

place the burden of reporting the percent of foreign ownership on the PAC's themselves, with penalties for noncompliance.

The United States is one of very few countries that allows foreign interests to contribute to its campaigns. Most of our major trading competitors—for example, China, Japan, South Korea, Thailand, Malaysia, and Mexico—all strictly forbid foreign campaign contributions. There is no reason why the United States should be any different.

In the interest of protecting our sovereignty and maintaining a political system that reflects the will of the American people, the United States since 1938 has attempted to restrain the ability of foreign governments, individuals, organizations, and corporate entities to influence our domestic political system. By amendment, first to the FARA and later to the Federal Election Campaign Act [FECA], the United States has sought to prevent campaign contributions and expenditures by foreign interests.

There is no reason to allow foreign money to influence our elections or permit foreign interests to buy access to our elected lawmakers and thereby put their imprint on public policy in this country.

Mr. Speaker, clearly the time for campaign finance reform has come. Our system needs to be fixed. We must eliminate foreign money from our political system once and for all and regain sovereignty in our election system, which is the cornerstone of our democracy.

This time Congress must act and must get it right.

NATIONAL MENTAL HEALTH IMPROVEMENT ACT OF 1997

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 5, 1997

Mr. STARK. Mr. Speaker, today I am introducing the National Mental Health Improvement Act of 1997. This bill will provide parity in insurance coverage of mental illness and improve mental health services available to Medicare beneficiaries. It represents an urgently needed change in coverage to end discrimination against those with mental illness and to reflect the contemporary methods of providing mental health care and preventing unnecessary hospitalizations.

My bill prohibits health plans from improving treatment limitations or financial requirements on coverage of mental illness, if similar limitations or requirements are not imposed on coverage of services for other health conditions. The bill also expands Medicare part A and part B mental health and substance abuse benefits to include a wider array of settings in which services may be delivered. It eliminates the current bias in the law toward delivering services in general hospitals by permitting services to be delivered in a variety of residential and community-based settings. Through use of residential and community-based services, costly inpatient hospitalizations can be avoided. Services can instead be delivered in settings which are most appropriate to an individual's needs.

In 1993, as a nation, we spent approximately \$67 billion for the treatment of mental illness and another \$21 billion for substance

abuse disorders. Medicare expenditures in these areas for 1993 were estimated at \$3.6 billion or 2.7 percent of Medicare's total spending. Over 80 percent of that cost was for inpatient hospitalization.

In addition to the direct medical costs associated with the treatment of mental illness, there are significant social costs resulting from these disorders. Treatable mental and addictive disorders exact enormous human, social, and economic costs—individual suffering, breakup of families, suicide, crime, violence, homelessness, impaired performance at work, and partial or total disability. It is estimated that mental and addictive disorders cost the economy well over \$300 billion annually. This includes productivity losses of \$150 billion, health care costs of \$70 billion, and other costs, e.g. criminal justice, of \$80 billion.

Two to three percent of the population experience severe mental illness disorders. Many more suffer from milder forms of mental illness. Roughly 1 out of 10 Americans suffer from alcoholism or alcohol abuse and 1 out of 30, from drug abuse. This population is very diverse. With appropriate treatment, the mental health problems of some people can be resolved. Others have chronic problems that can persist for decades. Indeed, there are those who battle mental illness their entire lives. Mental illness and substance abuse disorders come in many forms and include many different diagnoses as well as ranges in levels and duration of disability. Still, these disorders do not have full parity in coverage by insurance plans.

In the last congressional session, parity in the treatment of mental illness was a widely and hotly debated issue. The final version of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997 included Title VII—Parity in the Application of Certain Limits to Mental Health Benefits. This represents a start in creating solutions to address a problem that has been ignored far too long. But it's not enough. The act essentially states that if a health insurance plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate annual or lifetime limit on mental health benefits. Additionally, in the act, "mental health benefits" refers to benefits with respect to mental health services, as defined under the terms of the plan or coverage, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

Furthermore, the Act included exemptions in coverage requirements for small employers. If an employer has at least 2 but not more than 50 employees, they can be exempt from the new coverage requirement. Finally, if a group health plan experiences an increase in costs of at least 1 percent, they can be exempted in subsequent years. The inclusion of title VII into the VA—HUD bill is important because it represents a starting place. But now we must do more.

My bill today addresses two fundamental problems in both public, as well as private, health care coverage of mental illness today. First, despite the prevalence and cost of untreated mental illness, we still lack full parity for treatment. The availability of treatment, as well as the limits imposed, are now linked to coverage for all medical and surgical benefits.

Whatever limitations exist for those benefits will also apply to mental health benefits.

Let's not forget the small employers either. If a company qualifies for the small employer exemption, the insurance companies will be able to set different, lower limits on the scope and duration of care for mental illness compared to other illness. This means that people suffering from depression may get less care and coverage than those suffering a heart attack. Yet, both illnesses are real.

Additionally, access problems to mental health benefits can result from these restrictions. In general, about 50 percent of all health plans limit mental illness coverage in some form. Approximately 88 percent limit hospitalization to 30 to 60 days. Outpatient benefits are limited by visit or dollar amounts in 85.5 percent of medium to large plans and 70 percent of small plans. About 80 percent of all plans limit inpatient care in some form and 99 percent of plans limit outpatient coverage.

Access to equitable mental health treatment is essential. It can be done at a reasonable price. The increased costs in insurance premiums in the private sector is in the range of 3.2 to 4.0 percent. It is estimated that about \$2.50 per month is the cost of fully offsetting the premium increase by an increase in the deductible. Two dollars and fifty cents is a small price to pay for ending health care discrimination.

Second, the diagnoses and treatment of mental illness and substance abuse has changed dramatically since the Medicare benefit was designed. Treatment options are no longer limited to large public psychiatric hospitals. The great majority of people can be treated on an outpatient basis, recover quickly, and return to productive lives. Even those who once would have been banished to the back wards of large institutions can now live successfully in the community. But the Medicare benefit package of today does not reflect the many changes that have occurred in mental health care.

This bill would permit Medicare to pay for a number of intensive community-based services. In addition to outpatient psychotherapy and partial hospitalization that are already covered, beneficiaries would also have access to psychiatric rehabilitation, ambulatory detoxification, in-home services, day treatment for substance abuse, and day treatment for children under age 19. In these programs, people can remain in their own homes while receiving services. These programs provide the structure and assistance that people need to function on a daily basis and return to productive lives.

They do so at a cost that is much less than inpatient hospitalization. For example, the National Institute of Mental Health in 1993 estimated that the cost of inpatient treatment for schizophrenia can run as high as \$700 per day, including medication. The average daily cost of partial hospitalization in a community mental health center is only about \$90 per day. When community-based services are provided, inpatient hospitalizations will be less frequent and stays will be shorter. In many cases, hospitalizations will be prevented altogether.

This bill will also make case management available for those with severe mental illness or substance abuse disorders. People with severe disorders often need help managing many aspects of their lives. Case management assists people with severe disorders by

making referrals to appropriate providers and monitoring the services received to make sure they are coordinated and meeting the beneficiaries' needs. Case managers can also help beneficiaries in areas such as obtaining a job, housing, or legal assistance. When services are coordinated through a case manager, the chances of successful treatment are improved.

For those who cannot be treated while living in their own homes, this bill will make several residential treatment alternatives available. These alternatives include residential detoxification centers, crisis residential programs, therapeutic family or group treatment homes, and residential centers for substance abuse. Clinicians will no longer be limited to sending their patients to inpatient hospitals. Treatment can be provided in the specialized setting best suited to addressing the person's specific problem.

Right now in psychiatric hospitals, benefits may be paid for 190 days in a person's lifetime. This limit was originally established primarily in order to contain Federal costs. In fact, CBO estimates that under modern treatment methods, only about 1.6 percent of Medicare enrollees hospitalized for mental disorders or substance abuse used more than 190 days of service over a 5-year period.

Under the provisions of this bill, beneficiaries who need inpatient hospitalization can be admitted to the type of hospital that can best provide treatment for his or her needs. Inpatient hospitalization would be covered for up to 60 days per year. The average length of hospital stay for mental illness in 1995 for all populations was 11.5 days. Adolescents averaged 12.2 days; 14.6 for children; 16.6 days for older adolescents; 8.6 days for the aged and disabled; 9.9 days for adults. A stay of 30 days or fewer is found in 93.5 percent of the cases. The 60-day limit, therefore, would adequately cover inpatient hospitalization for the vast majority of Medicare beneficiaries, while still providing some modest cost containment. Restructuring the benefit in this manner will level the playing field for psychiatric and general hospitals.

The bill I am introducing today is an important step toward providing comprehensive coverage for mental health. Further leveling the health care coverage playing field to include mental illness and timely treatment in appropriate settings will lessen health care costs in the long run. These provisions will also lessen the social costs of crime, welfare, and lost productivity to society. This bill will assure that the mental health needs of all Americans are no longer ignored. I urge my colleagues to join me in support of this bill.

A summary of the bill follows:

TITLE I PROVISIONS

The bill prohibits health plans from imposing treatment limitations or financial requirements on coverage of mental illness if similar limitations or requirements are not imposed on coverage of services for other conditions.

The bill amends the tax code to impose a tax equal to 25 percent of the health plan's premiums if health plans do not comply. The tax applies only to those plans who are willfully negligent.

TITLE II PROVISIONS

The bill permits benefits to be paid for 60 days per year for inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse. The benefit is the same in both psychiatric and general hospitals.

The following "intensive residential services" are covered for up to 120 days per year: residential detoxification centers; crisis residential or mental illness treatment programs; therapeutic family or group treatment home; and residential centers for substance abuse.

Additional days to complete treatment in an intensive residential setting may be used from inpatient hospital days, as long as 15 days are retained for inpatient hospitalization. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of inpatient services.

A facility must be legally authorized under State law to provide intensive residential services or be accredited by an accreditation organization approved by the Secretary in consultation with the State.

A facility must meet other requirements the Secretary may impose to assure quality of services.

Services must be furnished in accordance with standards established by the Secretary for management of the services. Inpatient hospitalization and intensive residential services would be subject to the same deductibles and copayment as inpatient hospital services for physical disorders.

PART B PROVISIONS

Outpatient psychotherapy for children and the initial 5 outpatient visits for treatment of mental illness or substance abuse of an individual over age 18 have a 20% copayment. Subsequent therapy for adults would remain subject to the 50% copayment.

The following intensive community-based services are available for 90 days per year with a 20% copayment (except as noted below): partial hospitalization; psychiatric rehabilitation; day treatment for substance abuse; day treatment under age 19; in home services; case management; and ambulatory detoxification.

Case management would be available with no copayment and for unlimited duration for "an adult with serious mental illness, a child with a serious emotional disturbance, or an adult or child with a serious substance abuse disorder (as determined in accordance with criteria established by the Secretary)."

Day treatment for children under age 19 would be available for up to 180 days per year.

Additional days of service to complete treatment can be used from intensive residential days. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of intensive residential services.

A non-physician mental health or substance abuse professional is permitted to supervise the individualized plan of treatment to the extent permitted under State law. A physician remains responsible for the establishment and periodic review of the plan of treatment.

Any program furnishing these services (whether facility-based or freestanding) must be legally authorized under State law or accredited by an accreditation organization approved by the Secretary in consultation with the State. They must meet standards established by the Secretary for the management of such services.

SALUTE TO ORVENE S.
CARPENTER

HON. ELTON GALLEGLY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 5, 1997

Mr. GALLEGLY. Mr. Speaker, I would like to salute Orvene S. Carpenter for many years of

outstanding service to his community on the occasion of his retirement.

Orvene Carpenter began his public service over 50 years ago in the city of Port Hueneme when he was appointed postal clerk. He was later elected to the city council and served for 30 years, becoming the longest tenured councilmember in the history of the city of Port Hueneme. He was elected mayor in 1990.

I have had the great pleasure of working with Mr. Carpenter for many years. During that time he has been responsible for numerous accomplishments and outstanding progress in the city of Port Hueneme. He will be missed greatly in both the government and civic arenas in which he was so active.

His innumerable contributions will serve as a legacy to his years of dedication. I want to congratulate him and wish him the very best in his retirement.

INTRODUCTION OF LEGISLATION TO ALLOW PENALTY-FREE WITH- DRAWALS FROM CERTAIN RE- TIREMENT PLANS DURING PERI- ODS OF UNEMPLOYMENT

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 5, 1997

Mr. McDERMOTT. Mr. Speaker, today I am introducing legislation that would allow people to receive penalty-free withdrawals of funds from certain retirement plans during long periods of unemployment. I am pleased that Representatives CHARLES RANGEL, ROBERT MATSUI, JOHN LEWIS, RONALD DELLUMS, ESTEBAN TORRES, ELEANOR HOLMES NORTON, ROBERT RUSH, MAURICE HINCHEY, VIC FAZIO, ZOE LOFGREN, EVA CLAYTON, and CHARLES CANADY have joined me as original cosponsors of this legislation.

This legislation would allow penalty-free withdrawals from individual retirement accounts [IRA's] and qualified retirement plans—401(k) and 403(b)—if the taxpayer has received unemployment compensation for 12 weeks under State or Federal law. Under the legislation, the distribution of funds would have to be made within 1 year of the date of unemployment.

Under current law, when a taxpayer withdraws money from an IRA or a qualified retirement plan before age 59½, he or she is forced to pay an additional 10 percent tax on the amount withdrawn. This additional tax is intended to recapture at least a portion of the tax deferral benefits of these plans. This tax is in addition to regular income taxes the taxpayer must pay as the funds are included in the taxpayer's income. The early-withdrawal tax also serves as a deterrent against using the money in those accounts for nonretirement purposes.

The vetoed Balanced Budget Act of 1995 includes a provision which is the same as this legislation with respect to withdrawals from IRA's. This provision recognizes that when an individual or family is faced with long periods of unemployment, they may have no other choice but to draw upon these funds to meet their everyday living expenses. During this financially stressful time, an additional 10 percent tax for early withdrawal is unfair and only serves to make the family's financial situation