in the Balkan strife and certainly none that would justify the course of action on which we are embarked. The NATO credibility argument is not persuasive. Had the alliance led by the U.S. not constantly threatened Milosevic with military action if he did not submit himself to NATO's demands, we would not have found ourselves in the put-up-or-shut-up corner. Expansion of the conflict to say, Turkey or Greece, or Turkey and Greece, is equally implausible. Clearly the conflicts are limits to the territory of the former Yugoslavia, and Milosevic' desire to reassert his and Serbia's domination. Support for human rights is indeed a laudable national interest, but as suggested above, our intervention in the region has had the opposite of the desired effect.

Where we do have strong national interests are vis a vis Russia, and there the Kosovo is quite possibly going to result in, if not permanent, at least long-lasting damage to reformist elements in Russian politics on whom we count for achieving societal transformations there. Or alternatively, as now seems quite likely, if Russian involvement in the settlement takes place, that might well lead to a diluted result bearing little resemblance to our stated conditions when we began this war. Or both of those might happen.

My third point: What next? Having embarked on what in my judgment is a foolish and ill-considered air war, it seems to me that the U.S. now has only two options: Stop the bombing, cutting whatever deal the Russians can broker for us, that now seems to be underway, perhaps, or immediately and massively escalate, with the specific twin goals of removing Milosevic and eliminating all Serbian fighting units in Kosovo. The first option is the one I prefer, because as I said at the outset I believe minimizing human suffering must be the goal. Each day of bombing is accompanied by more ethnic cleansing, raping and summary executions of Kosovars. It of course also leads to casualties among Serbia's civilian population. Forty-plus days of bombing have seemingly not stopped Milosevic's evil in Kosovo one whit, indeed, have accelerated it. The cessation of bombing is of course fraught with danger, since it will mean an outcome, no doubt far short of our stated objectives when we began this war, it will mean a resurgent Russia on the world scene, which might not be a bad thing, but that Russia could well be far different from the one we had hoped for, and now a truly credibility-deficient NATO. But we should have thought of those matters earlier, and in the meantime, each day brings more casualties.

I for one have reached my tolerance level of the daily dosage of atrocity stories juxtaposed with confident NATO spokespersons detailing the quote-unquote in the air war the previous night's 600 sorties have resulted in, where clearly the latter has not diminished the former.

The other option is massive force now. I do not advocate this course, but it seems to me the only other viable option. Paratroopers dropped in throughout Kosovo, going after Milosevic himself on the grounds of his long-overdue designation as a wanted war criminal. The other NATO partners will balk, and the U.S. should be ready to act alone, wasting no more time. Yes, this approach will result in still more deaths, and other atrocities among the suffering Kosovars, but at least the end of the agony will be sooner than with our present incomprehensible approach.

In sum, the U.S. should not be engaged in this war in the first place, but since it is, we must either win it quickly, or get our quickly. Otherwise the lives of many, many more innocent people will be on our American conscience.

PREVENTING ABUSE OF THE HOSPITAL PAYMENT SYSTEM: INTRODUCTION OF MEDICARE MODERNIZATION NO. 5

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 25, 1999

Mr. STARK. Mr. Speaker, in the Balanced Budget Act of 1997, Congress provided that for 10 hospital diagnosis related groups (DRG's), we would not pay the full DRG if the patient was discharged to further treatment in a nursing home, home health agency, or to a rehab or long-term-care hospital. I include at the end of my statement the conference report language describing this provision. Note that as originally passed by the House and Senate, it applied to all hospital discharges—not just 10 DRG's.

The administration and the Congress were worried that some hospitals have been gaming the Medicare hospital prospective payment system. They have been discharging patients early to downstream treatment facilities (which they often own), collecting the full DRG payment, and requiring Medicare to pay for longer and more expensive treatments in these downstream facilities.

Many of the nation's hospitals are lobbying for the repeal of this discharge provision—even though repeal would cost Medicare billions of dollars in the years to come. The intensity of the lobbying on this issues shows that early discharge to subsidiaries has become a major strategy of many hospitals. It may have been part of the Columbia/HCA scheme to maximize Medicare revenues.

Mr. Speaker, I think we should return to our earlier decision and apply the policy to all discharges, not just 10 DRG's.

The HHS inspector general has found that hospitals that own nursing homes discharge patients much earlier than average, and the patient then stays in the nursing home longer than average—an extra 8 days (OEI–02–94–00320). The OIG has also found that patients' stays are shorter when they are discharged to a home health agency. With about half the nation's hospitals owning a home health agency, this is another way to double dip.

The bill I am introducing will save Medicare billions of additional dollars in the years to come, and it will remove a temptation to abuse patients by pushing them out of hospitals too soon.

I hope that this legislation—one of a series of bills I am introducing to modernize Medicare and make it more efficient—will be enacted as part of our efforts to save Medicare for the Baby Boom generation.

CERTAIN DISCHARGE TO POST ACUTE CARE

Section 10507 of the House bill and Section 5465 of the Senate amendment

CURRENT LAW

PPS hospitals that move patients to PPS-exempt hospitals and distinct-part hospital units, or skilled nursing facilities are currently considered to have ''discharged'' the patient and receive a full DRG payment. Under current law, a ''transfer'' is defined as moving a patient from one PPS hospital to another PPS hospital. In a transfer case, payment to the first PPS hospital is made on a per diem basis, and the second PPS hospital is paid the full DRG payment.

HOUSE BILL

Defines a ''transfer case'' to include an individual discharged from a PPS hospital who is: (1) admitted as an inpatient to a hospital or distinct-part hospital unit that is not a PPS hospital for further inpatient hospital services; (2) is admitted to a skilled nursing facility or other extended care facility for extended care services; or (3) receives home health service from a home health agency if such services directly relate to the condition or diagnosis for which the individual received inpatient hospital services, and if such services were provided within an appropriate period, as determined by the Secretary in regulations promulgated no later than September 1, 1998. Under the provision, a PPS hospital that ''transferred'' a patient would be paid on a per diem basis up to the full DRG payment. The PPS-exempt hospital or other facility would be paid under its own Medicare payment policy.

Effective Date. With respect to transfer from PPS-exempt hospitals and SNFs, applies to discharges occurring on or after October 1, 1997. For home health care, applies to discharges occurring on or after October 1, 1998.

SENATE AMENDMENT

Similar provision, except defines a transfer case as including the case of an individual who, immediately upon discharge from and pursuant to the discharge planning process of a PPS hospital, is admitted to a PPS-exempt hospital, hospital unit, SNF, or other extended care facility. The provision does not include home health services in the definition of a transfer.

CONFERENCE AGREEMENT

The conference agreement would provide that for discharges occurring on or after October 1, 1998, those that fall within a specified group of 10 DRGs would be treated as a transfer for payment purposes. The Secretary would be given the authority to select the 10 DRGs focusing on those with high volume and high post acute care. The provision would apply to patients transferred from a PPS hospital to a PPS-exempt hospital or unit, SNF, discharges with subsequent home health care provided within an appropriate period (as defined by the Secretary), and for discharges occurring on or after October 1, 2000, the Secretary may propose to include additional post discharge settings and DRGs to the transfer policy.

Payments to PPS hospitals would be fully or partially based on Medicare's current payment policies applicable to patients transferred from one PPS hospital to another PPS hospital (per diem rates). The Secretary would determine whether the full transfer policy or a blended payment rate (50% of the transfer per diem payment and 50% of the total DRG payment) would apply based on the distribution of marginal costs across days, so that if a substantial portion of the costs of a case are incurred in the early days of a hospital stay the payment would reflect these costs. For FY 2001, the Secretary would be required to publish a proposed rule which included a description of the effect of the transfer policy. The Secretary would be authorized to include in the proposed rule and final rule for FY 2001 or a subsequent fiscal year, a description of additional post-discharge services that would result in a qualified discharge and diagnosis-related groups

specified by the Secretary in addition to the 10 diagnosis-related groups originally selected under this policy.

The Conferees are concerned that Medicare may in some cases be overpaying hospitals for patients who are transferred to a post acute care setting after a very short acute care hospital stay. The Conferees believe that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.

The Conferees expect that the application of the Transfer policy to 10 high volume/high post-acute use DRGs will provide extensive data to examine hospital behavioral effects under the new transfer policy

THE CRA SUNSHINE ACT OF 1999

HON. BILL McCOLLUM

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 25, 1999

Mr. McCOLLUM. Mr. Speaker, I am pleased to introduce the CRA Sunshine Act of 1999. This is a modest effort to reform the Community Reinvestment Act (CRA) and bring more openness to it.

CRA groups have reported over $9 billion in cash payments received or pledged by banks as a result of CRA activities. A total of $694 billion in CRA commitments have been made or pledged due to CRA. While these pledges are made and collected as a direct result of federal legislation, the details of these payments are often unknown because many agreements include confidentiality clauses. Congress never intended that CRA dollars be used for anything other than investing in low and moderate income areas. There is concern that some CRA dollars are being used by CRA activists to pay for consulting fees, hiring contracts, administrative fees, and other nonloan activities. By shining light on the details of agreements made pursuant to CRA, this Act would remove the mystery from deals between banks and CRA organizations while ensuring that CRA truly benefits those that it was designed to benefit.

I encourage my colleagues to join me in supporting this important legislation.

INTRODUCTION OF THE BANKING PRIVACY ACT

HON. JAY INSLEE

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 25, 1999

Mr. INSLEE. Mr. Speaker, I rise today, with many of my colleagues, to introduce the Banking Privacy Act. We recognize the threat to consumer privacy and want to return control over an individual's personal financial information back to the consumer.

My constituents are shocked when I tell them that their banking transaction experiences are not private. With certain exceptions, financial institutions may legally share all of the information about you and your bank account activity with affiliated businesses—or anyone else, for that matter. This shared information includes the amount of each check that you write, to whom each check is written, the date of each check, the amount and date of any deposits into your account, and any ''outside information'' available, such as information submitted on your initial application for an account. Under existing law, financial institutions are not obligated to honor your request to restrict the dissemination of this personal information.

I became interested in banking privacy laws after reading a letter from a constituent who was upset about his bank's plans to share his private financial records. I was shocked to learn of the stunning absence of statuary protections of consumer privacy. Suppose banks, insurance companies, and securities firms become affiliated, something that will occur more frequently in the future. Will a bank tip off affiliated stock brokers every time their consumers have a sudden increase in their bank account balance, causing the consumer to be subjected to even more telemarketing calls? Will banks ''profile'' their customers after reviewing their financial information, then have affiliates telemarket products to those customers? Will life insurance companies affiliated with banks review personal checking records for indications of risky behavior, then increase rates based on that information? Under current law, there is nothing to prevent these types of situations.

As Congress moves to modernize the financial services industry and allow the lines between banks, securities firms, and insurance companies to blur, financial institutions gain a new profit incentive by sharing customers' personal financial information. Customers who prefer to keep their financial information private have no recourse.

The Banking Privacy Act is a first step to return control over an individual's personal financial information back to that consumers. The Act applies to federally insured depository institutions, their affiliates and financial institutions covered under the Bank Holding Company Act.

Currently, under the Fair Credit Reporting Act, banks must disclose to their customers their privacy policies to customers and make allowances to opt-out of certain types of information sharing practices. Specifically excluded from this law is customer ''transaction and experience'' information.

Transaction and experience information is information about a checking or savings account, information contained on an account application, or even purchasing patterns deduced through a customer's checking account—''account profiling.'' Transaction and experience information may be shared with affiliated companies or even sold to third parties for marketing purposes. There is no law to prevent such activity from taking place.

The information is currently used to market financial services to customers based on their financial patterns. Banks routinely perform this type of information sharing. However, as we move to modernize the financial industry, there will be greater demand for this type of personal account information to market products and services to a targeted group of consumers.

For example, it is not impossible to imagine that a bank holding company learned that a customer received a life insurance settlement and then made that information available to a securities firm or data broker to market services to that customer. While many consumers will appreciate the benefit of this information sharing, the decision to share the information belongs in the hands of the consumer and not the financial institution.

Customers should be able to opt-out of information sharing policies in their banks and financial institutions. The Banking Privacy Act will require banks and financial institutions to disclose their privacy policies and allow consumers to opt-out of information sharing plans—including transaction and experience information.

The Banking Privacy Act will not affect the routine operations of a bank. There are specific exemptions in the bill relating to the day to day practices that banks have in place which do not impact consumer privacy. The bill will protect consumers from unwanted marketing based on their intimate financial details and give consumers control over the use and sharing of their financial information.

Federally insured depository institutions have an obligation to help take a stand for consumer privacy. The government provides a safety net for the banks in the form of insurance and safety provisions. These same banks have to provide a safety net for taxpayer privacy.

Financial privacy should not be sacrificed at the altar of financial industry modernization. Americans have the right to freedom of speech and freedom of religion, and we ought to have the right to freedom from prying eyes into our personal financial business. Financial institutions should not be allowed to share private financial information without customer consent. The Banking Privacy Act is a necessary and practical response to the erosion of financial privacy and the potential explosion in cross-marketing among affiliated financial institutions.

I want to also thank and commend my colleagues for joining me as cosponsors of the Banking Privacy Act. Representatives MICHAEL CAPUANO, BOB FILNER, MAURICE HINCHEY, JOSEPH HOEFFEL, PAUL KANJORSKI, BARBARA LEE, JIM MCDERMOTT, LYNN RIVERS, BERNIE SANDERS, JAN SCHAKOWSKY and PETE STARK have all cosponsored this bill and I appreciate their assistance.

I urge my colleagues to support and pass the Banking Privacy Act.

IN MEMORY OF PAUL N. DOLL

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 25, 1999

Mr. SKELTON. Mr. Speaker, it is with deep sadness that I inform the House of the death of Paul N. Doll of Jefferson City, Missouri.

Paul Doll was born on April 4, 1911, in Hamilton, Missouri, a son of Ernest E. and Emma Louise Colby Doll. He was a 1928 graduate of Hamilton High School and a 1932 graduate of Kidder Junior College. He received a bachelor's degree in 1936 and a master's degree in 1937 in agricultural engineering from their University of Missouri-Columbia. In 1984, he received an honorary doctorate from the University of Missouri.

Doll's career in public service and agriculture began immediately after his graduation in 1937. He was a county extension agent