In this position he will have the opportunity to expand support for this entire range of south Florida's cultural life. As in so many communities, the council faces the task of providing first rate art and entertainment at prices that allow the broadest rage of the community to share in the experience.

In his new role, Mr. Aguirre will have the opportunity to inject into the arts community the same energy and enthusiasm he has brought to Diarro Las Americas and his other civic involvements. Those other involvements range from the Red Cross and Florida International University to defense of press freedoms as a leader in the Inter American Press Association which represents 1,400 newspapers throughout this hemisphere.

It is difficult to overstate the importance of art and culture to the enjoyment of life. As Cuban poet and patriot, Jose Marti, said, ''beauty is a natural right * * * where it appears, light, strength and happiness arise.'' We are all too aware of the problems that mark urban life. But one of the joys of an area like south Florida is the broad and diverse cultural life that it can support.

Again, congratulations to Mr. Alejandro Aguirre on his new responsibilities and best wishes for a successful and satisfying tenure.

INTRODUCTION OF THE FOREST FOUNDATION CONSERVATION ACT

HON. RICHARD H. BAKER

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mr. BAKER. Mr. Speaker, today, I have introduced the Forest Foundation Conservation Act.

The Forest Foundation Conservation Act will amend the National Forest Foundation Act to extend and increase the matching funds authorized for the National Forest Foundation and to permit the National Forest Foundation to license the use of trademarks, tradenames, and other such devices to identify that a person is an official sponsor or supporter of the U.S. Forest Service or the National Forest System.

Our Nation has been blessed with a national treasure—America's national forest lands. A growing population, increasing demands on forests and related resources, and more competition for uses and benefits are placing great stress on our forest lands and the U.S. Forest Service.

Now, more than ever, America's forest lands and the individuals who work so diligently to manage these forest lands need support from people who care. The National Forest Foundation, a citizen-directed, nonprofit organization, was created to coordinate the needed support. The Forest Foundation Conservation Act will allow the National Forest Foundation to develop innovative public-private partnerships so that America's pristine forest land and its resources will be conserved for future generations.

I believe that it is the responsibility of each citizen to help conserve our Nation's resources and provide organizations like the National Forest Foundation with the resources it needs to help maintain America's forest lands for generations to come. I hope that my colleagues will join me in supporting this legislation which will help us improve the quality and infrastructure of our National Forests.

TRIBUTE TO NEW YORK SPEAKER SHELDON SILVER

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mrs. MALONEY of New York. Mr. Speaker, today the 105th Congress begins. While there is much talk swirling in the Capitol Hill air about the Speaker, I want to rise and pay tribute to my Speaker, New York Speaker Sheldon Silver.

On Sunday, January 5, 1997, Speaker Silver received a well-deserved award at the silver anniversary of one of New York City's outstanding community groups, the United Jewish Council of the east side. I am proud to represent the diverse and vibrant neighborhood of the lower east side, and prouder still of the magnificent contributions made to the community by the UJC. The UJC currently administers a variety of social services to over 16,000 residents. From senior centers, to housing, to nutrition programs, to immigrant assistance, the UJC's contributions to the quality of life in our city are without limit.

Mr. Speaker, space prohibits me from congratulating the entire leadership of the UJC, but I want to commend Rabbi Yitzchok Singer, Heshy Jacob, David Weinberger, Joel Kaplan, and Judy and Willie Rapfogel for all that they have done for this special neighborhood.

The lower east side simply would not be the same without Sheldon Silver. Born, raised, and educated in the neighborhood, Shelly graduated from Yeshiva University and Brooklyn Law School. In 1976, Shelly began his stellar career in public service when he was elected to the assembly. After serving in the prestigious leadership posts of chairman of the election law and then the ways and means committees, Shelly ascended to the Speakership in 1994, where he now sits as the most influential Democrat in the State of New York.

Sheldon Silver's tenure as Speaker has been marked by extraordinary success. He has made his mark on criminal justice, welfare, and education issues, and has remained a powerful and articulate advocate for New York's working and middle class families.

It has been an extraordinary honor for me to serve side by side with Speaker Silver, representing the lower east side community. Shelly is a man of principle and honor. His ethical and moral world view is shaped by his deep religious convictions, but he is also a friend to New Yorkers of every race, religion, and ethnic background. If I could borrow one word from Shelly's own Yiddish vocabulary, I would have to summarize his many attributes by calling him a ''mensch.''

Mr. Speaker, as Congress beings a new session, I ask all of my colleagues to join me in paying tribute to one of our Nation's outstanding public officials, my Speaker, the Honorable Sheldon Silver.

CAMPAIGN AND LOBBYING REFORMS IN FIRST 100 DAYS

HON. MARCY KAPTUR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Ms. KAPTUR. Mr. Speaker, we must dedicate our efforts within the first 100 days of the 105th Congress to passing comprehensive campaign finance and foreign lobbying reform legislation.

The events of the last election, with the worsening situation of foreign influence and the continuing flood of campaign contributions and expenditures, compel us to act. Now is the time.

Just as in past Congresses, I am once again introducing legislation calling for a constitutional amendment authorizing Congress and the States to set reasonable expenditure limits for elections to Federal and State office. It is simply wrong to equate campaign money with free speech. The only way to limit the exorbitant levels of money being spent on campaigns is through a constitutional amendment.

In addition, I'm proposing once again legislation to stop foreign contributions and influence, as was witnessed in the closing weeks of the elections. My bill creates a clearinghouse of political activities information within the F.E.C.

Finally, we must end the revolving door between Government service and lobbying for foreign interests. My ''Foreign Agents Compulsory Ethics in Trade Act'' measure will impose a lifetime ban on high-level Government officials from representing, aiding or advising foreign governments and foreign political parties. The act also imposes a 5-year prohibition on representing, aiding or advising foreign interests—including commercial interests—before the Government of the United States.

Mr. Speaker, we should make it our goal to adopt these reforms within the first 100 days of the 105th Congress.

THE MANAGED CARE CONSUMER PROTECTION ACT OF 1997

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mr. STARK. Mr. Speaker, along with Mr. JOHN LEWIS, Mr. GEJDENSON, Mr. SERRANO, Mr. SANDERS, and Mr. FILNER, I am pleased to introduce ''The Managed Care Consumer Protection Act of 1997,'' a bill that will provide critically needed consumer protections to millions of Americans in managed care health plans.

Health care consumers who entrust their lives to managed care plans have consistently found that many plans are more interested in profits than in providing appropriate care. In the process of containing costs patients are often harmed. My constituent mail has been full of horror stories explaining the abuses that occur at the hands of HMOs and other forms of managed care.

For example, David Ching of Fremont, California had a positive experience in a Kaiser Permanente plan and then joined an employer sponsored HMO expecting similar service. He

soon learned that some plans would rather let patients die than authorize appropriate treatment. His wife developed colon cancer, but went undiagnosed for 3 months after the first symptoms. Her physician refused to make the appropriate specialist referral because of financial incentives and could not discuss proper treatment because of the health plan's policy. Mrs. Ching is now dead.

In a similar case, Jennifer Pruitt of Oakland wrote to me about her father who also had cancer. He went to his gatekeeper primary care physician numerous times with pain in his jaw. The doctor, who later admitted that she had never treated a cancer patient, refused to refer Mr. Pruitt to a specialist. Eventually, after months of pain, a dentist sent Mr. Pruitt to a specialist outside of the HMO network. The cancer was finally diagnosed, but it had spread too rapidly during the months that the health plan delayed. Mr. Pruitt died from a cancer that is very treatable if detected early.

These tragedies and others like them might have been avoided if the patients had known about the financial incentives not to treat, or if the physicians had not been gagged from discussing treatment options, or if there had been legislation forcing health plans to provide timely grievance procedures and timely access to care. It's too late for these victims, but it is not too late to provide these protections for the millions of people in managed care today.

Consumer protections in managed care must be developed. Such unfavorable outcomes are not isolated events. They are widespread enough for industry studies to have noted a trend. Empirical evidence shows that restrictive practices pose special risks for people with chronic illnesses and poor health, and that primary care physicians in HMOs are less likely to diagnose or treat patients with depressive disorders appropriately. Another study concluded that the successes of prepaid care in relatively healthy populations are unlikely to be replicated among sicker patients. All this evidence indicates that managed care is not doing its job as well as it should. Those who are ill and most need health care are not getting it.

A few years ago, Congress recognized a crisis in the health care industry. Expenditures were soaring and overutilization was the rule. At that time, I chose to address this problem with laws that prohibited physicians from making unnecessary referrals to health organizations or services that they owned.

Others responded by pushing Americans into new managed care plans that switched the financial incentives from a system that overserves to a system that underserves. They got what they asked for. The current system rewards the most irresponsible plans with huge profits, outrageous executive salaries, and a license to escape accountability. Unfortunately, patients are dying unnecessarily in the wake of this health care delivery revolution. It must stop.

Several states have already addressed the managed care crisis. In 1996, more than 1,000 pieces of managed care legislation flooded state legislatures. As a result, HMO regulations were passed in 33 states addressing issues like coverage of emergency services, utilization review, post-delivery care and information disclosure. Unfortunately, many states did not pass these needed safeguards resulting in a piecemeal web of protections that lacks continuity. The states have spoken; now it's time for federal legislation to finish the job and provide consumer protections to all Americans in managed care.

The bill I offer today is a revision of earlier bills, H.R. 1707 and H.R. 4220, the Medicare Consumer Protection Act of 1995 and 1996 respectively. This legislation includes a comprehensive set of protections that will force managed care plans to be accountable to all of their patients and to provide the standard of care they deserve.

This legislation includes measures to protect patients from the abuses of managed care on several fronts.

My bill will put an end to pre-authorization of emergency medical care. Patients will not be denied coverage for care provided in emergency rooms. Current denials create obstacles for HMO patients and leave them with thousands of dollars in medical bills. According to HCFA, 40% of claim disputes between Medicare beneficiaries and participating Medicare HMOs involve emergency services. This bill establishes the prudent layperson definition of an emergency, so a reasonable layperson can anticipate claims that would be covered versus those that would be denied. It also prohibits plans from denying coverage for 911 emergencies.

My bill includes provisions which will bring utilization review back to its intended function, ensuring that patients receive all medically necessary and appropriate care without overusing services. Utilization review boards will be standardized through accreditation by the Secretary of Health and Human Services. These review programs must update policies to ensure consistency and compliance with medical standards and treatment protocols.

This legislation also establishes, for the first time, an ''Office of Medicare Advocacy'' whose sole function is to act on behalf of Medicare beneficiaries. The bill establishes a ''1–800'' number to facilitate better communication between the Health Care Financing Administration and the beneficiary. The office would develop a number of outreach programs to help inform Medicare beneficiaries concerning the Medicare program. Additionally, the office would have the authority to hear appeals in cases of an emergency or a life threatening event.

Recent testimony by the ''Physician Payment Review Commission (PPRC)'' emphasized the need for increased information and appeals processes. Describing a recent survey of Medicare beneficiaries done by PPRC, the testimony reported:

> A significant percentage of these (Medicare) enrollees who sought additional information about their plan had problems getting their questions answered. Also, a third of enrollees said they did not know they had the right to appeal a plan's decision not to provide or pay for a service. Our study suggests that plans may need to take additional steps to inform consumers in these areas.

The Office of Medicare Advocacy will do much to better inform Medicare beneficiaries, to advise beneficiaries of their rights and to facilitate comparative information concerning Medicare Managed Care plans.

In the United States Congress, we have the ability to put an end to abuse in managed care and guarantee that Americans who choose managed care get the care for which they pay. We also have a responsibility to ensure that Americans are protected from companies who place more emphasis on their own financial interests than on patients' needs. It is irresponsible to do anything less.

Following is a summary of the consumer protections provided for in this bill.

''MANAGED CARE CONSUMER PROTECTION ACT OF 1997''

SUMMARY

I. MANAGED CARE ENROLLEE PROTECTIONS—APPLIES TO MEDICARE MANAGED CARE AS WELL AS PRIVATE PLANS

A. Utilization Review

1. Any utilization review program that attempts to regulate coverage or payment for services must first be accredited by the Secretary of Health and Human Services or an independent, non-profit accreditation entity;

2. Plans would be required to provide enrollees and physicians with a written description of utilization review policies, clinical review criteria, and the process used to review medical services under the program;

3. Organizations must periodically review utilization review policies to guarantee consistency and compliance with current medical standards and protocols;

4. Individuals performing utilization review could not receive financial compensation based upon the number of certification denials made;

5. Negative determinations about the medical necessity or appropriateness of services or the site of services would be required to be made by clinically-qualified personnel of the same branch of medicine or specialty as the recommending physician;

B. Assurance of Access

1. Plans must have a sufficient number, distribution and variety of qualified health care providers to ensure that all enrollees may receive all covered services, including specialty services, on a timely basis (including rural areas);

2. Patients with chronic health conditions must be provided with a continuity of care and access to appropriate specialists;

3. Plans would be prohibited from requiring enrollees to obtain a physician referral for obstetric and gynecological services.

4. Plans would demonstrate that enrollees with chronic diseases or who otherwise require specialized services would have access to designated Centers of Excellence;

C. Access to Emergency Care Services

1. Plans would be required to cover emergency services provided by designated trauma centers;

2. Plans could not require pre-authorization for emergency medical care;

3. A definition of emergency medical condition based upon a prudent layperson definition would be established to protect enrollees from retrospective denials of legitimate claims for payment for out-of-plan services;

4. Plans could not deny any claim for an enrollee using the ''911'' system to summon emergency care.

D. Due Process Protections for Providers

1. Descriptive information regarding the plan standards for contracting with participating providers would be required to be disclosed;

2. Notification to a participating provider of a decision to terminate or not to renew a contract would be required to include reasons for termination or non-renewal. Such notification would be required not later than 45 days before the decision would take effect, unless the failure to terminate the contract would adversely affect the health or safety of a patient;

3. Plans would have to provide a mechanism for appeals of termination or non-renewal decisions.

E. Grievance procedures and deadlines for responding to requests for coverage of services.

1. Plans would have to establish written procedures for responding to complaints and grievances in a timely manner;

2. Patients will have a right to a review by a grievance panel and a second review by an independent panel in cases where the plan decision negatively impacts their health services;

3. Plans must have expedited processes for review in emergency cases.

F. Non-discrimination and service area requirements

1. In general, the service area of a plan serving an urban area would be an entire Metropolitan Statistical Area (MSA). This requirement could be waived only if the plan's proposed service area boundaries do not result in favorable risk selection.

2. The Secretary could require some plans to contract with Federally-qualified health centers (FQHCs), rural health clinics, migrant health centers, or other essential community providers located in the service area if the Secretary determined that such contracts are needed in order to provide reasonable access to enrollees throughout the service area.

3. Plans could not discriminate in any activity (including enrollment) against an individual on the basis of race, national origin, gender, language, socioeconomic status, age, disability, health status, or anticipated need for health services.

G. Disclosure of plan information

1. Plans would provide to both prospective and current enrollees information concerning; Credentials of health service providers; Coverage provisions and benefits including premiums, deductibles, and copayments; Loss ratios explaining the percentage of premiums spent on health services; Prior authorization requirements and other service review procedures; Covered individual satisfaction statistics; Advance directives and organ donation information; Descriptions of financial arrangements and contractual provisions with hospitals, utilization review organizations, physicians, or any other health care service providers; Quality indicators including immunization rates and health outcomes statistics adjusted for case mix; An explanation of the appeals process; Salaries and other compensation of key executives in the organization; Physician ownership and investment structure of the plan; A description of lawsuits filed against the organization; Plans must provide each enrollee annually with a disclosure statement regarding whether the plan restricts the plans malpractice liability in relation to liability of physicians operating under the plan.

2. Information would be disclosed in a standardized format specified by the Secretary so that enrollees could compare the attributes of all plans within a coverage area.

H. Protection of physician-patient communications

1. Plans could not use any contractual agreements, written statements, or oral communication to prohibit, restrict or interfere with any medical communication between physicians, patients, plans or state or federal authorities.

I. Patient access to clinical studies

1. Plans may not deny or limit coverage of services furnished to an enrollee because the enrollee is participating in an approved clinical study if the services would otherwise have been covered outside of the study.

J. Minimum Childbirth benefits

1. Insurers or plans that cover childbirth benefits must provide for a minimum inpatient stay of 48 hours following vaginal delivery and 96 hours following a cesarean section.

2. The mother and child could be discharged earlier than the proposed limits if the attending provider, in consultation with the mother, orders the discharge and arrangements are made for follow-up post delivery care.

II. AMENDMENTS TO THE MEDICARE PROGRAM, MEDICARE SELECT AND MEDICARE SUPPLEMENTAL INSURANCE REGULATIONS.

A. Orientation and Medical Profile Requirements

1. When a Medicare beneficiary enrolls in a Medicare HMO, the HMO must provide an orientation to their managed care system before Medicare payment to the HMO may begin;

2. Medicare HMOs must perform an introductory medical profile as defined by the Secretary on every new enrollee before payment to the HMO may begin.

B. Requirements for Medicare Supplemental policies (MediGap)

1. All MediGap policies would be required to be community rated;

2. MediGap plans would be required to participate in coordinated open enrollment;

3. The loss ratio requirement for all plans would be increased to 85 percent.

C. Standards for Medicare Select policies

1. Secretary would establish standards for Medicare Select in regulations. To the extent practical, the standards would be the same as the standards developed by the NAIC for Medicare Select Plans. Any additional standards would be developed in consultation with the NAIC.

2. Medicare Select Plans would generally be required to meet the same requirements in effect for Medicare risk contractors under section 1876. Community Rating, Prior approval of marketing materials, Intermediate sanctions and civil money penalties.

3. If the Secretary has determined that a State has an effective program to enforce the standards for Medicare Select plans established by the Secretary, the State would certify Medicare Select plans.

4. Fee-for-service Medicare Select plans would offer either the MediGap ''E'' plan with payment for extra billing added or the MediGap ''J'' plan.

5. If an HMO or competitive medical plan (CMP) as defined under section 1876 offers Medicare Select, then the benefits would be required to be offered under the same rules as set forth in the MediGap provisions above.

D. Arrangements with out-of-area dialysis services.

E. Coordinated open enrollment

1. The Secretary would conduct an annual open enrollment period during which Medicare beneficiaries could enroll in any MediGap plan, Medicare Select, or an HMO contracting with Medicare. Each plan would be required to participate.

F. Comparative Information

1. The Secretary must provide on an annual basis for publication and use on the internet information in comparative form and standard format describing the policies offered, benefits and costs, disenrollment and complaint rates, and summaries of the results of site monitoring visits.

G. Office of Medicare Advocacy

1. Establishes Office of Medicare Advocacy within the Health Care Financing Administration. The purpose of the office is to act on behalf of Medicare recipients, especially to address complaints and concerns. A toll free telephone number would be established to facilitate communication. Additional outreach programs such as town meetings would be developed and an internet site would be established for posting information.

2. The office would have authority to provide for an expedited review and resolution of complaints under emergency circumstances as described in the bill.

H. Exclusion from Medicare and Medicaid Program

1. If plan submits information relating to the quality of services provided that is material and false, the Secretary shall exclude the plan from continuing to qualify for Medicare and Medicaid payments.

III. AMENDMENTS TO THE MEDICAID PROGRAM

A. Orientation and Immunization Requirements

1. When a Medicaid beneficiary enrolls in a Medicaid HMO, the HMO must provide an orientation to their managed care system before Medicaid payment to the HMO may begin;

2. Medicaid HMOs must perform an introductory medical profile as defined by the Secretary on every new enrollee before payment to the HMO may begin.

3. When children under the age of 18 are enrolled in a Medicaid HMO, the immunization status of the child must be determined and the proper immunization schedule begun before payment to the HMO is made.

A BEACON-OF-HOPE FOR ALL AMERICANS: CHRISTINE MCFADDEN

HON. MAJOR R. OWENS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7 , 1997

Mr. OWENS. Mr. Speaker, with the 1996 election behind us, this Nation has completed another cycle for the ongoing democratic process which makes America great. The electoral process and the public officials selected through this process are invaluable assets in our quest to promote the general welfare and to guarantee the right to life, liberty, and the pursuit of happiness. It is important, however, Mr. Speaker, that we also give due recognition to the equally valuable contribution of nonelected leaders throughout our Nation. The fabric of our society is generally enhanced and enriched by the hard work done year after year by ordinary citizens. Especially in our inner city communities which suffer from long public policy neglect, local grassroots leaders provide invaluable service. These are men and women who engage in activities which generate hope. I salute all such heroes and heroines as Beacons-of-Hope.

Christine McFadden is one of these Beacons-of-Hope residing in the central Brooklyn community of New York City and New York State. Ms. McFadden currently serves as the program director for Renaissance Development Corporation, a nonprofit social service agency whose focus is to help enhance the quality of life in the Brownsville community by providing a variety of services for the young and elderly.

In addition to her work, Ms. McFadden's church is very special to her. She has often stated that her church allows her to serve God and mankind. As a member of the Macedonia Church, Christine McFadden has served on the board of trustees; mother's board; missionary board; senior choir; and is currently secretary of the building fund.

Ms. McFadden's deep love and affection are evident in her tireless contributions to the Girl Scouts of America. This year will mark her 39th year as a scout leader. Additionally, Ms. McFadden currently serves as the correspondence secretary for the Brownsville Tenant Council and is a member of the advisory board for Bay Center. She has also served on