extremely prolific writer. I know that thousands of others have enjoyed reading his clever ''Valley Tales'' columns in the Echo as much as I have over the years, Some of these columns have now been published in two books, offering many newcomers to Reverend Smith's writings the opportunity to learn from his insight into the Lebanon Valley region.

Most recently, Reverend Smith was elected to and served the maximum term of 3 years as the president of the Lebanon Valley Historical Society. Under his leadership, the historical society thrived, its membership and event attendance multiplying dramatically. Among other opportunities, the society provided people the chance to learn about the historical homes in the area, where many of the meetings were held. During his term of service, Reverend Smith took a faltering organization and, through his hard work and dedication, brought it back to life, so that it may now flourish and grow further in the future.

Mr. Speaker, committed and creative individuals such as Reverend Smith are among our most valuable resources in retaining a positive perspective on our cultural and societal history. I ask that all Members join me in expressing our sincerest gratitude and admiration for Reverend Smith and his impressive endeavors, and wishing him continued success in his efforts to preserve the rich heritage of the Lebanon Valley.

THE HEALTH INSURANCE BILL OF RIGHTS ACT

HON. JOHN D. DINGELL

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 25, 1997

Mr. DINGELL. Mr. Speaker, the legislation we are unveiling today is not based on theoretical or theological constructs. It is rooted in the real-life experience of people dealing with their health care system.

Ten years ago, fewer than one in seven Americans with private insurance were enrolled in some form of managed care. Today, three of every four Americans with private insurance are in managed care. Including Medicaid and Medicare beneficiaries, more than 140 million Americans were covered by managed care plans as of 1995.

There is a growing body of anecdotal and statistical evidence to suggest that many of the changes in our health care system over these last few years are not without flaws or imperfections.

Let me be clear. Managed care plans, and health maintenance organizations, perform good and great works every day. With managed care, we get a better overview of the care provided, so that we can identify and end improper or unnecessary practices. We can better coordinate the care received by a single patient. And we can get the benefits of bargaining collectively with providers to cut costs.

The traditional fee-for-service system built in a series of incentives to generate more revenue by providing more services. My concern is that the pendulum may have swung back too far in the other direction. We've gone from cost being no consideration to cost being the only consideration in providing health care. And neither extreme is healthy for the public.

You may have heard the stories: Heart attack victims forced to drive miles to an approved emergency treatment hospital. Patients denied payment for emergency care. Medicaid HMO's refusing to pay for antibiotics to stop a childhood dysentery epidemic. Cardiac surgery centers selected on the basis of price rather than survival rate. Marketers charged with mail fraud, forgery, or bribery. According to surveys, 80 percent of the American people agree that quality care is often compromised to save money.

I don't believe these problems are necessarily typical of HMO's or the managed care business. The vast majority of plans are operated by honorable men and women. The same can be said of any other endeavor or profession. Most stockbrokers are honest, as are most doctors, or police, or even—believe it or not—most Members of Congress. But that doesn't obviate the need for laws or regulations to corral and control the bad actors.

Concern about the practices of some managed care plans prompted us to pass legislation in the last Congress to guarantee that a woman and her doctor would decide how long she should remain in the hospital after giving birth. This Congress, Congresswomen DELAURO and ROUKEMA and I introduced similar legislation on the length of stay after a mastectomy.

I'm well aware that some have criticized legislation on births or mastectomies because they are specific to one condition. I find that criticism amusing. When we tried to enact comprehensive health care reform, many of the same people told us we were doing too many things all at once.

I'm also aware of another criticism, and that is that Congress should not be making medical decisions.

I couldn't agree more. Congress shouldn't have to concern itself with the length of a hospital stay after a mastectomy or birth. Those decisions should be made by qualified medical professionals and their patients. But the harsh fact of the matter is that when cost, and not care, is the primary consideration, the wisdom of doctors and patients is too often supplanted by insurance companies. The Congress is simply acting to restore some balance to the equation.

That's the guiding principle behind the legislation that Senator KENNEDY and I are introducing today, the Health Insurance Bill of Rights Act.

This legislation deals with the four cornerstones of a system that tips the balance in favor of the client—a system that puts patients first—access, quality, information, and dispute resolution.

First, the bill would ensure that patients can get their health care in the best place and from the best people—whether it is a primary care provider, a specialist, a specialty hospital, or even a high-quality clinical trial. The key here is the health of the patient, not whether a provider is a member of the health plan's network.

The legislation will make sure that a sick patient can complete a course of treatment with the doctor and hospital the patient knows and trusts, and that a healthy patient will have real choice of providers in receiving routine health care. For example, a woman who regularly sees an obstetrician-gynecologist can consider that doctor as her primary care provider. Or a cancer patient's oncologist can refer the patient to other specialists for related treatments, without going through a ''gatekeeper.''

Our bill deals carefully with the thorny issue of drug substitution. We don't mandate prescription drug coverage, and we don't forbid drug formularies. We simply say that health plans ought to consult with their own doctors in developing their formularies, and ought to provide a way for those doctors to substitute drugs when they believe it's medically necessary.

Second, quality.

This bill lays out a number of components of a good quality assurance program—components that mirror what the best of your health plans already do for their patients. We would require health plans to collect data and make information available in plain language, so patients can compare different plans and make wise choices.

Third is patient information. The minimum quality and information components in this bill are things we have been told patients want and need to know: The plans' criteria for determining medical necessity, appropriateness, efficiency, and access; their policies to ensure confidentiality of medical records; the scope of their utilization management activities; and the way the plans evaluate consumer satisfaction. In other words, the bare-bones components of a top-notch health plan.

Our bill would require health plans to provide simple information like addresses, telephone numbers, what benefits are included, the cost of premiums, and any cost-sharing requirements. Patients also need to know about the credentials of providers, how to obtain authorization for services, and how to get referrals to providers who are not plan participants. In other words, patients ought to have enough information at their fingertips to navigate the system without frustration and failure. I am sure that any good health plan would be not only willing but anxious for consumers to have all of this information.

And while on the subject of information and communication, I should also mention that this bill incorporates the patient-friendly concepts first introduced by Representatives MARKEY and GANSKE in the last Congress—the concepts that underlie the ability of doctors and patients to communicate freely and understand each other effectively.

Finally, the legislation provides an absolutely essential component of a consumer-friendly health plan—an appeals process that works: Timely notice of a plan's decision not to provide a certain benefit, or not to pay for it, and a workable process for the patient to appeal. This process must be fast when it needs to be fast—such as when the patient is seriously ill or near death. And, as the icing on this cake, the plan must have a real, fair, dispute resolution process which takes account of the views of the patient and provider as well as a third party, such as an ombudsman, who can look at the situation from a new perspective.

This legislation was developed through consultations with literally dozens of interested and affected parties: Consumer groups, hospitals, medical professionals, health plans, and others. It is modeled on State statutes that were fully bipartisan. For instance, the State of New York, with a Republican Governor and Democratic legislature, has enacted similar legislation.

I'm well aware that I'll be criticized for proposing Government intervention and regulation. But the fact is that through our democratic institutions, we routinely establish fair

terms for competition. We prohibit practices we deem unfair, discriminatory, outlandish, or improper. The American people expect Government to set minimum standards of behavior, and keep the playing field level.

In the area of health insurance, we need to see that competition is based on more than just price. Price often tells us very little about value or quality. One of the arguments for changing the Consumer Price Index is the argument that it fails to take into account improvements in quality. And let me observe that if price were the only consideration in buying a care, we'd all be driving around in Yugos.

When it comes to health care, I don't want a Yugo, and I don't need a Rolls-Royce. A Dodge or Chevy or Ford will do quite nicely.

In this instance, that means a system in which patients receive appropriate, quality health care, in which they can understand decisions about their care, and in which they can act effectively on their own behalf. My legislation will accomplish that.

TRIBUTE TO CAPT. RALPH MARTIN ALFORD

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 25, 1997

Mr. SKELTON. Mr. Speaker, today I wish to recognize a truly outstanding navel officer, Capt. Marty Alford, U.S. Navy. Captain Alford will soon be completing his assignment as the Director of the Navy Liaison Office to the House of Representatives, which will also bring to a close a long and distinguished career in the U.S. Navy. It is a pleasure for me to recognize just a few of his many outstanding achievements.

A native of Columbia, MO, Captain Alford was commissioned an ensign upon graduation from the U.S. Naval Academy in 1971. Following graduation, he entered flight training, receiving his wings of gold, and designation as a naval aviator in June 1973. Captain Alford's initial tour was with Patrol Squadron 10, homeported at Naval Air Station Brunswick, ME, flying the P–3B Orion aircraft. In February 1977, Captain Alford reported for duty as flag lieutenant to commander, Naval Safety Center, Norfolk, VA. After 18 months he transferred to the staff of commander, Carrier Group 8, also in Norfolk, where he again served as flag lieutenant and aide. Captain Alford's next tour found him at the naval air station in Jacksonville, FL with Patrol Squadron 30. Qualifying as an instructor pilot in both the P–3B and P–3C aircraft, he also served as assistant training officer and maintenance material control officer. In March 1982, he transferred to Patrol Squadron 1 at the naval air station in Barbers Point, HI. He served as training officer and operations officer while completing deployments to Cubi Point in the Philippines and to Kadena Air Base in Okinawa, Japan. In January 1985, Captain Alford reported for duty to Patrol Squadron 4 in Hawaii as the executive officer and deployed to Diego Garcia.

In May 1986, Captain Alford assumed command of Patrol Squadron 4 and led the squadron through a successful deployment to Naval Air Station Adak, AK. Upon successful completion of his command tour at sea in May 1987, Captain Alford began a 1 year assignment as operations officer for Commander Patrol Wing 2, followed by challenging duty in Washington, DC, as an action officer in the Strategy, Plans and Policy Division of the Naval Staff. Following selection for Fleet Reserve Squadron Command in July 1989, Captain Alford reported as commanding officer of Patrol Squadron 31 at Naval Air Station Moffet field in California. After completing his second command tour in July 1990, he began a 1 year assignment as a student at the National War College at Fort McNair in Washington, DC. After graduating in June 1991, he was assigned to the staff of the Assistant Chief of Naval Operations, Air Warfare as a branch head. Captain Alford reported as commander, Patrol Wing 10 in March 1992 and led the wing through several highly successful operational deployments and numerous detachments throughout the world in support of a wide variety of missions. Captain Alford completed his third major command tour in October 1993 and reported as Director, Navy Liaison to the House of Representatives in February 1994.

Mr. Speaker, Marty Alford, his wife Terri, and their two children, Michelle and Mary Beth, have made many sacrifices during his 26-year naval career. Marty has spent a significant amount of time away from his family to support the vital role our naval forces play in ensuring the security of our great Nation. Captain Alford is a great credit to the U.S. Navy and the country he so proudly served. As he now prepares to depart the Navy for new challenges ahead, I call upon my colleagues from both sides of the aisle to wish him and his family every success, as well as fair winds and following seas, always.

THE 401(k) PENSION PROTECTION ACT

HON. GARY A. CONDIT

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 25, 1997

Mr. CONDIT. Mr. Speaker, I have today introduced the 401(k) Pension Protection Act of 1997. Last year I introduced a similar bill, H.R. 3688. This legislation would close an important gap in pension protection affecting tens-of-millions of working Americans.

Federal law currently provides less protection to participants in 401(k) plans than it provides to participants in traditional pension plans. A traditional plan may not invest more than 10 percent of its assets in the company sponsoring the plan. The purpose of this limitation is the protection of employees who might otherwise lose their jobs and pensions at the same time.

This limitation does not apply to 401(k)s, despite their having become the predominant form of American pension plan, enrolling 23 million employees and investing nearly $700 billion. When a company goes bankrupt with a large percentage of its 401(k) invested in the company, the impact on employees can be catastrophic. The largest department store chain in California went bankrupt with more than half of its 401(k) invested in the chain's stock, 10,000 401(k) participants, many near retirement after decades of work, lost 92 percent of their stock investment.

The 401(k) Pension Protection Act would prevent this from occurring. The bill applies the 10 percent limit to 401(k)'s—unless the participants, not the company sponsoring the plan, make the investment decisions. After all, it is the employees' money, they bear the investment risk, and their 401(k)'s, unlike traditional plans, have no Pension Benefit Guaranty Corporation insurance. No participant should be required to invest more than 10 percent of his or her 401(k) contribution, known as a salary deferral, in the company sponsoring the plan.

Mr. Speaker, millions-of-Americans are working hard every day to save for their retirement and provide for their families. Enactment of this legislation will protect the retirement assets of working Americans. I urge our colleagues to join me in support of this important measure.

H.R. —

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''401(k) Pension Protection Act of 1997''.

SEC. 2. SECTION 401(K) INVESTMENT PROTECTION.

(a) LIMITATIONS ON INVESTMENT IN EMPLOYER SECURITIES AND EMPLOYER REAL PROPERTY BY CASH OR DEFERRED ARRANGEMENTS.—Paragraph (3) of section 407(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1107(d)) is amended by adding at the end the following new subparagraph:

''(D) The term 'eligible individual account plan' does not include that portion of an individual account plan that consists of elective deferrals (as defined in section 402(g)(3) of the Internal Revenue Code of 1986) pursuant to a qualified cash or deferred arrangement as defined in section 401(k) of the Internal Revenue Code of 1986 (and earnings thereon), if such elective deferrals (or earnings thereon) are required to be invested in qualifying employer securities or qualifying employer real property or both pursuant to the documents and instruments governing the plan or at the direction of a person other than the participant (or the participant's beneficiary) on whose behalf such elective deferrals are made to the plan. For the purposes of subsection (a), such portion shall be treated as a separate plan. This subparagraph shall not apply to an individual account plan if the fair market value of the assets of all individual account plans maintained by the employer equals not more than 10 percent of the fair market value of the assets of all pension plans maintained by the employer.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(2) TRANSITION RULE FOR PLANS HOLDING EXCESS SECURITIES OR PROPERTY.—

(A) IN GENERAL.—In the case of a plan which on the date of the enactment of this Act, has holdings of employer securities and employer real property (as defined in section 407(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1107(d)) in excess of the amount specified in such section 407, the amendment made by this section applies to any acquisition of such securities and property on or after such date, but does not apply to the specific holdings which constitute such excess during the period of such excess.

(B) SPECIAL RULE FOR CERTAIN ACQUISITIONS.—Employer securities and employer real property acquired pursuant to a binding written contract to acquire such securities and real property entered into and in effect on the date of the enactment of this Act, shall be treated as acquired immediately before such date.