144(b)(6)(A)(i)) 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 ''subparagraph (B)''.

(2) Section 514(b)(6)(B) of such Act (29 U.S.C. 1144(b)(6)(B)) is amended—

(A) by inserting ''(i)'' after ''(B)'';

(B) by striking ''which are not fully insured'' and inserting ''under which any benefit is not fully insured''; and

(C) by striking ''Any such exemption'' and inserting:

''(ii) Subject to part 7, any exemption under clause (i)''.

(c) CONFORMING AMENDMENT TO DEFINITION OF PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 1002(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes the sponsor (as defined in section 701(6)) of a multiple employer welfare arrangement which is or has been a multiple employer health plan (as defined in section 701(4)).''.

(d) DEFINITIONS.—

(1) GROUP HEALTH PLAN.—Section 3 of such Act (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

''(42) 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 under 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 3(7) of such Act (29 U.S.C. 1002(7)) is amended—

(A) by inserting ''(A)'' 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, 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.''.

(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:

''(43)(A) Except as provided in subparagraph (B), the term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or a health maintenance organization.

''(B) Such term does not include coverage under any separate policy, certificate, or contract only for one or more of any of the following:

''(i) Coverage for accident, credit-only, vision, disability income, long-term care, nursing home care, community-based care dental, on-site medical clinics, or employee assistance programs, or any combination thereof.

''(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supplemental coverage provided under a group health plan.

''(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) 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 ''1986)''; and

(C) by adding at the end the following new subparagraph:

''(B) 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 514 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', and 'insurer' have the meanings given such terms in section 701.''.

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement 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 items:

''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 provising 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. 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.

Section 514 of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating subsections (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d)(1) The provisions of this title shall supercede any and all State laws which regulate 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 (without varying the premium rates of any particular employer on 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 State laws prohibit 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 guaranteed access to health insurance coverage, during the period for which such certification is in effect, the law of 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 a voluntary health insurance association. Any such certification shall be in effect for such period, not greater than 3 years, as is designated in such certification.

''(B) For purposes of this paragraph, the certification by a State that such State provides 'guaranteed access' to health insurance coverage to the residents of such State means—

''(i) certification that the number of residents of such State who are covered by a group health plan or otherwise have health insurance coverage exceeds 90 percent of the total number of the residents of such State, or

''(ii) certification that—

''(I) the small group market in such State provides guaranteed issue for employees with respect to at least one option of health insurance coverage offered by insurers and health maintenance organizations in such market, and

''(II) the State has implemented rating reforms in the small group market in such State which are designed to make health insurance coverage more affordable.

''(3)(A) Paragraph (2) shall not apply in the case of any voluntary health insurance association with respect to any State if the qualified association demonstrates to the Secretary (in such form and manner as shall be prescribed in regulations of the Secretary) that—

''(i) such qualified association operates in the majority of the 50 States and in at least 2 of the regions of the United States,

''(ii) the arrangement covers, or is to cover (in the case of a newly established arrangement), at least 7,500 participants and beneficiaries, and

''(iii) under the terms of the arrangement, either—

''(I) the qualified association does not exclude from membership any small employer in the State, or

''(II) the arrangement accepts every small employer in the State that applies for coverage.

''(B)(i) Subject to clause (ii), paragraph (2) shall not apply with respect to a voluntary health insurance association operating in any State if such association was operating in such State as of March 6, 1996.

''(ii) Clause (i) shall apply in the case of an arrangement in connection with any State only if the qualified association demonstrates to the Secretary (in such form and manner as shall be prescribed in regulations of the Secretary) either—

''(I) that the qualified association does not exclude from membership any small employer in the State, or

''(II) that the arrangement accepts every small employer in such State that applies for coverage.

''(C) Subparagraphs (A) and (B) shall not apply in the case of any State which has made a certification under paragraph (2) and which, as of January 1, 1996, had enacted a law that either—

''(i) provided guaranteed issue of individual health insurance coverage offered by insurers and health maintenance organizations in the individual market using pure community rating and did not provide for any transition period (after the effective date of the guaranteed issue requirement) in the implementation of pure community rating; or

''(ii) 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.

''(5) For purposes of this subsection—

''(A) The term 'voluntary health insurance association' means a multiple employer welfare arrangement—

''(i) under which benefits include medical care (within the meaning of section 607(1)),

''(ii) under which all benefits consisting of such medical care are fully insured,

''(iii) which is maintained by a qualified association,

''(iv) under which no employer is excluded as a participating employer (except to the extent that requirements of the type referred to in section 131(d)(2) of the Health Coverage Availability and Affordability Act of 1996 are not met), the requirements of section 103 of such Act (as referred to in section 104(b)(1) of such Act) are met, and all health insurance coverage options are aggressively marketed to eligible employees and their dependents, and

''(v) under which, with respect to the operations of the arrangement in any State, the health insurance coverage is provided by an insurer or health maintenance organization to which the laws of such State applies.

''(B) The term 'qualified association' means an association with respect to which the following requirements are met:

''(i) The sponsor of the association is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)).

''(ii) The sponsor of the association is established as a permanent entity which receives the active support of its members.

''(iii) The constitution and bylaws of the association provide for periodic meetings on at least an annual basis.

''(iv) The association collects dues or contributions from its members on a periodic basis, without conditioning such dues or contributions on the basis of the health status of the employees of such members or the dependents of such employees or on the basis of participation in a group health plan or voluntary health insurance association.

Such term includes a group of qualified associations, as defined in the preceding provisions of this clause.

''(C) The term 'small group market' means the health insurance coverage market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer.

''(D) The term 'small employer' means, in connection with a group health plan with respect to a calandar 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, 2 or 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:

''(i) The East Region, consisting of the States of Maine, New Hampshire, Vermont, New York, Massachusetts, Rhode Island, Connecticut, New Jersey, Pennsylvania, Delaware, Maryland, West Virginia, and Ohio and the District of Columbia.

''(ii) The Southeast Region, consisting of the States of Texas, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, and Tennessee.

''(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.

''(iv) The West Region, consisting of the States of Oregon, Washington, Idaho, Nevada, California, New Mexico, Arizona, Nebraska, Wyoming, Hawaii, Alaska, Colorado, and Utah.''.

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)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting before the period the following: '', except 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) of such Act (29 U.S.C. 1144(b)(6)) (as amended by section 301) is amended by adding at the end the following new subparagraph:

''(G) For additional rules relating to exemption from subparagraph (A)(ii) of multiple employer health plans, see part 7.''.

SEC. 164. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement,'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 165. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to 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(d)) or 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 under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) A plan or other arrangement is established or maintained in accordance with this subparagraph only if the following requirements are met:

''(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement, or

''(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement, except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit), nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment),

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Health Coverage Availability and Affordability Act 1996 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) 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 701(2)), or

''(ii)(I) the plan or arrangement is a multiemployer plan, and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) A plan or arrangement is 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 employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 166. TREATMENT OF CHURCH PLANS.

(a) SPECIAL RULES FOR CHURCH PLANS.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of such Act (as added and amended by the preceding provisions of this Act) is amended by adding at the end the following new section:

''SEC. 709. SPECIAL RULES FOR CHURCH PLANS.

''(a) ELECTION FOR CHURCH PLANS.—

''(1) IN GENERAL.—Notwithstanding section 4(b)(2), if the church or convention or association of churches which maintains a church plan covered under this section makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulations prescribe), then, subject to this section, the provisions of this part (and other provisions of this title to the extent that they apply to group health plans which are multiple employer welfare arrangements) shall apply to such church plan, with respect to benefits provided under such plan consisting of medical care, as if—

''(A) section 4(b)(2) did not contain an exclusion for church plans, and

''(B) such plan were an arrangement eligible to apply for an exemption under this part.

''(2) ELECTION IRREVOCABLE.—An election under this subsection with respect to any church plan shall be binding with respect to such plan, and, once made, shall be irrevocable.

''(b) COVERED CHURCH PLANS.—A church plan is covered under this section if such plan provides benefits which include medical care and some or all of such benefits are not fully insured.

''(c) SPONSOR AND BOARD OF TRUSTEES.—For purposes of this part, in the case of a church plan to which this part applies pursuant to an election under subsection (a), in treating such plan as if it were a multiple employer welfare arrangement under this part—

''(1) the church, convention or association of churches, or other organization described in section 3(33)(C)(i) which is the entity maintaining the plan shall be treated as the sponsor referred to in section 703(a)(1), and the requirements of section 703(a)(1) shall not apply, and

''(2) the board of trustees, board of directors, or other similar governing body of such sponsor shall be treated as the board of trustees referred to in section 703(a)(2), and the requirements of section 703(a)(2) shall be deemed satisfied with respect to the board of trustees.

''(d) DEEMED SATISFACTION OF TRUST REQUIREMENTS.—The requirements of section 403 shall not be treated as not satisfied with respect to a church plan to which this part applies pursuant to an election under subsection (a) solely because assets of the plan are held by an organization described in section 3(33)(C)(i), if—

''(1) such organization is incorporated separately from the church or convention or association of churches involved, and

''(2) such assets with respect to medical care are separately accounted for.

''(e) DEEMED SATISFACTION OF EXCLUSIVE BENEFIT REQUIREMENTS.—The requirements of section 404 shall not be treated as not satisfied with respect to a church plan to which this part applies pursuant to an election under subsection (a) solely because assets of the plan which are in excess of reserves required for exemption under section 514(b)(6)(B) are held in a fund in which such assets are pooled with assets of other church plans, if the assets held by such fund may not, under the terms of the plan and the

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 plans 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)(2)) 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 the preceding provisions of this title) is further amended by inserting after the item relating to section 703 the following new item:

''Sec. 709. 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(a)) is amended—

(1) in paragraph (8), by striking ''or'' at the end;

(2) in paragraph (9), by striking the period and inserting '', or''; 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 part 7 for an exemption under section 514(b)(6)(B) which such State has the power to enforce pursuant to section 506(c)(1).''.

(c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—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 employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit 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)(B),

''(2) having been established or maintained under or pursuant to 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(d)) or 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 under similar provisions of State public employee relations laws, or

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) 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 UNDER ERISA EXEMPTION ARE MET.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n)(1) 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 under the insurance laws of 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,

a district court of the United States shall enter an order requiring that the arrangement cease activities.

''(2) Paragraph (1) shall not apply in the case of a multiple employer welfare arrangement if the arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) are fully insured, within the meaning of section 701(1), and

''(B) with respect to each State in which the arrangement offers or provides benefits, the arrangement is operating in accordance with applicable State insurance laws that are not superseded under section 514.

''(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the arrangement.''.

(e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence: ''The terms of each multiple employer health plan (within the meaning of section 701(4)) shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 168. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) STATE AUTHORITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

''(1) STATE ENFORCEMENT.—

''(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the requirements under section 514(d) or the requirements under part 7 for an exemption under section 514(b)(6)(B). The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

''(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

''(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

''(D) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

''(2) ASSISTANCE TO STATES.—The Secretary shall—

''(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, 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. 169. 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 described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1997) 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 such 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

''(B) if any 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 registration statement 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 701(4)), the State insurance commissioner of the domicile State of such arrangement, or

''(ii) in the case of an arrangement which is not a multiple employer health plan, 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 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 responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

''(4) Any agreement entered into under section 506(c) with a State as the primary domicile State with respect to any multiple employer welfare arrangement shall provide for simultaneous filings of reports required under this subsection with the Secretary and with the State insurance commissioner of such State.

''(5) For purposes of this subsection, the term 'domicile State' means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for an exemption under this 514(b)(6)(B), most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different 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)) shall issue to each participating employer—

''(A) a document equivalent to the summary plan description required of plans under this part,

''(B) information describing the contribution rates applicable to participating employers, and

''(C) a statement indicating—

''(i) that the arrangement is not a licensed insurer under the laws of any State,

''(ii) the extent to which any benefits under the arrangement are fully insured,

''(iii) if any benefits under the arrangement are not fully insured, whether the arrangement has been granted an exemption under section 514(b)(6)(B) (or whether such an exemption has ceased to be effective).

''(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.—Section 110 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1030) is amended by adding at the end the following new subsection:

''(c) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are participating employers under a multiple employer welfare arrangement under which all coverage consists of medical care (within the meaning of section 607(1)) and is fully insured (as defined in section 701(1)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. The Secretary of Labor shall prescribe the alternative method referred to in section 110(c) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

SEC. 171. EFFECTIVE DATE; TRANSITIONAL RULE.

(a) EFFECTIVE DATE.—Except as otherwise provided in section 170(b), the amendments made by this subtitle shall take effect January 1, 1998. The Secretary shall issue all regulations necessary to carry out the amendments made by this subtitle before January 1, 1998.

(b) TRANSITIONAL RULE.—

(1) IN GENERAL.—If the sponsor of a multiple employer welfare arrangement which, as of the effective date specified in subsection (a), provides benefits consisting of medical care (within the meaning of section 607(1) of the Employee Retirement Income Security Act of 1974) files with the Secretary of Labor an application for an exemption under section 514(b)(6)(B) of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, then section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the period following such date and ending on the earlier of—

(A) the date on which the Secretary denies the application under the amendments made by this title or determines, in the Secretary's sole discretion, that such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such arrangement would be detrimental to the interests of individuals covered under such arrangement, or

(B) 18 months after such effective date.

(2) NO PENDING STATE ACTION.—Subparagraph (A) shall apply in the case of an arrangement only if, at the time of the application for the exemption under section 514(b)(6)(B), the arrangement does not have pending against it an enforcement action by a State.

Subtitle D—Definitions; General Provisions

SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—Subject to the succeeding provisions of this subsection and subsection (d)(1), the term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (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 of 1986).

(2) LIMITATION OF REQUIREMENTS TO PLANS WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The requirements of subtitle A and part 1 of subtitle B shall apply in the case of a group health plan for any plan year, or for health insurance coverage offered in connection with a group health plan for a year, only if the group health plan has two or more participants as current employees on the first day of the plan year.

(3) EXCLUSION OF PLANS WITH LIMITED COVERAGE.—An employee welfare benefit plan shall be treated as a group health plan under this title only with respect to medical care which is provided under the plan and which does not consist of coverage excluded from the definition of health insurance coverage under subsection (c)(4)(B).

(4) TREATMENT OF CHURCH PLANS.—

(A) EXCLUSION.—The requirements of this title insofar as they apply to group health plans shall not apply to church plans.

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE.—For purposes of applying section 101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a church plan that, pursuant to subparagraph (A), is not subject to the requirements of this title.

(5) TREATMENT OF GOVERNMENTAL PLANS.—

(A) ELECTION TO BE EXCLUDED.—If the plan sponsor of a governmental plan which is a group health plan to which the provisions of this subtitle otherwise apply makes an election under this paragraph for any specified period (in such form and manner as the Secretary of Health and Human Services may by regulations prescribe), then the requirements of this title insofar as they apply to group health plans shall not apply to such governmental plans for such period.

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE IF ELECTION MADE.—For purposes of applying section 101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a governmental plan that, under an election under subparagraph (A), is not subject to the requirements of this title.

(6) TREATMENT OF MEDICAID PLAN AS GROUP HEALTH PLAN.—A State plan under title XIX of the Social Security Act shall be treated as a group health plan for purposes of applying section 101(c)(1), unless the State elects not to be so treated.

(7) TREATMENT OF MEDICARE AND INDIAN HEALTH SERVICE PROGRAMS AS GROUP HEALTH PLAN.—Title XVIII of the Social Security Act and a program of the Indian Health Service shall be treated as a group health plan for purposes of applying section 101(c)(1).

(b) INCORPORATION OF CERTAIN DEFINITIONS IN EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Except as provided in this section, the terms ''beneficiary'', ''church plan'', ''employee'', ''employee welfare benefit plan'', ''employer'', ''governmental plan'', ''multiemployer plan'', ''multiple employer welfare arrangement'', ''participant'', ''plan sponsor'', and ''State'' have the meanings given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(c) OTHER DEFINITIONS.—For purposes of this title:

(1) APPLICABLE STATE AUTHORITY.—The term ''applicable State authority'' means, with respect to an insurer or health maintenance organization in a State, the State insurance commissioner or official or officials

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 5 years,

(B) has been formed and maintained in good faith for purposes other than obtaining insurance,

(C) does 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 the renewal and continuation in force of 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 vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609.

(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 insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or a health maintenance organization.

(B) EXCEPTION.—Such term does not include coverage under any separate policy, certificate, or contract only for one or more of any of the following:

(i) Coverage for accident, credit-only, vision, disability income, long-term care, nursing home care, community-based care dental, on-site medical clinics, or employee assistance programs, or any combination thereof.

(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supplemental coverage provided under a group health plan.

(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) Such other coverage, comparable to that described in previous clauses, as may be specified in regulations prescribed under this title.

(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, or

(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,

if (other than for purposes of part 2 of subtitle B) it is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

(6) HEALTH STATUS.—The term ''health status'' includes, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

(7) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term ''individual health insurance coverage'' means health insurance coverage offered to individuals if the coverage is not offered in connection with a group health plan (other than such a plan that has fewer than two participants as current employees on the first day of the plan year).

(8) INSURER.—The term ''insurer'' means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and which (except for purposes of part 2 of subtitle B) is subject to State law which regulates insurance (within the meaning of section 514(b)(2)(A) of the Employee Retirement Income Security Act of 1974).

(9) MEDICAL CARE.—The term ''medical care'' means—

(A) 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,

(B) amounts paid for, or services in the form of, transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(10) NETWORK PLAN.—The term ''network plan'' means, with respect to health insurance coverage, an arrangement of an insurer or a health maintenance organization under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the insurer or health maintenance organization.

(11) WAITING PERIOD.—The term ''waiting period'' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the minimum period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the plan.

(d) TREATMENT OF PARTNERSHIPS.—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this paragraph) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (1)) as an employee welfare benefit plan which is a group health plan.

(2) TREATMENT OF PARTNERSHIP AND PARTNERS AND EMPLOYER AND PARTICIPANTS.—In the case of a group health plan—

(A) the term ''employer'' includes the partnership in relation to any partner; and

(B) the term ''participant'' includes—

(i) in connection with a group health plan maintained by 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.

(e) 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 and does not include the market for such coverage issued only by an insurer or HMO that makes such coverage available only on the basis of affiliation with a bona fide association (as defined in subsection (c)(2)).

(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 (as defined in subsection (c)(2)).

(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 obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer and does not include health insurance coverage available solely in connection with a bona fide association (as defined in subsection (c)(2)).

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 for a period that is shorter than the applicable period provided for under such subtitles;

(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 60-day periods provided for under sections 101(b)(3)(A), 101(b)(3)(B)(ii), and 102(b)(2); or

(C) in defining pre-existing condition, to have a look-back period that is shorter than the 6-month period described in section 101(b)(1)(A).

(b) NO OVERRIDE OF ERISA PREEMPTION.—Except as provided specifically in subtitle C, nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 193. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided for in this title, the provisions of this title shall 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 health insurance coverage issued, renewed, in effect, or operated on or after July 1, 1998.

(b) CONSIDERATION OF PREVIOUS COVERAGE.—The Secretaries of Health and Human Services, Treasury, and Labor shall jointly establish rules regarding the treatment (in determining qualified coverage periods under sections 102(b) and 141(b)) of coverage before the applicable effective date specified in subsection (a).

(c) TIMELY ISSUANCE OF REGULATIONS.—The Secretaries of Health and Human Services, the Treasury, and Labor shall issue such 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 (or to authorize any regulation that requires) the coverage of any specific procedure, treatment, or service under a group health plan or health insurance coverage.

SEC. 195. FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY.

Congress finds the following in relation to the provisions of this title:

(1) Provisions in group health plans and health insurance coverage that impose certain pre-existing conditions impact the ability of employees to seek employment in interstate commerce, thereby impeding such commerce.

(2) Health insurance coverage is commercial in nature and is in and affects interstate commerce.

(3) It is a necessary and proper exercise of Congressional authority to impose requirements under this title on group health plans and health insurance coverage (including coverage offered to individuals previously covered under group health plans) in order to promote commerce among the States.

(4) Congress, however, intends to defer to States, to the maximum extent practicable, in carrying out such requirements with respect to insurers and health maintenance organizations that are subject to State regulation, consistent with the provisions of the Employee Retirement Income Security Act of 1974.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION; MEDICAL LIABILITY REFORM

SEC. 200. REFERENCES IN TITLE.

Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

Subtitle A—Fraud and Abuse Control Program

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''FRAUD AND ABUSE CONTROL PROGRAM

''SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

''(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

''(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

''(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

''(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

''(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

''(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

''(3) GUIDELINES.—

''(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

''(B) INFORMATION GUIDELINES.—

''(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

''(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

''(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

''(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

''(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

''(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

''(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

''(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

''(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

''(1) a policy of health insurance;

''(2) a contract of a service benefit organization; and

''(3) a membership agreement with a health maintenance organization or other prepaid health plan.''.

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

''(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

''(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

''(i) such gifts and bequests as may be made as provided in subparagraph (B);

''(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Coverage Availability and Affordability Act of 1996, and title XI; and

''(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

''(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

''(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

''(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

''(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

''(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

''(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

''(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

''(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, in an amount not to exceed—

''(I) for fiscal year 1997, $104,000,000,

''(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 in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

''(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

''(II) for fiscal year 1998, not less than $80,000,000 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 $110,000,000 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 $140,000,000 and not more than $150,000,000; and

''(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

''(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer 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, $47,000,000;

''(ii) for fiscal year 1998, $56,000,000;

''(iii) for fiscal year 1999, $66,000,000;

''(iv) for fiscal year 2000, $76,000,000;

''(v) for fiscal year 2001, $88,000,000;

''(vi) for fiscal year 2002, $101,000,000; and

''(vii) for each fiscal year after fiscal year 2002, $114,000,000.

''(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel 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.

''(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

''(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

''(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

''(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.''.

SEC. 202. MEDICARE INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

''MEDICARE INTEGRITY PROGRAM

''SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

''(2) Audit of cost reports.

''(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

''(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

''(1) the entity has demonstrated capability to carry out such activities;

''(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

''(3) the entity demonstrates to the Secretary that the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

''(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

''(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

''(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

''(2)(A) Except as provided in subparagraph (B), the provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section.

''(B) Competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary, except that the Secretary may contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

''(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

''(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.''.

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

''(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).''.

SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The

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 of the Social Security Act with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(b) 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 section 1128, section 1128A, or section 1128B 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 discourage 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 the collection 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 pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(c) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(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 submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, 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 ''MEDICARE 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 1128(h))'' 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'' and inserting ''a Federal health care program''.

(4) In the second sentence of subsection (a)—

(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 (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 1128(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 1128(h).''.

(b) 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.

Title XI (42 U.S.C. 1301 et seq.), as amended by section 201, is amended by inserting after section 1128C the following new section:

''GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

''SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

''(1) IN GENERAL.—

''(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

''(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient 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 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

''(iii) advisory opinions to be issued pursuant to subsection (b); and

''(iv) special fraud alerts to be issued pursuant to subsection (c).

''(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received 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, 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.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that 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 may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

''(A) An increase or decrease in access to health care services.

''(B) An increase or decrease in the quality of health care services.

''(C) An increase or decrease in patient freedom of choice among health care providers.

''(D) An increase or decrease in competition among health care providers.

''(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

''(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

''(G) An increase or decrease in the potential overutilization of health care services.

''(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

''(i) whether to order a health care item or service; or

''(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

''(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

''(b) 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 the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

''(D) What constitutes an inducement 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).

''(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

''(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) BINDING 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, 1128A, 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;

''(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(v) the manner in which advisory opinions will be made available to the public.

''(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

''(i) the Secretary shall be required to respond to a party requesting an advisory opinion by not 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.—

''(1) IN GENERAL.—

''(A) REQUEST 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 suspect or of particular concern under the medicare program or a State health care program, as defined in section 1128(h) (in this subsection referred to as 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.

''(2) 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 may result in any of the consequences 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 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a–7(b)) is amended to read as follows:

''(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law—

''(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

''(i) in connection with the delivery of a health care item or service, or

''(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

''(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(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 action 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) or 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 FOR FAILURE 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) (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(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)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) 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 has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR DISCOUNTING AND MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to written agreements entered into on or after January 1, 1997.

SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSITION OF ASSETS IN ORDER TO OBTAIN MEDICAID BENEFITS.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)) is amended—

(1) by striking ''or'' at the end of paragraph (4);

(2) by adding ''or'' at the end of paragraph (5); and

(3) by inserting after paragraph (5) the following new paragraph:

''(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),''.

SEC. 218. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this subtitle shall take effect January 1, 1997.

Subtitle C—Data Collection

SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 201 and 205, is amended by inserting after section 1128D the following new section:

''HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

''SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, 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).

''(b) REPORTING OF INFORMATION.—

''(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

''(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

''(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

''(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

''(C) The nature of the final adverse action and whether such action is on appeal.

''(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

''(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

''(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

''(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

''(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

''(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

''(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

''(B) procedures in the case of disputed accuracy of the information.

''(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

''(d) ACCESS TO REPORTED INFORMATION.—

''(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

''(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

''(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

''(1) FINAL ADVERSE ACTION.—

''(A) IN GENERAL.—The term 'final adverse action' includes:

''(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

''(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

''(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

''(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

''(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, nonrenewability, or otherwise, or

''(III) any other negative action or finding by such Federal or State agency that is publicly available information.

''(iv) Exclusion from participation in Federal or State health care programs.

''(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

''(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

''(2) PRACTITIONER.—The terms 'licensed health care practitioner', '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 (or any individual who, 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 medicaid 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 1128C(c).

''(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).''.

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER 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 impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.''.

Subtitle D—Civil Monetary Penalties

SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking ''programs under title XVIII'' and inserting ''Federal health care programs (as defined in section 1128B(f)(1))''.

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid 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 1128B(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 or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

''(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

''(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

''(ii) 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.

''(B) 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.''.

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) (42 U.S.C. 1320a–7a(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 a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(4) by inserting after paragraph (3) the following new paragraph:

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

''(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

''(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given''; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end; and

(3) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or''.

(e) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting ''up to $10,000 for each instance''.

(f) PROCEDURAL PROVISIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)), as amended by section 215(a)(2), is amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).''.

(g) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended—

(A) by striking ''or'' at the end of paragraph (3);

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

(D) by inserting after paragraph (4) the following new paragraph:

''(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);''.

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. 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—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than

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 ''presents'' 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(i) (42 U.S.C. 1320a–7a(i)), as amended by section 231(g)(2), is amended by adding at the end the following new paragraph:

''(7) The term 'should know' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity 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 1835(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 Law

SEC. 241. DEFINITIONS RELATING TO FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 1 of title 18, United States Code, is amended by adding at the end the following:

''§ 24. Definitions relating to Federal health care offense

''(a) As used in this title, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(1) section 669, 1035, 1347, or 1518 of this title; or

''(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program.

''(b) As used in this title, the term 'health care benefit program' means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 2 of title 18, United States Code, is amended by inserting after the item relating to section 23 the following new item:

''24. Definitions relating to Federal health care offense.''.

SEC. 242. HEALTH CARE FRAUD.

(a) OFFENSE.—

(1) IN GENERAL.—Chapter 63 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 or artifice—

''(1) 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 results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.''.

(2) 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.''.

(b) CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—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. 1395i) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 243. THEFT OR EMBEZZLEMENT.

(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

''(a) Whoever embezzles, steals, or otherwise without authority knowingly converts to the use of any person other than the rightful owner, or intentionally misapplies 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.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''669. Theft or embezzlement in connection with health care.''.

SEC. 244. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''§ 1035. False statements relating to health care matters

''(a) Whoever, in any matter involving a health care benefit program, knowingly—

''(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

''(2) makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry,

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 5 years, 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.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

''1035. False statements relating to health care matters.''.

SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

''§ 1518. Obstruction of criminal investigations of health care offenses

''(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following new item:

''1518. Obstruction of criminal investigations of health care offenses.''.

SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following:

''(F) Any act or activity constituting an offense involving a Federal health care offense.''.

SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense.''.

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting ''or a Federal health care offense'' after ''title)''.

SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 223 of title 18, United States Code, is amended by adding after section 3485 the following:

''§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—In any investigation relating to any act or activity involving a

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 records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, 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 agent authorized by appointment or by 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 by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on 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 court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under 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 summons and thus produces the materials sought, 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 unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefor.

''(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

''(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.''.

(b) 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 procedures.''.

(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 3486 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)(1)''.

(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 the Treasury 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 ''payment of the costs of 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 forfeited, 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 from such properties; 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 forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(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 remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation 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 506(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. 251. PURPOSE.

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 such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

SEC. 252. ADMINISTRATIVE SIMPLIFICATION.

(a) IN GENERAL.—Title XI (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) CLEARINGHOUSE.—The term 'clearinghouse' 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, medical diagnostic codes, or medical procedure codes.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other 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 that—

''(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or clearinghouse; and

''(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.

''(5) HEALTH PLAN.—The term 'health plan' means a 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 medicaid program under title XIX.

''(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

''(D) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently 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 the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits and has 50 or more participants (as defined in section 3(7) of such Act).

''(F) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

''(G) 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 Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code.

''(J) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(K) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

''(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' means any information, including demographic information collected from an individual, that—

''(A) is created or received by a health care provider, health plan, employer, or clearinghouse; and

''(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 1173(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:

''(1) An health plan.

''(2) A clearinghouse.

''(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

''(b) 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.

''(c) 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 rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

''(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has developed, adopted, or modified any standard relating to a standard that the Secretary is authorized or required to adopt under this part—

''(i) paragraph (1) shall not apply; and

''(ii) subsection (f) shall apply.

''(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards adopted under this part.

''(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

''(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the National Committee on Vital and Health Statistics established under section 306(k) 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.

''(g) APPLICATION TO MODIFICATIONS OF STANDARDS.—This section shall apply to a modification to 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 consistent with 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.

''(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

''(b) UNIQUE HEALTH IDENTIFIERS.—

''(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

''(2) 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.

''(2) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

''(d) 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) 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—

''(i) threats or hazards to the security or integrity of the information; and

''(ii) unauthorized uses or disclosures 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.—

''(A) STANDARDS.—The Secretary, in coordination 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 subparagraph (A) shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

''(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, payment card or numbers, or other electronic means.

''(g) TRANSFER OF INFORMATION AMONG HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

''TIMETABLES FOR ADOPTION OF STANDARDS

''SEC. 1174. (a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of the Health Coverage Availability and Affordability 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 paragraph (2), the Secretary shall review the standards adopted under section 1173, and shall adopt modifications to the standards (including additions to the standards), as determined appropriate, but not more frequently than once every 6 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

''(2) SPECIAL RULES.—

''(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially 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—

''(A) the health plan may not refuse to conduct such transaction as a standard transaction;

''(B) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

''(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

''(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

''(A) directly transmitting and receiving standard data elements of health information; or

''(B) submitting nonstandard data elements to a clearinghouse for processing into standard data elements and transmission by the clearinghouse, and receiving standard data elements through the clearinghouse.

''(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 through 1174 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

''(b) COMPLIANCE WITH STANDARDS.—

''(1) INITIAL COMPLIANCE.—

''(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

''(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting '36 months' for '24 months'. For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

''(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small insurance plans, if the Secretary determines that such extension is appropriate.

''GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS

''SEC. 1176. (a) GENERAL PENALTY.—

''(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

''(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

''(b) LIMITATIONS.—

''(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act if the act constitutes an offense punishable under section 1177.

''(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision 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.

''(3) FAILURES DUE TO REASONABLE CAUSE.—

''(A) 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 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 by exercising reasonable diligence would have known, that the failure to comply occurred.

''(B) EXTENSION OF PERIOD.—

''(i) 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.

''(ii) ASSISTANCE.—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.

''(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty 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 excessive relative to the compliance failure involved.

''WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

''SEC. 1177. (a) OFFENSE.—A person who knowingly and in violation of this part—

''(1) uses or causes to be used a unique health identifier;

''(2) obtains individually identifiable health information relating to an individual; or

''(3) discloses individually identifiable health information to another person,

shall be punished as provided in subsection (b).

''(b) PENALTIES.—A person described in subsection (a) shall—

''(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

''(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

''(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

''EFFECT ON STATE LAW

''SEC. 1178. (a) GENERAL EFFECT.—

''(1) GENERAL RULE.—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 a 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 the Secretary determines—

''(i) is necessary to prevent fraud and abuse, or for other purposes; or

''(ii) addresses controlled substances.

''(b) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.''.

(b) CONFORMING AMENDMENTS.—

(1) REQUIREMENT FOR MEDICARE PROVIDERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking ''and'' at the end of subparagraph (P);

(B) by striking the period at the end of subparagraph (Q) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (Q) the following new subparagraph:

''(R) to contract only with a clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the clearinghouse is required to comply with the standard or specification.''.

(2) TITLE HEADING.—Title XI (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION''.

SEC. 253. CHANGES IN MEMBERSHIP AND DUTIES OF 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) in paragraph (1), by striking ''16'' and inserting ''18'';

(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 health information systems, health services research, consumer interests in health information, health data standards, epidemiology, and the provision of health services. Members of the Committee 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) 16 shall be appointed by the Secretary.'';

(4) by amending paragraph (5) (as so redesignated) to read as follows:

''(5) The Committee—

''(A) shall assist and advise the Secretary—

''(i) to delineate statistical problems bearing on health and health services which are of national or international interest;

''(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 assessing health status and health services, their distribution and costs, for use (I) within the Department of Health and Human Services, (II) by all programs administered or funded 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 head of the agency 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 agencies and to 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 state of the Nation's health, its health services, their costs and distributions, 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;

''(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; 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;

''(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 Governments are receiving information of sufficient quality to meet their responsibilities under such part;

''(D) any problems that exist with respect to implementation of such part; and

''(E) the extent to which timetables under such part are being met.''.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

SEC. 261. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—Effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990, section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(1) in clause (iii), by striking ''clause (i)'' and inserting ''clause (i)(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.

''(v)(I) 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 policies sold or issued on or after 90 days 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 benefits under this title.

''(II) For purposes of this subparagraph, a health insurance policy (which may be a contract with a health maintenance organization) that is a replacement product for another health insurance policy that is being terminated by the issuer, that is being provided to an individual entitled to benefits under part A on the basis of section 226(b), and that coordinates against or excludes items and services available or paid for under this title is not considered to 'duplicate' health benefits 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 from payment, items and services to the extent available or paid for under this title.

''(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this 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 policy or rider during such period, if such policy or rider meets the nonduplication requirements of clause (iv) or (v).

''(vii) A State may not impose, in the case of the sale, issuance, or renewal of a health insurance policy (other than a medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that meets the nonduplication requirements of this section pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B, any requirement relating to any duplication (or nonduplication) of health benefits under such policy or rider with health benefits to which the individual is otherwise entitled to under this title.''.

(b) CONFORMING AMENDMENTS.—Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking ''with respect to (i)'' and inserting ''with respect to'', and

(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 vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR 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 law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(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, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—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.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims 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 and 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'' is that measure 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 in the future to or on behalf of a claimant, 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;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(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 injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(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 employee 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 which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or distribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(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 or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a health benefit plan including services related to 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 paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(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 conducted for that purpose, sells, distributes, rents, leases, prepares, blends, packages, labels a product, is otherwise involved in placing a product in the stream of commerce, or installs, repairs, or maintains the harm-causing aspect of a product. The term does not include—

(A) a seller or lessor of real property;

(B) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(C) any person who—

(i) acts in only a financial capacity with respect to the sale of a product; or

(ii) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, 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, Puerto Rico, 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 2-year 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 case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 282. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages 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, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of noneconomic damages attributable to such defendant in direct 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 subtitle 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. This subsection does not preempt or supersede any State or Federal law to the extent that such 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 separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(5) DRUGS AND DEVICES.—

(A) IN GENERAL.—(i) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based 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 any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such 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 the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an 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 claim shall contain provisions relating to statute of limitations, noneconomic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are identical to the provisions relating to such matters in this subtitle.

TITLE III—TAX-RELATED HEALTH PROVISIONS

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 VII 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.

''(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed—

''(A) except as provided in subparagraph (B), the lesser of—

''(i) $2,000, or

''(ii) the annual deductible limit for any individual covered under the high deductible health plan, or

''(B) in the case of a high deductible health plan covering the taxpayer and any other eligible individual who is the spouse or any dependent (as defined in section 152) of the taxpayer, the lesser of—

''(i) $4,000, or

''(ii) the annual limit under the plan on the aggregate amount of deductibles required to be paid by all individuals.

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.

''(3) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

''(A) any amount is paid to any medical savings account of such individual which is excludable from gross income under section 106(b) for such year, or

''(B) in a case described in paragraph (2)(B), any amount is paid to any medical savings account of either spouse which is so excludable for such year.

''(4) PRORATION OF LIMITATION.—

''(A) IN GENERAL.—The limitation under paragraph (1) shall be the sum of the monthly limitations for months during the taxable year that the individual is an eligible individual if—

''(i) such individual is not an eligible individual for all months of the taxable year,

''(ii) the deductible under the high deductible health plan covering such individual is not the same throughout such taxable year, or

''(iii) such limitation is determined under paragraph (1)(B) for some but not all months during such taxable year.

''(B) MONTHLY LIMITATION.—The monthly limitation for any month shall be an amount

equal to 1/12 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 that such individual is covered under a high deductible health plan were true for the entire taxable year.

''(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual—

''(i) who is covered under a high deductible health plan 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—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.

''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

''(i) coverage for any benefit provided by permitted insurance, and

''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

''(2) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' means a health plan which—

''(A) has an annual deductible limit for each individual covered by the plan which is not less than $1,500, and

''(B) 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 deductible for preventive care if the absence of a deductible for such care is required by State law.

''(3) PERMITTED INSURANCE.—The term 'permitted insurance' means—

''(A) Medicare supplemental insurance,

''(B) insurance if substantially all of the coverage provided under such insurance relates to—

''(i) liabilities incurred under workers' compensation laws,

''(ii) tort liabilities,

''(iii) liabilities relating to ownership or use of property, or

''(iv) such other similar liabilities as the Secretary may specify by regulations,

''(C) insurance for a specified disease or illness, and

''(D) insurance paying a fixed amount per day (or other period) of hospitalization.

''(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

''(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a rollover contribution 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 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled 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.

''(2) 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 individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

''(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

''(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

''(I) a health plan during any period of continuation 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.

''(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(d)(2) (relating to no deduction for rollovers).

''(B) 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 payments).

''(D) Section 408(g) (relating to community property laws).

''(E) Section 408(h) (relating to custodial accounts).

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(f) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder (or any spouse or dependent of the holder) shall not be includible in gross income.

''(B) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

''(i) TREATMENT IF HOLDER IS SPOUSE.—If, after the death of the account holder, the account holder's interest is payable to (or for the benefit of) the holder's spouse, the medical savings account shall be treated as if the spouse were the account holder.

''(ii) TREATMENT IF DESIGNATED HOLDER IS NOT SPOUSE.—In the case of an account holder's interest in a medical savings account which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

''(I) such account shall cease to be a medical savings account as of the date of death, and

''(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder or of the spouse or dependents of such holder shall be included in the gross income of such holder.

''(B) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all medical savings accounts of the account holder shall be treated as 1 account,

''(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—If the aggregate contributions (other than rollover contributions) for a taxable year to the medical savings accounts of an individual exceed the amount allowable as a deduction under this section for such contributions, paragraph (2) shall not apply to distributions from such accounts (in an amount not greater than such excess) if—

''(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

''(4) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from a medical savings account of such holder which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 59½.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains age 59½.

''(5) 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 is paid into a 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.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

''(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

''(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(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.

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount in subsection (b)(1), (c)(2), or (d)(1)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the medical care cost adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(B) such component for August of 1996.

''(h) REPORTS.—The Secretary may require the trustee of a medical savings account to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 is amended by inserting after paragraph (15) the following new paragraph:

''(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—In the case of an employee who is an eligible individual, gross income does not include amounts contributed by such employee's employer to any medical savings account of such employee.

''(2) COORDINATION WITH DEDUCTION LIMITATION.—The amount excluded from the gross income of an employee under this subsection for any taxable year shall not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

''(3) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

''(4) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

''(5) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220.''

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) any payment made to or 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).''

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by inserting after paragraph (18) the following new paragraph:

''(19) any payment made to or 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) of the Internal Revenue Code of 1986.''

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or 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).''

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) any payment made to or 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).''

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) any payment made to or 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).''

(d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by inserting ''106(b),'' before ''117''.

(e) EXCLUSION OF MEDICAL SAVINGS ACCOUNTS FROM ESTATE TAX.—Part IV of subchapter A of chapter 11 is amended by adding at the end the following new section:

''SEC. 2057. MEDICAL SAVINGS ACCOUNTS.

''For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any medical savings account (as defined in section 220(d)) included in the gross estate.''

(f) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by striking ''or'' at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)), or'', and

(4) by adding at the end the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings accounts (within the meaning of section 220(d)), the term 'excess contributions' means the sum of—

''(1) the amount by which the amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) exceeds the amount allowable as a deduction under section 220 for such contributions, and

''(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of distributions out of the account included in gross income under section 220(f) (2) or (3) and the excess (if any) of the maximum amount allowable as a deduction under section 220 for the taxable year over the amount contributed to the accounts.

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) applies shall be treated as an amount not contributed.''

(g) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.''

(2) Paragraph (1) of section 4975(e) is amended to read as follows:

''(1) PLAN.—For purposes of this section, the term 'plan' means—

''(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

''(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) Subsection (a) of section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

''(a) REPORTS.—

''(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) 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.

''(2) PROVISIONS.—The provisions referred to in this paragraph are—

''(A) subsections (i) and (l) of section 408 (relating to individual retirement plans), and

''(B) section 220(h) (relating to medical savings accounts).''

(i) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) (defining specified 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) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.

''Sec. 221. Cross reference.''

(2) The table of sections for part IV of subchapter A of chapter 11 is amended by adding at the end the following new item:

''Sec. 2057. Medical savings accounts.''

(k) 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.—Paragraph (1) of section 162(l) is amended to read as follows:

''(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 equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

''For taxable years beginning in calendar year—	The applicable percentage is—
1998	35 percent
1999, 2000, or 2001	40 percent
2002	45 percent
2003 or thereafter	50 percent.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1997.

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

SEC. 321. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

''SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—For purposes of this title—

''(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,

''(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

''(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance contract' means any insurance contract if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

''(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(C) such contract is guaranteed renewable,

''(D) such contract does not provide for a cash surrender value or other money that can be—

''(i) 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 (B) of 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 MEDICARE.—

''(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

''(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) REFUNDS OF PREMIUMS.—Paragraph (1)(E) 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 under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual, and

''(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

''(ii) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

''(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) Eating.

''(ii) Toileting.

''(iii) Transferring.

''(iv) Bathing.

''(v) Dressing.

''(vi) Continence.

Nothing in this section shall be construed to require a contract to take into account all of the preceding activities of daily living.

''(3) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

''(4) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

''(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 the dollar amount in effect for such period

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 by insurance or otherwise) for qualified long-term care services provided during such period for such insured.

''(2) PERIODIC PAYMENTS.—For purposes of paragraph (1), 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 day (or the equivalent amount in the case of payments on another periodic basis).

''(4) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (3) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(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) IN GENERAL.—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)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

''(A) by the sum of any charges (but not premium payments) 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 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

''(4) PORTION DEFINED.—For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a qualified long-term care insurance contract.''

(b) LONG-TERM CARE INSURANCE NOT PERMITTED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: ''Such term shall not include any long-term care insurance contract (as defined in section 4980C).''

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 (relating to contributions by employer to accident and health plans), as amended by section 301(c), is amended by adding at the end the following new subsection:

''(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—Effective on and after January 1, 1997, gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

''(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program 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 maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.''

(c) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Subsection (f) of section 4980B 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)).''

(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 sitused at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), and

(B) services provided under, or reimbursed by, such contract shall be treated for such purposes as qualified long-term care services (as defined in section 7702B(c) of such Code).

(3) EXCHANGES OF EXISTING POLICIES.—If, after the date of enactment of this Act and before January 1, 1998, a contract providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance contract within 60 days thereafter shall be treated as an exchange.

(4) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a rider which is treated as a qualified long-term care insurance contract under section 7702B, and

(B) the addition of any provision required to conform any other long-term care rider to be so treated,

shall not be treated as a modification or material change of such contract.

SEC. 322. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 7702B(c)), or''.

(b) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended by inserting before the period ''or for any qualified long-term care insurance contract (as defined in section 7702B(b))''.

(2)(A) Paragraph (1) of section 213(d) is amended by adding at the end the following new flush sentence:

''In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).''

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraphs:

''(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

''In the case of an individual with an attained age before the close of the taxable year of:	**The limitation is:**
40 or less	$ 200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500.

''(B) INDEXING.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(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.

''(11) CERTAIN PAYMENTS TO RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to 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 respect to such service, or

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in any of paragraphs (1) through (8) of section 152(a). This paragraph shall not apply for purposes of section 105(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.—Amounts paid for qualified long-term care services (as defined in section 7702B(c) of the Internal Revenue Code of 1986, as added by this Act) furnished in any taxable year beginning before January 1, 1998, shall not be taken into account under section 213 of the Internal Revenue Code of 1986.

SEC. 323. REPORTING REQUIREMENTS.

(a) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new section:

''SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.

''(a) REQUIREMENT OF REPORTING.—Any person who pays long-term care benefits shall make a return, according to the forms or regulations prescribed by the Secretary, setting forth—

''(1) the aggregate amount of such benefits paid by such person to any individual during any calendar year, and

''(2) the name, address, and TIN of such individual.

''(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(1) the name of the person making the payments, and

''(2) the aggregate amount of long-term care benefits paid to the individual which are required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

''(c) LONG-TERM CARE BENEFITS.—For purposes of this section, the term 'long-term care benefit' means—

''(1) any amount paid under a long-term care insurance policy (within the meaning of section 4980C(e)), and

''(2) payments which are excludable from gross income by reason of section 101(g).''.

(b) PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by redesignating clauses (ix) through (xiv) as clauses (x) through (xv), respectively, and by inserting after clause (viii) the following new clause:

''(ix) section 6050Q (relating to certain long-term care benefits),''.

(2) Paragraph (2) of section 6724(d) is amended by redesignating subparagraphs (Q) through (T) as subparagraphs (R) through (U), respectively, and by inserting after subparagraph (P) the following new subparagraph:

''(Q) section 6050Q(b) (relating to certain long-term care benefits),''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

''Sec. 6050Q. Certain long-term care benefits.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits paid after December 31, 1996.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 325. POLICY REQUIREMENTS.

Section 7702B (as added by section 321) is amended by adding at the end the following new subsection:

''(f) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3), and

''(C) the requirements relating to nonforfeitability under paragraph (4).

''(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

''(3) DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any policy if such policy meets the requirements of section 4980C(d)(1).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

''(iii) The nonforfeiture provision shall provide at least one of the following:

''(I) Reduced paid-up insurance.

''(II) Extended term insurance.

''(III) Shortened benefit period.

''(IV) Other similar offerings approved by the Secretary.

''(5) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term 'long-term care insurance policy' has the meaning given such term by section 4980C(e).''.

SEC. 326. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

''SEC. 4980C. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

''(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

''(b) AMOUNT.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirements of subsection (c) or (d) are not met with respect to each long-term care insurance policy.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) RESPONSIBILITIES.—The requirements of this subsection are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also

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 the waiting period or because of any applicable preexisting condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insurance policy, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(f)(2)(B).

''(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial.

''(d) DISCLOSURE.—The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

''(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance.''.

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Requirements for issuers of long-term care insurance policies.''.

SEC. 327. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this part shall prevent a State from establishing, implementing, or continuing in effect standards related to the protection of policyholders of long-term care insurance policies (as defined in section 4980C(e) of the Internal Revenue Code of 1986), if such standards are 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. The provisions of section 321(g) (relating to transition rule) shall apply to such contracts.

(b) ISSUERS.—The amendments made by section 326 shall apply to actions taken after December 31, 1996.

Subtitle D—Treatment of Accelerated Death Benefits

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:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, the following amounts shall be treated as an amount paid by reason of the death of an insured:

''(A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.

''(B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual (as defined in section 7702B(c)(2)) but only if such amount is received under a rider or other provision of such contract which is treated as a qualified long-term care insurance contract under section 7702B and such amount is treated under section 7702B (after the application of subsection (d) thereof) as a payment for qualified long-term care services (as defined in such section).

''(2) TREATMENT OF VIATICAL SETTLEMENTS.—

''(A) IN GENERAL.—In the case of a life insurance contract on the life of an insured described in paragraph (1), if—

''(i) any portion of such contract is sold to any viatical settlement provider, or

''(ii) any portion of the death benefit is assigned to such a provider,

the amount paid for such sale or assignment shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

''(B) VIATICAL SETTLEMENT PROVIDER.—The term 'viatical settlement provider' means any person regularly engaged in the trade or business of purchasing, or taking assignments of, life insurance contracts on the lives of insureds described in paragraph (1) if—

''(i) such person is licensed for such purposes in the State in which the insured resides, or

''(ii) in the case of an insured who resides in a State not requiring the licensing of such persons for such purposes—

''(I) such person meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners, and

''(II) meets the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining amounts paid by such person in connection with such purchases or assignments.

''(3) DEFINITIONS.—For purposes of this subsection—

''(A) TERMINALLY ILL INDIVIDUAL.—The term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.

''(B) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)).

''(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

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:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).

''(3) EXCEPTION FOR LONG-TERM CARE RIDERS.—Paragraph (1) shall not apply to any rider which is treated as a long-term care insurance contract under section 7702B.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on January 1, 1997.

(2) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)), and

(B) the addition of any provision required to conform an accelerated death benefit rider to the requirements of such section 818(g),

shall not be treated as a modification or material change of such contract.

Subtitle E—High-Risk Pools

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:

''(26) Any membership organization if—

''(A) such organization is established by a State exclusively to provide coverage for medical care (as defined in 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,

''(B) the only individuals receiving such coverage through the organization are individuals—

''(i) who are residents of such State, and

''(ii) who, by reason of the existence or history of a medical condition, are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization or are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

''(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) (relating to organization to which section applies) is amended by adding 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) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

''(i) 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) is not a Blue Cross or Blue Shield organization or health 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 subsections:

''(f) 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.—

''(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 consent 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 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.

''(2) APPLICABLE EXCESS RESERVES.—

''(A) IN GENERAL.—For purposes of 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 supplemental reserve) as of the close of the taxpayer's last taxable year beginning before December 31, 1995, over

''(ii) the lesser of—

''(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

''(II) the balance of the reserves described in subclause (I), reduced in the same manner as under section 585(b)(2)(B)(ii) 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 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 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

''(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5) and (6) or subsection (e)(1).

''(3) 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 REQUIREMENT MET.—

''(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—

''(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

''(II) 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 property described in 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 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 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.

''(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1), subparagraph (B) shall be applied with respect to such group.

''(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)(iii), there shall be taken into account only the excess (if any) 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 (2)(A)(ii) of this subsection.

''(B) TREATMENT UNDER ELECTIVE CUT-OFF METHOD.—For purposes of applying section 585(c)(4)—

''(i) the balance of the reserve taken into account under subparagraph (B) thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

''(ii) no amount shall be includible in gross income by reason of such reduction.

''(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 credit union by reason 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 subsection (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 50 is amended by adding at the end the following new sentence:

''Paragraphs (1)(A), (2)(A), and (4) of the section 46(e) 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 paragraph (1) and by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (4).

(4) Section 246 is amended by striking subsection (f).

(5) Clause (i) of section 291(e)(1)(B) is amended by striking ''or to which section 593 applies''.

(6) Subparagraph (A) of section 585(a)(2) is amended by striking ''other than an organization to which section 593 applies''.

(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)(ii)''.

(B) Subparagraph (B) of section 593(e)(1) is amended to read as follows:

''(B) then out of the balance taken into account under subsection (g)(2)(A)(ii) (properly adjusted for amounts charged against such reserves for taxable years beginning after December 31, 1987),''.

(C) Paragraph (1) of section 593(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 581) to another corporation if, immediately after the distribution, such bank and such other corporation are members of the same affiliated group (as defined in section 1504) and the provisions of section 5(e) of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect.''

(8) Section 595 is hereby repealed.

(9) Section 596 is hereby repealed.

(10) Subsection (a) of section 860E is amended—

(A) by striking ''Except as provided in paragraph (2), the'' in paragraph (1) and inserting ''The'',

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows ''subsection'' and inserting a period.

(11) Paragraph (3) of section 992(d) is amended by striking ''or 593''.

(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 amended by striking ''or to which section 593 applies''.

(15) Subparagraph (B) of section 1361(b)(2) is amended by striking ''or to which section 593 applies''.

(16) 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, and

(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.

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:

''(F) IDENTIFICATION NUMBER REQUIREMENT.—The term 'eligible individual' does not include any individual who does not include on the return of tax for the taxable year—

''(i) such individual's taxpayer identification number, and

''(ii) if the individual is married (within the meaning of section 7703), 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:

''(l) IDENTIFICATION NUMBERS.—Solely 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 Administration (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).''.

(c) EXTENSION OF PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Section 6213(g)(2) (relating to the definition of mathematical or clerical errors) is amended by striking ''and'' at the end of subparagraph (D), by striking the period at the end of subparagraph (E) and inserting a comma, and by inserting after subparagraph (E) the following new subparagraphs:

''(F) 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

''(G) an entry on a return claiming the credit under section 32 with respect to net earnings from self-employment described in section 32(c)(2)(A) to the extent the tax imposed by section 1401 (relating to self-employment tax) on such net earnings has not been paid.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

Subtitle C—Treatment of Individuals Who Lose United States Citizenship

SEC. 421. REVISION OF INCOME, ESTATE, AND GIFT TAXES ON INDIVIDUALS WHO LOSE UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subsection (a) of section 877 is amended to read as follows:

''(a) TREATMENT OF EXPATRIATES.—

''(1) IN GENERAL.—Every nonresident alien individual who, within the 10-year period immediately preceding the close of the taxable year, 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 B, shall be taxable for such taxable year in the manner provided in subsection (b) if the tax imposed pursuant to such subsection exceeds the tax which, without regard to this section, is imposed pursuant to section 871.

''(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if—

''(A) the average annual net income tax (as defined in section 38(c)(1)) of such individual for the period of 5 taxable years ending before the date of the loss of United States citizenship is greater than $100,000, or

''(B) the net worth of the individual as of such date is $500,000 or more.

In the case of the loss of United States citizenship in any calendar year after 1996, such $100,000 and $500,000 amounts 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 '1994' for '1992' in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.''

(b) EXCEPTIONS.—

(1) IN GENERAL.—Section 877 is amended by striking subsection (d), by redesignating subsection (c) as subsection (d), and by inserting after subsection (b) the following new subsection:

''(c) TAX AVOIDANCE NOT PRESUMED IN CERTAIN CASES.—

''(1) IN GENERAL.—Subsection (a)(2) shall not apply to an individual if—

''(A) such individual is described in a subparagraph of paragraph (2) of this subsection, and

''(B) within the 1-year period beginning on the date of the loss of United States citizenship, such individual submits a ruling request 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 subparagraph if—

''(i) the individual became at birth a citizen 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 individual'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 subparagraph if, for each year in the 10-year period ending on the date of loss of United States citizenship, the individual was present in the United States for 30 days or less. The rule of section 7701(b)(3)(D)(ii) shall apply for purposes of this subparagraph.

''(C) RENUNCIATION UPON REACHING AGE OF MAJORITY.—An individual is described in this subparagraph if the individual's loss of United States citizenship occurs before such individual attains age 18½.

''(D) INDIVIDUALS SPECIFIED IN REGULATIONS.—An individual is described in this subparagraph if the individual is described in a category of individuals prescribed by regulation 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)''.

(c) TREATMENT OF PROPERTY DISPOSED OF IN NONRECOGNITION TRANSACTIONS; TREATMENT OF DISTRIBUTIONS FROM CERTAIN CONTROLLED FOREIGN CORPORATIONS.—Subsection (d) of section 877, as redesignated by subsection (b), is amended to read as follows:

''(d) SPECIAL RULES FOR SOURCE, ETC.—For purposes of subsection (b)—

''(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 domestic 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 CORPORATION.—Any income or gain derived from stock in a foreign corporation but only—

''(i) if the individual losing United States citizenship owned (within the meaning of section 958(a)), or is considered as owning (by applying the ownership rules of section 958(b)), at any time during the 2-year period ending on the date of the 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

''(ii) 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 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 any gain shall be recognized for the taxable year which includes such date.

''(B) EXCHANGES TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any exchange during the 10-year period described in subsection (a) if—

''(i) 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 no income was 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 in whole or part by reference to 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 by substituting the 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 recognition of gain) 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),

''(B) the holding by another person of a right to acquire the property, or

''(C) a short sale or any other transaction.''

(d) CREDIT FOR FOREIGN TAXES IMPOSED ON UNITED STATES SOURCE INCOME.—

(1) Subsection (b) of section 877 is amended by adding at the end 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.''

(2) 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 2107 is amended to read as follows:

''(a) TREATMENT OF EXPATRIATES.—

''(1) RATE OF TAX.—A tax computed in accordance with the table contained in section 2001 is hereby imposed on the transfer of the taxable estate, determined as provided in section 2106, of every decedent nonresident not a citizen of the United States if, within the 10-year period ending with the date of death, such decedent 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.

''(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—

''(A) IN GENERAL.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

''(B) EXCEPTION.—Subparagraph (A) shall not apply to a decedent meeting the requirements of section 877(c)(1).''

(B) CREDIT FOR FOREIGN DEATH TAXES.—Subsection (c) of section 2107 is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

''(2) CREDIT FOR FOREIGN DEATH TAXES.—

''(A) IN GENERAL.—The tax imposed by subsection (a) shall be credited with the amount of any estate, inheritance, legacy, or succession taxes actually paid to any foreign country in respect of any property which is included in the gross estate solely by reason of subsection (b).

''(B) LIMITATION ON CREDIT.—The credit allowed by subparagraph (A) for such taxes paid to a foreign country shall not exceed the lesser of—

''(i) the amount which bears the same ratio to the amount of such taxes actually paid to such foreign country in respect of property included in the gross estate as the value of the property included in the gross estate solely by reason of subsection (b) bears to the value of all property subjected to such taxes by such foreign country, or

''(ii) such property's proportionate share of the excess of—

''(I) the tax imposed by subsection (a), over

''(II) the tax which would be imposed by section 2101 but for this section.

''(C) PROPORTIONATE SHARE.—For purposes of subparagraph (B), a property's proportionate share is the percentage of the value of the property which is included in the gross estate solely by reason of subsection (b) bears to the total value of the gross estate.''

(C) EXPANSION OF INCLUSION IN GROSS ESTATE OF STOCK OF FOREIGN CORPORATIONS.—Paragraph (2) of section 2107(b) is amended by striking ''more than 50 percent of'' and all that follows and inserting ''more than 50 percent of—

''(A) the total combined voting power of all classes of stock entitled to vote of such corporation, or

''(B) the total value of the stock of such corporation,''.

(2) GIFT TAX.—

(A) IN GENERAL.—Paragraph (3) of section 2501(a) is amended to read as follows:

''(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 877(a)(2).

''(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 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 this paragraph.''

(f) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

(1) IN GENERAL.—Section 877 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

''(1) IN GENERAL.—Any long-term resident of the United States who—

''(A) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

''(B) 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 and sections 2107, 2501, and 6039F 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 commencement.

''(2) LONG-TERM RESIDENT.—For purposes of this subsection, 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 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 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) STEP-UP IN BASIS.—Solely 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 EXEMPT 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 out 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 (d), by redesignating subsection (e) as subsection (d), and by inserting after subsection (d) (as so redesignated) the following new subsection:

''(e) CROSS REFERENCE.—

''For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''

(B) Paragraph (3) of section 2501(a) (as amended by subsection (e)) is amended by adding at the end the following new subparagraph:

''(E) CROSS REFERENCE.—

''For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''

(g) EFFECTIVE DATE.—

(1) IN 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.—

(A) 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 11349 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 is so 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.

SEC. 422. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

''SEC. 6039F. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

''(a) IN GENERAL.—Notwithstanding any other provision of law, any individual who loses United States citizenship (within the meaning of section 877(a)) shall provide a statement which includes the information described in subsection (b). Such statement shall be—

''(1) provided not later than the earliest date of any act referred to in subsection (c), and

''(2) provided to the person or court referred to in subsection (c) with respect to such act.

''(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

''(1) the taxpayer's TIN,

''(2) the mailing address of such individual's principal foreign residence,

''(3) the foreign country in which such individual is residing,

''(4) the foreign country of which such individual is a citizen,

''(5) in the case of an individual having a net worth of at least the dollar amount applicable under section 877(a)(2)(B), information detailing the assets and liabilities of such individual, and

''(6) such other information as the Secretary may prescribe.

''(c) ACTS DESCRIBED.—For purposes of this section, the acts referred to in this subsection are—

''(1) the individual's renunciation of his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)),

''(2) the individual's furnishing 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 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)),

''(3) the issuance by the United States Department of State of a certificate of loss of nationality to the individual, or

''(4) the cancellation by a court of the United States of a naturalized citizen's certificate of naturalization.

''(d) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year (of the 10-year period beginning on the date of loss of United States citizenship) during any portion of which such failure continues in an amount equal to the greater of—

''(1) 5 percent of the tax required to be paid under section 877 for the taxable year ending during such year, or

''(2) $1,000,

unless it is shown that such failure is due to reasonable cause and not to willful neglect.

''(e) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

''(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

''(A) a copy of any such statement, and

''(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

''(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

''(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual losing United States citizenship (within the meaning of section 877(a)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

''(f) REPORTING BY LONG-TERM LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—In lieu of applying the last sentence of subsection (a), any individual who is required to provide a statement under this section by reason of section 877(e)(1) shall provide such statement with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

''(g) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if he determines that applying this section to such individuals is not necessary to carry out the purposes of this section.''

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

''Sec. 6039F. Information on individuals losing United States citizenship.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to—

(1) 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

(2) 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 such date.

In no event shall any statement required by such amendments be due before the 90th day after the date of the enactment of this Act.

SEC. 423. REPORT ON TAX COMPLIANCE BY UNITED STATES CITIZENS AND RESIDENTS LIVING ABROAD.

Not later than 90 days after the date of the enactment of this Act, the Secretary of the Treasury shall prepare and submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report—

(1) describing the compliance with subtitle A of the Internal Revenue Code of 1986 by citizens and lawful permanent residents of the United States (within the meaning of section 7701(b)(6) of such Code) residing outside the United States, and

(2) recommending measures to improve such compliance (including improved coordination between executive branch agencies).

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas [Mr. ARCHER], the gentleman from California [Mr. STARK], the gentleman from Virginia [Mr. BLILEY], and the gentleman from Michigan [Mr. DINGELL] will each be recognized for 22½ minutes; and the gentleman from Pennsylvania [Mr. GOODLING] and the gentleman from Missouri [Mr. CLAY] will each be recognized for 15 minutes.

The Chair recognizes the gentleman from Texas [Mr. ARCHER].

GENERAL LEAVE

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.

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

There was no objection.

Mr. ARCHER. Mr. Speaker, I yield such time as he may consume to the gentleman from Ohio [Mr. HOBSON].

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

Mr. HOBSON. 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 removes 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 paperwork 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 provision is bipartisan and bicameral—it was 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 preexisting conditions that have denied them health insurance or have denied them 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 we did 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 bureaucratic 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 explosion of government bureaucracy. This legislation is a direct response 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 individuals and families without health care; streamline administrative costs and procedures; combat fraud and abuse in the health care industry; invoke medical malpractice reform that discourages unnecessary litigation currently driving up the cost of health care; and above all preserve the quality and freedom of choice that exists in our current market-based system.

One of the most important and unique components of this health care reform legislation is the creation of medical savings accounts [MSA's]. This provision will allow individuals and families to purchase a high deductible health plan and make tax deductible contributions to MSA's for the purpose of saving money for health care expenditures. In addition, contributions by employers on behalf of their employees will be excludable from taxable income. This proposal will finally provide an ideal way for young individuals and young families just starting out, to obtain affordable, quality health care coverage.

Estimates indicate that at least 1 million people will open medical savings accounts. Approximately 650,000 people who earn between $40,000 and $75,000 per year will choose MSA's; while 120,000 people who earn between $30,000 and $40,000 per year will join. The vast majority of those benefiting from the MSA will be 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 (103d). 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, availability and affordability 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 the M in MSA stands for middle income. The joint committee estimates 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.

The bill further insures affordability of 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 the 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 of 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 legerdemain to turn a silk purse into a sow's ear.

The Democratic substitute will, in fact, bring back the Roukema-Kassebaum-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 flimflamming 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 Medicare money on MSA tax breaks. 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.

There is also a payoff to American Family Life. It takes out the Medigap anti-duplication laws, will return us to the days of ripping off seniors by unscrupulous insurance salesmen.

□ 1830

The payoff 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 keep it simple. We should support 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.

I introduced the first insurance 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 and create 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 every single year; 3.6 million will face job lock. That is 3.6 million workers, but all of their dependents as well. They are the people whose fears will be allayed by tonight's legislation. One hundred and thirty-eight million workers and their dependents are covered by employer plans, and any one of them at any time could need what we do here tonight. This is, indeed, a giant step toward health security for all working Americans.

Underneath that bill, included in it, is the accomplishment of other goals that we have long aspired to. For 5 years we have tried to spread long-term care insurance to protect seniors against the cost of nursing home care, without forcing them to spend down to poverty. This is a remarkable piece of legislation. It is long overdue. It represents the culmination of solid study over 5 years. Mr. Speaker, I urge the Members' support.

Mr. STARK. 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 preexisting 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 301 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 additions to the bill 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, the cost of health insurance. 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.

Mr. Speaker, we have an opportunity tonight to move forward in a bipartisan legislative manner. Senator KASSEBAUM and KENNEDY's bill was put forth here by the gentlewoman from Connecticut, Mrs. ROUKEMA, and many Members of this body. We could take this bill, this simple, precise bill, and have portability for health insurance. That is all we have to do. We do not have to do everything that would just complicate matters. 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 want to move to company B, but company B does not have any health insurance program. You get a job at company C, 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.

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 on Ways and Means. That is unfortunate, because I know that the chairman agrees with me that we are trying to return power to our States. This bill moves in exactly the opposite direction. By preempting our States in health insurance, which has been a traditional role for State governments to regulate, this bill moves in the wrong direction. It preempts our States without providing adequate Federal protection.

Mr. Speaker, let me just give one example of the impact that this bill will have, if it becomes law, on the State of Maryland. We enacted small market reform in our State. It covers employers that have employees, between 2 and 50 employees. It also covers the association plans, and now also covers our self-employed. The plan is working.

Mr. Speaker, let me just read from a letter that I received from our State officials:

> The reforms went into effect July 1, 1994. . . . The small business community (the Maryland Chamber, Retail Merchants Association, individual businesses) and insurance agents report the reforms have stabilized the market, increased price competition, and increased choice of delivery systems.

The reforms proved so successful to the general assembly that they expanded it to include the self-employed.

Yet, the provisions that are included in this bill would seriously jeopardize our ability to continue that plan in Maryland, for, you see, companies would be able to come under Federal regulation and void the State plan, and therefore, defeat the purpose of the pooling arrangements in our State. That is unfortunate and it is wrong.

Let me give a second example. My State has passed the emergency room care legislation, that uses the ''reasonable lay person'' definition on when that person should be reimbursed for care in an emergency room. We are not waiting for the Federal Government to act on it. The Federal Government has not acted on it. Do not penalize my State by allowing more and more insurance plans to be able to get out from under State regulation and be able to avoid their responsibility to cover emergency room care. That is what this bill will allow to happen. More and more companies will be able to avoid State regulation. That is wrong. It should not happen. We should allow the States to respond.

Let me quote, if I might, from the National Association of Insurance Commissioners:

> Unfortunately, we continue to have grave concerns that subtitle C of title I of H.R. 3160 would significantly erode existing State level insurance reforms. The net effect of the final provisions relating to MEWA's is extremely damaging to States authority to govern their own insurance market.

Mr. Speaker, I do not understand why we are moving in the wrong direction by taking more power, rather than giving our States the ability to control health insurance. The National Association of State legislators opposed those provisions in the bill, and for good reason. I regret that the only option we have is to support the Democratic substitute if we want to deal with preexisting conditions.

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 thank the gentleman for yielding time to me.

Mr. Speaker, 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 coverage through their employers do no 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. Speaker, this mere 30 percent deduction 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. Speaker, 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 asked and was given permission to revise and extend his remarks.)

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 away and hurt everybody else in terms of premiums. 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 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? Mr. Speaker, I 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. Nothing exceeds 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 asked and was given permission to revise and extend his remarks.)

Mr. MCCRERY. Mr. Speaker, medical savings accounts will provide hard-working Americans 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 easily 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 costs. Furthermore, this bill helps 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 asked and was given permission to revise 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 first thing in it is data collection. I mentioned that under the rule, they collect data, they have electronic clearinghouses that can shift that information. There is no privacy protection in this bill whatsoever. This is the first time the Federal Government has gotten into collecting health care data, and there are no privacy protections.

But worst about this bill is that it purports to be about portability. Portability means you have insurance, you lose your job, what happens to you? Well, how can you carry your insurance until you get your next job, or what do you do to cover your family? Now, this bill says that, if you were in a company that had 50 people or you had a group insurance and you go out there and you start looking for insurance, the insurance company or the State can decide what they are going to offer you.

Mr. Speaker, we are not going to get the same policy we have now. No one listening to this should think that portability means what I have now I will have tomorrow, because it simply is not so. We give the insurance companies the ability to say, we will give you the average actuarial value policy. What does that mean? It has never been done in the United States. This is a pig in a poke. Anybody who thinks that the insurance companies when they do not have to give you insurance are going to give you the same thing, they are going to jack the price. And you are going to get less benefits, particularly if you have any kind of medical problem.

They are going to medically underwrite you. If you have cancer or heart attack or anything, diabetes, whatever, you suddenly are going to find out you do not have the same benefits you had under your old group policy.

Now, let us say we have a job and we lose it and move to another company. We may get into the next company, but the company that has more than 50 employees has no guarantee that they can go out and buy a policy. There is no guarantee of issue to an employer who has more than 50 people.

Mr. Speaker, all of these proposals fit the insurance company's ability to cherry pick and avoid the sick people and make their choices and find ways to make money. Anything that is in this bill could be done now by the insurance companies. The Republicans have put out there essentially what I say is a guarantee that we can buy a Cadillac in this country. Now, we can pass a bill and say everybody can buy a Cadillac. We guarantee that Cadillac dealerships must issue us the keys to a Cadillac.

Mr. Speaker, why do people not have Cadillacs? They have not got the money to buy Cadillacs. This bill is a fraud because it says, we get portability. But just like a bill that says we get a Cadillac, we would not get one.

Now, if that were not enough, if it were not just the issue of portability, the opportunities for fraud by insurance companies are increased in this bill. We passed a law since I came to Congress that said that insurance companies could not sell a policy to old

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 policy?

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 ability 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. MORAN. Mr. Speaker, as 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 account 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 arms, their breasts, their backs, their hips, their hands, their legs, their circulatory system. Imagine excluding these things from coverage.

Let me tell my colleagues why 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 the first 30 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 had specific experience. Carol Schreul 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 my colleagues 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 preexisting 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 that 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. It is a sham, Mr. Speaker. 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 it has no relevancy to what we are talking about today.

Mr. Speaker, I yield 1 minute to the gentleman from Texas [Mr. SAM JOHNSON].

Mr. SAM 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 costs.

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 their own health care dollars, make it more cost-conscious and bring down the total cost of medical costs 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. ARCHER. 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 commonsense 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 caught in the net, Americans who are now uninsured. That means the mon 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.

□ 1900

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Nevada [Mr. ENSIGN], a respected member of the Committee on Ways and Means.

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

Mr. ENSIGN. Mr. Speaker, in southern Nevada, with the fastest-growing senior population in the country, I constantly hear from elderly constituents

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 this 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 fair share. 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 forms of insurance 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 and do not have access to 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 why the Republicans would come in with an insurance plan 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 insured by 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 too much to consume 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 cannot afford to have these type of savings accounts which are there to protect those who already have.

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 die just 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 a bill. This is from 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 pays for 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 hoot about. 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, which would get us the Roukema-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 on 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.

We have 40 million people 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 a big 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 chairmen 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 majority.

The Democrats had more than 40 years. In fact, it has been more than 10 years since the last health insurance bill has been on the floor. The Democrats owned Washington in the entire 103d 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 provided 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 talked about that poor beleaguered person, and I am sure he is and he has been for a long time and he was during the entire time the Democrats were in the majority.

The major committees in the House, not just one committee, the major 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 about right for responsible and reasonable health care reform. We have actually accomplished a modest improvement for the self-employed. We moved their deductibility from 30 percent to 50 percent, prospectively. That is really all that we thought was prudent and appropriate.

Criticism from the minority over this? We do not do enough, 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 control they did absolutely nothing. They allowed the deductibility for health care to lapse. When you were running the place, why were not you more responsible?

H.R. 3103 reforms tort law in the area of medical malpractice. Is it radical? Half the States limit noneconomic damages. Is it controversial? Last March, with 247 votes, 44 Democrats, 23 from the North, 21 from the South, joining the new majority, the responsible Democrats and the Republicans passed medical malpractice reform. We put it in the product liability bill. The exact same language as passed the floor of the House is in this bill. We have put together increased penalties for fraud and abuse. Tougher rules, stiffer penalties. We find it, we fix it, and we make sure that we can fight it. Stiffer penalties, stronger rules. What is wrong with requiring the government to tell people when they ask the government is this OK?

What is wrong with advisory opinions? Apparently, the gentleman from California [Mr. STARK] did not find anything wrong with advisory opinions last June, outside the context of the political responses we have been hearing today. In H.R. 1912, the gentleman from California [Mr. STARK] introduced a bill to deal with health care fraud and abuse. On page 41, the gentleman from California has a provision, subtitled (d), advisory opinions, on kickbacks, and self-referrals.

We also have greater availability and greater affordability of health insurance, you have heard from many of my colleagues in the area of medical savings accounts. We have heard over here from the minority, how horrendous is this provision. Well, is it really? It is choice. It does not say that you must, it says you can. It does not say you shall, it says you may. It is a choice. It is one more choice. Possibly it is a product that people who now cannot find a product in the marketplace will use.

Who are those people? We have heard the profile of those individuals characterized as the healthy and the wealthy. Take a look at, again, the chart that the gentleman from Texas, Mr. SAM JOHNSON, focused on. According to the Joint Tax Committee, 51 percent of the people who are going to find this a useful product are in the $50,000 to $74,000 range, middle class. On the far right of the chart that is $100,000 and above; that is everybody who makes more than $100,000, $200,000, $300,000, $400,000, a million. That is out there less than 12%. That is that enormous group on the other end of the chart. Let us look at the lower end, from $40,000 to $49,000, 13 percent, from $30,000 to $39,000, 11 percent, the vast majority of people who will find this product usable are the middle and the lower middle class.

□ 1915

What is wrong with small employers being able to voluntarily pool their resources so they can save on their health insurance, just like large employers? We begin to make sure that people who more and more need to invest in long-term health care, their cost of the insurance, and the cost of the health care itself, thanks to the gentleman from Nevada, an amendment in the Committee on Ways and Means, 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 22½ 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 Affordability 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 real reforms, and most importantly, it makes health insurance coverage both available—and affordable—for millions of Americans.

The substitute represents a consensus agreement that was developed as a result of the provisions that were reported out of the Commerce Committee, as well as those developed by the Committee on Ways and Means, the Committee on the Judiciary, and the Committee on Economic and Educational Opportunities. It is designed to address the interrelated issues of accessibility and affordability of health insurance coverage.

The provisions of this bill within the jurisdiction of the Commerce Committee are designed to deal with the difficult problem of job lock, or, put more simply, an employee's reluctance to change jobs because of pre-existing condition exclusions in health care coverage. This bill will ensure that individuals who have an opportunity to move to new or better jobs will not have to face limitations in their coverage for pre-existing medical conditions that will affect them or their families. This bill will also assure people in group health plans that they cannot be excluded from coverage, or from renewing their coverage, based on their health status. It provides limits on the period of exclusion for a pre-existing condition and assures that, once covered, the condition will not be excluded from future coverage if the individual meets the requirements of the bill.

The Commerce Committee reported provisions also provide for guaranteed availability of coverage to employees in the small group market. Each insurer that offers coverage in the small group market would have to accept every small employer and every eligible individual within the group.

The bill would also ensure portability of health insurance for qualifying individuals moving from group to individual coverage. This is accomplished by giving States flexibility to achieve individual coverage through a variety of means that include risk pools, group conversion policies, open enrollment by one or more insurers and guaranteed issue.

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 malpractice system which will help contain 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 simplification. The General Accounting Office has estimated that fraud and abuse accounts for one out of every ten dollars spent on health care. Regrettably, fraud and abuse not only contributes 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 penalties for violations will ensure the continued integrity of the nation's health care system.

The administrative simplification provisions are needed to ensure that there are standards for the transmission of financial and administrative data. Much of this information is currently transmitted in an electronic format. 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 Americans.

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 for various 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; no guarantees for 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 and punish wrongdoers.

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 80%.

No other controversial provisions to weigh down the bill, slow down the conference, or provoke a Presidential veto.

Keep it simple. Keep it 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 sorry.'' Now he is back. What a difference.

Mr. Speaker, I yield 5 minutes to the gentleman from Florida [Mr. BILIRAKIS] the chairman of the subcommittee.

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

Mr. Speaker, I am pleased to be here today to add my voice to those in favor of health care reform for America's families.

I must say 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 contained in this legislation.

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 markup 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 proposal, 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 thus 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 expand 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 gentlewoman 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-Kennedy 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-Kennedy-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 will inevitably lead to more gridlock and inaction. 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, two prominent Republican leaders in the Senate, Senator KASSEBAUM 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, 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, malpractice, expansion and medical savings account, let us understand and be frank about that, that medical malpractice reform, medical savings account and ERISA expansion are controversial components. They are controversial, 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 commonsense reform they deserve.

And it should be noted that within the last 24 hours 2 prominent Republican leaders in the Senate have confirmed their firm opposition to an omnibus bill.

Should that happen, I expect the American people to hold the 104th Congress accountable, as well they should.

Now don't get me wrong. Some of the reforms in H.R. 3103 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 an 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 are complex and controversial and should be properly considered independently.

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-segmentation happened, the health insurance premiums for older, sicker individuals would skyrocket beyond imagination.

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 Federal law governing employee benefits such as health care or pensions.

The single, most important lesson I learned about ERISA from my time on the subcommittee was this: the more you think you've learned about ERISA and how it works, the more you realize how little you truly know.

I am increasingly of the view that while ERISA as originally devised served a useful purpose, we need a new ERISA for the modern context.

As more and more employers self-insure, thereby receiving a pre-emption from any State insurance rule, regulation or law, employees find themselves at the mercy of their employer's choice of health benefit plan.

For example, New Jersey and other States have enacted laws that require at least 48 hours of hospitalization coverage for women giving birth. These laws are a response to the efforts of managed care networks to discharge women, and their newborn children, within 24 hours of labor and delivery.

When employers self-insure, their employees do not receive the benefit of any of these protections because of the ERISA preemption.

With the expected rapid growth in managed care networks and their enrolles in the future, this trend will only get worse, not better.

Consequently, rather than the significant expansion of the current ERISA as envisioned in H.R. 3103, I believe we need to carefully examine ERISA and devise a new form of this law to meet our current needs.

We should not be considering any ERISA expansion as part of a larger package, where these kinds of issues get lost in the shuffle.

Passing a clean version of the Kassebaum-Roukema plan avoids all of these problems. I hope that we don't let this golden opportunity to slip through our collective fingers.

☐ 1930

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa [Mr. GANSKE], a valued member of the committee.

Mr. GANSKE. Mr. Speaker, this bill will help fix a health care system that has been beyond the means for many Americans.

Now a worker who wants to pursue his career but cannot change jobs because of an illness in the family would be covered by a new employer's insurance, group-to-group portability. Now an employee who is laid off or 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 insurance for the firm's five employees because one of them has a chronic illness, would be able to better 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 health 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

really need tonight is a clean bill, not loaded down with medical savings accounts and all the other things that are being suggested by the Republican leadership.

Mr. Speaker, the gentlewoman was trying to address portability and preexisting conditions, essentially expand coverage for many people now who cannot get coverage, and also keep health insurance affordable, and she achieves that essentially by saying that if you lose your job or change jobs, the insurance companies still have to provide you with individual coverage. She also limits the situations where the insurance companies can refuse to cover you because of preexisting medical conditions.

This is a very modest bill. We, on the Democratic side, managed to get 172 Members here to cosponsor her bill. In the Senate, there are 54 current cosponsors of the Kassebaum-Kennedy bill, so we know we can move this legislation, and the legislation is good because it is very modest. It basically keeps the insurance pool intact. It does not encourage healthy people to opt out. It does not bring in a lot of new people who are unemployed or who cannot afford insurance or who are critically ill that would increase the costs of health insurance.

But lo and behold, what do we get from the Republican leadership? They throw in the medical savings accounts, and what does that do? It breaks the risk pool. It breaks the insurance risk pool. Essentially what it does is to encourage healthy people and wealthy people to opt out and buy catastrophic coverage and get a tax break to put their money aside and leave everyone else in this risk pool so that they have to pay higher premiums, because it is going to cost more to insure them. It does the very thing, the very opposite, if you will, of what the gentlewoman from New Jersey, Mrs. ROUKEMA, and Senators KASSEBAUM and KENNEDY strove to do.

Mr. Speaker, what will 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. BLILEY. 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 basic 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 minor changes 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.

We have to stop the unjust practice of denying those with preexisting conditions insurance coverage. 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 never might 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 account.

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 for a change let us say they have taken the right path and pass a bill like Roukema-Kennedy-Kassebaum. 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. BLILEY. 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 coverage 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 Georgia.

H.R. 3103 takes the right approach in dealing with their anxiety, ensuring that people who change or lose their jobs will have access to health care, regardless of preexisting conditions. This is important and deals with the same issues as the Kassebaum bill. However, while this is a good starting point, it just does not go far enough. Providing portability is important but on its own, it fails to deal with the forces that drive health care costs higher.

Mr. Speaker, it is nonsense to tell the American people that we will increase their access to health care without making health care more affordable. If we do nothing to bring down the cost of health care, we have the same old problem. We will be told that some provisions were included in this bill to kill health care reform. That is bull. Increasing access and reducing health care costs are two sides of the same coin.

This bill attempts to remove the influence of the trial lawyers in medicine by reforming the medical liability system. It gives young people, a large portion of whom do not have coverage, more health care choices. We must pass H.R. 3103.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts [Mr. STUDDS].

Mr. STUDDS. Mr. Speaker, if I might have the attention of the distinguished chairman.

Am I correct that his bill prohibits group health plans or insurers offering coverage through group health plans from requiring a participant to pay a premium contribution that is greater than a premium contribution for a similarly situated participant or beneficiary solely on the basis of the health status of the participant or beneficiary?

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

Mr. STUDDS. I yield to the gentleman from Virginia.

Mr. BLILEY. Mr. Speaker, the gentleman is correct.

Mr. STUDDS. Am I further correct that the word ''solely'' in this provision means that there can be no discrimination at all in the setting of premium contribution amounts for a participant on the basis of health status?

Mr. BLILEY. Mr. Speaker, if the gentleman will continue to yield, the gentleman is correct.

Mr. STUDDS. Mr. Speaker, although I am somewhat underwhelmed by both of the propositions before us, I think this is a significant step in the right direction.

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 12¾ 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 asked and was given permission to revise and extend his remarks.)

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 gentlewoman 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/Bliley 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-Bliley bill.

□ 1945

Genetic testing has proved effective in certain cases, and it can be argued that the detection of a gene or a certain genetic characteristic will not necessarily result in the onset of a particular illness. So, we have an ambiguity here. We have an opportunity where somebody could have a defect which somebody would interpret different ways which would prevent them from having good health care insurance.

Genetic testing is moving along, as we all know, and it raises many ethical and legal and social questions relating to access to genetic testing, insurability and employability, and we need to make this confidential. The purpose of the Genetic Privacy Act, which I have provided, is to establish some guidelines concerning disclosure and use of genetic information with the goal of balancing the rights of the individuals against the needs of society.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from New Jersey [Mr. MENENDEZ].

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

Mr. MENENDEZ. Mr. Speaker, I rise in support of the substitute 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 that it was too much. We ended up with nothing. Hundreds of thousands of New Jerseyans 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 Americans with preexisting illnesses 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 the President, 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 Democratic substitute.

Mr. BLILEY. Mr. Speaker, I yield 1½ minutes to the gentleman from Pennsylvania [Mr. FOX].

Mr. FOX of Pennsylvania. Mr. Speaker, I rise to support the Archer-Bliley 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.

As my colleagues know, the United States spends far more per capita on health care than any other major Nation in the world. But yet despite the rising costs of health care, millions of Americans are without health insurance and millions more expected to join the ranks of the uninsured.

The solution to the problem, I believe, Mr. Speaker, is in fact contained in H.R. 3103. The reforms before us here tonight 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 change from one-employer 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 first time, to 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 make tax-deductible contributions 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 thinks to a special interest giveaway 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 40 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. BILILEY. 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 special interests? Weigh on in, because my colleagues are the ones who are in the pocket of the American trial bar.

Let us get to the real issue here. Medical savings accounts gives choice to Americans. It takes it away from our Washington bureaucrat command and control allies and puts it in the hands of the American public where it belongs. That is what our constituents want, and once they 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 1½ 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 insurance companies argue that domestic violence is a preexisting 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 an amendment which I offered which would once and for all put an end to this outrage. Women who are battered are entitled to health insurance just like anyone else.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from California [Mr. COX], chairman of the Republican Policy Committee.

Mr. COX of California. Mr. Speaker, I would just like to thank my colleague from Vermont. My understanding of his remarks is that he is pleased with the bill because it includes provisions that will make sure that domestic violence is covered, that it is not excluded from our protections as a preexisting condition.

That is my understanding. Is that correct?

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

Mr. COX of California. I yield to the gentleman from Vermont.

Mr. SANDERS. Included both in the Republican bill and the Dingell bill as well, yes.

Mr. COX of California. I thank the gentleman for pointing out that additional salutary impact of this legislation.

There is something else in this legislation that I would like to highlight, in addition to the fact that it will solve the problems that we have all agreed need to be solved on preexisting conditions and on portability of coverage. That is reducing costs in the way that the Congressional Budget Office has told us is the most effective way possible.

A September 1993 Office of Technology Assessment report said that a ceiling on noneconomic damages in medical lawsuits is the best way that we can get a grip on costs. Earlier in this session we have devoted our attention to this issue, and this Congress has, by overwhelming bipartisan vote, approved this kind of health care liability reform that, I want to point out, is also included in this bill and provides a very solid reason for voting for it.

One of the key elements is what in California we call MICRA. It is health care cost control that we have had in place for many, many years. It was passed by a Democratic legislature, signed by a Democratic governor. It is bipartisan in this Congress, as well. I was very pleased to be the Member who offered this legislation in the first session of Congress and to see the strong bipartisan support that it won.

We do have too many frivolous lawsuits, and, as a matter of fact, we can through this proven technique, already a law in California, control them for the benefit of every single individual insured person in America. Driving down health care costs this way is very, very important.

Mr. DINGELL. I yield 1½ minutes to the distinguished gentleman from Massachusetts [Mr. OLVER].

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

Mr. Speaker, among the many provisions, hundreds of pages of provisions which the insurance industry added to the Kennedy-Kassebaum bill that passed the Senate with, God forbid, bipartisan support, the most insidious of those provisions are those that provide for the 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 reform. It eliminates the denials for preexisting 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, and 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.

□ 2000

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman 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 add a series of controversial provisions to a popular health insurance reform bill, clouding chances for quick passage.''

The gentleman from Virginia [Mr. BLILEY] himself has said that, ''If you load up the wagon, it is heavier to pull.'' Do not sacrifice health care reform. 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 Golden Rule Insurance Co., but for the American people, for the working families of this country who deserve to have relief from the perils of a disastrous illness. Vote against this bill, vote for the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from California [Mr. FAZIO].

Mr. FAZIO of California. Mr. Speaker, when President Clinton stood here a few months ago and announced his support for a bill that had been authored by Senator KASSEBAUM and the gentlewoman from New Jersey, Mrs. ROUKEMA, to be joined by the gentlemen from Massachusetts, Senator TED KENNEDY, and JOSEPH KENNEDY, the country was ecstatic. They were convinced for the first time we would actually do something about the need to make health insurance portable and to prevent prior conditions from making insurance either unavailable or unaffordable to many people.

Tragically, we are here tonight debating 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 insurance salesmen in my district claim they would never sell policies for.

We have watered down portability, we have limited 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 coverage. They are not going to be able to keep the kind of plan they have had. This proposal ensures they will pay more.

Tragically, in the process of making this bill difficult to pass and sign, we have not done enough to help small business people who need 80 percent, if not 100 percent, deductibility, and we have weakened consumer protections and gutted State law.

Please oppose this bill and support the substitute.

Mr. Speaker, I offer my strong support for the Democratic substitute.

The Republican bill is loaded down with special interest amendments like MSA's political paybacks for the Golden Rule Insurance Co.

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 insurance when they switch jobs, regardless of their condition.

The Democratic substitute addresses several 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 conditions.

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 affordability. Increasing deductibility will help millions of farmers, small businesses, and other working 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.

This substitute represents legislation that we can pass today and that the President would sign tomorrow. It has received wide bipartisan support, both here in the House and in the other body.

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 gentleman 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 incremental, to be sure. It would have guaranteed that health care was affordable, but at least it would have been accessible. 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, wholesome slices of health insurance reform and slapped a whole lot of extraneous junk food on top, creating a health care hoagie of medical savings accounts, 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 interests is no vice. ''The American Medical Association wants it, we will just toss it into this bill.''

Barbara Tuchman wrote a very famous book back in the early 1980's, entitled the ''March of Folly'', basically chronicling throughout the ages the mistakes.

Mr. BLILEY. 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 Energy and Commerce for yielding time to me. As a matter of fact, Mr. Speaker, I thank all of those chairmen of the committees who have worked together to make this bill possible, and the subcommittee chairmen, and I would be remiss if I did not thank the staff of the combined 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 questions me, it wonders me, I guess you would say, who are those special interests 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 employees 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 interest?

Is it a special interest for a family who wants to get health care and make choices 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 dinosaurs that still want to have big Federal 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 minimum, the very minimum to cover the ladies and gentleman 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

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 legislature 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, coming from proponents of the President's ill-conceived centralized, federalized health care scheme, can only be seen as a farce. I contend that the President's first health care bill was far too big. The Kennedy approach now advocated 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 preexisting 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 these things, 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 rule, 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.

The Chair recognizes the gentleman from Pennsylvania [Mr. GOODLING].

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 accountability. Unfortunately, until this point, efforts to nationalize health care have deprived our people of the added security that would result from the commonsense and bipartisan elements of targeted health insurance reform contained in the measure we are now considering. 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 health care plan. The American people 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 which are 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 and more.

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 reasons. Smaller employers and their employees would also have an expanded choice of health insurance coverage because of provisions in the bill allowing employers to choose their coverage from among all of the products offered by insurers and HMO's participating in the small group market.

I believe these changes reflect the kind of important reforms the American public expect of us. But we must also help those who have no coverage at all. The problem of the uninsured is primarily one of small businesses that cannot afford to buy insurance for their workers.

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.* * * H.R. 995 [the bill reported by the Committee] takes this approach. We are pleased that the bill uses ERISA as its vehicle.''

By utilizing the time-tested features contained in ERISA, the provision under subtitle C, like those under H.R. 995, build upon the successes produced by private sector innovation and market competition.

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 Availabilty and Affordability Act present this Congress with perhaps its best opportunity since the passage of ERISA to expand 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, by increasing 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 coverge before portability protection for preexisting conditions 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 employees must give to received 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 without requiring a demonstration that 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 controversial such as provisions requiring 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.

☐ 2015

Mr. CLAY. Mr. Speaker, I yield myself 3 minutes.

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

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 millions of people. They 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 1983. 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 still be reviewing their 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.

And to whom will these angry, aggrieved consumers turn when this happens? Their State insurance regulator? No. Consumers will turn to the Labor Department and Members of Congress for relief. And, as with the savings and loans insolvencies of the 1980's, the urge and political pressure to bail out these MEWA's and protect constituents will be irresistible.

Finally, considering the hostility, not to mention the appropriations riders and budget cuts, that has met Labor Department regulatory activity during this Congress, it is almost certain that the Labor Department will be a weak regulator.

Do you want the Federal Government to assume responsibility for regulating large, multistate health plans whose insolvencies could expose the Federal Government to multimillion-dollar bailouts—especially in an era of Federal Government downsizing, anti-regulating zeal, and diminishing budgets?

Mr. Speaker, this bill brings market fragmentation to an even higher plain. It carves up the multiemployer plan market, treating large plans differently than small plans, old plans differently than new plans, single industry plans differently than multiindustry plans, plans in one State differently than plans in another.

Its exemptions, its exceptions to the exemptions, and its loopholes to the exceptions to the exemptions—never mind the bill's grandfathering of scoundrels along with the saints—makes this bill look like swiss cheese and smell like limburger.

Finally, the United States has an extremely fragmented health insurance market. This bill would make it worse. The expansion of self-funded plans would greatly exacerbate market fragmentation.

The bill's expansion of the ERISA preemption to self-funded multiemployer plans, and 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 MEWA's. And, many employers that now offer an insured product to their employees—through Blue Cross-Blue Shield, for example—will transfer their coverage to these Federal MEWA's.

These Federal, self-funded MEWA's will siphon healthier, younger groups from traditional insurance markets and, as a consequence, will undermine those markets as well as State health reform initiatives. As healthier groups 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.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS,
Washington, DC, March 28, 1996.

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''), has provided comments upon H.R. 995, H.R. 3063 and H.R. 3070.

We appreciate the legislation's extension of portability reforms to self-funded health care plans governed by the Federal Employee Retirement Income Security Act (''ERISA''); the NAIC has long called for these reforms and federal intervention in this area is laudable. We also appreciate certain clarification that were made to provisions in the bills adopted by the committees of jurisdiction relating to state flexibility and the Medicare anti-duplication prohibitions. However, as detailed below, we continue to have serious concerns with the bill's provisions relating to multiple employer welfare arrangements (''MEWAs'').

We commend the additional clarifications made within Title 1, Subtitle D, Section 192, relating to ''State Flexibility to Provide Greater Protection''. The bill contains further limits on the scope of its preemption than were contained in H.R. 3063 and H.R. 3070. The legislative now states that it does not preempt those state laws ''that related to matters not specifically addressed'' in the bill. The bill also specifically saves several areas of state laws. We appreciate this enhanced state flexibility. We do, however, remain concerned about the absence of a broader construction clause explicitly saving from preemption any state laws that are not inconsistent with the bill and which provide greater beneficiary protection. In the absence of such a clause, the bill might be construed to ''preempt the field'' of any state law that touches upon any area minimally mentioned in the bill, even if the bill's provisions were not intended to preempt such state law. Since this a new area of federal intervention, we urge caution and care in the final crafting of preemption language.

We also appreciate the significant strides made in refining the range of health insurance policies which are not to be considered duplicative for the purposes of the application of the new Medicare anti-duplication provisions. We would appreciate the opportunity to clarify the states' remaining jurisdiction concerning health insurance policies governed by these provisions (possibly within legislative history) and to provide technical comments. We would like to commend you for tightening the consumer protections in these provisions from the earlier provisions adopted by amendment in committee.

We reiterate the concerns raised in our letter of March 18, 1996 to Chairmen Archer and Bliley concerning the long term care insurance related provisions within the legislation.

Unfortunately, we continue to have grave concerns that Subtitle C of Title 1 of H.R. 3160 would significantly erode existing state-level insurance reforms. The net effect of the final provisions relating to MEWAs is extremely damaging to states' authority to govern their own insurance market. The final language contains many layers of savings for, and exemptions from, state laws. This maze clouds the picture. Upon close examination of the multiple tiers of provisions, the bill preempts state laws governing health insurance, including those governing MEWAs, in all but a small number of states.

In sum, the changes made to Subtitle C do not represent a significant improvement from those contained within H.R. 995. We therefore remain opposed to most of the provisions contained within Subtitle C of Title I of the bill and reiterate the prior concerns expressed by the NAIC Committee on this topic. (See Joint NAIC Committee/NCSL letter dated March 5, 1996 to Representative William Goodling).

In addition, the bill still preempts state rating laws applicable to association plans thereby creating an unlevel playing field between these plans and other insured plans. Market fragmentation will thereby worsen and costs within the insured market could spiral. With respect to association plans, the bill also preempts state mandated benefit laws which have been enacted by the states.

The state budgetary impact of the bill is still likely to be significant. 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.

The bill strips states of their oversight responsibility over a significant class of MEWAs. We question whether states could in good conscience accept responsibility for MEWA activities by asking the U.S. Department of Labor, pursuant to the option in the bill, for the authority to enforce the inadequate federal standards set forth in the bill. While gaps and ambiguities in federal law have led to some enforcement difficulties, this should be addressed by clarifications in federal law, not by the sweeping preemption of state regulatory authority over MEWAs proposed through H.R. 3160.

Thank you for your consideration of our comments. We look forward to continuing to work together on legislation to promote portability and availability of health insurance. Please feel free to call Kevin Cronin, the NAIC's Acting Executive Vice President and Washington Counsel at (202) 624–7790, with any questions you may have.

Sincerely,

BRIAN K. ATCHINSON,
President, NAIC,
Superintendent, Maine Bureau of Insurance.

NATIONAL CONFERENCE OF STATE LEGISLATURES,
Washington, DC, March 27, 1996.

Hon. JOHN JOSEPH MOAKLEY,
Ranking Member, Committee on Rules,
U.S. House of Representatives, Washington, DC.

DEAR REPRESENTATIVE MOAKLEY: On behalf of the National Conference of State Legislatures, I would like to share our thoughts on H.R. 3160, pending health insurance reform legislation. NCSL supports efforts to extend portability to individuals covered by ERISA plans and to establish minimum federal standards for insured plans. We are pleased that Title I, Subtitles A and B, build on the foundation for reform built by states over the last several years. We have been assured that the intent of Subtitles A and B is to continue to support state regulation and innovation in the small group and individual markets. We are pleased that changes have been made since the mark-up of H.R. 3070 and H.R. 3103, to provide additional clarity with regard to the ability of states to exceed the federal standards, established in the bill. We continue to have some concerns. For example, Section 103(b)(1) that states, ''. . . 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 to pay a premium or contribution which is greater than such premium or contribution for a similarly situated participant or beneficiary *solely* on the basis of the health status of the participant or beneficiary.'' NCSL is concerned that state rating laws that prohibit or restrict the use of health status in a manner different than prescribed in the bill, may be preempted. For example, in cases where plans that include a rating component in addition to health status, state rating reforms may not apply. We hope to work with you to obtain additional clarity.

While we support the thrust of Subtitles A and B of Title I, NCSL opposes Subtitle C and urges you not to include these provisions in the House health insurance reform bill. Subtitle C fails to recognize the traditional role of states in the regulation of insurance and the important contributions state legislators have made in increasing accessibility and portability of health insurance and addressing fraud and consumer protection issues with regard to Multiple Employer Welfare Associations, by eliminating state authority to oversee Multiple Employer Welfare Associations (MEWAs). Instead, Subtitle C: (1) creates incentives for the establishment of federally regulated MEWAs, moving more individuals out of the reach of state insurance regulators and the protections those regulators provide; (2) permits some MEWAs to operate without receiving full federal approval; and (3) expands the Department of Labor's (DOL) authority over employer solvency and MEWAs, but fails to authorize funds for expanding DOL staff to perform these functions. NCSL opposes this preemption of state authority and the deregulation of MEWAs.

The MEWA provisions of H.R. 3160 would: (1) disrupt the existing health insurance market, undermining existing state efforts to improve access to health care and adversely affecting insurance premiums overall, and (2) make it easier for unscrupulous individuals to commit fraud under the protective umbrella of this proposed federal law which fails to provide adequate protections

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. Work 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 carriers to renew coverage 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 guaranteed renewal; 11 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 enrolled over 100,000 individuals last year. Finally, states are continuing to work with MEWAs to strike a balance between reasonable state regulations, 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,

WILIAM POUND,
Executive Director.

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

Mr. GOODLING. Mr. Speaker, I yield such time as he may consume to the gentleman from Indiana [Mr. BUYER].

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

Mr. BUYER. Mr. Speaker, I rise in support of the bill to open access and make health care affordable.

Mr. Speaker, today, with the passage of this bill, H.R. 3103, we will be expanding health care coverage to millions of Americans. After years of discussing how best to bring reform to our health care system, this bill brings meaningful incremental health care reform. H.R. 3103, the Health Care Coverage Availability and Affordability Act, addresses two crucial needs in our health care system—access and affordability.

First, let's review our current situation. Eighty-five percent of the population has health insurance, mostly through their employer. The uninsured, approximately 39 million Americans, today are not poor and are not elderly. The poor are covered by Medicaid; the elderly are covered by Medicare. Of the uninsured, 47 percent were employed full time; 38 percent worked part-time; 16 percent were unemployed. If incentives can be created in the market so more employed individuals can get affordable coverage and those between jobs can get coverage; then, the number of uninsured individuals will go down. Meaning millions of Americans will be covered by medical insurance.

Furthermore, many individuals cannot get coverage due to pre-existing conditions or because it is too expensive. Many businesses cannot get coverage because one of the employees or a dependent of an employee has a pre-existing condition. Employees are discouraged from changing jobs or starting their own businesses because they cannot get coverage due to a pre-existing condition.

H.R. 3103 will help create incentives so more individuals receive affordable insurance. First, it addresses the problems of access and affordability. Under H.R. 3103, group health plans (large employer plans, insurers, health maintenance organizations) are prohibited from imposing a pre-existing condition exclusion that exceeds 12 months for conditions that were diagnosed or treated within the previous 6 months on individuals that move from one group plan to another group plan. Pre-existing conditions would not affect newborns, adopted children, or pregnancy. Health insurance providers must reduce previous condition exclusion periods for an individual who enrolls in another program by the amount of time the individual was covered by a group health plan, health insurance, and HMO or Medicaid. Health insurance providers may not deny coverage to individuals in group health plans because of (1) a medical condition, (2) claims experience, (3) receipt of treatments for a medical condition, (4) medical history, (5) evidence of insurability or (6) disability.

H.R. 3103 also ensures portability of health insurance for those moving from group coverage to individual coverage, such as someone leaving a large employer to start a business. Many States, including Indiana, have addressed this issue. Under H.R. 3103, States are given the flexibility to address this problem such as by risk pools, or conversion policies, open enrollment periods, guaranteed issue, or any means that a State sees fit. However, for those State's that have not acted adequately, an insurer or HMO issuing individual health insurance coverage would have to offer an insurance policy equal to the average acturial value of the plans offered in the individual market by that insurer. The insurer would be prohibited to decline to issue coverage based on health status.

One of the key provisions of the bill allows small employers to voluntarily form groups for the purpose of self-insuring or providing health care coverage. Associations, like the NFIB or the Farm Bureau, would be able to band their members together for health insurance purposes and be treated like large multi-state employers. The regulatory structure that enables General Motors or IBM or AT&T to offer health insurance coverage, will now exist for the local hardware store, the corner grocer, and the farmer to purchase affordable health care coverage.

Voluntary health insurance associations are not new. In northwest Indiana a group of businesses have banded together to gain market clout to buy health care coverage for their employees. Typically, the employers in the alliance enjoy savings of 10 percent to 40 percent and can access 11 different health plans. H.R. 3103 should make their task easier and the bill should encourage other entities to band together to get access to affordable health insurance.

These provisions address the regulatory side of health insurance. By themselves, they make this bill worthy of support, but H.R. 3103 does not stop at insurance reform. It includes noteworthy tax relief as well.

First, H.R. 3103 increases the health insurance deduction for self-employed individuals from 30 percent to 50 percent by the year 2003. In 1995, Congress made this deduction permanent and raised it from 25 percent to 30 percent. We need to take care of the entrepreneurial spirit of America which lies in small business. This bill will increase the deduction to 50 percent. As large employers get a complete write-off of health insurance expenses, this bill brings an element of tax fairness to the system.

The bill also extends the medical expense tax deduction to include long-term care services that are curing or rehabilitative in nature, or are maintenance and personal care required by the chronically ill. This should give some relief to taxpayers who need long-term care. In additon, benefits paid out under life insurance ''accelerated death benefits'' contracts would not be treated as taxable income to the terminally or chronically ill beneficiary.

H.R. 3103 also includes Medical Savings Accounts. Individuals covered by a high deductible health insurance plan or their employer could make tax deductible contributions to a medical savings account. Funds could only be used for qualified medical expenses and disbursements for non-medical reasons would be treated as taxable income and subject to an additional 10 percent penalty. MSAs are true portability. The account belongs to the individual and is under the individual's control. This is a creative solution to provide more affordable insurance coverage and greater choice.

Finally, H.R. 3103 addresses fraud. Recent studies estimate that fraud costs consumers 5 to 10 percent of ever health care dollar spent. This is literally billions of dollars and leads to higher costs and higher premiums. It authorizes the Secretary of Health and Human Services and the Attorney General to jointly establish a national program to combat health care fraud. Under Medicare, the Secretary of HHS is required to establish a program to encourage individuals to report suspected fraud and abuse in the Medicare Program. Individuals who have been convicted of felonies relating to health care fraud or controlled substances would be excluded from Medicare and State health care programs for a minimum of 5 years. Criminal penalties would be revised and enhanced.

H.R. 3103 is a good bill with much needed reform. It goes beyond simple portability and addresses access, affordability, and choice. Once enacted, it will mean that someone today without insurance has a better chance of getting it and affording it tomorrow.

Mr. GOODLING. Mr. Speaker, I yield 4½ minutes to the gentleman from Illinois [Mr. FAWELL], who has spent probably hundreds of hours putting this legislation together and guiding us in committee.

Mr. FAWELL. Mr. Speaker, I thank the gentleman for yielding me this time.

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

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 had for years under ERISA.

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 a 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 * * * a massive improvement''. Here's what NFIB says. I am going to be quoting from a letter from them.

NFIB is seeking to correct a basic unfairness in our health care system. Big business is allowed to buy 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 premiums of corporate America are going down, while small business premiums are going up.

H.R. 3160 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 give(s) 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 recent editorial 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 arrange with an insurer 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 way, what good is portability?

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 have 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? The people who cut your hair, serve you at restaurants, repair your car, clean your clothes—the millions of people working in small businesses all over America and who produce most of our new jobs.

I urge my colleagues to vote no on the substitute and vote yes 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 COVERAGE AVAILABILITY AND AFFORDABILITY ACT OF 1996

TITLE I—INCREASED AVAILABILITY AND PORTABILITY OF HEALTH PLAN INSURANCE COVERAGE

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 that exceeded 12 months for conditions for which medical advice, diagnosis, or treatment was received or recommended within the previous 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 so long as these individuals become insured within 30 days of birth or placement 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 treatment of the condition to which the information was applicable had not been sought during the 6 months prior to becoming covered.

Group health plans, insurers, and health maintenance organizations (HMOs) would be required to credit periods of qualified previous coverage toward the fulfillment of a preexisting condition exclusion period when an individual moves from one source of group health coverage to another. Specifically, a preexisting condition limitation period would be reduced by the length of the aggregate period of any qualified prior coverage. Prior coverage would not have to be credited toward a preexisting condition limitation period if the individual experienced a break in qualified group coverage of more than 60 days. (Qualified group coverage means any period of coverage of the individual under a group health plan, health insurance coverage, Medicaid, Medicare, military health care, the Indian Health Service, state health insurance coverage or state risk pool, and coverage under the Federal Employee Health Benefits Program (FEHBP).) A waiting period for any coverage under a group health plan (or for health insurance coverage offered in connection with a group health plan) would not be considered a break in coverage.

Presentation of a certification of prior coverage would establish an individual's eligibility for credit against a preexisting condition limitation period. Group health plan administrators, insurers, HMOs, and state Medicaid programs would be required to provide such certifications of coverage upon request of the individual.

In determining whether an individual has met qualified coverage periods, a group health plan, insurer, or HMO offering group coverage could elect one of two methods. Under the first, it could include all periods, without regard to the specific benefits offered during the period of prior coverage. Under the second, it could look at periods of prior coverage on a benefit-specific basis and not include as a qualified coverage period a specific benefit unless coverage for that benefit was included at the end of the most recent period of coverage. Entities electing the second method would have to state prominently in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment or sale that the plan or coverage had made such an election and would have to include a description of the effect of this election. Upon the request of the plan, insurer, or HMO, the entity providing the certification would have to promptly disclose information on benefits under its plan. It could charge the reasonable cost for providing this information.

Sec. 103. Prohibiting exclusions based on health status and providing for enrollment periods.

This section provides for availability of coverage. The bill would ensure that employees and their dependents could not, based on health status, be excluded from enrolling in their group health plan and being continually enrolled. Health status is defined to include, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

Group health plans 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 this was the reason for declining enrollment, (3) 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.

In the event 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 applicable to the coverage of a 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 any waiting period applicable to that 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 of employers to health coverage to offer their employees. A group health plan which is a multiemployer plan, a multiple employer health plan (as defined in section 704 of ERISA), and a multiple employer welfare arrangement (providing medical care) may not deny an employer whose employees are covered under 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 is ceasing to offer any coverage in a geographic area, (5) for 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 a plan or arrangement to which subparagraph (C), (D), or (E) of section 3(40) of ERISA applies, to the extent necessary to meet the requirement of such subparagraph, or (7) in the case of a multiple employer health plan (as defined in section 701(4) of such Act), for failure to meet the requirements under part 7 of ERISA for exemption under section 514(b)(6)(B) of such Act. It is not included that anything in this section be construed to preclude any such plan or arrangement from establishing employer contribution requirements or group participation requirements not otherwise prohibited by this Act.

Sec. 104. Enforcement.

The above provisions would be enforced through penalties assessed through the Internal Revenue Code (IRC), Employee Retirement Income Security Act (ERISA), or through civil money penalties assessed by the Secretary of Health and Human Services (HHS). The Secretaries of Treasury, Labor, and HHS would be required to issue regulations that are nonduplicative and in a manner that assures coordination and nonduplication in their activities as provided for under this Act.

Enforcement through ERISA. Sections 101, 102, and 103 of Subtitle A (and the definitions under Subtitle D insofar as they are applicable to such sections) are deemed to be provisions of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) for purposes of applying the enforcement, fiduciary and other provisions of such title. The Secretary of Labor would only apply the sanctions under ERISA to an insurer or HMO that was subject to state law (within the meaning of section 514(b)(2)(A)) in the event that the Secretary determines that the state has not provided for enforcement of the above provisions of the Act. Sanctions would not apply in the event that the Secretary of Labor established that none of the persons against whom the liability would be imposed knew, or exercising reasonable diligence, would have known that a failure existed, or if the noncomplying entity acted within 30 days to correct the failure. In no case would a civil money penalty be imposed under ERISA for a violation for which an excise tax under the COBRA enforcement provisions under the Internal Revenue Code was imposed or for which a civil money penalty was imposed by the Security of HHS.

Enforcement through the IRC. IRC enforcement would be done through the Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance continuation provisions (section 4980B). In general, a noncomplying plan would be subject to an excise tax of $100 per day per violation. Penalties would not be assessed in the event that the failure was determined to be unintentional or a correction was made within 30 days. For purposes of applying the COBRA enforcement language, special rules would apply: (1) no tax could be imposed by this provision on a noncomplying insurer or HMO subject to state insurance regulation if the Secretary of HHS determined that the state had an effective enforcement mechanism; (2) in the case of a group health plan of a smaller employer that provided coverage solely through a contract with an insurer or HMO, no tax would be imposed upon the employer if the failure was solely because of the product offered by the insurer or HMO; and (3) no tax penalty would be assessed for a failure under this provision if a sanction had been imposed under ERISA or by the Secretary of HHS with respect to such failure.

Enforcement through Civil Money Penalties. A group health plan, insurer, or HMO that failed to meet the above requirements would be subject to a civil money penalty. Rules similar to those imposed under the COBRA penalties would apply. The maximum amount of penalty would be a $100 for each day for each individual with respect to which a failure occurred. In determining the penalty amount, the Secretary would be required to take into account the previous record of compliance of the person being assessed with the applicable requirements of the bill, the gravity of the violation, and the overall limitations for unintentional failures provided under the IRC COBRA provisions. No penalty could be assessed if the failure was not intentional or if the failure was corrected within 30 days. A procedure would be available for administrative and judicial review of a penalty assessment.

The authority for the Secretary of HHS to impose civil money penalties would not apply to enforcement with respect to any entity which offered health insurance coverage and which was an insurer or HMO subject to state regulation (within the meaning of section 514(b)(2)(A) of ERISA) by an applicable state authority if the Secretary of HHS determined that the state had established an enforcement plan. In no case would a civil money penalty be imposed under this provision for a violation for which an excise tax under COBRA or civil money penalty under ERISA was assessed.

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.

This section provides for guaranteed availability of general coverage in the small group market. Each insurer or HMO that offered general coverage in the small group market in a state would have to: (1) accept every small employer in the state that applied for such coverage; and (2) accept for enrollment every eligible individual who applied for enrollment during the initial enrollment period in which the individual first became eligible for coverage under the group health plan. No restriction based on health status could be placed on the ability of an eligible individual to enroll.

The small group market is generally defined as employer groups with more than 2 and less than 51 employees. An eligible individual is one in relation to the employer as determined: (1) in accordance with the terms of the plan; (2) as provided by the insurer or HMO under rules which would have to be applied uniformly; and (3) in accordance with applicable state laws. Special rules would apply to network plans and HMOs to ensure that this guaranteed availability provision did not lead to capacity problems. In addition, such entities would not have to enroll a small group whose employees worked or lived outside the entity's service area. Insurers and HMOs could deny enrollment to an eligible small group in the event that the group failed to meet certain minimum participation or contribution requirements that were consistent with state law.

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 or large group market, 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 renewability requirement would apply in the event that the employer failed to pay the premiums, committed fraud, violated the participation rules, or moved outside the service area. In addition, guaranteed renewability would not apply if: (a) the insurer or HMO ceased to offer any such coverage in a state (or in the case of a network plan, in a geographic area); (b) in the event that the insurer or HMO uniformly terminated offering a particular type of coverage and provided adequate notice and the opportunity to elect other health insurance being offered in that market; and (c) in the event that the entity discontinued offering all health insurance coverage in the small or large group market or in both markets in a state, provided for adequate notice. In the last instance, such an entity could not reenter the market it left for at least 5 years.

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 from State regulation of multiple employer health plans.

Sec. 161, Subsection (a). Rules governing state regulation of multiple employer health plans.

This subsection adds a new Part 7 (Rules Governing State Regulation of Multiple Employer Health Plans) to Title I of ERISA, as follows:

''Sec. 701. Definitions.

This section defines the following terms: insurer, fully-insured, medical care (as under current law), multiple employer health plan, participating employer, sponsor, and state insurance commissioner.

''Sec. 702. Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions from State regulation of multiple employer health plans.

This section clarifies the conditions under which multiple employer health plans (MEHPs), non-fully-insured multiple employer arrangements providing medical care, may apply for an exemption from certain state laws. The exemption process is contained in current ERISA law, which also contains restrictions on the ability of states to fully regulate such entities. Specifically, existing section 514(b)(6)(A)(ii) of ERISA provides that in the case of such a partly insured or fully self-insured arrangement, any law of any State which regulates insurance may apply only ''to the extent not inconsistent with other parts of ERISA.'' However, under section 514(b)(6)(B), the Department of Labor (DOL) may issue an exemption from

state law with respect to such self-insured arrangements.

''Section 702 clarifies that only certain legitimate association health plans and other arrangements (described below) which are not fully insured are eligible for an exemption and thereby treated as ERISA employee welfare benefit plans. This is accomplished by clarifying the duty of the Secretary of Labor to implement the provisions of current law section 514(b)(6)(B) to provide such exemptions for MEHPs. Under section 514(a) of ERISA, States are preempted from regulating employee welfare benefit plans, but an exception is made under section 702 to allow states to enforce the conditions of an exemption granted a MEHP.

''Section 702 further sets forth criteria which a self-insured arrangement must meet to qualify for an exemption and thus become a MEHP. The Secretary shall grant an exemption to an arrangement only if: (1) a complete application has been filed, accompanied by the filing fee of $5,000; (2) the application demonstrates compliance with requirements established in sections 703 and 704 below; (3) the Secretary finds that the exemption is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of the individuals covered under the arrangement, and (4) all other terms of the exemption are met (including financial, actuarial, reporting, participation, and such other requirements as may be specified as a condition of the exemption).

''The application must include the following: (1) identifying information about the arrangement and the states in which it will operate; (2) evidence that ERISA's bonding requirements will be met; (3) copies of all plan documents and agreements with service providers; (4) a funding report indicating that the reserve requirements of section 705 will be met, the contribution rates will be adequate to cover obligations, and that a qualified actuary (a member in good standing of the American Academy of Actuaries or an actuary meeting such other standards the Secretary considers adequate) has issued an opinion with respect to the arrangement's assets, liabilities, and projected costs; and (5) any other information prescribed by the Secretary. Exempt arrangements must notify the Secretary of any material changes in this information at any time, must file annual reports with the Secretary, and must engage a qualified actuary.

''Section 702 also provides for a class exemption from section 514(b)(6(A)(ii) of ERISA for large MEHPs that have been in operation for at least five years on the date of enactment. An arrangement qualified for this class exemption if: (1) at the time of application for exemption, the arrangement covers at least 1,000 participants and beneficiaries, or has at least 2,000 employees of eligible participating employers; (2) a complete application has been filed and is pending; and (3) the application meets requirements established by the Secretary with respect to class exemptions. Class exemptions would be treated as having been granted with respect to the arrangement unless the Secretary provides appropriate notice that the exemption has been denied. It is expected that the standards applicable to entities eligible for a class exemption will be no less protective than if an individual exemption were granted to such an entity.

''Sec. 703. Requirements relating to sponsors, board of trustees, and plan operations.

This section establishes eligibility requirements for MEHPs. Applications must comply with requirements established by the Secretary. Applications must demonstrate that the arrangement's sponsor has been in existence for a continuous period of at least 5 years and is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for a least annual meetings, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group, including a corporation or similar organization that operates on a cooperative basis within the meaning of section 1381 of the IRC) for purposes other than that of obtaining or providing medical care. Also, the applicant must demonstrate that the sponsor is established as a permanent entity, has the active support of its members, and collects dues from its members without conditioning such on the basis of the health status or claims experience of plan participants or beneficiaries or on the basis of the member's participation in the MEHP.

''Section 703 also requires that the arrangement be operated, pursuant to a trust agreement, by a ''board of trustees'' which has complete fiscal control and which is responsible for all operations of the arrangement. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation which is adequate to carry out the terms of the arrangement and to meet all applicable requirements of the exemption and Title I of ERISA. The rules also require that all employers who are association members be eligible for participation under the terms of the plan. Eligible individuals of such participating employers cannot be excluded from enrolling in the plan because of health status as required under section 103 of the Act (nor be excluded by purchasing an individual policy of health insurance coverage for a person based on their health status). The rules also stipulate that premium rates established under the plan with respect to any particular participating employer cannot be based on the claims experience of the particular employer.

''In addition to the associations described above, certain other entities are eligible to seek an exemption as MEHPs under section 514(b)(6)(B) of ERISA. These include (1) franchise networks (section 703(b)), (2) certain existing collectively bargained arrangements which fail to meet the statutory exemption criteria (section 703(c)), and (3) certain arrangements not meeting the statutory exemption criteria for single employer plans (section 703(d)). (Section 709 of ERISA, added by Section 166, also makes eligible certain church plans electing to seek an exemption.)''

''Sec. 704. Other Requirements For Exemption.

''Section 704 requires a MEHP to meet the following requirements: (1) its governing instruments must provide that the board of trustees serves as the named fiduciary and plan administrator, that the sponsor serves as plan sponsor, and that the reserve requirements of section 705 are met; (2) the contribution rates must be adequate, and (3) any other requirements set out in regulations by the Secretary must be met.''

''Sec. 705. Maintenance of Reserves.

''Section 705 requires MEHPs to establish and maintain reserves sufficient for unearned contributions, benefit liabilities incurred but not yet satisfied and for which risk of loss has not been transferred, expected administrative costs, and any other obligations and margin for error recommended by the qualified actuary. The minimum reserves must be no less than 25% of expected incurred claims and expenses for the year or $400,000. The Secretary may provide additional requirements relating to reserves and excess/stop loss coverage and may provide adjustments to the levels of reserves otherwise required to take into account excess/stop loss coverage or other financial arrangements.''

''Sec. 706. Notice Requirements for Voluntary Termination.

''Section 706 provides that, except as permitted in section 707, a MEHP may terminate only if the board of trustees provides 60 days advance written notice to participants and beneficiaries and submits to the Secretary a plan providing for timely payment of all benefit obligations.''

''Sec. 707. Corrective Actions and Mandatory Termination.

''Section 707 requires a MEHP to continue to meet the reserve requirements even if its exemption is no longer in effect. The board of trustees must quarterly determine whether the reserve requirements of section 705 are being met and, if they are not, must, in consultation with the qualified actuary, develop a plan to ensure compliance and report such information to the Secretary. In any case where a MEHP notifies the Secretary that it has failed to meet the reserve requirements and corrective action has not restored compliance, and the Secretary determines that the failure will result in a continuing failure to pay benefit obligations, the Secretary may direct the board to terminate the arrangement.''

''Sec. 708. Additional Rules Regarding State Authority.

Under section 708(a), a state which certifies to the Secretary that it provides guaranteed access to health coverage may elect to opt out of the MEHP provisions outlined above and deny a MEHP the right to offer coverage in the small group market (or otherwise regulate such MEHP with respect to such coverage), except as described below. A state 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 otherwise have health insurance coverage, or (2) the state has, in 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 states without such guaranteed access, MEHPs could offer coverage in the small group market in the state as long as they meet the standards set forth in Part 7. For purposes of item (2) above and the similar provision under section 162 of the bill, it is intended that states that have achieved very high levels of health insurance coverage through means such as tax-preferred status for entities required to provide guaranteed issue, community-rated coverage be considered to meet the requirement under (2) regardless of how long a state law requiring such has been in effect.

''Section 708(b) provides a limited exception to the above described state opt out for certain large, multi-state arrangements. The state opt out (described in item (2) in the above paragraph) does not apply to new and existing MEHPs that meet the following criteria: (1) the sponsor operates in a majority of the 50 states and in 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) at the time the application to become a MEHP is filed, the arrangement does not have pending against it any enforcement action by the state. In addition, the state opt out (described in items (1) and (2) in the above paragraph) does not apply in a state in which an arrangement meeting the MEHP standards operates on March 6, 1996, to the extent a state enforcement action is not pending against such an entity at the time an application for an exemption is made. The above two exceptions do not apply to any state which, as of January 1, 1996, either (1) has enacted a law providing for guaranteed issue of

fully community rated individual health insurance coverage offered by insurers and HMOs, or (2) requires insurers offering group health coverage to reimburse insurers individual coverage for losses resulting from their offering individual 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 after March 6, 1996) nondiscriminatory 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 the above rule.

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 benefits are fully-insured, under which no employer is excluded as a participating employer (subject to minimum participation requirements of an insurer), under which the enrollment requirements of section 103 of the Act apply, under which all health insurance coverage options are aggressively marketed, and under which the health insurance coverage is provided by an insurer or HMO to which the laws of the state in which it operates apply.

The term qualified association means an association in which the sponsor of the association is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1) of ERISA), is established as a permanent entity which receives the active support of its members and meets at least annually, and collects dues without conditioning such dues on the basis of the health status or claims experience of plan participants or beneficiaries or on the basis of participation in a VHIA.

Section 162 sets forth the preemption rules applicable to VHIAs. This provision would preempt two types of state laws and leave unaffected any other applicable state law not otherwise preempted under current law (i.e., section 514 of ERISA). The first type of law preempted is a law which might otherwise preclude an insurer or HMO from setting premium rates based on the claims experience of the employers participating in a VHIA (without varying the premium rates of a particular employer on the basis of the employer's own experience). As a result of this provision, a qualified association could form a VHIA and offer health insurance coverage and establish and distribute plan costs in a manner similar to that permitted under current law for self-insured plans. This will empower employees and employers to form groups to more effectively and cost-efficiently purchase fully-insured health insurance coverage.

Section 162 also preempts a second type of State law that requires health insurance coverage in connection with group health plans to cover specific items or services consisting of medical care (but does not preempt laws prohibiting the exclusion of specific diseases). This will enable employers and employees to establish health insurance packages 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 health coverage may deny a VHIA the right to offer coverage in the small group market (or otherwise regulate such VHIA with respect to such coverage), except as described below. A state 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 otherwise have health insurance coverage, or (2) the state has, in 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 described state opt out for certain large, multi-state arrangements. The state opt out (described in item (2) in the paragraph above) does not apply to VHIAs that meet the following criteria: (1) the sponsor operates in a majority of the 50 states and in 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 opt out (described in items (1) and (2) in the paragraph two paragraphs above) does not apply in 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, as of January 1, 1996, either (1) has enacted a law providing for guaranteed issue of fully community rated individual health insurance coverage offered by insurers and HMOs, or (2) requires insurers offering group health coverage to reimburse insurers offering individual coverage for losses resulting from their offering individual coverage on an open enrollment basis.

Sec. 163. State authority fully applicable to self-insured multiple employer welfare arrangements providing medical care which are not exempted under new part 7.

This section clarifies the scope of ERISA preemption to make clear the authority of states to fully regulate non-fully-insured MEWAs which are not provided an exemption under new Part 7 of ERISA.

Sec. 164. Clarification of treatment of single employer arrangements

This section modifies the treatment of certain single employer arrangements under the section of ERISA that defines a MEWA (section 3(40)). The treatment of a single employer plan as being excluded from the definition of MEWA (and thus from state law) is clarified by defining the minimum interest required for two or more entities to be in ''common control'' as a percentage which cannot be required to be greater than 25%. Also a plan would be considered a single employer plan if less than 25% of the covered employees are employed by other participating employers.

Sec. 165. Clarification of treatment of certain collectively bargained arrangements.

This section clarifies the conditions under which multiemployer and other collectively-bargained arrangements are exempted from the MEWA definition, and thus exempt from state law. This is intended to address the problem of ''bogus unions'' and other illegitimate health insurance operators. The provision amends the definition of MEWA to exclude a plan or arrangement which is established or maintained under or pursuant to a collective bargaining agreement (as described in the National Labor Relations Act, the Railway Labor Act, and similar state public employee relation laws). (Current law requires the Secretary to ''find'' that a collective bargaining agreement exists, but no such finding has ever been issued). It then specifies additional conditions which 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 or other form of compensation to certain persons that is related to the volume or number of employers or individuals solicited or enrolled in the plan.

(2) A maximum 15 percent rule applies to the number of covered individuals in the plan who are not employees (or their beneficiaries) within a bargaining unit covered by any of the collective bargaining agreements with a participating employer or who are not present or former employees (or their beneficiaries) of sponsoring employee organizations or employers who are or were a party to any of the collective bargaining agreements.

(3) The employee organization or other entity sponsoring the plan or arrangement must certify annually to the Secretary the plan has met the previous requirements.

(4) If the plan or arrangement is not fully insured, it must be a multiemployer plan meeting specific requirements of the Labor Management Relations Act (i.e., the requirement for joint labor-management trusteeship under section 302(c)(5)(B)).

(5) If the plan or arrangement is not in effect as of the date of enactment, the employee organization or other entity sponsoring the plan or arrangement must have existed for at least 3 years or have been affiliated with another employee organization in existence 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(b)(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.

Sec. 167. Enforcement provisions relating to multiple employer welfare arrangements.

This section amends specific provisions of ERISA to establish enforcement provisions relating to the multiple employer elements of the bill: (1) a civil penalty applies for failure of MEWAs to file registration statements under section 169 of the bill; (2) the section provides for State enforcement through Federal courts with respect to violations by multiple employer health plans, subject to the existence of enforcement agreements described in section 168 below; (3) willful misrepresentation that an entity is an exempted

MEWA or collectively-bargained arrangement may result in criminal penalties; (4) the section provides for cease activity orders for arrangements found to be neither licensed, registered, or otherwise approved 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 section provides for the responsibility of the fiduciary or board of trustees of a MEHP to comply with the required claims procedure under ERISA.

Sec. 168. Cooperation between Federal and State authorities.

This section amends section 506 of ERISA (relating to coordination and responsibility of agencies enforcing ERISA and related laws) to specify State responsibility with respect to self-insured Multiple Employer Health Plans and Voluntary Health Insurance Associations. A State may enter into an agreement with the Secretary for delegation 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 lower level or quality of enforcement. However, if the Secretary delegates authority to a State, the Secretary can continue to exercise such authority concurrently with the State. The Secretary is required to provide enforcement assistance to the States with respect to MEWAs.

Sec. 169. 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 starting on or after January 1, 1997) 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. 170. Single annual filing for all participating employers.

This section amends ERISA's section 110 (relating to alternative methods of compliance with reporting and disclosure requirements) to provide for a single annual filing for all participating employers of fully insured MEWAs.

Sec. 171. 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 State regulation are deemed to be excluded for a period not to exceed 18 months unless the Secretary denies the exemption or finds the MEWAs application deficient, provided that the arrangement does not have pending against it an enforcement action by a state. The Secretary can revoke the exemption at any time if it would be detrimental to the interests of individuals covered under the Act.

Subtitle D—Definitions; General Provisions

Sec. 191. Definitions; scope of coverage, and

Sec. 192. State flexibility to provide greater protection.

In addition to providing definitions of terms used in this title of the Act, this subtitle provides that, subject to the ERISA savings clause below, nothing in Subtitle A, B, or D should be construed to preempt state laws: (1) that relate to matters not specifically addressed in such subtitles, (2) that require insurers or HMOs to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition period for a period that is shorter than the applicable period provided under such subtitles; (3) that 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 60-day periods provided for under sections 101 and 102, or (4) that, in defining ''preexisting condition'' to have a 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 Secretaries 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 for yielding me the time.

Mr. Speaker, I rise in opposition to H.R. 3103, and a little background. I was honored to serve 20 years in the Texas legislature, Mr. Speaker, and work for many of those years with the statehouse members to beef up and strengthen our State health insurance regulation laws so that people who buy group insurance would know what they are purchasing. Here today I see this bill would actually abolish that protection, not only in the State of Texas, but State legislatures all over the country have worked for many years to provide and strengthen State oversight of these laws.

Mr. Speaker, yesterday I asked the Committee on Rules to make in order my amendment striking the preemption of these multiple employer welfare arrangements, also known as the MEWA insurance laws, because what happens now is in all of our States, we regulate them. This bill will take away that State regulation and move it to Washington to definitely a universal national standard developed and implemented from Washington and will replace these carefully crafted local State insurance laws that meet the needs of our local States and not necessarily what is from Washington.

Mr. Speaker, that is right. The majority of the Republicans want to move the regulation of these insurance laws from the States to an agency led by what one of my Republican colleagues said in his turn were Communists.

We hear a lot of rhetoric from the other side about giving more power to the States, and yet in this issue the Republicans want to take away the States' authority to regulate these health plans and give it to the Federal Government. While we have heard about local control rhetoric so much, the House Republicans want to expand the authority of the Department of Labor with these regulations.

In his own estimates, Secretary Reich will have to develop 26 new regulations to deal with the federalization of multiple employer welfare arrangements. The Federal Government got out of this business of regulating MEWA's in 1983 because the States were better equipped to deal with the high instances of fraud on the local level. But now we see this bill will preempt those States rights, and what will it mean to the average American family. State statutes requiring that certain benefits covered by health insurance policies may no longer apply.

Again, let me give an example from the State of Texas. In 1973 we changed the law that required insurance policies in Texas have to cover newborn infants. Up until then, a newborn infant had to survive 14 days before the group insurance policy would cover them. That was a mandated benefit, and 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 MEWA'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.

Then there is another set 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

because they have been sick, and that people should be able to take their insurance from job to job.

□ 2030

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 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 politics is 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, a man who 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 the substitute offered by the gentlewoman from New Jersey [Mrs. ROUKEMA] does not pass tonight, they can 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 do 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 would say 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 really 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 a 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 does not have 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 on the part 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 be required to register and maintain substantial capital reserves—a minimum of $400,000 or 25 percent of the expected claims—whichever was higher.

MEHPs would allow small employers to band together around the country, thereby avoiding expensive State-mandated benefits. Right now, small businesses pay up to 30 percent more in premiums than big businesses that can make use of ERISA exemptions.

The substitute does not allow small employers to form MEHPs across State lines.

I urge my colleagues to support 3103.

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentleman from North Carolina [Mr. BALLENGER].

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

Mr. Speaker, I rise in strong support of H.R. 3103, and want to address the provisions relating to medical savings accounts for MSA's.

During the debate over the President's health care reform package during the 103d Congress, we saw that Americans view choice as fundamental to our health care system. By allowing people the chance to choose a high-deductible health insurance plan and to place the premium savings into a personal savings account, we are providing a way for people to manage their health care expenses. This plan would be used to cover major health costs while the savings account would cover routine and preventive care.

Under this bill, individuals could deposit up to $2,000 per year and could save, in the account, what they didn't use. Any withdrawals from the account for non-medical expenses would be taxable and subject to an early withdrawal penalty of 10 percent. Also, MSAs would allow patients to choose their own doctors and participate in their own care. These accounts belong to the individual and are portable during a job change.

Employers are currently able to offer MSA-like plans. However, unlike other traditional plans, the Government does not allow these plans to be tax deductible. MSAs should receive equal treatment, because recent studies indicate that these plans reduce the health care costs for employers by around 12 percent compared to traditional plans. This cost reduction directly enables employers to maintain quality health benefit plans to their employees at no additional charge. As we look for market-oriented ways to contain the costs of health care, MSAs should be viewed as an attractive option.

Mr. CLAY. Mr. Speaker, I yield 2 minutes to the gentleman from Indiana [Mr. ROEMER].

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

Mr. ROEMER. Mr. Speaker, I wish for once Members of Congress would put themselves in the shoes of hard-working Americans, whether those shoes are loafers or construction boots, and then Americans would work together to reform in a simplistic and bipartisan commonsense way our health care system.

Now, we have two choices tonight: We can either support H.R. 3103, a convoluted measure that is highly controversial, with all kinds of special-interest provisions that will never become law, or we can support a bipartisan provision from Senator KENNEDY, Senator KASSEBAUM, and the gentlewoman from New Jersey [Mrs. ROUKEMA].

There is a bipartisan approach, a commonsense approach to provide

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 have diabetes or leukemia. And 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 to not let the insurance companies be prejudiced against these people.

Vote for our children. Vote for our hard-working people in America, and vote for commonsense bipartisanship.

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 had 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 benefits in bulk.

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 car 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, but the American people should not be misled.

☐ 2045

The noble goal of universal health care, health care for all Americans, is not being discussed tonight. The administration bill in the 103d Congress was striving to help Americans join the other civilized, industrialized nations and provide health care for the 43 million Americans who are not covered with any health care plan.

This bill moves us no closer to health care for everybody. Looming over all of us in our present health care system is the dangerous threat to the Medicaid entitlement. That is not being discussed, but the Medicaid entitlement is America's beachhead for universal health care. Even if we pass the highly desirable Kennedy-Kassebaum-Dingell substitute, we will be taking a giant step backward if we throw away the Medicaid entitlement within a few weeks.

The American people must not be swindled. Two actions are needed. Tonight we have to pass the substitute, and we also have to make certain that in the future, the next few weeks, we deny the Governors, the majority Republicans in this body, the opportunity to roll back the clock to destroy 30 years of good health care by eliminating the Medicaid entitlement. The Medicaid entitlement is absolutely necessary for the 43 million Americans who are not covered. The hope for those 43 million lies in keeping the Medicaid entitlement and expanding it.

This was the noble goal of the administration's bill in the 103d Congress. It was very difficult because they were looking to close that gap. It was very difficult because the 103d Congress proposal by the administration was attempting to have America join the other civilized industrialized nations for universal health care.

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentleman from Delaware [Mr. CASTLE].

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 contained in 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 compliment the leadership on this side of the aisle. I would like to point out, too, that you will notice that no 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 able to 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.

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 acts to correct 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 start 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 Kennedy-Kassebaum-Roukema health care reform bill, which has the support of Senate Republicans and Democrats as well as the President.

The Democratic substitute would replace H.R. 3103 with language from the Kennedy-Kassebaum-Roukema bill. This bill would expand access to health insurance for Americans by increasing portability and limiting insurance companies' ability to deny coverage because of pre-existing conditions. The political consensus for the Kennedy-Kassebaum-Roukema bill means that it could become law in a matter of weeks.

But H.R. 3103 embraces controversial, divisive policies that doom any chance of insurance reform and minimal health security for the American people.

As a long-time advocate of fiscal responsibility, I must oppose the provisions in this bill establishing generous Medical Savings Accounts [MSAs]. The MSAs would result in a significant loss of taxpayer dollars without a substantial revenue offset. Under this bill, individuals could deposit up to $2,000 annually and families up to $4,000 in tax-free MSAs. The Joint Committee on Taxation has estimated 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 Medicare program—the health plan for America's senior citizens. This is the same Medicare program that the Republicans claim is in such a dire financial crisis.

Any savings achieved through Medicare reforms should be used to shore up the Medicare trust fund. Failing that, these savings should be used to lower deductibles and increase benefits for Medicare beneficiaries. It makes no sense to use this savings to offset a tax break for the limited number of individuals who can afford MSAs.

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 Republican leadership's bill would, therefore, steal money from Medicare recipients to pay for tax breaks for healthier Americans.

Ironically, H.R. 3103 would also remove state oversight and replace it with Federal regulation to advantage insurance companies. This would be a severe blow to the States' rights movement. For the past year we have heard Republicans disparage the role of the Federal Government. Yet, under this legislation, the Republican leadership conveniently tosses aside this argument in favor of Federal supremacy over insurance coverage. This legislation preempts existing state insurance reforms and State regulation of self-funded multiple employer plans [MEWAs].

In Oregon, local leaders have developed a series of health care initiatives with the active support of insurers, consumers and the business community. H.R. 3103 could seriously jeopardize these reforms, as well as reforms already enacted in other States.

Every American should have lifetime access to quality, affordable health care. All of our major economic competitors have adopted comprehensive health care reforms. Surely the United States of America, the greatest industrial power on Earth, can adopt the minimal protections in the Kennedy-Kassebaum-Roukema bill.

If you truly want to bring some relief to our constituents, I urge my colleagues to support the Democratic substitute which would replace the controversial Republican leadership's proposal with the language in the Kennedy-Kassebaum-Roukema bill.

Mr. CLINGER. Mr. Speaker, I rise in strong support of the ''Health Coverage Availability and Affordability Act of 1996.'' This legislation takes very practical, needed steps to ensure working Americans that they will always have access to health insurance regardless of their health, their family's health, or their employer. H.R. 3103 will ensure Americans portability and renewability of their health coverage while eliminating the fear of losing coverage because of pre-existing condition limitations when changing or losing a job.

I am particularly pleased to see provisions in the bill that set tough policies to combat health care fraud and abuse. Recent studies estimate that overcharging, double billing, and charging for services not rendered to patients cost consumers up to 10 percent of every health care dollar spent. This results in both higher health care costs and insurance premiums for everyone.

Under H.R. 3103, penalties for defrauding the Government through Federal health care programs, such as Medicare and Medicaid, will be stiffened. Furthermore, the bill will require the Secretary of Health and Human Services 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 Availability 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 individuals and entities who have been convicted of felony offenses relating to health care fraud; require the Secretary to provide beneficiaries with an explanation of each item or service for which payment was made under Medicare; and require the Secretary to establish a program to encourage individuals to report suspected fraud and abuse in the Medicare program.

I firmly believe that the fraud and abuse provisions 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 held 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 certain State insurance regulations—an exemption 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 business premiums by as much as a third, even while paying State 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 measure which will ensure working people and families that they will always have access to health insurance regardless of their health, their family's health, or their employer. Accordingly, I commend my colleague, Representative 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 encourage 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 federally-funded health care system; and allows self employed individuals and small businesses to voluntarily associate to purchase health insurance which would be available to all member organizations.

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 reforms 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 reform moving through the legislative process, I rise with some reservation to support H.R. 3103, the Health Coverage Availability Act of 1996.

My record clearly reflects my strong support of health insurance reform. In addition to efforts on rural health issues and system-wide reform, I have worked for many years to make health insurance both accessible and affordable 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 since 1954, working 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 issues 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 to square one.

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 not 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 pool 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 out in conference. Therefore, in the 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 commonsense 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 ultimate goal for us all is 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 tenure in the business world 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 supposed to cover 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 make contributions to an uninsurance 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 follow. Also, according to this bill 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 as well. 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.

The bill provides relief for 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 consumes 5 to 10 percent of ever health care dollar. This results in higher health care costs as well as higher in 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. Speaker, 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 paperwork 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 paperwork 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 free-standing bill on billing simplification, my Ohio colleague, DAVE HOBSON, took up the cause, improving upon our efforts. Congressman HOBSON'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 uninsurable 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 cigarette smoking 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 absolutely 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 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. The bulk of data indicates that 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 costs would provide only negligible savings to the health care system. According to separate reviews by the U.S. Department of Health and Human Services and CBO, the total 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—that are not accounted for in lost wages. 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/§ 282(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 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 ''consciously indifferent'' conduct; allow a bifurcated proceeding to determine issues relating to punitive damages; and completely ban punitive damages in the case of drugs or other devices that have been approved by the FDA or any other drug ''generally recognized as safe and effective'' pursuant to FDA-established conditions.

These proposed limitations raise a number of concerns. Arbitrary caps on punitive damages may provide unjustified windfalls to the few tortfeasors responsible for blatant and 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, the 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 all at once. Also, in contrast to many state law periodic payment provisions, the Republican 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 account for 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 system 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 damage caps have been held to violate state constitutional guarantees relating to equal protection, due process, and rights of trial by jury and access to the courts; and these very same concerns are likely to be present at the federal level. And by layering a system of federal rules on top of a two-century-old system of state common law, the Republican proposals will inevitably lead to confusing conflicts, not only within the federal and state courts, but 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 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 30 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''-vailability, ''A''-ffordability and ''A''-ccountability. 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 expenses.

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 health care 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 measure 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 coverage 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 preexisting 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 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 lawsuit 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 accountability to those who receive health care through their jobs. The American people deserve this and we owe it to them to pass it by a wide bi-partisan margin.

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 ROUKEMA 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 we need to 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 Medicaid, welfare, public housing, senior employment 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 Government is 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 take from job to job. But, I differ from my Republican colleagues in one important respect. 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 special interests that it severs the spine that holds it together and paralyzes the legislative process.

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. COMBEST). All time for debate has expired.

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 nature of a substitute is as follows:

Amendment in the nature of a substitute offered by Mr. DINGELL:

Strike all after the enacting clause and insert 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

TABLE OF CONTENTS OF TITLE

Sec. 100. Definitions.

SUBTITLE A—GROUP MARKET RULES

Sec. 101. Guaranteed availability of health coverage.
Sec. 102. Guaranteed renewability of health coverage.
Sec. 103. Portability of health coverage and limitation on preexisting condition exclusions.
Sec. 104. Special enrollment periods.
Sec. 105. Disclosure of information.

SUBTITLE B—INDIVIDUAL MARKET RULES

Sec. 110. Individual health plan portability.
Sec. 111. Guaranteed renewability of individual health coverage.
Sec. 112. State flexibility in individual market reforms.
Sec. 113. Definition.

SUBTITLE C—COBRA CLARIFICATIONS

Sec. 121. Cobra clarification.

SUBTITLE D—PRIVATE HEALTH PLAN PURCHASING COOPERATIVES

Sec. 131. Private health plan purchasing cooperatives.

SUBTITLE E—APPLICATION AND ENFORCEMENT OF STANDARDS

Sec. 141. Applicability.
Sec. 142. Enforcement of standards.

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:

(1) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under 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(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(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), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))) 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 1882(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.

(5) FAMILY.—

(A) IN 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), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(6) GROUP HEALTH PLAN.—

(A) IN 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 1882(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.

(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.

(7) 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 purchases or pays for health benefits (such as provider or hospital benefits) on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. A health plan purchasing cooperative established under section 131 shall not be considered to be a group purchaser.

(8) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a group health plan or an individual health plan.

(9) HEALTH STATUS.—The term ''health status'' includes. with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

(10) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(11) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term under section 3(16)(B) of the Employee Retirement

Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

(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, Guam, 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 an employee health benefit plan or a health plan issuer from establishing premium; discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of 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 who will be expected to enroll because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer is 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)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only eligible 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 or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(e) CONSTRUCTION.—

(1) MARKETING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering group health plans to actively market such plans.

(2) INVOLUNTARY OFFERING OF GROUP HEALTH PLANS.—Nothing is this section shall be construed to require a health plan issuer to involuntarily offer group health plans in a 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 subsections (b) and (c), a group health plan shall be renewed or continued in force by 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 health plan issuer has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser;

(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) PARICIPANT.—Subject to subsections (b) and (c), coverage under an employee health benefit plan or group health plan shall 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 such plan has not received timely premium payments.

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to an application 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 part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 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. 1102(37)) from establishing employer contribution rules or group participation rules; or

(C) permit individuals to decline coverage under an employee health benefit plan if such right is not otherwise available under such plan.

(b) TERMINATION OF GROUP HEALTH PLANS.—

(1) PARTICULAR TYPE OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of group health plan. A group health plan of such type may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each group purchaser covered under a group health plan of this type (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 90 days prior to the date of the discontinuation of such plan;

(B) the 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 one or more replacement plans, the health plan issuer acts uniformly without regard to the health status of participants or beneficiaries covered under the group health plan, or new participants or beneficiaries who may become eligible for coverage under the group health plan.

(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 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.

(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 under applicable State law, or if not so defined, an employer with not more than 50 employees); or

(ii) to all other group health plans offered by the health plan 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 involved during the 5-year period beginning on the date of the discontinuation of the last group health plan not so renewed.

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 subtitle 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 COVERAGE AND LIMITATION ON 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 an individual who, within 30 days of the date of birth or placement for adoption (as determined under section 609(c)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(c)(3)(B)), was covered under the plan; and

(3) the limitation or exclusion does not apply to a pregnancy.

(b) CREDITING OF PREVIOUS QUALIFYING COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (4), an employee health benefit plan or a health plan issuer offering a group health plan shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage. With respect to an individual described in subsection (a)(2) who maintains continuous coverage, no limitation or exclusion of benefits relating to treatment of a preexisting condition may be applied to a child within the child's first 12 months of life or within 12 months after the placement of a child for adoption.

(2) DISCHARGE OF DUTY.—An employee health benefit plan shall provide documentation of coverage to participants and beneficiaries who coverage is terminated under the 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; and

(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such plan.

An employee health benefit plan shall retain the documentation provided to a participant or beneficiary under subparagraphs (A) and (B) for at least the 12-month period following the date on which the participant or beneficiary ceases to be covered under the plan. Upon request, an employee health benefit plan shall provide a second copy of such documentation or such participant or beneficiary within the 12-month period following the date of such ineligibility.

(3) DEFINITIONS.—As used in this section:

(A) PREVIOUS QUALIFYING COVERAGE.—The term ''previous qualifying coverage'' means the period beginning on the date—

(i) a participant or beneficiary is enrolled under an employee health benefit plan or a group health plan, and ending on the date the participant or beneficiary is not so enrolled; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) or under a public or private health plan established under Federal or State law, and ending on the date the individual is not so enrolled;

for a continuous period of more than 30 days (without regard to any waiting period).

(B) LIMITATION OR EXCLUSION OF BENEFITS RELATING TO TREATMENT OF A PREEXISTING CONDITION.—The term ''limitation or exclusion of benefits relating to treatment of a preexisting condition'' means a limitation or exclusion of benefits imposed on an individual based on a preexisting condition of such individual.

(4) EFFECT OF PREVIOUS COVERAGE.—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 the treatment of a preexisting condition, subject to the limits in subsection (a)(1), only to the extent that such service or benefit was not previously covered under the group health plan, employee health benefit plan, or individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) LATE ENROLLEES.—Except as provided in section 104, 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.

(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 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 described in subsection (c), 90 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 (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, 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 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 laws 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 who—

(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 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of eligibility for coverage, other than COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(3) 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;

each 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 failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or placed for adoption 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 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.

(2) EXCEPTION.—With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under applicable law shall not be subject to the disclosure requirements of such paragraph.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State reporting and disclosure requirements to the extent that such requirements are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(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. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) that is not a material reduction in covered services or benefits provided,''; and

(B) by adding at the end thereof 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 date of 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 delivery by mail through which employee health benefit plans may 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''; and

(C) by inserting ''including the office, contact, or title of the individual at the Department of Labor through 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 benefits 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 (3) may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in an individual health plan—

(A) decline to offer coverage to such individual, or deny enrollment to such individual based on the health status of the individual; or

(B) 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 subtitle A).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent a health plan issuer offering an individual health plan from 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 issuer that issues or renews individual health plans.

(4) PREMIUMS.—Nothing in this subsection shall be construed to affect the determination of a health plan issuer as to the amount of the premium payable under an individual health plan under applicable State law.

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—As used in subsection (a)(1), the term ''eligible individual'' means an individual who—

(1) 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 desired to enroll in the individual health plan.

(2) is not eligible for coverage under a group health plan or an employee health benefit plan;

(3) has not had coverage terminated under a group health plan or employee health benefit plan for failure to make required premium payments or contributions, or for fraud or misrepresentation of material fact; and

(4) 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 OF 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 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)) 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 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 State from requiring health plan issuers offering coverage to individuals under an individual health plan to actively market such plan.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

(a) IN GENERAL.—Subject to subsections (b) and (c), coverage for individuals under an individual health plan shall be renewed or continued in force by a health plan issuer at the option of the individual, except that the requirement of this subsection shall not apply in the case of—

(1) the nonpayment of premiums or contributions by the individual in accordance with the terms of the individual health plan or where the health plan issuer has not received timely premium payments;

(2) fraud or misrepresentation of material fact on the part of the individual; or

(3) the termination of the individual health plan in accordance with subsection (b).

(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—

(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of individual health plan to individuals, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 90 days prior to the date of the expiration of the plan.

(B) the health plan issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently being offered 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 replacement plans, the health plan issuer acts uniformly without regard to the health status of particular individuals.

(21) DISCONTINUANCE OF ALL INDIVIDUAL HEALTH PLANS.—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 142(d)) 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) all individual health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(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 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 renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan issuer which offers a network plan (as defined in paragraph (2)) may deny continued participation under the plan to individuals who neither live, reside, nor work in an area in which the individual health plan is offered, but only if such denial is applied uniformly, without regard to health status of particular individuals.

(2) NETWORK PLAY.—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 covered under such health plan, in whole or in part, through arrangements with providers.

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 by one or more health plan issuers, high-risk 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 chief insurance regulatory official of the State, that such State law does not achieve the goals of providing access to affordable health care coverage for those 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 plan or employee health benefit plan for individuals described in sections 110 and 111.

(C) evaluate whether the State law or program provides individuals described in sections 110 and 111 with a choice of health plans or a health plan providing comprehensive coverage, and

(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 may not make a determination under such subsection until the expiration of the 12-month period beginning on the date on which such notification is made, or until January 1, 1998, whichever is later. With respect to a State that provides notice under this paragraph and that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act, the Secretary 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''), through a process which the Secretary of Health and Human Services determines has included consultation with representatives of the insurance industry and consumer groups, adopts a model standard or standards for reform of the individual health insurance market, and

(2) the Secretary of Health and Human Services determines, within 30 days of the adoption of such NAIC standard or standards, that such standards comply with the goals of sections 110 and 111:

a State that elects to adopt such model standards or substantially adopt such model standards shall be deemed to have met the requirements of sections 110 and 111 and shall be subject to a determination under subsection (a).

SEC. 113. DEFINITION.

(a) IN GENERAL.—As used this title, the term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health 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 2(6).

(b) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(1) Coverage only for accident, or disability income insurance, or any combination thereof.

(2) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(3) Coverage issued as a supplement to liability insurance.

(4) Liability insurance, including general liability insurance and automobile liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Coverage for a specified disease or illness.

(8) Hospital of fixed indemnity insurance.

(9) Short-term limited duration insurance.

(10) Credit-only, dental-only, or vision-only insurance.

(11) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb–2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(II) 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'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', 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 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'',

(2) ELECTION.—Section 2205(1)(C) 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 the last sentence of section 2202(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 2206(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) BIRTH OR ADOPTION OF A CHILD.—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 sentence:

''Such term 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.''.

(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 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'',

(B) in subparagraph (D)(i), by inserting before '', or'' the following '', 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 '', or''; 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 date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 606(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(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 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 continued coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i) 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''.

(B) in clause (iv)(I), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this subclause 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 subsection because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in clause (v), 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''.

(2) ELECTION.—Section 4980B(f)(5)(A)(ii) of the Internal Revenue Code of 1986 is amended—

(A) in subclause (I), by striking ''or'' at the end thereof;

(B) in subclause (II), by striking the period and inserting '', or'', and

(C) by adding at the end thereof the following new subclause:

''(III) in the case of an qualified beneficiary described in the last sentence of paragraph (2)(B)(i), the date such individual is determined to have been disabled.''.

(3) NOTICES.—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 continued coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring on or after the date of enactment of this Act for plan years beginning after December 31, 1997.

(e) NOTIFICATION OF CHANGES.—Not later than 60 days prior to the date on which this section becomes effective, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Cooperatives

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERATIVES.

(a) DEFINITION.—As used in this title, the term ''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 individual 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) desires to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Secretary of such desire, the State, upon a determination that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall make a determination of whether such group meets the requirements of this section in a timely fashion. Each such cooperative shall also be registered with the Secretary.

(2) STATE REFUSAL TO CERTIFY.—If a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with the standards under this title, the Secretary shall certify and oversee the operations of such cooperative in such State.

(3) INTERSTATE COOPERATIVES.—For purposes of this section a health plan purchasing cooperative operating in more than one State shall be certified by the State in which the cooperative is domiciled. States may enter into cooperative agreements for the purpose of certifying and overseeing the operation of such cooperatives. For purposes of this subsection, a cooperative shall be considered to be domiciled in the State in which most of the members of the cooperative reside.

(c) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each health plan purchasing cooperative shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the cooperative under this section. The Board shall be composed of a board cross-section of representatives of employers, employees, and individuals participating in the cooperative. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of individual health plans or group health plans may not hold or control any right to vote with respect to a cooperative.

(2) LIMITATION ON COMPENSATION.—A health plan purchasing cooperative may not provide compensation to members of the Board of Directors. The cooperative may provide reimbursements 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 be a representative of 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 limits on the maximum 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) residing within the area served by the cooperative who meet such requirements as members on a first-come, first-served basis, or on another basis established by the State to ensure equitable access to the cooperative.

(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by a health plan purchasing cooperative. With respect to a State that has not established such rules, a health plan purchasing cooperative operating in the State shall define the boundaries of the area to be served by the cooperative, except that such boundaries may not be established on the basis of health status of the populations that reside in the area.

(e) DUTIES AND RESPONSIBILITIES.—

(1) IN 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 disseminate comparative health plan materials (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; and

(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 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) cooperating 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.

(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 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 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; and

(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 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 requirement 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 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 of premium rates among employers, plan sponsors, or individuals that are members of health plan purchasing cooperative 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 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) 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, category or care, or services of any class or type of provider.

(D) EXCEPTION.—In those 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.

(h) RULES 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 individuals, plan sponsors, or employers to purchase group health plans or individual health plans through a health plan purchasing cooperative;

(4) require that a health plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State.

(5) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefits plans, or

(6) confer authority up 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.

(i) APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of parts 4 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 pan purchasing cooperative as if such plan were an employee welfare benefit plan.

Subtitle E—Application and Enforcement of Standards

SEC. 141. APPLICABILITY.

(A) CONSTRUCTION.—

(1) ENFORCEMENT.—

(A) 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 insurance 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 by a health plan issuer in connection with an employee health benefit plan, the requirements of standards imposed under the title shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official of officials designated by the State to enforce the requirements of this title.

(B) LIMITATION.—Except as provided in subsection (c), the Secretary shall not enforce the requirements or standards of this title as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a Sate enforce the requirements or standards of this title as they relate to employee health benefit plans.

(2) PREEMPTION OF STATE LAW.—Nothing in this title shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements—

(A) not prescribed in this title; or

(B) related to the issuance, renewal, or portability of health insurance or the establishment or operation of group purchasing arrangements, that are consistent with, and are not in direct conflict with, this title and provide greater protection or benefit to participants, beneficiaries or individuals.

(b) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(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 participant or beneficiary in excess of those provided under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each 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 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 State enforcement law.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—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, 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) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State 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 issuer operating in such State shall be subject to civil enforcement as 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) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(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.

(f) TECHNICAL AMENDMENT.—Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting ''and under the Health Insurance Reform Act of 1996'' before the period.

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 conclude a two-part study, and prepare and submit reports, in accordance with this section.

(b) EVALUATION OF AVAILABILITY.—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, expert opinions, 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 nongroup 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 January 1, 1999, 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 nongroup 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 employee health benefit plans, on 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.

TITLE II—INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS

TABLE OF CONTENTS OF TITLE

TITLE II—INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS

Sec. 200. Amendment of 1986 Code.

Subtitle A—Increase in Deduction For Health Insurance Costs of Self-Employed Individuals

Sec. 201. Increase in deduction for health insurance costs of self-employed individuals.

SUBTITLE B—REVENUE OFFSETS

CHAPTER 1—TREATMENT OF INDIVIDUALS WHO EXPATRIATE

Sec. 211. Revision of tax rules on expatriation.

Sec. 212. Information on individuals expatriating.

CHAPTER 2—FOREIGN TRUST TAX COMPLIANCE

Sec. 221. Improved information reporting on foreign trusts.

Sec. 222. Modifications of rules relating to foreign trusts having one or more United States beneficiary.

Sec. 223. Foreign persons not to be treated as owners under grantor trust rules.

Sec. 224. Information reporting regarding foreign gifts.
Sec. 225. Modification of rules relating to foreign trusts which are not grantor trusts.
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 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—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) is amended to read as follows:

''(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 equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

''For taxable years beginning in calendar year—	The applicable percentage is—
After 1996 and before 2002	50 percent.
2002 or thereafter	80 percent.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle B—Revenue Offsets

CHAPTER 1—TREATMENT OF INDIVIDUALS WHO EXPATRIATE

SEC. 211. REVISION OF TAX RULES ON EXPATRIATION.

(a) IN GENERAL.—Subpart A of part II of subchapter N of chapter 1 is amended by inserting after section 877 the following new section:

''SEC. 877A. TAX RESPONSIBILITIES OF EXPATRIATION.

''(a) GENERAL RULES.—For purposes of this subtitle—

''(1) 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 for 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 be taken into account for the taxable year of the sale unless such gain is excluded from gross income under part III of subchapter B, and

''(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 1091 shall not apply (and section 1092 shall apply) to any such loss.

''(3) EXCLUSION FOR CERTAIN GAIN.—The amount which would (but for this paragraph) 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 this paragraph, allocable expatriation 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

''(ii) the expatriate 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.

''(B) LIMITATION ON AMOUNT OF ESTATE, GIFT, AND GENERATION-SKIPPING TRANSFER TAXES.—The aggregate amount of taxes imposed under subtitle B with respect to any transfer 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)).

''(c) 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 individual under any treaty of the United States which would preclude assessment or collection of any tax which may be imposed by reason of this paragraph, and

''(iii) complies with such other requirements as the Secretary may prescribe.

''(D) ELECTION.—An election under subparagraph (A) shall apply to all property to which this section would apply but for the election and, once made, shall be irrevocable. Such election shall also apply to property the basis of which is determined in whole or in part by reference to the property with respect to which the election was made.

''(b) ELECTION TO DEFER TAX.—

''(1) IN GENERAL.—If the taxpayer elects the application of this subsection with respect to any property—

''(A) no amount shall be required to be included in gross income under subsection (a)(1) with respect to the gain for such property for the taxable year of the sale, but

''(B) the taxpayer's tax for the taxable year in which such property is disposed of shall be increased by the deferred tax amount with respect to the property.

Except to the extent provided in regulations, subparagraph (B) shall apply to a disposition whether or not gain or loss is recognized in whole or in part on the disposition.

''(2) DEFERRED TAX AMOUNT.—

''(A) IN GENERAL.—For purposes of paragraph (1), 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—

''(I) beginning on the 91st day after the expatriation date, and

''(II) ending on the due date for the taxable year described in paragraph (1)(B),

by using the rates and method applicable under section 6621 for underpayments of tax for such period.

For purposes of clause (ii), the due date is the date prescribed by law (determined without regard to extension) for filing the return of the tax imposed by this chapter for the taxable year.

''(B) ALLOCATION OF LOSSES.—For purposes of subparagraph (A), any losses described in subsection (a)(2)(B) shall be allocated ratably among the gains described in subsection (a)(2)(A).

''(3) SECURITY.—

''(A) IN GENERAL.—No election may be made under paragraph (1) with respect to any property unless adequate security is provided with respect to such property.

''(B) ADEQUATE SECURITY.—For purposes of subparagraph (A), security with respect to any property 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.

''(4) 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—

''(A) immediately before death if such property is held at such time, and

''(B) at any time the security provided with respect to the property fails to meet the requirements of paragraph (3) and the taxpayer does not correct such failure within the time specified by the Secretary.

''(6) ELECTIONS.—An election under paragraph (1) shall only apply to property described in the election and, once made, is irrevocable. An election may be under paragraph (1) with respect to an interest in a trust with respect to which gain is required to be recognized under subsection (f)(1).

''(c) COVERED EXPATRIATE.—For purposes of this section—

''(1) 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 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.

''(2) EXCEPTIONS.—An individual shall not be treated as a covered expatriate if—

''(A) the individual—

''(i) became at birth a citizen of the United States and a citizen of another country and, as of the expatriation date, continues to be a citizen of, and is taxed as a resident of, such other country, and

''(ii) has been a resident of the United Stats (as defined in section 7701(b)(1)(A)(ii)) for not more than 8 taxable years during the 15-taxable year period ending with the taxable year during which the expatriation date occurs, or

''(B)(i) the individual's relinquishment of United States citizenship occurs before such individual attains age 18½, and

''(ii) the individual has been a resident of the United States (as so defined) for not more than 5 taxable years before the date of relinquishment.

''(d) PROPERTY TO WHICH SECTION APPLIES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided by the Secretary, this section shall apply to—

''(A) any interest in property held by a covered expatriate on the expatriation date the gain from which would be included in the gross income of the expatriate if such interest had been sold for its fair market value on such data in a transaction in which gain is recognized in whole or in part, and

''(B) any other interest in a trust to which subsection (f) applies.

''(2) EXCEPTIONS.—This section shall not apply to the following property:

''(A) UNITED STATES REAL PROPERTY INTERESTS.—Any United States real property interest (as defined in section 897(c)(1)), 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 CERTAIN RETIREMENT PLANS.—

''(i) IN GENERAL.—Any interest in a qualified retirement plan (as defined 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.—

''(I) IN GENERAL.—Under regulations prescribed by the Secretary, interests in foreign pension plans or similar retirement arrangements or programs.

''(II) LIMITATION.—The value of property which is treated as not sold by reason of this subparagraph shall not exceed $500,000.

''(e) DEFINITIONS.—For purposes of this section—

''(1) EXPATRIATE.—The term 'expatriate' means—

''(A) any United States citizen who relinquishes his citizenship, or

''(B) any long-term resident of the United States who—

''(i) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

''(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.

''(2) EXPATRIATION 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 349(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 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)).

''(C) the date the United States 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 for the taxable year 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).

''(f) SPECIAL RULES APPLICABLE TO BENEFICIARIES' INTERESTS IN TRUST.—

''(1) IN GENERAL.—Except as provided in paragraph (2), if an individual is determined under paragraph (3) to hold an interest in a trust—

''(A) the individual shall not be treated as having sold such interest,

''(B) such interest shall be treated as a separate share in the trust, and

''(C)(i) such separate share shall be treated as a separate trust consisting of the assets allocable to such share,

''(ii) the separate trust shall be treated as having sold its assets immediately before the expatriation date for their fair market value and as having distributed all of its assets to the individual as of such time, and

''(iii) the individual shall be treated as having recontributed the assets to the separate trust.

Subsection (a)(2) shall apply to any income, gain, or loss of the individual arising from a distribution described in subparagraph (C)(ii).

''(2) SPECIAL RULES FOR INTERESTS IN QUALIFIED TRUSTS.—

''(A) IN GENERAL.—If the trust interest described in paragraph (1) is an interest in a qualified trust—

''(i) paragraph (1) and subsection (a) shall not apply, and

''(ii) in addition to any other tax imposed by this title, there is hereby imposed on each distribution with respect to such interest a tax in the amount determined under subparagraph (B).

''(B) AMOUNT OF TAX.—The amount of tax under subparagraph (A)(ii) shall be equal to the lesser of—

''(i) the highest rate of tax imposed by section 1(e) for the taxable year in which the expatriation date occurs, multiplied by the amount of the distribution, or

''(ii) the balance in the deferred tax account immediately before the distribution determined without regard to any increases under subparagraph (C)(ii) after the 30th day preceding the distribution.

''(C) DEFERRED TAX ACCOUNT.—For purposes of subparagraph (B)(ii)—

''(i) OPENING BALANCE.—The opening balance in a deferred tax account with respect to any trust interest in an amount equal to the tax which would have been imposed on the allocable expatriation gain with respect to the trust interest if such gain had been included in gross income under subsection (a).

''(ii) INCREASE FOR INTEREST.—The balance in the deferred tax account shall be increased by the amount of interest determined (on the balance in the account at the time the interest accrues), for periods after the 90th day after the expatriation date, by using the rates and method applicable under section 6621 for underpayments of tax for such periods.

''(iii) DECREASE FOR TAXES PREVIOUSLY PAID.—The balance in the tax deferred account shall be reduced—

''(I) by the amount of taxes imposed by subparagraph (A) on any distribution to the person holding the trust interest, and

''(II) in the case of a person holding a nonvested interest, to the extent provided in regulations, by the amount of taxes imposed by subparagraph (A) on distributions from the trust with respect to nonvested interests not held by such person.

''(D) ALLOCABLE EXPATRIATION GAIN.—For purposes of this paragraph, the allocable expatriation gain with respect to any beneficiary's interest in a trust in the amount of gain which would be allocable to such beneficiary's vested and nonvested interests in the trust if the beneficiary held directly all assets allocable to such interests.

''(E) TAX DEDUCTED AND WITHHELD.—

''(i) IN GENERAL.—The tax imposed by subparagraph (A)(ii) shall be deducted and withheld by the trustees from the distribution to which it relates.

''(ii) EXCEPTION WHERE FAILURE TO WAIVE TREATY RIGHTS.—If an amount may not be deducted and withheld under clause (i) by reason of the distributee failing to waive any treaty right with respect to such distribution—

''(I) the tax imposed by subparagraph (A)(ii) shall be imposed on the trust and each trustee shall be personally liable for the amount of such tax, and

''(II) any other beneficiary of the trust shall be entitled to recover from the distributee the amount of such tax imposed on the other beneficiary.

''(F) DISPOSITION.—If a trust ceases to be a qualified trust at any time, a covered expatriate disposes of an interest in a qualified trust, or a covered expatriate holding an interest in a qualified trust dies, then, in lieu of the tax imposed by subparagraph (A)(ii), there is hereby imposed a tax equal to the lesser of—

''(i) the tax determined under paragraph (1) as if the expatriation date were the date of such cessation, disposition, or death, whichever is applicable, or

''(ii) the balance in the tax deferred account immediately before such date.

Such tax shall be imposed on the trust and each trustee shall be personally liable for the amount of such tax and any other beneficiary of the trust shall be entitled to recover from the covered expatriate or the estate the amount of such tax imposed on the other beneficiary.

''(G) DEFINITIONS AND SPECIAL RULE.—For purposes of this paragraph—

''(i) QUALIFIED TRUST.—The term 'qualified trust' means a trust—

''(I) which is organized under, and governed by, the laws of the United States or a State, and

''(II) with respect to which the trust instrument requires that at least 1 trustee of the trust be an individual citizen of the United States or a domestic corporation.

''(ii) VESTED INTEREST.—The term 'vested interest' means any interest which, as of the expatriation date, is vested in the beneficiary.

''(iii) NONVESTED INTEREST.—The term 'nonvested interest' means, with respect to any beneficiary, any interest in a trust

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 in favor of the beneficiary.

''(iv) ADJUSTMENTS.—The Secretary may provide for such adjustments to the bases of assets in a trust or a deferred tax account, and the timing of such adjustments, in order to ensure that gain is taxed only once.

''(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, historical patterns of trust distributions, and the existence of and functions performed by a trust protector or any similar advisor.

''(B) OTHER DETERMINATIONS.—For purposes of this section—

''(i) CONSTRUCTIVE OWNERSHIP.—If a beneficiary of a trust is a corporation, partnership, trust, 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.

''(g) TERMINATION OF DEFERRALS, ETC.—On the date any property held by an individual is treated as sold under subsection (a), notwithstanding any other provision of this title—

''(1) any period during which recognition of income or gain is deferred shall terminate, and

''(2) 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.—If 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 expatriation 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) DEFERRAL OF TAX.—The provisions of subsection (b) shall apply to the tax imposed by this subsection to the extent attributable to gain includible in gross income by reason of this section.

''(i) COORDINATION WITH ESTATE AND GIFT TAXES.—If subsection (a) applies to property held by an individual for any taxable year and—

''(1) such property is includible in the gross estate of such individual solely by reason of section 2107, or

''(2) section 2501 applies to a transfer of such property by such individual solely by reason of section 2501(a)(3).

then there 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.

''(j) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section, including regulations—

''(1) to prevent double taxation by ensuring that—

''(A) appropriate adjustments are made to basis to reflect gain recognized by reason of subsection (a) and the exclusion provided by subsection (a)(3), and

''(B) any gain by reason 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 United States citizenship, see section 7701(a)(47).''.

(b) INCLUSION IN INCOME OF GIFTS AND INHERITANCES FROM COVERED EXPATRIATES.—Section 102 (relating to gifts, etc. not included in gross income) is amended by adding at the end the following new subsection:

''(d) GIFTS AND INHERITANCES FROM COVERED EXPATRIATES.—Subsection (a) shall not exclude from gross income the value of any property acquired by gift, bequest, devise, or inheritance from a covered expatriate after the expatristion date. For purposes of this subsection, any term used in this subsection which is also used in section 877A shall have the same meaning as when used in section 877A.''.

(c) DEFINITION OF TERMINATION OF UNITED STATES CITIZENSHIP.—Section 7701(a) is amended by adding at the end the following new paragraph:

''(47) TERMINATION OF UNITED STATES CITIZENSHIP.—An individual shall not cease to be treated as a United States citizen before the date on which the individual's citizenship is treated as relinquished under section 877A(e)(3).''.

(d) CONFORMING AMENDMENTS.—

(1) Section 877 is amended by adding at the end the following new subsection:

''(f) APPLICATION.—This section shall not apply to any individual who relinquishes (within the meaning of section 877A(e)(3)) United States citizenship on or after February 6, 1995.''.

(2) Section 2107(c) is amended by adding at the end the following new paragraph:

''(3) CROSS REFERENCE.—For credit against the tax imposed by subsection (a) for expatriation tax, see section 877A(i).''.

(3) Section 2501(a)(3) is amended by adding at the end the following new flush sentence: ''For credit against the tax imposed under this section by reason of this paragraph, see section 877A(i).''.

(4) Paragraph (10) of section 7701(b) is amended by adding at the end the following new sentence: ''This paragraph shall not apply to any long-term resident of the United States who is an expatriate (as defined in section 877A(e)(1)).''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart A of part II of subchapter N of chapter 1 is amended by inserting after the item relating to section 877 the following new item:

''Sec. 877A. Tax responsibilities of expatriation.''.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall apply to expatriates (within the meaning of section 877A(e) of the Internal Revenue Code of 1986, as added by this section) whose expatriation date (as so defined) occurs on or after February 6, 1995.

(2) GIFTS AND BEQUESTS.—Section 102(d) of the Internal Revenue Code of 1986 (as added by subsection (b)) shall apply to amounts received from expatriates (as so defined) whose expatriation date (as so defined) occurs on and after February 6, 1995.

(3) SPECIAL RULES RELATING TO CERTAIN ACTS OCCURRING BEFORE FEBRUARY 6, 1995.—In the case of an individual who took 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 whose expatriation date (as so defined) occurs after February 6, 1995—

(A) the amendment made by subsection (c) shall not apply,

(B) the amendment made by subsection (d)(1) shall not apply for any period prior to the expatriation date, and

(C) the other amendments made by this section shall apply as of the expatriation date.

(4) DUE DATE FOR TENTATIVE TAX.—The due date under section 877A(h)(2) of such Code shall in no event occur before the 90th day after the date of the enactment of this Act.

SEC. 212. INFORMATION ON INDIVIDUALS EXPATRIATING.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

''SEC. 6039F. INFORMATION ON INDIVIDUALS EXPATRIATING.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, any expatriate (within the meaning of section 877A(e)(1)) shall provide a statement which includes the information described in subsection (b).

''(2) TIMING.—

''(A) CITIZENS.—In the case of an expatriate described in section 877(e)(1)(A), such statement shall be—

''(i) provided not later than the expatriation date (within the meaning of section 877A(e)(2)), and

''(ii) provided to the person or court referred to in section 877A(e)(3).

''(B) NONCITIZENS.—In the case of an expatriate described in section 877A(e)(1)(B), such statement shall be provided to the Secretary with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

''(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

''(1) the taxpayer's TIN,

''(2) the mailing address of such individual's principal foreign residence,

''(3) the foreign country in which such individual is residing,

''(4) the foreign country of which such individual is a citizen,

''(5) in the case of an individual having a net worth of at lease the dollar amount applicable under section 877A(c)(1)(B), information detailing the assets and liabilities of such individual, and

''(6) such other information as the Secretary may prescribe.

''(c) PENALTY.—Any individual failing to provide a statement 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) $1,000, unless it is shown that such failure is due to reasonable cause and not to willful neglect.

''(d) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

''(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

''(A) a copy of any such statement, and

''(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

''(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

''(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual relinquishing United States citizenship (within the meaning of section 877A(e)(3)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

''(e) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if the Secretary determines that applying this section to such individuals is not necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

''Sec. 6039F. Information on individuals expatriating.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to individuals to whom section 877A of the Internal Revenue Code of 1986 applies and whose expatriation date (as defined in section 877A(e)(2)) occurs on or after February 6, 1995, except that no statement shall be required by such amendments before the 90th day after the date of the enactment of this Act.

CHAPTER 2—FOREIGN TRUST TAX COMPLIANCE

SEC. 221. IMPROVED INFORMATION REPORTING ON FOREIGN TRUSTS.

(a) IN GENERAL.—Section 6048 (relating to returns as to certain foreign trusts) is amended to read as follows:

''SEC. 6048. INFORMATION WITH RESPECT TO CERTAIN FOREIGN TRUSTS.

''(a) NOTICE OF CERTAIN EVENTS.—

''(1) GENERAL RULE.—On or before the 90th day (or such later day as the Secretary may prescribe) after any reportable event, the responsible party shall provide written notice of such event to the Secretary in accordance with paragraph (2).

''(2) CONTENTS OF NOTICE.—The notice required by paragraph (1) shall contain such information as the Secretary may prescribe, including—

''(A) the amount of money or other property (if any) transferred to the trust in connection with the reportable event, and

''(B) the identify of the trust and of each trustee and beneficiary or class of beneficiaries) of the trust.

''(3) REPORTABLE EVENT.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'reportable event' means—

''(i) the creation of any foreign trust by a United States person,

''(ii) the transfer of any money or property (directly or indirectly) to a foreign trust by a United States person, including a transfer by reason of death, and

''(iii) the death of a citizen or resident of the United States if—

''(I) the decedent was treated as the owner of any portion of a foreign trust under the rules of subpart E of part I of subchapter J of chapter 1, or

''(II) any portion of a foreign trust was included in the gross estate of the decedent.

''(B) EXCEPTIONS.—

''(i) FAIR MARKET VALUE SALES.—Subparagraph (A)(ii) shall not apply to any transfer of property to a trust in exchange for consideration of at least the fair market value of the transferred property. For purposes of the preceding sentence, consideration other than cash shall be taken into account at its fair market value and the rules of section 679(a)(3) shall apply.

''(ii) DEFERRED COMPENSATION AND CHARITABLE TRUSTS.—Subparagraph (A) shall not apply with respect to a trust which is—

''(I) described in section 402(b), 404(a)(4), or 404A, or

''(II) determined by the Secretary to be described in section 501(c)(3).

''(4) RESPONSIBLE PARTY.—For purposes of this subsection, the term 'responsible party' means—

''(A) the grantor in the case of the creation of an inter vivos trust.

''(B) the transferor in the case of a reportable event described in paragraph (3)(A)(ii) other than a transfer by reason of death, and

''(C) the executor of the decedent's estate in any other case.

''(b) UNITED STATES GRANTOR OF FOREIGN TRUST.—

''(1) IN GENERAL.—If, at any time during any taxable year of a United States person, such person is treated as the owner of any portion of a foreign trust under the rules of subpart E of part I of subchapter J of chapter 1, such person shall be responsible to ensure that

''(A) such trust makes a return for such year which sets forth a full and complete accounting of all trust activities and operations for the year, the name of the United States agent for such trust, and such other information as the Secretary may prescribe, and

''(B) such trust furnishes such information as the Secretary may prescribe to each United States person (i) who is treated as the owner of any portion of such trust or (ii) who receives (directly or indirectly) any distribution from the trust.

''(2) TRUSTS NOT HAVING UNITED STATES AGENT.—

''(A) IN GENERAL.—If the rules of this paragraph apply to any foreign trust, the determination of amounts required to be taken into account with respect to such trust by a United States person under the rules of subpart E of part I of subchapter J of chapter 1 shall be determined by the Secretary.

''(B) UNITED STATES AGENT REQUIRED.—The rules of this paragraph shall apply to any foreign trust to which paragraph (1) applies unless such trust agrees (in such manner, subject to such conditions, and at such time as the Secretary shall prescribe) to authorize a United States person to act as such trust's limited agent solely for purposes of applying sections 7602, 7603, and 7604 with respect to—

''(i) any request by the Secretary to examine records or produce testimony related to the proper treatment of amounts required to be taken into account under the rules referred to in subparagraph (A), or

''(ii) any summons by the Secretary for such records or testimony.

The appearance of persons or production of records by reason of a United States person being such an agent shall not subject such persons or records to legal process for any purpose other than determining the correct treatment under this title of the amounts required to be taken into account under the rules referred to in subparagraph (A). A foreign trust which appoints an agent described in this subparagraph shall not be considered to have an office or a permanent establishment in the United States, or to be engaged in a trade or business in the United States, solely because of the activities of such agent pursuant to this subsection.

''(C) OTHER RULES TO APPLY.—Rules similar to the rules of paragraphs (2) and (4) of section 6038A(e) shall apply for purposes of this paragraph.

''(c) REPORTING BY UNITED STATES BENEFICIARIES OF FOREIGN TRUSTS.—

''(1) IN GENERAL.—If any United States person receives (directly or indirectly) during any taxable year of such person any distribution from a foreign trust, such person shall make a return with respect to such trust for such year which includes—

''(A) the name of such trust,

''(B) the aggregate amount of the distributions so received from such trust during such taxable year, and

''(C) such other information as the Secretary may prescribe.

''(2) INCLUSION IN INCOME IF RECORDS NOT PROVIDED.—

''(A) IN GENERAL.—If applicable records are not provided to the Secretary to determine the proper treatment of any distribution from a foreign trust, such distribution shall be treated as an accumulation distribution includable in the gross income of the distributee under chapter 1. To the extent provided in regulations, the preceeding sentence shall not apply if the foreign trust elects to be subject to rules similar to the rules of subsection (b)(2)(B).

''(B) APPLICATION OF ACCUMULATION DISTRIBUTION RULES.—For purposes of applying section 668 in a case to which subparagraph (A) applies, the applicable number of years for purposes of section 668(a) shall be ½ of the number of years the trust has been in existence.

''(d) SPECIAL RULES.—

''(1) DETERMINATION OF WHETHER UNITED STATES PERSON RECEIVES DISTRIBUTION.—For purposes of this section, in determining whether a United States person receives a distribution from a foreign trust, the fact that a portion of such trust is treated as owned by another person under the rules of subpart E of part I of subchapter J of chapter 1 shall be disregarded.

''(2) DOMESTIC TRUSTS WITH FOREIGN ACTIVITIES.—To the extent provided in regulations, a trust which is a United States person shall be treated as a foreign trust for purposes of this section and section 6677 if such trust has substantial activities, or holds substantial property, outside the United States.

''(3) TIME AND MANNER OF FILING INFORMATION.—Any notice or return required under this section shall be made at such time and in such manner as the Secretary shall prescribe.

''(4) MODIFICATION OF RETURN REQUIREMENTS.—The Secretary is authorized to suspend or modify any requirement of this section if the Secretary determines that the United States has no significant tax interest in obtaining the required information.''.

(b) INCREASED PENALTIES.—Section 6677 (relating to failure to file information returns with respect to certain foreign trusts) is amended to read as follows:

"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 United States 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 '5 percent' for '35 percent'.

''(c) GROSS REPORTABLE AMOUNT.—For purposes of subsection (a), 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 value 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).

''(d) 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. The fact that a foreign jurisdiction would impose a civil or criminal penalty on the taxpayer (or any other person) for disclosing the required information is not reasonable cause.

''(e) 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 in respect of the assessment or collection of any penalty imposed by subsection (a).''.

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 6724(d), as amended by sections 11004 and 11045, is amended by striking ''or'' at the end of subparagraph (U), by striking the period at the end of subparagraph (V) and inserting ',or'', and by inserting after subparagraph (V) the following new subparagraph:

''(W) section 6048(b)(1)(B) (relating to foreign trust reporting requirements).''.

(2) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by striking the item relating to section 6048 and inserting the following new item:

''Sec. 604 Information with respect to certain foreign trusts.''.

(3) The table of sections for part I of subchapter B of chapter 68 is amended by striking the item relating to section 6677 and inserting the following new item:

''Sec. 6677. Failure to file information with respect to certain foreign trusts''

(d) EFFECTIVE DATES.—

(1) REPORTABLE EVENTS.—To the extent related to subsection (a) of section 6048 of the Internal Revenue Code of 1986, as amended by this section, the amendments made by this section shall apply to reportable events (as defined in such section 6048) occurring after the date of the enactment of this Act.

(2) GRANTOR TRUST REPORTING.—To the extent related to subsection (b) of such section 6048, the amendments made by this section shall apply to taxable years of United States persons beginning after the date of the enactment of this Act.

(3) REPORTING BY UNITED STATES BENEFICIARIES.—To the extent related to subsection (c) of such section 6048, the amendments made by this section shall apply to distributions received after the date of the enactment of this Act.

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 679(a) is amended by striking subparagraph (B) and inserting the following:

''(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 transferred property. For purposes of the preceding sentence, consideration other than cash shall be taken into account at its fair market value.''.

(2) Subsection (a) of section 679 (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)(B) 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).

''(B) TREATMENT OF PRINCIPAL PAYMENTS ON OBLIGATION.—Principal payments by the trust on any obligation referred to in subparagraph (A) shall be taken into account on and after the date of the payment in determining the portion of the trust attributable to the property transferred.

''(C) PERSONS DESCRIBED.—The persons described in this subparagraph are—

''(i) the trust,

''(ii) any grantor or beneficiary of the trust, and

''(iii) any person who is related (within the meaning of section 643(i)(2)(B)) to any grantor or beneficiary of the trust.''.

(b) EXEMPTION OF TRANSFERS TO CHARITABLE TRUSTS.—Subsection (a) of section 679 is amended by striking ''section 404(a)(4) or 404A'' and inserting ''section 6048(a)*(3)(B)(ii)''.

(c) OTHER MODIFICATIONS.—Subsection (a) of section 679 is amended by adding at the end the following new paragraphs:

''(4) SPECIAL RULES APPLICABLE TO FOREIGN GRANTOR WHO LATER BECOMES A UNITED STATES PERSON.—

''(A) IN GENERAL.—If a nonresident alien individual has a residency starting date within 5 years after directly or indirectly transferring property to a foreign trust, this section and section 6048 shall be applied as if such individual transferred to such trust on the residency starting date an amount equal to the portion of such trust attributable to the property transferred by such individual to such trust in such transfer.

''(B) TREATMENT OF UNDISTRIBUTED INCOME.—For purposes of this section, undistributed net income for periods before such individual's residency starting date shall be taken into account in determining the portion of the trust which is attributable to property transferred by such individual to such trust but shall not otherwise be taken into account.

''(C) RESIDENCY STARTING DATE.—For purposes of this paragraph, an individual's residency starting date is the residency starting date determined under section 7701(b)(2)(A).

''(5) OUTBOUND TRUST MIGRATIONS.—If—

''(A) an individual who is a citizen or resident of the United States transferred property to a trust which was not a foreign trust, and

''(B) such trust becomes a foreign trust while such individual is alive,

then this section and section 6048 shall be applied as if such individual transferred to such trust on the date such trust becomes a foreign trust an amount equal to the portion of such trust attributable to the property previously transferred by such individual to such trust. A rule similar to the rule of paragraph (4)(B) shall apply for purposes of this paragraph.''.

(d) MODIFICATION RELATING TO WHETHER TRUST HAS UNITED STATES BENEFICIARIES.—Subsection (c) of section 679 is amended by adding at the end the following new paragraph:

''(3) CERTAIN UNITED STATES BENEFICIARIES DISREGARDED.—A beneficiary shall not be treated as a United States person in applying this section with respect to any transfer of property to foreign trust if such beneficiary first became a United States person more than 5 years after the date of such transfer.''.

(e) TECHNICAL AMENDMENT.—Subparagraph (A) of section 679(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)),''.

(f) REGULATIONS.—Section 679 is amended by adding at the end the following new subsection:

''(d) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers of property after February 6, 1995.

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 title to the trust property 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 subservient to the grantor, or

''(ii) the only amounts distributable from such trust (whether income or corpus) during the lifetime of the grantor are amounts 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 for services rendered.

''(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 paragraph (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.—If—

''(A) but for this subsection, a foreign person would be treated as the owner of any portion of a trust, and

''(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 to the extent 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 ''subsection (f) and'' before ''sections 674''.

(b) CREDIT FOR CERTAIN TAXES.—Paragraph (2) of section 665(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 672(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) DISTRIBUTION BY CERTAIN FOREIGN TRUSTS THROUGH NOMINEES.—

(1) Section 643 is amended by adding at the end the following new subsection:

''(h) DISTRIBUTION BY CERTAIN FOREIGN TRUSTS THROUGH NOMINEES.—For purposes of this part, any amount paid to a United States person which is derived directly or indirectly from a foreign trust of which the payor is not the grantor shall be deemed in the year of payment to have been directly paid by the foreign trust to such United States person.''.

(2) Section 665 is amended by striking subsection (c).

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided by paragraph (2), the amendments made by this section shall take effort on the date of the enactment of this Act.

(2) EXCEPTION FOR CERTAIN TRUSTS.—The amendments made by this section shall not apply to any trust—

(A) which is treated as owned by the grantor or another person under section 676 or 677 (other than subsection (a)(3) thereof) of the Internal Revenue Code of 1986, and

(B) which is in existence on September 19, 1995.

The preceding sentence shall not apply to the portion of any such trust attributable to any transfer to such trust after September 19, 1995.

(e) 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 1491 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. 224. INFORMATION REPORTING REGARDING FOREIGN GIFTS.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 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 (other than an organization described in section 501(c) and exempt from tax under section 501(a)) during any taxable year exceeds $10,000, such United States person shall furnish (at such time and in such manner as the Secretary shall prescribe) 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 a United States person fails to furnish the information required by subsection (a) with respect to any foreign gift within the time prescribed therefor (including extensions)—

''(A) the tax consequences of the receipt of such gift shall be determined by the Secretary in the Secretary's sole discretion from the Secretary's own knowledge or from such information as the Secretary may obtain through testimony or otherwise, and

''(B) such United States person shall pay (upon notice and demand by the Secretary and in the same manner as tax) an amount equal to 5 percent of the amount of such foreign gift for each month for which the failure continues (not to exceed 25 percent of such amount in the aggregate).

''(2) REASONABLE CAUSE EXCEPTION.—Paragraph (1) shall not apply to any failure to report a foreign gift if the United States person shows that the failure is due to reasonable cause and not due to willful neglect.

''(d) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning after December 31, 1996, the $10,000 amount under subsection (a) shall be increased by an amount equal to the product of such amount and the cost-of-living adjustment for such taxable year under section 1(f)(3), except that subparagraph (B) thereof shall be applied by substituting '1995' for '1992'.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section.''.

''(b) CLERICAL AMENDMENT.—The table of sections for such subpart is amended by inserting after the item relating to section 6039F the following new item:

''Sec. 6039G. Notice of large gifts received from foreign persons.''.

''(c) 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.

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 668 (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 section 667(a)—

''(1) INTEREST DETERMINED USING UNDERPAYMENT RATES.—The interest charge determined under this section with respect to any distribution is the amount of interest which would be determined on the partial tax computed under section 667(b) for the period described in paragraph (2) using the rates and the method under section 6621 applicable to underpayments of tax.

''(2) PERIOD.—For purposes of paragraph (1), the period described in this paragraph is the period which begins on the date which is the applicable number of years before the date of the distribution and 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 this subparagraph with respect to any undistributed income year is the product of—

''(i) the undistributed net income for such year, and

''(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) UNDISTRIBUTED INCOME YEAR.—For purposes of this subsection, the 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 all of which the beneficiary receiving the distribution was not a citizen or resident of the United States.

''(5) DETERMINATION OF UNDISTRIBUTED NET INCOME.—Notwithstanding section 666, 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 portion of 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.''.

(b) ABUSIVE TRANSACTIONS.—Section 643(a) is amended by inserting after paragraph (6) the following new paragraph:

''(7) ABUSIVE TRANSACTIONS.—The Secretary shall 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.''.

(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—

''(1) GENERAL RULE.—Except as provided in regulations, if a foreign trust makes a loan of cash or marketable securities directly or indirectly to—

''(A) any grantor or beneficiary of such trust who is a United States person, or

''(B) any United States person not described in subparagraph (A) who is related to such grantor or beneficiary,

the amount of such loan shall be treated as a distribution by such trust to such grantor or beneficiary (as the case may be).

''(2) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) CASH.—The term 'cash' includes foreign currencies and cash equivalents.

''(B) RELATED PERSON.—

''(i) IN GENERAL.—A person is related to another person if the relationship between such persons would result in a disallowance of losses under section 267 or 707(b). In applying section 267 for purposes of the preceding sentence, section 267(c)(4) shall be applied as if the family of an individual includes the spouses of the members of the family.

''(ii) ALLOCATION.—If any person described in paragraph (1)(B) is related to more than one person, the grantor or beneficiary to whom the treatment under this subsection applies shall be determined under regulations prescribed by the Secretary.

''(C) EXCLUSION OF TAX-EXEMPTS.—The term 'United States person' does not include any entity exempt from tax under this chapter.

''(D) TRUST NOT TREATED AS SIMPLE TRUST.—Any trust which is treated under this subsection as making a distribution shall be treated as not described in section 651.

''(3) SUBSEQUENT TRANSACTIONS REGARDING LOAN PRINCIPAL.—If any loan is taken into account under paragraph (1), any subsequent transaction between the trust and the original borrower regarding the principal of the loan (by way of complete or partial repayment, satisfaction, cancellation, discharge, or otherwise) shall be disregarded for purposes of this title.''

(2) TECHNICAL AMENDMENT.—Paragraph (8) of section 7872(f) is amended by inserting '', 643(i).'' before ''or 1274'' each place it appears.

(d) EFFECTIVE DATES.—

(1) INTEREST CHARGE.—The amendment made by subsection (a) shall apply to distributions after the date of the enactment of this Act.

(2) ABUSIVE TRANSACTIONS.—The amendment made by subsection (b) shall take effect on the date of the enactment of this Act.

(3) LOANS FROM TRUSTS.—The amendment made by subsection (c) shall apply to loans of cash or marketable securities after September 19, 1995.

SEC. 226. RESIDENCE OF ESTATES AND TRUSTS, ETC.

(a) TREATMENT AS UNITED STATES PERSON.—

(1) IN GENERAL.—Paragraph (30) of section 7701(a) is amended by striking subparagraph (D) and by inserting after subparagraph (C) the following:

''(D) any estate or trust if—

''(i) a court within the United States is able to exercise primary supervision over the administration of the estate or trust, and

''(ii) in the case of a trust, one or more United States fiduciaries have the authority to control all substantial decisions of the trust.''.

(2) CONFORMING AMENDMENT.—Paragraph (31) of section 7701(a) is amended to read as follows:

''(31) FOREIGN ESTATE OR TRUST.—The term 'foreign estate' or 'foreign 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 shall apply—

(A) to taxable years beginning after December 31, 1996, or

(B) at the election of the trustee of a trust, to taxable years ending after the date of the enactment of this Act.

Such an election, once made, shall be irrevocable.

(b) DOMETIC TRUSTS WHICH BECOME FOREIGN TRUSTS.—

(1) IN GENERAL.—Section 1491 (relating to imposition of tax on transfers to avoid income tax) is amended by adding at the end the following new flush sentence:

''If a trust which is not a foreign trust becomes a foreign trust, such trust shall be treated for purposes of this section as having 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:

''(c) PENALTY.—In the case of any failure to file a return required by the Secretary with respect to any transfer described in section 1491 with respect to a trust, the person required to file such return shall be liable for the penalties provided in section 6677 in the same manner as if such failure were a failure to file a return under section 6048(a).''.

(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 RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS

SEC. 231. 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 subsections:

''(f) 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.—

''(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 consent 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 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.

''(2) APPLICABLE EXCESS RESERVES.—

''(A) IN GENERAL.—For purposes of 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 supplemental reserve) as of the close of the taxpayer's last taxable year beginning before December 31, 1995, over

''(ii) the lesser of—

''(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

''(II) the balance of the reserves described in subclause (I), reduced in the same manner as under section 585(b)(2)(B)(ii) 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 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 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

''(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5) and (6) or subsection (e)(1).

''(3) 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 REQUIREMENT MET.—

''(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—

''(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

''(II) 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 property described in 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 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 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.

''(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1), subparagraph (B) shall be applied with respect to such group.

''(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)(iii), there shall be taken into account only the excess (if any) 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 (2)(A)(ii) of this subsection.

''(B) TREATMENT UNDER ELECTIVE CUTOFF METHOD.—For purposes of applying section 585(c)(4)—

''(i) the balance of the reserve taken into account under subparagraph (B) thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

''(ii) no amount shall be includable in gross income by reason of such reduction.

''(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 credit union by reason 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 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) Subsection (d) of section 50 is amended by adding at the end the following new sentence:

''Paragraphs (1)(A), (2)(A), and (4) of the section 46(e) 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 paragraph (1) and by redesignating paragraph (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (4).

(4) Section 246 is amended by striking subsection (f).

(5) Clause (i) of section 291(e)(1)(B) is amended by striking ''or to which section 593 applies''.

(6) Subparagraph (A) of section 585(a)(2) is amended by striking ''other than an organization to which section 593 applies''.

(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)(ii)''.

(B) Subparagraph (B) of section 593(e)(1) is amended to read as follows:

(B) then out of the balance taken into account under subsection (g)(2)(A)(ii) (properly adjusted for amounts charged against such reserves for taxable years beginning after December 31, 1987).''.

(C) Paragraph (1) of section 593(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 581 to another corporation if, immediately after the distribution, such bank and such other corporation are members of the same affiliated group (as defined in section 1504) and the provisions of section 5(e) of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect.''.

(8) Section 595 is hereby repealed.

(9) Section 596 is hereby repealed.

(10) Subsection (a) of section 860E is amended—

(A) by striking ''Except as provided in paragraph (2), the'' in paragraph (1) and inserting ''The''.

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows ''subsection'' and inserting a period.

(11) Paragraph (3) of section 992(d) is amended by striking ''or 593''.

(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 amended by striking ''or to which section 593 applies''.

(15) Subparagraph (B) of section 1361(b)(2) is amended by striking ''or to which section 593 applies''.

(16) 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, and

(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.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Michigan [Mr. DINGELL] and a Member opposed will each control 30 minutes.

The Chair recognizes the gentleman from Michigan [Mr. DINGELL].

PARLIAMENTARY INQUIRY

Mr. DINGELL. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. DINGELL. Mr. Speaker, I believe I will have the right to close under this as the author of the amendment?

The SPEAKER pro tempore. Who seeks control in opposition?

Mr. THOMAS. Mr. Speaker, I seek to control the time in opposition.

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.

PARLIAMENTARY INQUIRY

Mr. THOMAS. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. THOMAS. Mr. Speaker, is it rather 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. BENTSEN. Mr. Speaker, I thank the gentleman from Michigan for yielding me time.

Mr. Speaker, I am pleased to join with my distinguished colleagues, Mr. DINGELL and Mr. SPRATT, in offering this substitute.

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 drove to meet 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's not the case for the young woman I recently met in my district who could not purchase health insurance because here 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-Spratt-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 ever 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 40 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 2 years ago. 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 commonsense, bipartisan, noncontroversial reforms 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, MARGE ROUKEMA. I want to congratulate my colleague from New Jersey for her leadership on this issue and urge her and others on her side of the aisle 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 Roukema bill. It phases in an increase from 30 to 80 percent the amount that self-employed individuals can deduct from their taxes for the cost of health insurance, affording the same treatment to the self-employed as we do to corporations.

Altogether, these reforms will help 28 million Americans to buy and keep health insurance.

Mr. Speaker, I want to underscore the broad consensus for these reforms. Most of us in this body from both sides of the aisle support them. The President supports them. More than 135 organizations representing business, workers, and health care providers support them. These include the American Medical Association, the American Hospital Association, the AFL–CIO, the Independent Insurance Agents, and the National Association of Manufacturers.

We need to remember the lessons learned from Congresses past regarding health care reform. A comprehensive, complicated reform bill is too controversial and cannot be enacted in whole. Instead we should pass this consensus bill of incremental reforms that will bring immediate help to millions of Americans.

But the addition of controversial provisions isn't the only reason we should pass this substitute. The Republican bill also has weaker portability provisions than the substitute and weakens important consumer protections.

The Republican bill weakens the portability provision by limiting group to individual transfer to a single plan. This will ensure that high risk individuals are pooled together and forced to pay exorbitant premiums.

The Republican plan also would limit the number of businesses that could benefit from this plan. The Republican plan only guarantees first-time issuance of insurance for businesses employing between 2 and 50 people. All businesses with more than 51 employees would not be protected.

This bill also would create a new class of insurance with lower capital and solvency requirements, thus increasing risk to the small businesses that purchase from these new plans. It would contradict the McCarran-Ferguson Act, creating federally regulated insurance using lower standards. And it provides a huge loophole for New York and New Jersey, but not the other 48 States.

Finally, the Republican plan would weaken consumer protection laws by eliminating regulations that prohibit the sale of duplicative health insurance policies to senior citizens. Under the bill, insurance companies would be permitted to sell policies that duplicate Medicare benefits and then collect premiums from seniors who already are covered under Medicare. They would pay twice. These plans are currently prohibited and I am concerned that many seniors will not be aware of the risks associated with purchasing such plans.

Mr. Speaker, this is a fairly easy vote. We can vote to increase the economic security of hundreds of millions of Americans who are currently covered by private insurance by passing this amendment and end once and for all insurance discrimination against: people with a preexisting medical condition; people who lose their job but still need health insurance; and small businesses of any size that want to buy safe, sound, and affordable health insurance for their employees.

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-Spratt-Dingell substitute.

Mr. THOMAS. 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. THOMAS. 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 this 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 provided and promoted access, equity, 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 under subtitle 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 secretary 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 substitution.

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.

□ 2100

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

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentlewoman from New Jersey [Mrs. ROUKEMA].

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

Mrs. ROUKEMA. Mr. Speaker, I thank the gentleman from Michigan [Mr. DINGELL] 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 incremental health reforms 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 simply make 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-Kennedy 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 this 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, that the Senate would ever be able to pass such a controversial and 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.

It's time for the Congress to stop 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 Bilirakis-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 will not be helped 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 the 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. Achieving this is NFIB's highest health reform priority. And I quote from their letter: ''Any substitute amendment that does not directly address this inequity between big and small business is unacceptable to the 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 the key 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 require the inclusion of elective abortions in all 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, each year 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. 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 Senators KASSEBAUM and KENNEDY'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 come out of Committee in the Senate will not be amended on the floor of that body where there are no germaneness rules and anything can be attached to anything.

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 or an injury, they can keep their insurance and not be ostracized by carriers as having preexisting conditions.

Mr. Speaker, there is something else the American 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 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 clean 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 potentially 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 convert 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 flexibility. They have got a Hobson's choice. That is because the base bill has been amended to let the States restrict individuals to a single policy, and that one policy is bound to become the high-risk pool for all the rejects 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 insurance affordability.

There is another provision very deep in this base bill which differs from the substitute. Both of us permit small employers to band together to purchase insurance, and, banded together, they can broaden their risk pool and get better rates. So far, so good. But the base bill goes on to exempt multiemployer health plans from State regulations that govern other multiemployer 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 government.

Here, do not take it from me, listen to what Mr. Gradison, 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 provision of the main bill before us. He says,

> We strongly oppose the provision contained in the House leadership bill which we believe will undermine the progress States have made in reforming their small employer insurance markets and leave an unstable health care 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 insurance—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 clean bill, unencumbered by pet provisions and special concessions.

The differences between the base bill, H.R. 3103, and our substitute, which is the Kennedy-Kassebaum-Roukema bill, are seemingly small but potentially insidious.

First of all, both the base bill and our substitute say that if you lose your job, you can convert from group to individual coverage once your 18-month extension under COBRA has expired. But in the substitute, we say that when you convert, you can pick among the policies a company offers. In the base bill, you lose this flexibility. That's because the base

bill was amended to let the States restrict individuals to a single policy; and that one policy is bound to become the high-risk pool for all the rejects and bad risks. This will make the premium cost excessive, probably beyond the reach of most who need it. Our substitute guarantees individual 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 preexisting 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 that 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 bypassing State laws, particularly on what constitutes 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 MSA's. This comes from the group that for the past year has told seniors that deep cuts in Medicare were needed to keep the trust fund solvent.

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 MSA's, but I would much rather use the tax offsets to cover the revenue losses to pay for a higher rate of deductibility. More small business people, more self-employed Americans, will benefit from being able to deduct 80 percent of their health insurance premiums than will 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 is not identical to Medicare coverage, say offering additional homecare visits, but include a rider in the policy that denies payment for any service covered by Medicare.

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 favor most is moving this bill. It is a shame to bog it down with controversial provisions, and a shame to blow this opportunity to do something bipartisan for a change.

Let's keep this bill on track; let's keep it clean and make it bipartisan. Vote for the Bentsen-Spratt-Dingell substitute.

Mr. THOMAS of California. Mr. Speaker, I yield 3 minutes to the gentlewoman from Connecticut [Mrs. JOHNSON], an extremely important member of the Committee on Ways and Means and the chairman of the Subcommittee on Oversight.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the chairman.

Mr. Speaker, I rise in strong opposition to the substitute, not because it is not an admirable bill. In fact, Senators KASSEBAUM and KENNEDY deserve enormous credit for bringing this issue of insurance reform to the top of the agenda of both Houses, but our bill is literally better. My amendment conformed this bill in many of its details to the Kassebaum-Kennedy bill, working with my chairman. Our bill actually adds protection, not in the Kassebaum-Kennedy bill, to assure that genetic information about an individual cannot be used to exclude that person from health coverage. Our bill is far better on portability. It is far more generous in its determination of what is continuous coverage and what is a break in service because it counts, that is gives credit for coverage, time on Medicare, Medicaid, DOD's Tricare, the Indian Health Service, the Federal Employees Health Benefits programs and State risk pools. Furthermore, our bill gives protection that the Kennedy-Kassebaum bill does not give to people covered under individual policies to assure that they can get into a new policy without discrimination if they move outside the service area or if the insurer goes out of business.

In many of its details, our bill is simply an improved version, a stronger bill than the Kennedy-Kassebaum bill. In its breadth it is also superior. This Chamber has had before it for 5 years, proposals to allow people to deduct the premiums of long-term-care insurance so that we can get employers providing long-term-care insurance and we can encourage seniors to buy long-term-care insurance so that in the future, seniors will not have to spend down to poverty, spend every cent they worked for and were able to save, to cover the costs of nursing home care.

□ 2115

That kind of public-private partnership is imperative to providing security and dignity to our seniors in their retirement years. This is the only bill that has ever brought those long-term-care provisions to the floor of the House in a form in which the President would sign the bill.

Furthermore, this bill will allow deduction of long-term home care costs. Think for how many seniors that is terribly important. For many, it will probably wipe out their entire tax liability.

So this bill is a thoughtful broadening, an inclusion of a number of terribly important health policy solutions that this House at other times has supported, that are not that controversial, that the President will clearly sign, and ought to be part of a health care reform—and part of this Congress' accomplishments.

So do not yield to the siren song of all we can pass is Kennedy-Kassebaum. It is simply far too little. It is too narrow a vision. It does not answer the needs of the American people.

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

Mr. BENTSEN. Mr. Speaker, I yield 3 minutes to the gentleman from California [Mr. WAXMAN].

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

Mr. WAXMAN. Mr. Speaker, today employees who have insurance coverage where they work fear that if they lose their job or change jobs they will not be able to get insurance. If they have a medical problem, they worry they will be excluded from coverage permanently or that they will have a long waiting period before they can be covered. They face the so-called ''job lock'' where they cannot move on to other or better jobs because they cannot risk the loss of their health insurance coverage, and if they lose their job, their situation is made worse by facing the loss of that insurance.

The substitute before us would change that. It would guarantee them access to health insurance coverage. It would assure them that an existing health problem would not be a reason to exclude them from coverage.

Now this base bill that we are seeking to amend has provisions that are similar to Kennedy-Kassebaum, the Dingell bill, the Roukema bill. There really is not a lot of difference between all these provisions. There are some differences, but they are minor, and they are differences that can be worked out if people sat down and talked them through. In fact, I voted for the Kennedy-Kassebaum-Roukema version of this legislation when it was in the Committee on Commerce. Everybody did. It was a unanimous vote.

But the Republican proposal before us adds some things that I think will make this legislation fail ultimately to become law. They take medical savings accounts, which may or may not be a good idea; the small employer pooling, which may or may not work. A lot of people fear that it will lead to cherry-picking of the least risky people by insurance companies. They make medical malpractice changes, which are very controversial because some people fear that this will deprive injured parties of their full redress. They take

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. I 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. BILIRAKIS], the chairman of the Health and Environment Subcommittee, a pioneer in health care reform, the man who led the bipartisan effort in the 103d 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 MSA's, and it also provides a sense of committee resolution to encourage MSA's. But that is where the common elements end. The substitute simply falls far short of the mark on true practical 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 is broken.

Mr. BENTSEN. Mr. Speaker, I yield 1½ 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 talked about a bipartisan effort called Roland-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 steps we can 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 be able to do a bipartisan 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 this 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 attempt that 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 gentlewoman 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 in with major 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 Roland-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 abuse; it goes for about 70 pages. I have a hard time understanding what is meant by a clean bill.

□ 2130

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 Champus, but 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 our conference with the Senate, but it will be a meaningful bill, and 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 asked and was given permission to revise and extend her remarks.)

Ms. WOOLSEY. Once again, Mr. Speaker, the Gingrich Republicans are standing in the way of meaningful health care reform and it's American 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 1½ minutes to the gentleman from Illinois [Mr. DURBIN].

Mr. DURBIN. 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 when 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 we do in 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.

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

Mr. WELLER. Mr. Speaker, I rise to oppose the substitute and support H.R. 3103, which deserves the votes of Democrats as well as 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 business. H.R. 3103 helps the little guy, the self-employed, and small business; frankly, people like my mother and father, fifth generation family farmers who, because their rates are based on two, face very high rates.

Mr. Speaker, H.R. 3103 helps make health insurance more affordable, the risk pools allowing small employers, perhaps through the Farm Bureau or the local Chamber of Commerce, to purchase in a cooperative fashion a bigger group policy, getting more affordable rates, also giving 100 percent tax deduction for long-term care, and raising the 50 percent self-employed taxes.

Mr. BENTSEN. Mr. Speaker, I yield 2 minutes to the gentleman from North Dakota [Mr. POMEROY].

Mr. POMEROY. Mr. Speaker, for 8 years I had the privilege of representing North Dakota as its State insurance commissioner. During that time I evaluated the health insurance crises experienced by families all across the State. While undoubtedly there were many facets to the problems I encountered, far and away the largest problem was affordability.

I am astounded that the previous speaker could talk about affordability as a health issue addressed by the majority plan and deride the substitute, when in fact, deductibility of health insurance premium geared specifically at enhancing the affordability of coverage is the feature best exemplified in the substitute, as opposed to the majority plan. Look at the facts: Fifty percent deductibility immediately under the substitute, and only 30 percent under the majority plan, phasing up to 80 percent deductibility under the substitute plan, and only 50 percent in the majority plan.

The difference between 80 percent and 50 percent deductibility is the difference between affordability and unaffordability of health insurance for farm families, for self-employed families in North Dakota and all across the country. The No. 1 problem for so many families with health insurance tonight, Mr. Speaker, is affordability. Let us make it more affordable by increasing the deductibility. Only the substitute, in my opinion, goes the limits it needs to increasing the deductibility for purposes of making this coverage more affordable.

Mr. BLILEY. Mr. Speaker, I yield 3 minutes to the deputy whip, the gentleman from Illinois [Mr. HASTERT], a gentleman who has put more work into this bill than anyone on the Committee on Commerce.

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

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 left it there until we moved it to 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 the Senate 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-individual, and we also make health care affordable for the American people.

If Members want real change in health care, 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 original 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. THOMAS. 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 concerns in the Committee on Rules, and 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 assuring 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 support many of the reform efforts 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 accomplish some real 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 preexisting 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. BLILEY. 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 asked 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 gentleman from Michigan, the gentleman 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 threats 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.

□ 2145

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. GIBBONS], 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 our colleagues over here, our Republicans friends.

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 as family income. Now, if we look very closely at that family, they are paying about an 18- or 20-percent tax level, but only 3 or 4 percent of that tax is income tax. All the rest of it is FICA tax. They are only getting a medical savings account deduction out of income tax, not out of FICA tax.

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 constituents over here even have to worry about an estate tax? Obviously, many of my 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

an estate tax. They have to have $600,000 before they pay a penny's worth of estate tax. This thing is just designed for very wealthy people.

Mr. BLILEY. Mr. Speaker, I yield 1 minute to the gentleman from Ohio [Mr. HOBSON].

Mr. HOBSON. 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 bipartisan bill, it is called Hobson-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 no opposition. This part of the bill passed out of the committee 30 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 asked and was given permission to revise and extend his remarks.)

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 colleague 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.

The fact is that we had that 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 the problems in large part 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 controversial 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 are getting 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 this a proposal 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 have preexisting conditions treated under their health insurance plans or under health insurance plans which would 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 vote for 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

AMA, the American Hospital Association, the Independent Insurance Agents, 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 bill limited only 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 our side of the aisle, as well as from Representative ROUKEMA, Senator KASSEBAUM, and Senator BENNETT 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 pass a bill that can be signed and become law. By voting against it, you will be telling them that they will have wait longer for health insurance reform—and how long? Perhaps years?—because you can't say no to the special interests who want to load this bill up with controversial add-ons and thereby kill its chances for passage.

Now I know that many of my colleagues, on both sides of the aisle, don't happen to think that each and every one of these provisions added by the Republican leadership is bad. Medical savings accounts, antitrust relief, malpractice reform—there are strongly held views on both sides of these issues. But regardless of our personal views on any of them, one thing is clear: they are all controversial; they all weigh this bill down; and they all significantly reduce the chances of enacting the kind of simple health insurance reform the American people are demanding.

Mr. Speaker, I urge my colleagues:

Don't kill this chance for health insurance reform by passing a Christmas tree instead of a clean bill. Support a clean bill by supporting the substitute. Vote "yes" on Dingell-Spratt-Bentsen.

Mr. THOMAS. Mr. Speaker, it is my privilege and honor to yield the remainder of the majority's time on this substitute to the Speaker of the House, the gentleman from Georgia [Mr. GINGRICH].

Mr. GINGRICH. Mr. Speaker, I thank my friend from California for yielding me the time to close, and I say I always rise with some slight trepidation after my dear friend from Michigan, who has been a leader in the House and is a very effective articulator of his side.

Mr. Speaker, I would say to him, however, that to describe as a Christmas tree a series of things the American people want is different than describing as a Christmas tree things only politicians want. And I do plead guilty to the charge that on a bipartisan basis we tried to reach out and actually listen to the American people, and that some people are very grateful to us for that.

Let me start, for example, with the Alzheimer's Association. The Alzheimer's Association wrote us and said:

> The Alzheimer's Association is writing in general support of the provisions in H.R. 3160 to clarify the Tax Code so that taxpayers may deduct their long-term care expenses as medical expenses. We are particularly pleased to note the committee's addition of specific language to assure that this deduction is available to taxpayers who are incurring expenses for care for persons who are cognitively impaired.

They go on to say:

> This change in the Tax Code has had strong bipartisan support for a number of years and has appeared in virtually every version of health reform legislation seriously considered over the last two Congresses.

Now, maybe to some of our friends that is a Christmas tree. But if one has a parent with Alzheimer's, if one has a loved one with Alzheimer's, or if one has a child with a chronic disease, or a child born with a genetic defect that requires permanent long-term care, this provision is a good step in the right direction, and we should be proud that we listened to the American people.

The American Health Care Association, largely representing folks who are involved in nursing homes, an area where we have a growing population and as more Americans live beyond 80 years of age there will be even more Americans, they said: ''We applaud and support your efforts to enact health insurance reform legislation that also addresses long-term care.''

Now, that is very important. And yes, it is true we added it to the bill because we listened. We think that, while the start in the Senate was a useful start and we respect the work of the other body, we do not think the House is bound automatically to simply say, oh, please send us something that we can rubber stamp.

□ 2200

The American Farm Bureau Federation wrote, and they said:

> A provision of the Health Coverage Availability and Affordability Act of 1996, one which deals with cooperative insurance purchasing arrangements, is particularly important to the 4.5-million-member families of the American Farm Bureau Federation. Farmers are, by and large, self-employed, and as such must purchase health insurance for themselves and their families. Many join together in cooperative purchasing arrangements in order to obtain quality health insurance plans at affordable rates. The Farm Bureau applauds and supports your effort on this issue and the section of the legislation that would facilitate voluntary insurance purchasing cooperatives so that individuals and small companies can negotiate and receive the same price advantage that many larger businesses presently receive.

So, yes, it is true we listened to the Farm Bureau, and we listened to the rural families of America and to the small family farmers.

The National Federation of Independent Businesses, and I am particularly surprised that so many of my friends who normally rail against the rich and declare class warfare and worry about the giant corporations, that they could get a letter like this from the National Federation of Independent Businesses and ignore it.

Here is what the National Federation of Independent Businesses said:

> As the House prepares to take up health care reform, I am writing to let you know how important the small employer pooling provisions of the Health Coverage Availability and Affordability Act are to the members of the National Federation of Independent Businesses. NFIB is seeking to correct a basic unfairness in our current health system, the fact that big business is allowed to buy health insurance under a different set of rules than small business. Because of the Employment Retirement Income Security Act, large self-insured businesses are exempted from State law, in their health plans, while small business is stuck with State insurance coverage mandates, premium taxes, and other forms of regulation. This inequity between big business and small business in large part explains why the premiums of corporate America are going down while small business premiums are going up. State mandates alone can increase premiums for small business by 30 percent. The Health Coverage Availability and Affordability Act 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. Achieving this is NFIB's highest health reform priority. Any substitute amendment that does not directly address this inequity between big and small businesses is unacceptable to the more than 600,000 members of the National Federation of Independent Businesses. I hope you will stand up for small business and oppose efforts to remove the small employer pooling provisions of the Health Coverage Availability and Affordability Act. Passage of these pooling provisions will drive coverage up and premiums down for small business.

I particularly congratulate the gentleman from Illinois [Mr. FAWELL], who has done such yeoman work in that area.

The Chamber of Commerce said here were the returns of their poll: 97.8 percent said they needed small employer pooling; 97.1 percent said they needed to allow self-employed individuals to fully deduct the cost of their health coverage; 96 percent said they needed administrative simplification; 92 percent said they wanted medical malpractice reform.

Let me say to my good friends on the left, yes, it is true, we listened to the American people. We heard the American people say that access was a start but access was not enough, you also have to have affordability because the truth is if you do not keep the price down, you do not have access if you are too poor to pay the premium.

So just passing some Washington law with a Washington rule for a Washington bureaucrat, that does not mean that a small business or a family farm can actually pay for it, does not get the job done. So we went to part 2, which was affordability. We guaranteed

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 is a medical doctor, who is infuriated at the level of fraud that we have in the system today, and Dr. COBURN is a Representative from Oklahoma 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 her autopsy and, since she was still alive, she does not think she had one, and their answer was that must have been an EKG. She said, ''Honey, I did not have that either.''

We had one of our colleagues who walked up to me one day and said, you know, his mother had called him, she 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.'' They said, ''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 police the system so people engaged in ripping off you, 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 with a 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, we are not going to risk vetoing coverage for all Americans in medical savings accounts, but we want to make the case. We want to try to convince him that he ought to be willing to sign it.

There are other items in here. Malpractice reform, my good friend admitted we need to do something, too, on malpractice reform. The trial lawyers should not be ripping America off.

I talked about a week ago to the American dental association. It occurred to me, if dentists acted like the Bar, they would be urging every child to get cavities. There would be commercials to eat sugar and not brush your teeth. Just think about it. It is terrible. A patient walks into a doctor's office. They should both be on the same team, fighting the disease, and there is a lawyer running an ad that says, ''Why don't you walk in there as a potential plaintiff and see if you can't find a good excuse to sue?'' It is culturally sick to have this kind of litigation, conflict-ridden system. We take the first step down the road.

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 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 consideration.

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 why we should vote ''no'' 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. Seldom 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 should not set maximum monetary amounts that can be awarded for pain and suffering, and for punitive damages. I cannot support this anti-consumer provisions.

With respect to Medical Savings Accounts, I took a hard look at this proposal. It seemed like a good idea to give individuals the option to contribute to a tax deductible savings account which must be used for medical purposes and also require them to enroll in a catastrophic health care plan with relatively lower premiums and a high yearly deductible.

Two questions came to mind: First, will this reform help the uninsured; and second, will this reform divide the pool of insured resulting in the systematic breakdown of the insurance system.

Medical Savings Accounts would not be attractive for the high risk and the poor, those who need health care the most, because they would be unable to afford the high yearly deductible over a extended period of time. If the poor did enroll in this plan they would be unlikely to obtain preventive care because it would have to be paid for from their account or from their own pocket.

Meanwhile, the healthy and wealthy, who do not have a problem obtaining health insurance, would be more likely to choose a Medical Savings Account because they can afford the high deductible. The different choices of these demographic groups will result in the healthy vacating the traditional insurance pool leaving only high-risk individuals remaining. The pool will be concentrated with high-risk individuals and costs will rise causing insurance to be unaffordable for many. Fewer people who need coverage will be insured. The Republican proposal for Medical Savings Accounts will divide the insurance pool leading to an insurance system breakdown.

Moreover, I feel compelled to speak out against the multiple employer welfare arrangement [MEWA] provisions contained in this bill. I am concerned that the federal regulation provided will not be adequate and that by preempting established State systems, programs will be harmed.

As a result of these new MEWA provisions, I am concerned that Hawaii may no longer be granted an ERISA exemption for the Hawaii Prepaid Health Care Act. Majority committee staff indicated that Hawaii's ERISA exemption was included in the bill reported out of the Committee on Economic and Education Opportunities. However, due to the extreme handicap of having to evaluate, debate, and vote on a bill mere hours after it is printed and made public, I have been unable to confirm whether or not Hawaii's exemption was preserved. The Federal Government will not be able to take on this new responsibility, liability, and expense. The retention of State authority is critical. Not to do so is a fatal flaw.

Mr. Speaker, the Democratic substitute focuses solely on insurance portability and prohibiting denial of coverage due to preexisting

conditions. We must not load up this bill with controversial provisions that will incite opposition and thwart the enactment of valuable and the noncontroversial provisions in this bill.

This substitute will not overhaul the health care system but will provide greater health security and make a positive difference in the lives of millions of Americans. We must not allow this opportunity to slip through our fingers.

I urge a yes vote for the Democratic substitute.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today as a member of the health profession to encourage my colleagues to support a comprehensive health care reform measure that would make appropriate health care accessible for all Americans. As we consider H.R. 3103, the Health Coverage Affordability and Availability Act, it is important that we realize that there is no clear consensus on the best means to attain universal coverage. Limitations on exclusions for preexisting conditions and guarantees for portability will help millions of Americans move away from job-lock and the terrifying prospect of losing health care coverage that comes with job loss or change brought about by corporate downsizing and other market forces.

As a nurse, it is my opinion that this Congress needs to continue to foster high standards in the health care industry and promote the economic and general welfare of Americans in the workplace. All year we have heard that the Medicare hospital trust fund is about to go bankrupt and therefore we have to make massive cuts in Medicare to save it. Now they propose taking the easiest money in Medicare—the money gained from fighting fraud—and spending it to give medical savings account tax breaks to younger people who are likely to be in the highest tax brackets and the healthiest members of our society.

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 pay backs that will sabotage the passage of good reforms. We must also remember the working poor of this Nation that are effectively priced-our 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 this opportunity for enacting meaningful health reform slip away by loading down this bill with a number of controversial provisions. The only way to enact health reform is to support the Kassebaum-Kennedy-Roukema alternative which the substitute embodies.

I yield back the balance of my time.

Mr. VENTO. Mr. Speaker, 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 is, Medicare, Medicaid, cuts.

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 the provisions before us today, but unfortunately, the Republican leadership are 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 agreed upon reforms.

In our dysfunctional 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 heath plans from excluding any employee on the basis of health status. Health plans would be required to renew coverage for groups and individuals as long as premiums are 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 clauses to avoid coverage 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 disengenous 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 will weaken 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 embarrassed 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 precedent over good people policy. The special interests wish list that the Republican leadership trys to satisfy, threatens 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 cosponsored 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 noes 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]

YEAS—192

Abercrombie	Berman	Brown (FL)
Ackerman	Bevill	Brown (OH)
Andrews	Bishop	Cardin
Baesler	Boehlert	Chapman
Baldacci	Bonior	Clay
Barcia	Borski	Clayton
Barrett (WI)	Boucher	Clement
Becerra	Brewster	Clyburn
Beilenson	Browder	Collins (MI)
Bentsen	Brown (CA)	Condit

Conyers
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Doyle
Duncan
Durbin
Edwards
Engel
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Gonzalez
Green
Gutierrez
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E.B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Martini
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran
Murtha
Nadler
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pomeroy
Poshard
Quinn
Rahall
Rangel
Reed
Richardson
Rivers
Roberts
Roemer
Rose
Roukema
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Sisisky
Skaggs
Skelton
Slaughter
Spratt
Stark
Stenholm
Studds
Stupak
Tanner
Tejeda
Thompson
Thornton
Thurman
Torkildsen
Torres
Torricelli
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Walsh
Ward
Waters
Watt (NC)
Waxman
Wilson
Wise
Woolsey
Wynn
Yates

NAYS—226

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehner
Bonilla
Bono
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Frisa
Funderburk
Gallegly
Ganske
Gekas
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Gordon
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Montgomery
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pombo
Porter
Portman
Pryce
Quillen
Radanovich
Ramstad
Regula
Riggs
Rogers
Rohrabacher
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Solomon
Souder
Spence
Stearns
Stockman
Stump
Talent
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Tiahrt
Upton
Vucanovich
Waldholtz
Walker
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Williams
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—14

Bryant (TX)
Coleman
Collins (IL)
Dooley
Eshoo
Fields (LA)
Fowler
McNulty
Neal
Ros-Lehtinen
Smith (TX)
Smith (WA)
Stokes
Weldon (PA)

□ 2225

Messrs. HILLEARY, NUSSLE, and STOCKMAN changed their vote from ''yea'' to ''nay.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. COMBEST). The question is on the engrossment and third reading of the bill.

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

□ 2230

MOTION TO RECOMMIT OFFERED BY MR. PALLONE

Mr. PALLONE. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore (Mr. COMBEST). Is the gentleman opposed to the bill?

Mr. PALLONE. Yes, Mr. Speaker, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. PALLONE moves to recommit the bill, H.R. 3103, to the Committee on Ways and Means with instructions that the Committee report the bill back to the House forthwith with the following amendment:

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

TABLE OF CONTENTS OF TITLE

Sec. 100. Definitions.

SUBTITLE A—GROUP MARKET RULES

Sec. 101. Guaranteed availability of health coverage.
Sec. 102. Guaranteed renewability of health coverage.
Sec. 103. Portability of health coverage and limitation on preexisting condition exclusions.
Sec. 104. Special enrollment periods.
Sec. 105. Disclosure of information.

SUBTITLE B—INDIVIDUAL MARKET RULES

Sec. 110. Individual health plan portability.
Sec. 111. Guaranteed renewability of individual health coverage.
Sec. 112. State flexibility in individual market reforms.
Sec. 113. Definition.

SUBTITLE C—COBRA CLARIFICATIONS

Sec. 121. Cobra clarification.

SUBTITLE D—PRIVATE HEALTH PLAN PURCHASING COOPERATIVES

Sec. 131. Private health plan purchasing cooperatives.

SUBTITLE E—APPLICATION AND ENFORCEMENT OF STANDARDS

Sec. 141. Applicability.
Sec. 142. Enforcement of standards.

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:

(1) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under 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(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(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), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))) 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 1882(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.

(5) FAMILY.—

(A) IN 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), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(6) GROUP HEALTH PLAN.—

(A) IN 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 1882(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.

(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.

(7) 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 purchases or pays for health benefits (such as provider or hospital benefits) on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. A health plan purchasing cooperative established under section 131 shall not be considered to be a group purchaser.

(8) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a group health plan or an individual health plan.

(9) HEALTH STATUS.—The term ''health status'' includes. with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

(10) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(11) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

(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, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Subtitle A—Group Market Rules

SECTION 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

(a) 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 an employee health benefit plan or a health plan issuer from establishing premium; discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of 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 who will be expected to enroll because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer is 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)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only eligible 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 or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(c) CONSTRUCTION.—

(1) MARKETING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering group health plans to actively market such plans.

(2) INVOLUNTARY OFFERING OF GROUP HEALTH PLANS.—Nothing is this section shall be construed to require a health plan issuer to involuntarily offer group health plans in a 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 subsections (b) and (c), a group health plan shall be renewed or continued in force by 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 health plan issuer has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser;

(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 shall 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 such plan has not received timely premium payments.

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to an application 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 part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 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. 1102(37)) from establishing employer contribution rules or group participation rules; or

(C) permit individuals to decline coverage under an employee health benefit plan if such right is not otherwise available under such plan.

(b) TERMINATION OF GROUP HEALTH PLANS.—

(1) PARTICULAR TYPE OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of group health plan. A group health plan of such type may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each group purchaser covered under a group health plan of this type (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 90 days prior to the date of the discontinuation of such plan;

(B) the 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 one or more replacement plans, the

health plan issuer acts uniformly without regard to the health status of participants or beneficiaries covered under the group health plan, or new participants or beneficiaries who may become eligible for coverage under the group health plan.

(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 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.

(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 under applicable State law, or if not so defined, an employer with not more than 50 employees); or

(ii) to all other group health plans offered by the health plan 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 involved during the 5-year period beginning on the date of the 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 subtitle 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 COVERAGE AND LIMITATION ON 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 an individual who, within 30 days of the date of birth or placement for adoption (as determined under section 609(c)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(c)(3)(B)), was covered under the plan; and

(3) the limitation or exclusion does not apply to a pregnancy.

(b) CREDITING OF PREVIOUS QUALIFYING COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (4), an employee health benefit plan or a health plan issuer offering a group health plan shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage. With respect to an individual described in subsection (a)(2) who maintains continuous coverage, no limitation or exclusion of benefits relating to treatment of a preexisting condition may be applied to a child within the child's first 12 months of life or within 12 months after the placement of a child for adoption.

(2) DISCHARGE OF DUTY.—An employee health benefit plan shall provide documentation of coverage to participants and beneficiaries who coverage is terminated under the 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; and

(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such plan.

An employee health benefit plan shall retain the documentation provided to a participant or beneficiary under subparagraphs (A) and (B) for at least the 12-month period following the date on which the participant or beneficiary ceases to be covered under the plan. Upon request, an employee health benefit plan shall provide a second copy of such documentation or such participant or beneficiary within the 12-month period following the date of such ineligibility.

(3) DEFINITIONS.—As used in this section:

(A) PREVIOUS QUALIFYING COVERAGE.—The term ''previous qualifying coverage'' means the period beginning on the date—

(i) a participant or beneficiary is enrolled under an employee health benefit plan or a group health plan, and ending on the date the participant or beneficiary is not so enrolled; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) or under a public or private health plan established under Federal or State law, and ending on the date the individual is not so enrolled;

for a continuous period of more than 30 days (without regard to any waiting period).

(B) LIMITATION OR EXCLUSION OF BENEFITS RELATING TO TREATMENT OF A PREEXISTING CONDITION.—The term ''limitation or exclusion of benefits relating to treatment of a preexisting condition'' means a limitation or exclusion of benefits imposed on an individual based on a preexisting condition of such individual.

(4) EFFECT OF PREVIOUS COVERAGE.—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 the treatment of a preexisting condition, subject to the limits in subsection (a)(1), only to the extent that such service or benefit was not previously covered under the group health plan, employee health benefit plan, or individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) LATE ENROLLEES.—Except as provided in section 104, 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.

(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 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 described in subsection (c), 90 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 (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, 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 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 laws 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 who—

(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 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of eligibility for coverage, other than COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(3) 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;

each 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 failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or placed for adoption 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 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.

(2) EXCEPTION.—With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under applicable law shall not be subject to the disclosure requirements of such paragraph.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State reporting and disclosure requirements to the extent that such requirements are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(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. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) that is not a material reduction in covered services or benefits provided,''; and

(B) by adding at the end thereof 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 date of 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 delivery by mail through which employee health benefit plans may 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''; and

(C) by inserting ''including the office, contact, or title of the individual at the Department of Labor through 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 benefits 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 (3) may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in an individual health plan—

(A) decline to offer coverage to such individual, or deny enrollment to such individual based on the health status of the individual; or

(B) 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 subtitle A).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent a health plan issuer offering an individual health plan from 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 issuer that issues or renews individual health plans.

(4) PREMIUMS.—Nothing in this subsection shall be construed to affect the determination of a health plan issuer as to the amount of the premium payable under an individual health plan under applicable State law.

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—As used in subsection (a)(1), the term ''eligible individual'' means an individual who—

(1) 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 desired to enroll in the individual health plan.

(2) is not eligible for coverage under a group health plan or an employee health benefit plan;

(3) has not had coverage terminated under a group health plan or employee health benefit plan for failure to make required premium payments or contributions, or for fraud or misrepresentation of material fact; and

(4) 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 OF 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 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)) 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 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 State from requiring health plan issuers offering coverage to individuals under an individual health plan to actively market such plan.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

(a) IN GENERAL.—Subject to subsections (b) and (c), coverage for individuals under an individual health plan shall be renewed or continued in force by a health plan issuer at the option of the individual, except that the requirement of this subsection shall not apply in the case of—

(1) the nonpayment of premiums or contributions by the individual in accordance with the terms of the individual health plan or where the health plan issuer has not received timely premium payments;

(2) fraud or misrepresentation of material fact on the part of the individual; or

(3) the termination of the individual health plan in accordance with subsection (b).

(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—

(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of individual health plan to individuals, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 90 days prior to the date of the expiration of the plan.

(B) the health plan issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently being offered 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 replacement plans, the health plan issuer acts uniformly without regard to the health status of particular individuals.

(21) DISCONTINUANCE OF ALL INDIVIDUAL HEALTH PLANS.—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 142(d)) 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) all individual health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(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 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 renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan issuer which offers a network plan (as defined in paragraph (2)) may deny continued participation under the plan to individuals who neither live, reside, nor work in an area in which the individual health plan is offered, but only if such denial is applied uniformly, without regard to health status of particular individuals.

(2) NETWORK PLAY.—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 covered under such health plan, in whole or in part, through arrangements with providers.

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 by one or more health plan issuers, high-risk 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 chief insurance regulatory official of the State, that such State law does not achieve the goals of providing access to affordable health care coverage for those 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 plan or employee health benefit plan for individuals described in sections 110 and 111.

(C) evaluate whether the State law or program provides individuals described in sections 110 and 111 with a choice of health plans or a health plan providing comprehensive coverage, and

(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 may not make a determination under such subsection until the expiration of the 12-month period beginning on the date on which such notification is made, or until January 1, 1998, whichever is later. With respect to a State that provides notice under this paragraph and that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act, the Secretary 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''), through a process which the Secretary of Health and Human Services determines has included consultation with representatives of the insurance industry and consumer groups, adopts a model standard or standards for reform of the individual health insurance market, and

(2) the Secretary of Health and Human Services determines, within 30 days of the adoption of such NAIC standard or standards, that such standards comply with the goals of sections 110 and 111:

a State that elects to adopt such model standards or substantially adopt such model standards shall be deemed to have met the requirements of sections 110 and 111 and shall be subject to a determination under subsection (a).

SEC. 113. DEFINITION.

(a) IN GENERAL.—As used this title, the term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health 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 2(6).

(b) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(1) Coverage only for accident, or disability income insurance, or any combination thereof.

(2) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(3) Coverage issued as a supplement to liability insurance.

(4) Liability insurance, including general liability insurance and automobile liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Coverage for a specified disease or illness.

(8) Hospital of fixed indemnity insurance.

(9) Short-term limited duration insurance.

(10) Credit-only, dental-only, or vision-only insurance.

(11) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb–2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(II) 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'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', 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 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'',

(2) ELECTION.—Section 2205(1)(C) 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 the last sentence of section 2202(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 2206(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) BIRTH OR ADOPTION OF A CHILD.—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 sentence:

''Such term 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.''.

(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 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'',

(B) in subparagraph (D)(i), by inserting before, '', or'' the following '', 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 '', or''; 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 date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 606(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(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 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 continued coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i) 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''.

(B) in clause (iv)(I), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this subclause 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 subsection because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in clause (v), 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''.

(2) ELECTION.—Section 4980B(f)(5)(A)(ii) of the Internal Revenue Code of 1986 is amended—

(A) in subclause (I), by striking ''or'' at the end thereof;

(B) in subclause (II), by striking the period and inserting '', or'', and

(C) by adding at the end thereof the following new subclause:

''(III) in the case of an qualified beneficiary described in the last sentence of paragraph (2)(B)(i), the date such individual is determined to have been disabled.''.

(3) NOTICES.—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 continued coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring on or after the date of enactment of this Act for plan years beginning after December 31, 1997.

(e) NOTIFICATION OF CHANGES.—Not later than 60 days prior to the date on which this section becomes effective, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Cooperatives

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERATIVES.

(a) DEFINITION.—As used in this title, the term ''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 individual 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) desires to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Secretary of such desire, the State, upon a determination that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall make a determination of whether such group meets the requirements of this section in a timely fashion. Each such cooperative shall also be registered with the Secretary.

(2) STATE REFUSAL TO CERTIFY.—If a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with the standards under this title, the Secretary shall certify and oversee the operations of such cooperative in such State.

(3) INTERSTATE COOPERATIVES.—For purposes of this section a health plan purchasing cooperative operating in more than one State shall be certified by the State in which the cooperative is domiciled. States may enter into cooperative agreements for the purpose of certifying and overseeing the operation of such cooperatives. For purposes of this subsection, a cooperative shall be considered to be domiciled in the State in which most of the members of the cooperative reside.

(c) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each health plan purchasing cooperative shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the cooperative under this section. The Board shall be composed of a board cross-section of representatives of employers, employees, and individuals participating in the cooperative. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of individual health plans or group health plans may not hold or control any right to vote with respect to a cooperative.

(2) LIMITATION ON COMPENSATION.—A health plan purchasing cooperative may not provide compensation to members of the Board of Directors. The cooperative may provide reimbursements 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 be a representative of 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 limits on the maximum 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) residing within the area served by the cooperative who meet such requirements as members on a first-come, first-served basis, or on another basis established by the State to ensure equitable access to the cooperative.

(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by a health plan purchasing cooperative. With respect to a State that has not established such rules, a health plan purchasing cooperative operating in the State shall define the boundaries of the area to be served by the cooperative, except that such boundaries may not be established on the basis of health status of the populations that reside in the area.

(e) DUTIES AND RESPONSIBILITIES.—

(1) IN 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 disseminate comparative health plan materials (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; and

(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 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) cooperating 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.

(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 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 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; and

(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 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 requirement 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 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 of premium rates among employers, plan sponsors, or individuals that are members of health plan purchasing cooperative 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 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) 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, category or care, or services of any class or type of provider.

(D) EXCEPTION.—In those 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.

(h) RULES 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 individuals, plan sponsors, or employers to purchase group health plans or individual health plans through a health plan purchasing cooperative;

(4) require that a health plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State.

(5) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefits plans, or

(6) confer authority up 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.

(i) APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of parts 4 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 pan purchasing cooperative as if such plan were an employee welfare benefit plan.

SUBTITLE E—APPLICATION AND ENFORCEMENT OF STANDARDS

SEC. 141. APPLICABILITY.

(a) CONSTRUCTION.—

(1) ENFORCEMENT.—

(A) 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 insurance 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 by a health plan issuer in connection with an employee health benefit plan, the requirements of standards imposed under the title shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official of officials designated by the State to enforce the requirements of this title.

(B) LIMITATION.—Except as provided in subsection (c), the Secretary shall not enforce the requirements or standards of this title as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a Sate enforce the requirements or standards of this title as they relate to employee health benefit plans.

(2) PREEMPTION OF STATE LAW.—Nothing in this title shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements—

(A) not prescribed in this title; or

(B) related to the issuance, renewal, or portability of health insurance or the establishment or operation of group purchasing arrangements, that are consistent with, and are not in direct conflict with, this title and provide greater protection or benefit to participants, beneficiaries or individuals.

(b) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(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 participant or beneficiary in excess of those provided under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each 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 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 State enforcement law.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—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, 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) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State 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 issuer operating in such State shall be subject to civil enforcement as 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) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(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.

(f) TECHNICAL AMENDMENT.—Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting ''and under the Health Insurance Reform Act of 1996'' before the period.

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 conclude a two-part study, and prepare and submit reports, in accordance with this section.

(b) EVALUATION OF AVAILABILITY.—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, expert opinions, 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 nongroup 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 January 1, 1999, 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 nongroup 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 employee health benefit plans, on 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 have offered this motion 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 additons. It would make it easier for workers who lose or change jobs to buy health coverage. It would limit the length of time that insurers could refuse to cover an applicant's preexisting medical problems.

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 crafted to keep premiums affordable, 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 wealthy and healthy. 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 floor tonight, has said as much. 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, let us all 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. 2893, 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 North Dakota and 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 Democratic substitute, and so I guess 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 gone. 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 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 should be shaved 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 care ills 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 our Nation's great private sector. The answer does not lie in a 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 one that will succeed. They know that the American people support each and every 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 me great pride and satisfaction, and this is a very proud day for the House and for the Nation. Health care reform is moving forward, and I predict it will be signed into law. We look forward to working with the President and the Senate on this bill. It will be our only chance to improve America's health care system. We must be careful not to let it slip away, without making as many changes as we can reasonably on behalf of the American people.

Too much medicine is bad for the patient, but too little will not help the patient get better. This bill is the right does of medicine. Vote ''no'' on the motion to recommit and ''aye'' on the bill.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

RECORDED VOTE

Mr. PALLONE. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. 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 will be taken on the question of final passage.

The vote was taken by electronic device, and there were—ayes 182, noes 236, not voting 13, as follows:

[Roll No. 105]

AYES—182

Abercrombie
Ackerman
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Beilenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (MI)
Condit
Conyers
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Durbin
Edwards
Engel
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Gibbons
Gonzalez
Green
Gutierrez
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran
Murtha
Nadler
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pomeroy
Quinn
Rahall
Rangel
Reed
Richardson
Rivers
Roemer
Rose
Roukema
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Sisisky
Skaggs
Skelton
Slaughter
Spratt
Stark
Stenholm
Studds
Stupak
Tanner
Tejeda
Thompson
Thornton
Thurman
Torres
Torricelli
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Walsh
Ward
Waters
Watt (NC)
Waxman
Wilson
Wise
Woolsey
Wynn
Yates

NOES—236

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brewster
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Geren
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Gordon
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Montgomery
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce
Quillen
Radanovich
Ramstad
Regula
Riggs
Roberts
Rogers
Rohrabacher
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Solomon
Souder
Spence
Stearns
Stockman
Stump
Talent
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Tiahrt
Torkildsen
Upton
Vucanovich
Waldholtz
Walker
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Williams
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—13

Bryant (TX)
Collins (IL)
Eshoo
Fields (LA)
Fowler
Martinez
McNulty
Neal
Ros-Lehtinen
Smith (TX)
Smith (WA)
Stokes
Weldon (PA)

☐ 2257

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. COMBEST). The question is on the passage of the bill.

Pursuant to House Resolution 392, the yeas and nays are ordered.

The yeas and nays were ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 267, nays 151, not voting 14, as follows:

[Roll No. 106]

YEAS—267

Allard
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barcia
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brewster
Browder
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clement
Clinger
Coble
Coburn
Collins (GA)
Combest
Condit
Cooley
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cunningham
Danner
Davis
de la Garza
Deal
DeLay
Diaz-Balart
Dickey
Dooley
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Geren
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Gordon
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Jacobs
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHale
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)

Minge
Molinari
Montgomery
Moorhead
Moran
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Orton
Oxley
Packard
Parker
Pastor
Paxon
Payne (VA)
Peterson (MN)
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Riggs
Roberts
Rogers
Rohrabacher
Rose
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Sisisky
Skeen
Smith (MI)
Smith (NJ)
Solomon
Souder
Spence
Stearns
Stenholm
Stockman
Studds
Stump
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thornton
Tiahrt
Torkildsen
Traficant
Upton
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NAYS—151

Abercrombie
Ackerman
Andrews
Baldacci
Barrett (WI)
Becerra
Beilenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clyburn
Coleman
Collins (MI)
Conyers
Costello
Coyne
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Doyle
Durbin
Edwards
Engel
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Gibbons
Gonzalez
Green
Gutierrez
Hastings (FL)
Hilliard
Hinchey
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Mascara
Matsui
McCarthy
McDermott
McKinney
Meehan
Meek
Menendez
Miller (CA)
Mink
Moakley
Mollohan
Murtha
Nadler
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Payne (NJ)
Pelosi
Peterson (FL)
Pomeroy
Rahall
Rangel
Reed
Richardson
Rivers
Roemer
Roukema
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Skaggs
Slaughter
Spratt
Stark
Stupak
Tejeda
Thompson
Thurman
Torres
Torricelli
Towns
Velazquez
Vento
Visclosky
Volkmer
Ward
Waters
Watt (NC)
Waxman
Williams
Wilson
Wise
Woolsey
Wynn
Yates

NOT VOTING—14

Bryant (TX)
Collins (IL)
Dornan
Eshoo
Fields (LA)
Fowler
McNulty
Neal
Ros-Lehtinen
Skelton
Smith (TX)
Smith (WA)
Stokes
Weldon (PA)

□ 2305

Mr. KENNEDY of Massachusetts and Mr. FOGLIETTA changed their vote from ''yea'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. 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:

HOUSE OF REPRESENTATIVES,
Washington, DC, March 28, 1996.

Hon. NEWT GINGRICH,
Speaker, U.S. House of Representatives, H232, The Capitol, Washington, DC.

DEAR MR. SPEAKER: Effective immediately, I hereby resign from the conference of H.R. 3019, the Omnibus Appropriations Act for Fiscal Year 1996, Conference Report.

Sincerely,

LOUIS STOKES,
Member of Congress.

The SPEAKER pro tempore. Without objection, the resignation is accepted and without objection, the Chair appoints the gentleman from Maryland [Mr. HOYER] to fill the resulting vacancy among the primary panel of conferees.

There was no objection.

The SPEAKER pro tempore. The clerk will notify the Senate of the change in conferees.

PARLIAMENTARY INQUIRIES

Mr. FAZIO of California. Mr. Speaker, I have a parliamentary inquiry. I have a question about the rule that is about to be brought before us on the farm bill.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. FAZIO of California. Mr. Speaker, I would ask, is there a waiver in this rule of the unfunded mandate provision?

The SPEAKER pro tempore. When the rule is read, the gentleman will under stand it. There is a waiver of all points of order in the resolution.

Mr. FAZIO of California. Among all those points of order that were waived, is one of them the unfunded mandate provision, Mr. Speaker?

Mr. SPEAKER pro tempore. The gentleman will understand when the resolution is read.

Mr. FAZIO of California. Further parliamentary inquiry, Mr.Speaker. Is there an analysis available to the Members from the Congressional Budget Office that would inform us as to whether this was in fact an unfunded mandate that would require——

Mr. SOLOMON. Mr. Speaker, yes there is.

The SPEAKER pro tempore. The gentleman should address that question to the Committee on Rules.

Mr. SOLOMON. Yes, there is.

CONFERENCE REPORT ON H.R. 2854, FEDERAL AGRICULTURE IMPROVEMENT AND REFORM ACT OF 1996

Mr. SOLOMON. Mr. Speaker, by direction of the Committee on rules, I call up House Resolution 393 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H.RES. 393

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 2854) to modify the operation of certain agricultural programs. All points of order against the conference report and against its consideration are waived.

SEC. 2. Senate Concurrent Resolution 49 is hereby agreed to.

The SPEAKER pro tempore. The gentleman from New York [Mr. SOLOMON] is recognized for 1 hour.

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

(Mr. SOLOMON asked and was given permission to extend his remarks and include extraneous matter.)

Mr. SOLOMON. Mr. Speaker, I would say to the Members, if I could just have their attention, we will dispose of this rule in 10 minutes, at the most, with no vote necessary, since it is not controversial. So let us get on with it.

Mr. Speaker, the rule before the House today is necessary to permit the House to consider the conference report on the Federal Agriculture Improvement and Reform Act, or FAIR Act.

The rule waives all points of order against the conference report and against its consideration. The waivers are necessary in large part because the Senate passed a much broader bill than the House.

For example, the Senate bill and the conference report contain an extension of the Food Stamp Program, while there was no such provision in the original House bill.

The rule also provides for the adoption of a Senate concurrent Resolution which directs the enrolling clerk to correct an error in the conference report as filed.

Mr. Speaker, this conference report represents the culmination of a long effort to change the way farming is done in America.

Instead of having farmers produce to meet the requirements of Government programs, this bill is designed to move the Government out of the farming business, and let farmers start producing to meet the needs of consumers.

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 Kansas [Mr. ROBERTS], 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 able Representative of the other body during long negotiations.

Finally I would like to thank the staff members on both sides of the hill 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 to me, 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 for major crops 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.

□ 2315

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 to ensure 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 antipoverty 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 freshwater river and its surrounding ecosystem—and not for the better. The periodic sheetflow of fresh water has been reduced, rechannelled and regulated for the convenience of agricultural interests and residential developments—causing a rapid loss of habitat necessary to sustain fisheries, waterfowl, and other 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've seen several smaller-scale 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 southwest Florida are already 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 I 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 over the next 7 years when we are 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, to give 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 why we pay 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 him, congratulate 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. HALL of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from California [Mr. FAZIO].

Mr. FAZIO of California. 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 when 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 that would strike that motion on the premise that it somehow was an unfunded mandate.

CBO has now ruled of course that 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 wishes to deem something an unfunded mandate and then ignore another unfunded mandate and present 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 so much credit for changing the way we do our business here. Many Members on both sides of the aisle, the gentleman from California [Mr. CONDIT], 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 protest over the continuing 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 commodity, 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 late 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 Democrats and 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 fill 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 upon 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 plant a crop 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 wash away farmers who 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 receive less attention than commodity 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 been accomplished 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.

While I cast a reserved ''yes'' vote for the farm bill conference report today, I unreservedly reaffirm my commitment to a strengthened American agriculture 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 Heritage Foundation 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, let us have some unfunded 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 fact 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 Members 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, and I move the previous question on the resolution.

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 concurred in pursuant to House Resolution 393 is as follows:

S. CON. RES. 49

Resolved by the Senate (the House of Representatives concurring), That the Clerk of the House of Representatives, in the enrollment of the bill (H.R. 2854) to modify the operation of certain agricultural programs, shall make the following corrections:

In section 215—

(1) in paragraph (1), insert ''and'' at the end;

(2) in paragraph (2), strike ''; and'' at the end and insert a period; and

(3) 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 Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. OXLEY). Pursuant to House Resolution 393, the 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 pro tempore. 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. Is the gentleman from Texas opposed?

Mr. DE LA GARZA. I am not opposed.

The SPEAKER pro tempore. The gentleman is not opposed. If the gentleman from Texas is not opposed, the gentlemen from Kansas and Texas and Missouri will each 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 asked and was given permission to revise and extend his remarks.)

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

The House has before it today a historic conference report, H.R. 2854, the Federal Agriculture Improvement and Reform Act of 1996. I call it historic because the Committees on Agriculture have produced a farm bill that represent 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 hope to try to conclude this.

The Senate has passed the similar conference report 74 to 26, and the reason that we are trying to expedite this bill is to get it to the President as fast as possible. We have assurance from the Secretary of Agriculture that the President will sign it, and farmers have been waiting and waiting and waiting. And so as soon as we conclude this debate, we will try to make it just as short as possible to accommodate not only every farmer and rancher 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 Committees 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 what is commonly referred to as the Freedom to Farm concept that I, along with Congressman Barrett of Nebraska, introduced

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 principal of supply management. Control supply and raise prices. Over the last 20 years the principal justification for the programs has been that farmers receive federal assistance in return for setting aside a portion of their acreage. That assistance was largely in the form of deficiency payments to compensate farmers for prices below a government-set target price for their production.

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) has tightened supplies so 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 rationale not only fails under close scrutiny by the many critics of agriculture policy, it has enabled our competitors to simply increase their production by more than we ''set aside,'' thereby causing significant impact on American farmers through lost market shares.

The budget cuts of the last ten years have produced greater and greater bureaucratic controls on farmers. In fact, decoupling of the payments from production actually occurred ten years ago when Congress froze payment yields to save money. In 1990 the concept of ''unpaid flex acres'' was introduced to further weaken and devalue the programs in a budget-cutting move. For the last ten years, in effect, Congressional farm policy has been driven almost completely by budget reduction, and the 1995 debate reaffirmed the budget as the driving force for program policy.

Most in the agricultural community have come to the realization that annual set-asides are counter-productive and only encourage our competitors to plant more and steal market share. However, to eliminate the Secretary of Agriculture's reliance on set-asides would cost either the taxpayers or the farmers $6.6 billion under the present farm program according to the Congressional Budget Office (CBO).

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; return to farmers the ability to 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 redtape and government interference. Complaints about endless waits at the county office would end. Hassles over field sizes and whether 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 monoculture 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. The restrictions on what they can plant are greatly reduced. Response to the market would assume a larger role in farmer planning. Divorcing payments from production (a process already begun when yields were frozen in 1985) will end any pressure from the government in choosing crops to pursue. All production incentives in the future should come from the marketplace.

The guarantee of a fixed (albeit declining) payment for seven years will provide the predictability that farmers have wanted and provide certainty to creditors as a basis for lending. The current situation in wheat, corn and cotton under which prices are very high, but large numbers of producers have lost their crops to weather or pests would be corrected by FFA. Those producers last year could not access the high prices without crops, and instead of getting help when they need it most, the old system cuts off their deficiency payments and even demands that they repay advance deficiency payments. FFA insures that whatever government financial assistance is available will be delivered, regardless of the circumstances, because the producer signs a binding contract with the Federal government for the next seven years.

Some of my colleagues have expressed reservations about making high payments during period of high prices. First, the payments will not be high. You can't cut the amount of money we have cut out of agriculture spending over the last 20 years and still have ''high'' payments. No farmer is likely to take his market transition payment and retire. Farmers will continue to farm.

Second, under FFA, the payments made to producers must be looked at from a new perspective. It is a transition to full farmer responsibility for his economic life. Just as farmers will need to look to the market for production and marketing signals, the FFA will require that farmers manage their finances to meet price swings. It is true that when prices are high, farmers will receive a full market transition payment. It is equally true that if prices decline, farmers will receive no more than the fixed market transition payment. That means the farmer must manage all his income, both market and government, to account for weather and price fluctuations.

In short, the FFP authorizes Transition Payments to farmers—as opposed to the current program's deficiency payments—to serve as a form of compensation as we move U.S. agriculture from an economy heavily influenced by the federal government to one in which the government's role is substantially reduced and the primary influence is the market place.

The old program provided market insulation for each bushel of production, but that system is collapsing under the weight of budget cuts. The FFA enhances the farmer's total economic situation—in fact, FFA results in the highest net farm income over the next 7 years of any of the proposals before Congress. This allows the farmer to become accustomed to saving when times are good and using those savings when times are tough. With government assistance declining, it is imperative that producers assume total responsibility for their economic futures. In the years that prices are strong and the farmer receives a payment, it will be his personal responsibility to save that money for the bad year or pay off debt so he can weather the bad years.

The severest critics of farm programs at the New York Times, the Washington Post, the Economist, and a host of regional newspapers have hailed FFA as the most significant reform in ag policy since the 30's. Many congressional critics have also decided that FFA represents the kind of reform they can support. If the ''welfare'' charge was to be leveled, it should have come from this corner. Instead, they believe FFA is the kind of reform that is needed. Nearly every agricultural economist who has commented on FFA has supported it structure and its probable effect on farmers and the agricultural sector.

The only people who are worried about it being classed as ''welfare'' are those populists who want to keep the status quo, some farm groups and others who are supportive of the old farm programs. Agriculture is now at a crossroads. It can either sink deeper into government controls and rapidly sagging government support, or it can strike out in a new direction that at least holds out the prospect of an assisted transition to the private marketplace. H.R. 2854 and the Freedom to Farm Act is that new direction and Congress needs to seize it.

Never before has a farm program proposal enjoyed such broad and diverse support as this one. From the Ivory Towers of academia and the think tanks to the editorial board rooms of our nation's newspapers to a broad

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 convoluted government programs, and exploding government 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, Iowa Cattleman's Association, Kansas Farm Bureau, Kansas Association of Wheat Growers, Kansas Bankers Association, Kansas Grain & Feed Association, Kansas Fertilizer & Chemical Association, North Dakota Grain Growers Association, the Minnesota Association of Wheat Growers, the National Turkey Federation, the National Sunflower 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 Norquist—Americans for Tax Reform; Fran Smith—Consumer Alert; Ed Hudgins—The Cato Institute; Jonathan Tolman—Competitive Enterprise Institute.

A SAMPLING OF NEWSPAPER ENDORSEMENTS

Wall Street Journal, New York Times, Washington Post, Des Moines Register, USA Today, Dallas Morning News, Chicago Tribune, Minneapolis Star Tribune, Denver Post, Kansas City Star, Wisconsin State Journal, The Daily Oklahoman, The Wichita Eagle, The Indianapolis News, The Hartford Courant, The Louisville Courier Journal, Washington Times, The Garden City Telegram, The Manhattan (KS) Mercury. Also, Feedstuffs, Farm Journal, New England Farmer.

ECONOMISTS

Prof. Willard W. Cochrane, University of Minnesota, Director Agricultural Economics, USDA, Kennedy Administration; Dr. Lynn Daft, Abel, Daft, Earley & Ward International, Agricultural Counselor, White House, Carter Administration; Dr. Bruce Gardner, University of Maryland, Assistant Secretary for Economics, USDA, Bush Administration; Dr. Dale Hathaway, National Center for Food & Agricultural Policy, Under Secretary for Economics, USDA, Carter Administration; Dr. Robert Innes, University of Arizona, Council of Economic Advisors, Clinton Administration; Dr. D. Gale Johnson, University of Chicago; Dr. William Lesher, Russell and Lesher, Assistant Secretary for Economics, USDA, Reagan Administration; Dr. Lawrence W. Libby, University of Florida; Dr. Don Paarlburg, Purdue University, Special Assistant, President Eisenhower, Director of Agriculture Economics, Assistant Secretary of Agriculture, USDA, Nixon-Ford Administrations; Dr. Robert Paarlburg, Wellesley College and Harvard University; Dr. C. Ford Runge, University of Minnesota; Dr. John Schnittker, Schnittker Associates, Under Secretary of Agriculture, USDA, Johnson Administration; Mr. Daniel A. Sumner, University of California—Davis, Assistant Secretary for Economics, USDA, Council of Economic Advisers, Bush Administration; Dr. Robert L. Thompson, Winrock International, Assistant Secretary for Economics, USDA—Reagan Administration; Dr. Luther Tweeten, 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 reforms 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 provides regulatory relief for farmers in terms of conservation compliance and wetlands by injecting a little common sense into the process.

This bill has a very strong trade title. It has strong embargo protection language that reminds the President 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—that 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 Commission 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 head and report to 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 input. On 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 Infoshare 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 grants, 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 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].

(Mr. GUNDERSON asked and was given permission to revise and extend 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 over 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 immediately. The support price will be set at $10.35/cwt in 1996, $10.20/cwt in 1997, $10.05/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 those 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 milk 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 bill.

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 formula price for manufacturing milk to any differential 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 differentials 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, contentious 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 relates to the Northeast Interstate 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 among the 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 in the region. 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 itself will 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 producer 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 Federal orders have set up 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 section 10(6) of the compact.

In short, Mr. Speaker, the legislation prevents the Northeast to use 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 [DEIP] to 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.

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 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 and a more 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. WALKER].

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 ''Use of Remote Sensing Data and 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 obtain and 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 for Commercial Application Program [EOCAP], based 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 steam 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–OH–CAP) program has the most expertise in bringing these diverse requirements and capabilities together.

Mr. WALKER. Subparagraph (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 shall require 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 interpretative 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.

□ 2330

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

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

Before I yield to the gentleman, I would just like to observe that the little Mutt and Jeff or whatever kind of show that went on was quite a joke, and this bill is quite a joke.

Mr. Speaker, I yield 5 minutes to the gentleman from North Dakota [Mr. POMEROY].

Mr. POMEROY. Mr. Speaker, I thank the gentleman for yielding me this time.

I would observe I have never heard my colleagues more eloquent.

I want to tell you at the outset that I feel badly all of you have to remain tonight for the debate preceding the vote. We asked the chairman to roll the vote. We are going to be here tomorrow. We might have had an extended debate, not inconveniencing you, but a full debate before the vote tomorrow.

The chairman refused the request to roll the vote, and that is why you will participate in the debate. We will not be rushed in our effort to get on the record our reservations about this bill. And I do not care what tactics they use to put us in an awkward situation debating the bill at 11:30 at night.

You are going to hear tonight a lot of thumping of the chests, a lot of patting on the back. We are passing a farm bill. You know, it is as though they did not realize the last farm bill expired at the end of 1995. We have had farmers all across the country considering very difficult decisions in terms of what to plant, what financing to get in place, not just the farmers but lenders, agribusiness men, all wondering about the actions of this Congress. As far as I am concerned, the House Ag Committee had one thing and one thing only to do in 1995, and that is get a farm bill passed. And the House Committee on Agriculture failed to do it.

Come 1996 January came and went, come February, against a vote that all of us opposed on this side of the aisle. The House voted to adjourn and went home, leaving several opportune weeks to get a farm bill in place wasted, as Members went back to their districts. Come March, the weeks start to toll, and now here, on March 28, and the chairman says we have to remain in session until sometime near midnight so we get a farm program in place for farmers.

I think it has been an absolutely shameful debacle of a process that has brought this bill that left the last farm bill expiring before we had a new program in place for our farmers, and that is just the start of my reservations about this particular farm bill before us.

I do not deny for a minute that the guaranteed payments, especially in the early going under the so-called freedom to farm bill we will be passing tonight, will be helpful to the farmers of North Dakota and across the country. It is what the farmers have been asked to give up for these early upfront payments that give me the most heartburn about this bill.

For decades we have preserved the safety net for family farmers, recognizing that they expose enormous amounts of capital, but have their fate turning largely upon market prices over which they have no control whatsoever.

We have provided a backstop when prices collapsed. We have given farmers a floor so that we do not drive them off their land, and this bill eliminates that hallmark of traditional family farm programs maintained by past Congresses.

What makes this bill even more troubling is that American farmers were assured in exchange for giving up this long-term safety net they would have regulatory relief. Well, there is a good deal in there about planting flexibility, and I think those are positive components of this bill. But if falls far short of regulatory relief. In conference committee the conference adopted an amendment proposed by the gentleman from South Dakota [Mr. JOHNSON] and myself to reform the swampbuster legislation. I think more reform was needed here. And yet, without question, farmers will find the increased flexibility somewhat helpful. More should have been done. The promise of regulatory relief really, I think falls short in delivery than what was promised. In many other ways, this bill is still superior to the freedom to the farm package that was before the House at the end of February. It contains an oilseed marketing loan and a fund for rural America, both provisions that we offered in the House agriculture committee, but they were defeated by the Republican majority Members. Now they are in the final report. It makes it a better bill. It does not make it a bill worthy of passage.

The debate on this bill has been long and contentious. It is unfortunate we did not have more of an opportunity for honest give-and-take in the terms of trying to resolve our differences. I think once the farmers of our Nation get a good look at this program, they will see that at the end of 7 years, they are left without a safety net, they are left without the freedom to farm payments, and they will realize that this deal has been a bad deal for rural America.

My sincere hope is that the Congress will have the chance to review and correct the grievous mistakes it is making in passing this legislation before the last family farmers in America are finally run out of business.

Mr. ROBERTS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Nebraska [Mr. BARRETT], the coauthor of the Freedom to Farm Act.

(Mr. BARRETT of Nebraska asked and was given permission to revise and extend his remarks.)

Mr. BARRETT of Nebraska. Mr. Speaker, I thank my chairman for yielding me this time.

Mr. Speaker, I do rise tonight in support of the conference report on H.R. 2854. I want to thank the chairman of the full ag committee for yielding to me and for his leadership in bringing

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 ever 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'm 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 agriculture policy. But that is simply not true. The cosmetic reforms included in this bill do not sufficiently address my concerns with this program.

The peanut program supports peanut quota holders at the expense of 250 million American consumers and taxpayers. The GAO has estimated that this program passes on $500 million per year in higher peanut prices to consumers.

The bill also lacks real reform of the sugar program. Like the peanut subsidy, the sugar program artificially inflates the price of sugar in America for the benefit of a handful of sugar growers. American consumers pay $1.4 billion more each year for products with sugar in them as 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 conference without having been debated 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 and Inspection Service's efforts to protect the U.S. food supply.

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, this 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 agreement 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 CAROL MOSELEY-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 two 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 making it cost-effective for farmers to set 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 conferees 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 for our agricultural and 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 bit about agriculture, quite a bit.

Mr. TAYLOR of Mississippi. Mr. Speaker, gentlemen and ladies, last year, during the welfare debate, I heard 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.

□ 2345

Something remarkable happened that day. Every single Member of this body voted to no longer pay people for not working. Many of us supported the 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 good thing.

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 work fences, 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, but I can tell you, freedom to farm is a bad idea, because you can never wean people off Government dependence by paying them to do nothing, whether they are a welfare mother or whether they are a father who happens to be a farmer. It does not work. It does not work with welfare, and it will not work with farming.

Please vote against this bill.

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

Mr. TAYLOR of Mississippi. I yield to the gentleman from Missouri.

Mr. VOLKMER. Mr. Speaker, I would like to point out to the House it is not just $80,000 to big investors that do not even live on the farm, they are in New York and Chicago and other places, they are getting the $80,000. They have not even been to the farm, and they are going to get the $80,000. But it is $36 billion, $36 billion over 7 years, to people that do not want to farm. That is right. Not $80,000; $36 billion. That is how much you are talking about, folks. Let us get the real numbers, Yes, $36 billion.

Mr. TAYLOR of Mississippi. Mr. Speaker, reclaiming my time, the new majority came to town promising to balance the budget, and yet this year's budget according to the Congressional Budget Office, will spend $270 billion more than we collect in taxes. If we can cut out anything, let us start with a program that pays people up to $80,000 a year not to go to work. Please vote against this bill.

Mr. VOLKMER. Mr. Speaker, I yield 4 minutes to the gentleman from Massachusetts [Mr. FRANK].

Mr. FRANK of Massachusetts. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I was sorry the gentleman from New York would not yield to me. He said there was a glass of milk here from Massachusetts. Yes, there is a dairy compact from New England, which I opposed, which I think will hurt the consumers which was not in the House bill or the Senate bill. As I understand it, it shows up in the conference report. Typical. If people want to know what contempt of Congress means, it is the way the House has been treated recently on major issues, with the minimum debate the rules of the House allow. And now I can understand why they do not want to debate this.

The gentleman from Mississippi talked about this program. This is the biggest welfare program we have left. It will be bigger than AFDC from the Federal dollar standpoint. What we are saying is, farmers will get welfare payments. There is a difference, however.

By the way, I am not the only one who first thought of this. I must give credit where credit was due. In 1990, RICHARD ARMEY, writing in the Heritage Foundation, said ''If the goal of our farm programs is to help needy farmers, we should do so directly with welfare payments rather than with the complex and costly system of price supports. That would only cost $4 billion a year, rather than $12 billion.''

Mr. ARMEY was a prophet, and that is what we are doing. We are giving to welfare to farmers because they are in need, rather than costly price supports. But the majority leader Mr. ARMEY is a little more expansive than the critic Mr. ARMEY, because we are going to do $35 billion over 7 years, so it is $5 billion a year rather than $4 billion.

Note it is 7 years. If you are a 3-year-old whose mother has not done everything she should have done, you get cut off after 2 years, as I understand it, in the bill. So the farmer's welfare lasts for 7 years.

Also if you are a 3-year-old, your parent has a work requirement. There is no work requirement in here for the farmers. There is not even, as I understand, it is a life requirement. If I am correct, under this bill a farmer who dies may pass on his share of these billions of dollars to his or her heirs.

So at the same time we talk about how tough we are going to be on the dependent children, we are going to cut them off after 2 years. We are 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 instead of requirements,'' 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 outrageous. What right do people have morally to condemn the poorest people in this country, to not 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 why 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 was 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 therefore 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. FRANK of Massachusetts. Mr. Speaker, reclaiming my time, let me just say, of course there is no foolishness in here about States rights. This is a pure, 100 percent unadulterated Federal entitlement. So we have fiscal discipline and toughness and harshness and work requirements and strict time limits for the very poor, but for those who can vote and those whose support politically is important to the majority, all of these hifalutin principles go out the window, and they are treated with a degree of consideration and care that the poor never get.

Mr. DE LA GARZA. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, we spend over $26 billion a year for food stamps, we provide additional monies for school lunch, for school breakfast, for temporary emergency food assistance, and for other assistance programs for migrants. No one can say that we are not attempting to care for the poor. Yet even as we try to provide assistance to the poor, we have managed to reduce expenditures in Agriculture programs in order to balance the budget.

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. However, I suggest to you all that 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 1995 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's views prevailed. Although I believe 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.

If we force ourselves 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 exist 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 6 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 marketplace, 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 export: first, 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. 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 continues cuts in spending. Overall, numerous 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 nutrition and a high-quality 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. VOLKMER. 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 here 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 that 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 at all, 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 Kansas, the chairman of 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 $60,000 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 basically, and the big cycle starts, 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.

I 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, they 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, they call 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 worn me down. I said then and I will say now it is the wrong way for agriculture, it is a disaster for this country, and I say vote against H.R. 2854.

Mr. ROBERTS. Mr. Speaker, I yield such time as he may consume to the gentleman from Virginia [Mr. GOODLATTE].

(Mr. GOODLATTE asked and was give permission to revise and extend his remarks.)

Mr. GOODLATTE. Mr. Speaker, I thank the chairman for yielding me time. I rise in 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 years. 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 accomplishes 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 and redtape. 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 redtape. 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 RICHARD POMBO 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 Federal 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 Okechobbee 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 Hose 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.

☐ 0000

Mr. ROBERTS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from New York [Mr. BOEHLERT], who has been such a help to us on the environmental section of the bill.

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

Mr. BOEHLERT. Mr. Speaker, I rise in support of the 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 would be 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 farmer 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 study this issue and issue 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 the conference report 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 suites 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 freedom 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 realization 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 state.

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 its 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 robust export markets with top-down we-know-best policies.

A vote for this bill is a refjection of those failed policies of the past. A vote for this bill

is a vote for reform. A vote for this bill shows the farmers of this country that this Congress truly cares about bringing agriculture policy into the 21st century. I commend Chairman ROBERTS for his efforts and I strongly urge my colleagues to support this bill.

Mr. ROBERTS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Wisconsin [Mr. ROTH].

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

Mr. Speaker, taken as a whole, this is a good bill. There are a number of essential programs. For example, one-fifth of all the $210 billion global trade in agriculture belongs to the United States, and we have to protect ourselves. But our leadership in this area 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 makes 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 bygone 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 toward a free market system, this particular provision takes us in the totally different direction.

Nevertheless, this is a good bill. Overall, it is a 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 help the United States remain 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. BEREUTER, Mr. HAMILTON 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 also reauthorizes and reforms 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 out-of-date artifact of a bye-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 regions.

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 and our exporters.

It will contribute 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 join me in voting for this landmark legislation.

Mr. DE LA GARZA. Mr. Speaker I yield 1 minute to the gentlewoman from North Carolina [Mrs. CLAYTON].

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

Mrs. CLAYTON. Mr. Speaker, I voted against this bill the first time it came before the House of Representatives and voted against it in committee. I had serious reservations then and still I have some reservations now. But, I will take comfort in the fact that this conference report is the best legislation for our farmers and ranchers that we can achieve at this point in time. I am certain though that we will revisit this topic in the near future.

It is obvious that this legislation is greatly improved from when it left the House. Cognizant of that fact, I will reluctantly support this bill. The conference report now includes funds for nutrition programs that were not present in the House version, funds for environmental improvement programs, and conservation programs and funds for rural development; however, I do not believe that the rural development funds are sufficient to meet the existing needs in our communities.

I believe so strongly in funding rural development properly that I introduced an amendment in the Agriculture Committee that asked for $3.5 billion for the Fund for Rural America. However, the amendment was defeated in committee by a party-line vote. It was then reintroduced as an en bloc amendment by the ranking minority member KIKA DE LA GARZA during floor consideration. Even though the amendment was again defeated in a roll call vote, the Senate version of the bill included the $3.5 billion for Rural Economic Development. Ultimately, the final figure was wheedled down to $300 million during the conference deliberations—only a drop in the bucket. But, I do think that these limited funds are a step in the right direction and will be well spent on the infrastructure and research needs of rural America.

I realize that small family farmers still need help while many of the traditional safety nets are being removed. After lengthy deliberation I have decided that farmers must have some protection and ability to farm their land.

We are fast approaching the planting season and need to begin to identify ways in which we can help our farmers put their crops in the ground.

I was also heartened that the conference report retains permanent agricultural authorization law, thereby reducing the chances that farmer programs would end altogether after the year 2002, when the authorization for the production flexibility contracts expires.

In addition, I was pleased to see that the peanut program was not abolished outright, but instead reformed substantially.

The conference report was also stengthened as it retained the Senate language for the new Environmental Quality Program [EQIP], which would provide payments to livestock producers and farmers for nutrient and manure management to improve water quality.

I urge my colleagues to join me in supporting this conference report.

Mr. DE LA GARZA. Mr. Speaker, I yield 1 minute to the gentleman from California [Mr. FARR],

Mr. FARR of California. Mr. Speaker, I rise this evening in support of this farm bill. It is not perfect. Freedom to farm certainly deserves a lot of debate. But this bill is better than no bill. California farmers in my district are the most productive specialty crop growers in the world. They produce $2.5 billion worth of fresh vegetables a year without any Federal price supports or even Federal water. But even market-driven agriculture needs a national farm policy and a vision toward the future. Conservation, research, rural development and market promotion are areas that need a Federal partner.

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 grants to private food programs that bring fresh, healthy food to low-income communities. I urge the support of this bill.

Mr. DE LA GARZA. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this is not perfect legislation, but I feel that we should approve it 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. I stated then that it was a long, long way from the banks of the Rio Grande to Washington, DC. A poor boy shining shoes in the streets of Mission, TX, to managing a farm bill. It is with great pride now that I do so. This will be the fourth time 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 over $60 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. We have done it with a scalpel, not with a meat ax. You should be proud of what agriculture has done and what we have worked for and what we will continue to work for. But for me today, this is my last hurrah.

Mr. Speaker, I yield to the gentleman from Kansas [Mr. ROBERTS], my chairman.

Mr. ROBERTS. Mr. Speaker, I thank the chairman emeritus of the Committee on Agriculture for yielding to me.

Note for my colleagues in the House, I know the hour is late, but note that I said the chairman emeritus of the House Committee on Agriculture. The gentleman from Texas, Mr. KIKA DE LA GARZA, is not the ranking member. He has been our leader, and in words that I cannot describe, the real chairman emeritus of the committee.

The fourth farm bill. He has seen us through the despair and the farm crisis days of the 1980's. He has seen us during unprecedented good times in the modern miracle of agriculture. He is without question the international secretary of state of agriculture. He has led the committee with comity, with leadership, with decency and always with a revering institutional memory of our committee. I think it is time that the House of Representatives rise and a thank you and a tribute to KIKA DE LA GARZA.

Mr. DE LA GARZA. Mr. Speaker, I thank the gentleman very much.

Mr. Speaker, I accept your ovation on behalf of all of those who were the wind beneath my wings when we flew.

Mr. Speaker, let me say that I thank all of my colleagues, and one final time, let me say that a long time ago I went on a submarine. I asked the commander how long he could keep that submarine underwater. We knew that the other side knew where our troops were, where our ships were, where our planes were. The only thing the other side did not know was where that submarine was under the ice cap. Because of this deterrent peace and democracy came out the winner throughout the world.

When I asked the commander how long, he said, ''As long as I have food for my crew.''

Mr. Speaker, it was farmers and ranchers of America for whom we worked tonight that brought the peace, that brought democracy, that made us the leader in the world we are today, and I dedicate this, my last words, to them who have kept us fed—the best fed people in the world.

Mr. Speaker, I support the conference report on H.R. 2854. I do this with the recognition that this conference report is not perfect. Most legislation that we pass in Congress is not perfect.

As I have said before, legislation is the art of the possible, and what is possible at this moment may not be possible 1 hour from now. However, as with any legislation, we as elected representatives must evaluate and decide whether or not, in its entirety, a specific piece of legislation addresses the concerns of our constituents. I have decided that this bill does just that.

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 American 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. Yet, 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.

My second concern was centered on 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 ameliorate wide fluctuations. Were the 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.

We are able to maintain the 1949 Act as permanent law. Although most would not advocate implementing the 1949 Act, it is important in that it reaffirms our future commitment to farmers and it will give us the impetus needed in 7 years to actively address agricultural programs.

Frankly, I am concerned about the political ability to maintain these guaranteed contracts in times of high prices or record farm income. However, I must trust that future Congresses will have the wisdom to do what is best for agriculture.

My third concern was that the House bill failed to address the totality 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 the very basic infrastructure development of water and waste water facilities.

The Fund for Rural America goes a long way in addressing these rural 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 continuation 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. 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]. I would ask the sponsor of the just-passed Congressional Review Act of 1996, the gentleman from Illinois and chairman of the Committee on the Judiciary [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. 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, those rules would not be allowed to go into effect for at least 60 calendar days. However, I advise my colleague 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.

□ 0015

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 the 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 to the President?

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 for this kind of circumstance. Certainly, it would be totally appropriate 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 my colleagues know that none of us at 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, along 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. STENHOLM], who were great partners along 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 myself with his 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 after 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. SPEAKER, I rise in support of H.R. 2854, the Federal Agriculture Improvement and Reform Act of 1996. This conference agreement will provide American farm producers with a definitive farm program plan as they begin planting the 1996 crop and prepare for a new crop marketing year. This bill gives farmers the direction they need while also delivering the U.S. taxpayer a program that represents budgetary savings over the next 7 years.

For many years now, the American consumer has enjoyed the most abundant and affordable supply of food and fiber in the world. Our Nation's Federal agricultural policy is responsible, in part, for this success and it is on that foundation that we must work toward the future.

The world around us has evolved over the past 6 years and now our agricultural livelihood must evolve in response to those changes. As we prepare for the next millennium of American agriculture, we will look to the future and see a global market that is more critical to the American producer than ever before. Moreover, in some reaches of the globe, the outlook has never looked so promising.

This conference agreement before us today is a step forward in the evolution of farm policy. H.R. 2854, the Federal Agriculture Improvement and Reform Act, includes budgetary saving provisions contained in the Balanced Budget Act of 1995. It represents sweeping change in farm policy by presenting farm producers with greater flexibility to pursue profits from the marketplace, but retains elements of the policy that has served us so well over the years such as the nonrecourse marketing loans.

This measure also contains improvements to the widely supported Food for Peace Program, which build on the successful aspects of the program by making modifications to refine and update the existing structure.

The Federal Agricultural Improvement and Reform Act represents compromises made to help ensure that producers in all regions of the country will make a smooth transition to a more market-oriented program. Most importantly, it offers the regulatory reform and flexibility that farmers have been seeking to help them plant for the world market rather than the U.S. Government. Moreover, H.R. 2854 moves future farming generations toward a more secure financial future by helping attain our responsible balanced Federal budget goals.

Today, we have the opportunity to get our Federal fiscal policy and farm legislation back on the right track through the passage of this conference report—I strongly urge its adoption.

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

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

Mr. ROBERTS. Mr. Speaker, I say to the gentleman from Missouri, ''Mr. EMERSON, we love you, man.''

And to Mr. POMEROY 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

welfare, and how we have halved the budget in regards to agriculture and saved $10 billion. But I am just going to autograph what I have down here, and turn it in, and revise and extend.

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 appropriateness of federal payments—''market transition payments'' under the Agricultural Market Transition Act—for farmers during periods of high prices. Some even liken market transition payments to welfare. 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? First, farm programs are not welfare and partisan statements equating farm programs with welfare do a disservice to farmers and ranchers.

Check Webster'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 simply meets the definition of ''disadvantaged'' to receive government assistance. In total contrast, farmers work on their land, and receive a payment for agreeing to a variety of conditions. FIRST, farmers must adhere to environmental mandates—conservation compliance and wetlands requirements—in return for a federal payment. There is a clear exchange of beneficial environmental practices for benefits received by farmers in the program. Second, the federal payment helps to offset unfair trading practices under which farmers live. Farmers are at the mercy of many trade restrictions. Major markets in the Middle East such as Iran and Iraq are under export embargoes. Threats to continued trade with China also pose significant concern in American agriculture. And finally, due to federal assistance, U.S. farmers can ensure a stable 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 would get an enormous ''windfall.'' For this scenario to work, farmers must be selling above average quantities of commodities at very high prices. But, does that often happen? The answer is no.

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 drop. Supply—tight or excessive—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.

Follow this example: Consider the two following scenarios that a wheat farmer could face:

High prices: Wheat: $5.00 per bushel; average production: 15/bu./acre; Gross Revenue acre: $75/acre.

Low Prices: Wheat: $3.00 per bushel; Average Production: 40 bu./acre; Gross Revenue/Acre: $120/acre.

Who's right?: Under the current government program in the situation outlined above, the farmer should receive a payment in the year of relative low prices even though his income is higher. In fact, those who complain about giving a payment when prices are high cannot justify their view when you compare farmers' gross revenues. When you actually look at the real world facts, the rhetorically-popular ''welfare'' argument no longer hold up.

Market transition payments allow 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 us—check with the economists: The economic consulting firm of Abel, Daft, Earley and Ward looked at the calculations and agreed. They said, ''variations in production more than offset 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 on crop value 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 small crop is typically not sufficient to offset the negative effect a small crop has on crop value.''

How to avoid a $2 billion payback 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 government-run farm program. The key in looking at the policy options is to consider farm income, not high price.

What about ''market conditions'': Market conditions involve much more than 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 down in various regions of the country, but prices are strong. One thing is very clear: The market transition payment is 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 (CCC expenditures): 1985 Act–$15.5 billion per year; 1990 Act–$10.6 billion per year; HR 2854–$6.7 billion per year.

2. Budget Certainty. Expenditures are capped so that ag program spending is no longer an open-ended entitlement.

CBO is the 1985 farm bill would cost $55 billion over 5 years—it cost nearly $80 billion.

The 1990 farm bill was supposed to cost about $41 billion—instead it cost $56 billion.

Under this bill there is budget certainty—expenditures will not exceed $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.

4. 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 buffer any shocks to land values that may come about 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 does not 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. Estimated average payments are corn: 36 cents per bushel, wheat: 63 cents per bushel, upland cotton: 7.3 cents per pound and rice: $2.43 per cwt.

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON RESOURCES,
Washington, DC, March 20, 1996.

Hon. PAT ROBERTS,
Chairman, Committee on Agriculture,
Washington, DC.

DEAR MR. CHAIRMAN: Although the Speaker declined to name members from the Committee on Resources as conferees on the House and Senate farm bills, both measures do contain provisions which fall within the Committee on Resources' jurisdiction. I am sending this letter to confirm our continued jurisdictional interest 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 (including endangered species) at critical stages in their development and their function in shoreline protection and flood protection all gave that Committee a strong jurisdictional interest 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 1985 Food Security Act report (H. Rept. 99–272, Part II) states ''(t)he Merchant Marine and Fisheries Committee's jurisdiction over fish 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 the acquisition of wetlands and other essential 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 recognized.

Section 545. Cooperative Work for Protection, Management, and Improvement of the National Forest System. The Committee on Resources has jurisdiction over ''forest reserves . . . created from the public domain''. This provision would affect the operation of these forests. With this understanding of our jurisdictional interest, however, we have no objection to having the provision included in the conference report.

Section 554, Wildlife Habitat Incentives Program. This section establishes a $50 million Wildlife Habitat Incentive Program overseen by the Secretary of Agriculture. The program will provide payments to landowners 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 should this provision be introduced as a separate bill. We have no objection to its inclusion in the conference report, but will fully exercise our jurisdiction over the implementation of the program in the future.

Section 557, Clarification of Effect of Resource Planning on Allocation or Use of Water. Section 557 amends the Forest and Rangeland Renewable Resources Planning Act and the Federal Land Policy and Management Act to ensure that private property rights, including water rights, will be recognized and protected in the course of special use permitting decisions. The Committee on Resources shares jurisdiction over these laws based on its jurisdiction over ''forest reserves and national parks created from the public domain''. Section 557 would affect the management of National Forests created from the public domain.

We agree with the policy underlying these amendments and would have no objection to including the provision in the conference report with this recognition of our shared jurisdiction.

Section 824, Aquaculture Assistance Programs. The Committee on Resources enjoys jurisdiction over aquaculture, as outlined in the discussion below. The amendments made by this section to the National Agricultural Research, Extension, and Teaching Policy Act of 1977 implement the National Aquaculture Act referenced below for the Department of Agriculture. Although we prefer that all aquaculture activities take place as part of the larger aquaculture plan developed under the National Aquaculture Act, the amendments made by this section are acceptable and we have no objection to including this provision in the final conference report.

Section 872, Stuttgart National Aquaculture Research Center. This provision is a slightly modified version of H.R. 33, a bill introduced in the 104th Congress by Congresswoman Lincoln to transfer a fish laboratory in Arkansas from the Department of the Interior to the Department of Agriculture. The bill was referred solely to the Committee on Resources, and passed by the House of Representatives on December 18, 1995, by voice vote under Suspension of the Rules.

With this understanding of our jurisdiction, we have no objection to including this measure in the conference report, with one change. We noticed after passage in the House that the bill contains a typographical error: it refers to ''station and stations''; it should be ''station or stations'' to execute properly.

Section 873, National Aquaculture Policy, Planning and Development. This section amends the National Aquaculture Act of 1980. The bill creating that Act (H.R. 20, 96th Congress) was referred originally to the Merchant Marine and Fisheries Committee. I was an original cosponsor of the measure. After it was reported, it was sequentially referred to the Committee on Agriculture. The reauthorization of the law in 1984 was provided for in H.R. 2676 (98th Congress); the referral pattern is the same. The law was again reauthorized in 1985 as part of the Food Security Act of 1985, which incorporated the National Aquaculture Act reauthorization measure H.R. 1544, a bill referred originally to Merchant Marine and sequentially to Agriculture. Finally, the Act was reauthorized in 1990 in the Food Security Act of 1990. As stated earlier, the Merchant Marine Committee received a sequential referral of the 1990 and 1985 farm bills, including a referral of sections of the bills dealing with aquaculture.

In addition, in the 103rd Congress, Congressman Studds introduced H.R. 4853, which amended the National Sea Grant College Program Act and the Coastal Zone Management Act to enhance marine aquaculture in the United States. This bill was referred solely to the Merchant Marine and Fisheries Committee. Mr. Studds also introduced H.R. 4854, which amended the National Aquaculture Act of 1980; that bill was jointly referred to the Merchant Marine and Agriculture Committees. Finally, in the 103rd Congress, Congresswoman Lambert introduced H.R. 4676, a bill which looks remarkably similar to Section 873. This bill was also jointly referred to Merchant Marine and Agriculture Committees. It is very clear that the Committee on Resources has a substantial jurisdictional interest in aquaculture.

Section 873 makes radical changes to the National Aquaculture Act, including changing the definition of ''aquaculture'' to exclude private ocean ranching of Pacific salmon in a State where such salmon is prohibited by law. In addition, the section adds a definition of ''private aquaculture'' to include the activities of ''the Federal Government, any State or local government, or any Indian tribe recognized by the Bureau of Indian Affairs.'' Most importantly, the amendments to the National Aquaculture Act strips the co-equal decision making authority of the Secretaries of Interior, Commerce and Agriculture in developing Federal aquaculture policy, and gives this authority to the Secretary of Agriculture, with a mere consultative role for the other Secretaries. In short, if adopted, these proposed amendments would cede authority for all forms of aquaculture, both onshore and offshore, to the Department of Agriculture.

This is a major policy departure from the original Act, In the 1980 law, it is clear that all three Departments will have equal status in developing policy, regulations and the continuing assessment of aquaculture in the United States. In fact, the Act authorizes equal funding for the three Departments for Fiscal Years 1991, 1992 and 1993.

While changes to the National Aquaculture Act may be warranted, we have not addressed this issue during the 104th Congress. Therefore, until the Committee on Resources has had an opportunity to examine the need for change in United States aquaculture policy and these specific changes, we ask that you drop this provision from any conference agreement at this time.

HOUSE BILL (H.R. 2854)

Section 507, Everglades Agricultural Area. Section 507, as added on the House Floor, provides $210 million to the Secretary of the Interior for restoration of the Florida Everglades. Even under a very restrictive view of the Rules of the House, the Committee on Resources would have primary jurisdiction over this provision as it affects the Everglades National Park, several National Wildlife Refuges, the Florida Keys National Marine Sanctuary and the restoration of the Everglades for the benefit of fish and wildlife.

One of the House conferees on this section, Congressman Richard Pombo has been working extensively with me and my staff to see that protections for the Everglades are effective, reasonable and in the public interest. Therefore, I would support the inclusion of an Everglades acquisition provision in the final conference report IF the provision is acceptable to Congressman Pombo.

New Provision. We understand that the conference committee may include a measure similar to section 872 of the Senate bill which transfers a fish culture laboratory in Marion, Alabama, from the Department of the Interior to the Department of Agriculture. This provision is taken from H.R. 1205, the Marion National Aquaculture Research Center Act of 1995, introduced by Congressman Hilliard. The bill was referred to both resources and Agriculture Committees.

Although we do not have the benefit of a hearing record on this measure (as with the Stuttgart fish laboratory transfer), we know of no reason why the laboratory should not be transferred between the departments. Therefore, with this recognition of our jurisdiction, we have no objection to this discretionary measure being included in the conference report.

I appreciate your consideration of these recommendations (which affect what I hope are noncontroversial provisions in 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 the Joint Explanatory Statement of the Committee of Conference on H.R. 2854, the Federal Agriculture 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 104–237 (Part 1) reads:

''* * * The Committee supports terminating the National Weather Service Agricultural and Fruit Frost specialized weather forecast programs in fiscal year 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 unwilling or unable to provide replacement services. Under no circumstances should such an extension last beyond April 1, 1996.

''* * * No additional money has been authorized for the continuation of existing Agricultural and Fruit Frost services and any expenses associated with these services, if necessary, should come from National Weather Service's operating budget * * *''

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 National Oceanic 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 not authorized appropriations for Agricultural Weather Service for FY 1996 or FY 1997, and no money should be appropriated for its continuation.

I hope this letter helps 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, DC.

DEAR 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 Explanatory Statement of the Committee of Conference on H.R. 2854, the ''Federal Agriculture Improvement and Reform Act of 1996'', was intended as an expression of support for a program within the Science Committee's jurisdiction and this Committee's concern that weather service be provided to rural areas and that those involved in agriculture continue to 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. KAPTUR. 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 of this bill establishes a permanent advisory committee to evaluate and review meat and poultry inspection programs. This proposal is similar in effect to the proposal made last summer in the Appropriations Committee to slow meat and poultry inspection reform by forcing USDA to undertake negotiated rulemaking at a late point in the regulatory process.

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, labor relations, employee work rules, 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. Have we learned nothing from the recent British experience?

Mrs. MORELLA. Mr. Speaker, the conference report of 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 State efforts to gain 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 to establish a meat and poultry inspection 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 authority 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 hearings or 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 Centers for Disease Control 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 provision is implemented, 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 conferees 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's 5th District, that revenue-based risk management tools are 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 operating for crop year 1996. I don't, and I don't believe the Conferees, 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 Conferees 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 ineffective 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 of the future.

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 decision-making 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 Advancement Program. It would consolidate existing grant and loan authorities and place primary administrative responsibility with the state directors of USDA's RECD 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 requirements that tie 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 reauthorizes 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 continue 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 designed in the depression area 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 control 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 freedom to farm 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 safewater 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 his 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 with my direct participation, establishing 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 also was 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 the city was continuing to work 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 in the future.

I also am very pleased to note that the conferees, 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 comply with the requirements of 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.

U.S. HOUSE OF REPRESENTATIVES,
March 26, 1996.

Mr. STEPHEN T. HONEY,
City Manager, City of Boulder, Boulder, CO.

DEAR TIM: I'm glad to have had the chance to briefly discuss with you the status of Boulder's application or renewal of the permit for the Lakewood Pipeline. I also appreciate your providing me a copy of your February 16 letter to Senator Brown expressing support for his amendment to the farm bill dealing with water facilities on national forest land.

Your letter repeats some of the city's previously expressed complaints about the U.S. Forest Service's approach to permitting renewal for the Lakewood Pipeline, and it provides a separate 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 believed 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 negotiated 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 instream-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), of alternate locations for 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 chance that the city intends to withdraw from that portion of the agreements? If so, I'd like to know more about that.

The letter also includes a discussion of projected problems with alternatives being considered in the NEPA review, including statements that I would have expected to be made in the form of comments on the imminently forthcoming draft Environmental Impact Statement.

As you know, I have believed that issues surrounding the Lakewood Pipeline permitting process can and should be settled locally through negotiations and without resorting to the expense and trouble of litigation or to legislation that would revise one or more of the laws applicable to the National Forest System. Because I believed that the Forest Service and the City of Boulder were making progress along those lines, I found it surprising that Senator Brown cited Boulder's experience in connection with the Lakewood Pipeline as demonstrating the need for new legislation.

I assume the city hasn't changed its position regarding the desirability of resolving this matter through the existing agreement with the Forest Service. And, if the city believes that the Forest Service is failing to fulfill its obligations under the memorandum of understanding or other agreements, I would like to know more about that failure and what steps I could take to assist to rectify the situation. In any case I'd appreciate an update about progress made and work completed under the framework of the existing agreements.

Thanks again for your continuing efforts to keep me informed and, where I can be useful, involved on this matter. I look forward to continuing to do what I can toward a successful outcome.

Sincerely yours,

DAVID E. SKAGGS.

CITY OF BOULDER, OFFICE OF THE CITY MANAGER,
March 26, 1996.

Hon. DAVID SKAGGS, LONGWORTH H.O.B., WASHINGTON, DC.

DEAR CONGRESSMAN SKAGGS, I am pleased to respond to your March 26th letter and your request for clarification on specific issues surrounding the Lakewood Pipeline Environmental Impact Statement (EIS).

Please keep in mind that as of today, March 26th, a draft EIS has not been released by the Forest Service. Although we have been working with the Forest Service staff in supplying information for them to review and possibly use in the EIS, we have not received any final, written documents from the Forest Service as to their assessment of the issues. Their preliminary assessment will be included in the draft EIS and their record of decision is scheduled to be implemented in November, 1996. As such, perhaps my February 16th letter was more an expression of the frustration about the timeliness for this project than the integrity of the project. If so, I apologize for that.

You are correct that the language for the water conveyance facility easement does not negate the City's claim to a permanent right-of-way, but rather postpones a decision on that right while the easement is in place. If the EIS contains all this information and an easement is executed, then this concern will be resolved.

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 says the Forest Service will assure compliance with all federal and state laws and 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 will 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. We do intend to fully and carefully comment on the draft EIS when it is released, but the comments may change depending upon the content of the draft EIS. I believe it is important for the City to discuss the issues throughout the process, but I apologize for any confusion which may have resulted from our concerns about what may appear in the draft EIS.

The City continues to work toward a successful outcome for this project. Your assistance and leadership in this project has been essential, and the City greatly appreciates your commitment to achieving the goals set forward in our joint MOU with the Forest Service.

Sincerely,

STEPHEN T. HONEY,
City Manager.

Mr. LIPINSKI. Mr. Speaker, I rise today to express my opposition to the safe meat and poultry inspection panel provision which was added at the last minute, with no hearings or public debate, to the farm bill. Although its title suggests otherwise, the safe meat and poultry inspection panel will actually hamper consumer protection efforts by delaying meat and poultry inspection reform.

The seven-member panel, consisting primarily of meat scientists, poultry scientists, and food scientists, would be responsible for reviewing every decision made by the USDA's Food Safety and Inspection Service [FSIS]. This industry-friendly panel would have broad authority over USDA decision making in such matters as inspection procedures, labor relations, employee work rules, food safety standards, food safety practices in meat and poultry plants, and approval of new technologies. Such broad authority gives tremendous power to a part-time panel that does not necessarily include public health doctors. Yet, even if the panel met full time year round, it could not meaningfully address the large volume of decisions made regularly by the USDA's FSIS. It is obvious that the safe meat and poultry inspection panel would quickly cause a bottleneck in the FSIS decision making process. The FSIS food safety reform agenda would be substantially delayed, if not entirely blocked, by this panel.

In fact, the safe meat and poultry inspection panel is actually an attempt at back door regulatory reform. It puts additional regulatory review power in the hands of industry-friendly panel members. This panel provision also adds two new Federal Register publication steps to the existing decision process. In other words, it creates another regulatory hurdle to delay implementation of additional safeguards. However, each delay in the reform process further undermines the public's confidence in the meat and poultry inspection system and food supply.

In these times of severe budget constraints, the Food Safety Inspection Service is struggling to simultaneously meet its current inspection responsibilities and make needed

food safety reforms. The agency certainly cannot afford to pay for another advisory panel; yet, this provision provides no new funds to finance the panel. I cannot believe that at a time when Americans want less Government, the Congress is creating an unfinanced panel that actually duplicates the work of the existing National Advisory Committee on Microbiological Criteria for Food [NACMCE], which has a diverse membership and has worked closely with the FSIS since 1987.

The safe meat and poultry inspection panel is not needed and would actually work against the consumer protection mission of the FSIS. It has no place in this otherwise fine farm bill compromise. Mr. Speaker, I appreciate this opportunity to express my opposition and greatly urge my colleagues to join me in opposition to the safe meat and poultry inspection panel.

Mrs. KENNELLY. Mr. Speaker, I rise in support of the conference report on the farm bill. I voted against this legislation when it was first addressed by the House, because I was concerned that the legislation did not address reauthorization of nutrition programs and did not include the northeast dairy compact. I am pleased that the conference committee saw fit to include these provisions in the conference report.

The northeast dairy compact was approved by all six New England and will play a significant role in boosting farm income and stabilizing the dairy industry in the northeast through interstate cooperation. It is my hope that this compact will serve as a model partnership between farmers and consumers to maintain stable milk prices.

I am also pleased that in reauthorizing many nutrition programs, the conference committee included the Community Food Security Act which will provide a one-time infusion of funds for projects designed to meet the food needs of low-income people. This vital assistance will help to make good quality, and reasonably priced food available to many low-income communities like those in my home city of Hartford.

While I believe that this farm bill conference report is greatly improved, I remain concerned about the seven year market transition, which would make payments to farmers without requiring them to farm at all. But I believe that the reauthorization of nutrition programs, strong conservation provisions, and the inclusion of the Community Food Security Act and the northeast dairy compact has greatly improved this legislation and I urge my colleagues to support passage of this legislation.

Mr. GOODLING. Mr. Speaker, I am pleased the House and Senate conferees for S. 1541, the Agricultural Market Transition Act of 1996, included a provision to protect horses during transport to slaughterhouses. In particular, I would like to thank Congressman STEVE GUNDERSON and Chairman PAT ROBERTS for their support.

Last year, I introduced H.R. 2433, the Safe Commercial Transportation of Horses for Slaughter Act, intended to improve the handling, care, and equipment requirement for the safe transportation of horses to slaughterhouse facilities. My colleague, Senator MITCH MCCONNELL, introduced similar legislation in the Senate. Since then, my office has received tremendous support for introducing this legislation from the public and Members of Congress who have large horseman populations in their congressional districts.

Two years ago, I sent a dear colleague to Members bringing their attention to an article I read in ''equidae,'' 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 or water. 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 GUNDERSON 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 regulation. 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 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.

RECORDED VOTE

Mr. VOLKMER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 318, noes 89, not voting 24, as follows:

[Roll No. 107]

AYES—318

Abercrombie
Ackerman
Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Baldacci
Ballenger
Barcia
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bentsen
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Bliley
Boehlert
Boehner
Bonilla
Bono
Boucher
Brewster
Browder
Brown (FL)
Brown (OH)
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chambliss
Chapman
Chenoweth
Christensen
Chrysler
Clayton
Clement
Clinger
Clyburn
Coble
Coburn
Collins (GA)
Combest
Condit
Cooley
Costello
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cunningham
Danner
Davis
de la Garza
Deal
DeLauro
DeLay
Deutsch
Diaz-Balart
Dickey
Dingell
Dixon
Doolittle
Dornan
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
Emerson
English
Ensign
Evans
Everett
Ewing
Farr
Fawell
Fazio
Fields (LA)
Fields (TX)
Flake
Flanagan
Foley
Forbes
Franks (CT)
Frisa
Frost
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Gekas
Geren
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goodling
Gordon
Graham
Greenwood
Gunderson
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (FL)
Hastings (WA)
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hilliard
Hinchey
Hobson
Hoekstra
Holden
Horn
Hostettler
Houghton
Hoyer
Hunter
Hutchinson
Hyde
Inglis
Istook
Jackson-Lee (TX)
Jefferson
Johnson (CT)
Johnson, E. B.
Johnson, Sam
Jones
Kanjorski
Kasich
Kelly
Kennedy (RI)
Kennelly
Kildee
Kim
King
Kingston
Klink
Klug
Knollenberg
Kolbe
LaFalce
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (GA)
Lewis (KY)
Lightfoot
Linder
Livingston
Longley
Lucas
Maloney
Manton
Manzullo
Mascara
Matsui
McCollum
McCrery
McDade
McHale
McHugh
McInnis
McIntosh
McKeon
Meek
Metcalf
Meyers
Mica
Mink
Molinari
Mollohan
Montgomery
Moorhead
Morella
Murtha
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Olver
Ortiz
Orton
Oxley
Packard
Parker
Pastor
Paxon
Payne (VA)
Peterson (FL)
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Reed
Regula
Richardson
Riggs
Roberts
Roemer
Rogers
Rohrabacher
Roth
Royce
Rush
Salmon
Sanders
Sawyer
Schaefer
Schiff

Schumer	Stump	Walker
Scott	Stupak	Walsh
Seastrand	Talent	Ward
Shadegg	Tanner	Watt (NC)
Shaw	Tate	Watts (OK)
Shays	Tauzin	Weldon (FL)
Shuster	Taylor (NC)	Weller
Sisisky	Tejeda	White
Skeen	Thomas	Whitfield
Skelton	Thompson	Wicker
Slaughter	Thornberry	Wilson
Smith (MI)	Thornton	Wise
Smith (NJ)	Thurman	Wolf
Solomon	Tiahrt	Woolsey
Souder	Torres	Wynn
Spence	Torricelli	Young (AK)
Spratt	Towns	Young (FL)
Stearns	Upton	Zeliff
Stenholm	Vucanovich	
Stockman	Waldholtz	

NOES—89

Andrews	Goss	Oberstar
Baesler	Green	Obey
Barrett (WI)	Gutierrez	Owens
Becerra	Hoke	Pallone
Blute	Jackson (IL)	Payne (NJ)
Bonior	Jacobs	Pelosi
Borski	Johnson (SD)	Peterson (MN)
Brown (CA)	Johnston	Pomeroy
Cardin	Kaptur	Rivers
Chabot	Kennedy (MA)	Roybal-Allard
Clay	Kleczka	Sabo
Collins (MI)	Levin	Sanford
Conyers	Lincoln	Saxton
Coyne	Lipinski	Scarborough
DeFazio	LoBiondo	Sensenbrenner
Dellums	Lofgren	Serrano
Dicks	Lowey	Skaggs
Doggett	Luther	Stark
Dooley	Markey	Taylor (MS)
Doyle	Martini	Torkildsen
Engel	McCarthy	Traficant
Fattah	McDermott	Velazquez
Filner	McKinney	Vento
Foglietta	Menendez	Visclosky
Ford	Miller (CA)	Volkmer
Fox	Miller (FL)	Wamp
Frank (MA)	Minge	Waters
Franks (NJ)	Moakley	Williams
Frelinghuysen	Moran	Zimmer
Gephardt	Nadler	

NOT VOTING—24

Beilenson	Lantos	Schroeder
Bryant (TX)	Martinez	Smith (TX)
Coleman	McNulty	Smith (WA)
Collins (IL)	Meehan	Stokes
Eshoo	Neal	Studds
Fowler	Ros-Lehtinen	Waxman
Gibbons	Rose	Weldon (PA)
Hayes	Roukema	Yates

☐ 0036

Mr. FOX of Pennsylvania changed his vote from ''aye'' to ''no.''

Mr. TORRES changed his vote from ''no'' to ''aye.''

So the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. ROBERTS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the conference report on H.R. 2854 just passed.

The SPEAKER pro tempore (Mr. OXLEY). Is there objection to the request of the gentleman from Kansas?

There was no objection.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was grant to:

Mrs. SMITH of Washington, (at the request of Mr. ARMEY) for today, on account of illness.

Mr. MCNULTY (at the request of Mr. GEPHARDT) for today after 2:15 p.m. and the balance of the week, on account of death in the family.

Ms. ESHOO (at the request of Mr. GEPHARDT) for today after 8:30 p.m. and the balance of the week, on account of a death in the family.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. JEFFERSON) to revise and extend their remarks and include extraneous material:)

Mr. SKELTON, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. PETE GEREN of Texas, for 5 minutes, today.

Mr. BROWDER, for 5 minutes, today.

EXTENSION OF REMARKS

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. KOLBE), 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. JACOBS.
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. GANSKE.
Mr. MOORHEAD.
Mr. EWING.
Mr. CUNNINGHAM.
Mr. RIGGS, in two instances.
Mr. SMITH of Michigan.
Mrs. KELLY.
Mr. OXLEY.
Mr. HORN.
Ms. 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. 2969. An act to eliminate the Board of Tea Experts by repealing the Tea Importation Act of 1897.

H.J. Res. 168. Joint resolution waiving certain enrollment requirements with respect to two bills of the 104th Congress.

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:

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. 113 (c) and (e); to the Committee on National Security.

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. 719(h); to the Committee on Government Reform and Oversight.

2313. A letter from the Executive Director, District of Columbia Financial Responsibility and Management Assistance Authority, transmitting a report entitled ''Report on the Mayor's District of Columbia FY 1997 Budget and Multiyear Plan'' adopted by the District of Columbia Financial Responsibility and Management Assistance Authority on March 21, 1996, pursuant to section 202(d)

of Public Law 104–8; to the Committee on Government Reform and Oversight.

2314. A letter from the Chairman, Nuclear Regulatory Commission, transmitting a copy of the annual report in compliance with the Government in the Sunshine Act during the calendar year 1995, pursuant to 5 U.S.C. 552b(j); to the Committee on Government Reform and Oversight.

2315. A letter from the Commissioner, Social Security Administration, transmitting a report of 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 Act of 1965 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. 3049. A bill to amend section 1505 of the Higher Education Act of 1965 to provide for the continuity of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development (Rept. 104–505). Referred to the Committee of the Whole House of 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 taxpayer protections; with an amendment (Rept. 104–506). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 2501. A bill to extend the deadline under the Federal Power Act applicable to the construction of a hydroelectric project in Kentucky, and for other purposes; with an amendment (Rept. 104–507). Referred to the Committee of the Whole House on the State of the Union.

Mr. BLILEY: Committee on Commerce. H.R. 2630. A bill to extend the deadline for commencement of construction of a hydroelectric project in the State of Illinois; 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. 2695. 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. 2773. A bill to extend the deadline under the Federal Power Act 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. 2816. A bill to reinstate the license for, and extend the deadline under the Federal Power Act applicable to the construction of, a hydroelectric project in Ohio, and for other purposes (Rept. 104–511). 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. 104–512). 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. 3180. A bill to increase penalties for sex offenses against children; to the Committee on the Judiciary.

By Ms. ESHOO:

H.R. 3181. 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. LAHOOD, 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. 3183. 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 from the Department of Defense; to the Committee on Veterans' Affairs.

By Mr. HORN (for himself, Mr. CLINGER, Mr. DAVIS, Mrs. MALONEY, and Mr. PETERSON of Minnesota):

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. BENTSEN, and Mr. SPRATT):

H.R. 3185. A bill to provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, 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 Committees on Commerce, and Economic and Educational Opportunities, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CLAY:

H.R. 3186. 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 air safety information; to the Committee on Transportation and Infrastructure.

By Mr. COMBEST:

H.R. 3188. A bill to amend title 49, United States Code, to limit the applicability of hazardous material transportation registration and fee 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. MORAN):

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 based on race, sex, or ethnic origin, in connection with Federal contracts; to the Committee on Government Reform and Oversight.

By Mr. KLINK:

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. MOORHEAD:

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. PICKETT:

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. BREWSTER, and Mr. LARGENT):

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. SHAYS:

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, and for other purposes; to the Committee on the Judiciary, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BARTON of Texas (for himself, Mr. PETE GEREN of Texas, Mr. ARCHER, Mr. SHADEGG, and Mr. HALL of Texas):

H.J. Res. 169. 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. PICKETT 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. 580: 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. HEINEMAN.
H.R. 1496: Mr. SAXTON.
H.R. 1560: Mr. MENENDEZ and Mrs. THURMAN.
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. DELAURO.
H.R. 1963: Mr. HILLIARD.
H.R. 2089: Mr. WHITE, Mr. MCDERMOTT, Mr. DICKS, and Mr. PETERSON of Minnesota.
H.R. 2200: Mr. ZELIFF, Mr. BONIOR, Mr. HOSTETTLER, and Mr. MONTGOMERY.
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. KLECZKA.
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. 2892: Mr. CLEMENT, Mr. CALVERT, Mr. OLVER, Mr. ABERCROMBIE, Mr. BAKER of Louisiana, and Mr. LIPINSKI.
H.R. 2912: Mr. KLECZKA, 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. DORNAN, Mr. FARR, Mr. OBERSTAR, and Mrs. SMITH of Washington.
H.R. 3159: Ms. BROWN of Florida.
H.J. Res. 70: Mr. TEJEDA, Mr. BERMAN, and Mr. SANDERS.
H. Con. Res. 26: Ms. MOLINARI.
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. MCINNIS.
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.