structure does not provide sufficient flexibility to allow hospitals to network or merge, vital steps which rural hospitals must take to ensure survival. While the 1995 Balanced Budget Act contained several provisions that would have accomplished many of our goals, those provisions were felled by President Clinton's veto pen.

During floor consideration of H.R. 3103, the Health Care Availability and Affordability Act, I tried to offer an amendment that would have addressed many rural concerns. Although my amendment was not allowed, I received a personal assurance from the House leadership that rural health would be dealt with yet this year.

In mid-May, I gave a speech before the National Rural Health Association in which I outlined the primary needs of rural health care as I saw it. Following that speech, we held several meetings with the core membership of the Rural Health Care Coalition and our constituent health associations.

The result is a comprehensive consensus bill that reflects a broad view of how to better provide access to health care for rural America.

This bill seeks to increase access to health care for rural citizens in four areas:

First, it reduces the wide variation existing between urban and rural areas in the Medicare adjusted average per capita cost [AAPCC] payment made to health maintenance organizations (HMOs). While HMOs serving some urban areas are receiving upwards of $650, the AAPCC payment in 1995 for Vernon County, WI, was $211. This kind of disparity results in HMOs falling over themselves to serve urban areas while shunning rural Americans who have paid the same Medicare tax all of their lives.

Improving the payment formula will actually allow for greater health care options and competition in rural America. This bill will help to make HMOs and PSOs an option for Medicare beneficiaries in western Wisconsin, an option that does not currently exist.

Second, it encourages rural providers to form networks to reduce costs, share services, and provide more efficient services. It does so by providing grant money for communities to create rural health networks, creating two new categories of hospitals under Medicare, and encouraging community health centers to expand into areas not presently served.

This bill also provides to States and private entities (1) grants to develop comprehensive plans to increase access to health care for rural communities, and (2) technical assistance and development grants to assist hospitals in creating provider networks.

At a time when we are trying to balance the budget, the Federal Government can no longer carry under-utilized facilities. However, rural communities cannot afford to go without essential emergency and primary care services. To address these needs, we create two new categories of limited-service hospitals under Medicare. Rural Emergency Access Care Hospitals provide only 24 hour emergency care to communities in need of an emergency facility, but not a full-service hospital. Rural primary care hospitals may provide a broader range of services and for a period of up to 4 days.

Further, in order to bolster an expansion of community health centers, our bill directs the Secretary of DHHS, when making new grants under the Public Health Service Act, to give priority to areas not presently served by community health centers [CHCs] and to CHCs located in or adjacent to community hospitals.

This bill also expresses the sense of the Congress that the Federal Trade Commission should promptly complete its review of the anti-trust standard to be applied to provider networks. Rural providers need anti-trust relief that will allow them the flexibility necessary to provide adequate care with limited resources, and to ensure that network arrangements do not violate current laws and regulations. A thorough review will reveal whether there is a need for further legislation in this sensitive area.

Third, this bill provides incentives to physicians and other health care professionals to locate and provide services in rural areas. We exempt National Health Service Corps loan repayments and scholarships from federal income taxes and direct the Secretary of DHHS to give priority placement to areas that have created community rural health networks.

In addition, this bill increases the Medicare incentive payment already paid to providers in health professional shortage areas [HPSAs] from 10 to 20 percent. However, we limit the payment to primary care providers in rural HPSAs, where recruitment efforts are more difficult.

Finally, it provides a good first step toward recognition of tele-medicine as an emerging technology with enormous potential in rural medicine. Our bill directs the Secretary of Health and Human Services to develop a payment methodology under Medicare for telemedicine services provided in rural areas.

Mr. POSHARD and I, as well as key coalition members, realize that the introduction of this bill represents the first step in the legislative process. We are committed to working with the chairmen on the committees of jurisdiction to ensure that essential rural health access provisions are enacted into law this year.

SAFE DRINKING WATER ACT AMENDMENTS OF 1996

SPEECH OF

HON. JANE HARMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 25, 1996

Ms. HARMAN. Mr. Speaker, I rise today in strong support of H.R. 3604, the Safe Drinking Water Act Amendments. This bill is supported by environmentalists, industry, State and local governments, and consumer advocates. This bill is proof that Congress can pass strong environmental legislation if it works together on a bipartisan basis.

In my view, keeping our water clean is one of our Nation's most pressing environmental concerns. A strong Clean Water Act is necessary to keep our oceans, lakes, and rivers clean for all to enjoy. Similarly, a strong Safe Drinking Water Act is essential to keep harmful pollutants out of our drinking water, which is literally our lifeblood.

This legislation will do just that. The bill, for the first time, authorizes $7.6 billion for the State drinking water revolving loan fund, which is used by our communities to build and improve drinking water treatment facilities. Equally as important, the legislation guarantees that Americans will be informed of exactly which pollutants are in their drinking water. My State of California already has a successful right-to-know statute—I'm glad that the rest of the Nation has again followed our lead.

This legislation also proves that there is an effective way to balance environmental protection with economic concerns. The bill reforms rigid regulations by providing EPA with more flexibility in setting standards for drinking water contaminants. I'm pleased that the bill will allow EPA to consider costs and benefits in establishing standards for new contaminants.

Mr. Speaker, this bill represents a reasonable, responsible approach to environmental protection. It is evidence of how successful we can be if we put partisanship behind us.

DEPARTMENTS OF VETERANS AFFAIRS AND HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES APPROPRIATIONS ACT, 1997

SPEECH OF

HON. CARDISS COLLINS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 25, 1996

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 3666) making appropriations for the Departments of Veterans Affairs and Housing and Urban Development, and for sundry independent agencies, boards, commissions, corporations, and offices for the fiscal year ending September 30, 1997, and for other purposes:

Mrs. COLLINS of Illinois. Mr. Chairman, I rise to again voice strong objections over rampant Republican extremism manifested in proposed cuts and decreased spending levels for the Departments of Veterans Affairs and Housing Urban Development.

There is little doubt that most of us want a more streamlined and efficient Government. We want to make sure that our Government spends taxpayers' resources responsibly and frugally, but some of my colleagues on the other side of the aisle are being remiss in their duty as legislators as they continue their efforts to force the restructuring the Government services—Republican style—by making destructive, irrational and ineffectual cuts in spending.

While I fully understand the overwhelming constraints facing the House during this year's appropriations process, I also understand the critical needs of my constituents of the Seventh Congressional District.

H.R. 3666, the Republican's VA–HUD, and Independent Agencies appropriations for fiscal year 1997, has a total of $84.3 billion in fiscal year 1997—2 percent more than the fiscal year 1996 funding level, but $3.2 billion, or 4 percent less than requested by the administration—for programs and activities of the Veterans Affairs and Housing and Urban Development Departments, and for independent agencies including the Environmental Protection Agency, National Aeronautics and Space Administration, National Science Foundation, and Federal Emergency Management Agency.

We must make certain that the agencies charged with administering certain vital services, are able to responsibly and effectively carry out their mission. Falling short of this

goal will certainly prove detrimental to the safety and well being of our citizens.

My constituents call daily to say they oppose decreased funding for the Community Development Block Grant by 10 percent in fiscal year 1997. In fact, Chicago's Mayor Daley recently contacted me to pass along his thoughts about the Republican cuts.

The Community Development Block Grant program is exactly the kind of program this Congress should be holding up—and preserving—as a model for how partnerships between the Federal, State, and local governments should operate.

John H. Stroger, Jr., President, Cook County Board of Commissioners, also predicted that the reduction of $1,579,100 under H.R. 3666, would translate to many of our low income constituents not receiving needed assistance for housing rehabilitation, senior citizen facilities and services, and neighborhood improvements. Definitely unacceptable cuts indeed!

Mr. Speaker, cuts in veterans benefits also impacts my district. The bill before us today has a total of $38.8 billion in fiscal year 1997 for programs and benefits provided by the Veterans Affairs Department.

By the year 2010, the majority of our veterans will be over the age of 62, while the fastest growing veteran population today is over 80 years of age. It is estimated that about 2.9 million patients will receive VA medical treatment in fiscal year 1997. This is a matter of grave concern to me, because many veterans in my district depend on veterans compensation as a sole source of income. But equally important, these veterans also need their eligibility for access to adequate health care.