are not spreading American values of peace and democracy throughout Latin America.

It is not in American interests to continue support for the U.S. Army School of the Americas. For the sake of human rights and democracy, I urge my colleagues to support the Moakley amendment to end funding for the SOA.

FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS ACT, 2000

SPEECH OF

HON. LUCILLE ROYBAL-ALLARD

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 29, 1999

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 2606) making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2000, and for other purposes;

Ms. ROYBAL-ALLARD. Mr. Chairman, the Foreign Operations Appropriation bill for fiscal year 2000 that was reported by the appropriations subcommittee, was a fair and bipartisan bill, given the tight funding restrictions.

Although the subcommittee's allocation of $12.8 million was $2.7 million below the FY 1999 funding level, I am pleased that the panel included increases in critical programs such as, the Child Survival Account and the Assistance for Displaced and Orphaned and Children Account within U.S.A.I.D. These programs provide critically needed assistance to sick, needy, and orphaned children in developing countries.

I would like thank Chairman SONNY CALLAHAN and Ranking Member NANCY PELOSI for including $34 million, for the U.S. Agency for International Development's Collaborative Research Support Programs—a 100% increase over last year's funding. This program utilizes our leading universities, including the University of California, to help developing countries make improvements in agriculture. Supporting agricultural research is critical because we know that political stability is largely dependent on a developing country's ability to maintain a stable food supply. The Collaborative Research Support Program helps developing counties achieve this goal, thereby furthering our own interests as well as theirs.

However, despite the increases in these valuable programs, I must strongly object to the $200 million that was cut from the World Bank's International Development Association at the direction of the Republican leadership. Cutting funds from this multilateral development program sends a message to other member-countries that the U.S. believes it is O.K. to shirk one's responsibility to developing countries. We should not send this message.

I object, not only to the substance of this cut, but also to the manner in which this cut was made. As I previously stated, the bill reported out of subcommittee was a fair, bi-partisan bill. Unfortunately, the continuing insistence of the Republican leadership to make last minute cuts to our appropriations bills during full committee and House floor consideration has sorely undermined what should be a bi-partisan process.

Not providing responsible levels of funding for our government programs not only hurts our country, but results in increased emergency spending in the long run. While I will vote in favor of the bill in order to move the process along, it is my hope that the Republican leadership will recognize the shortsightedness of this strategy and restore this bill and others to their original funding levels.

FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS ACT, 2000

SPEECH OF

HON. NORMAN D. DICKS

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Monday, August 2, 1999

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 2606) making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2000, and for other purposes:

Mr. DICKS. Mr. Chairman, the United States is the world's largest trader. Our exports directly support almost 12 million U.S. jobs and have accounted for 30 percent of the U.S. economic growth over the past decade. With 94 percent of the world's population and the fastest-growing markets all located overseas, there is no question that U.S. exports are key to our nation's economic success and future.

Competition for these growing markets is fierce, and competitive financing is often the critical element to winning sales for U.S. goods and services. It is therefore crucial to our nation's interest to preserve and strengthen U.S. export finance and the Export-Import Bank to provide the foundation and means for expanding overseas trade.

In FY 1998, the Bank supported $13 billion in exports that otherwise may not have been sold. These sales have sustained tens of thousands of well-paying jobs here in the United States. Furthermore, the Bank is working to help U.S. exporters maintain a foothold in countries like South Korea and Brazil, which are suffering difficulties yet still offer important opportunities for exporters.

The Ex-Im Bank is also an important source of assistance to small businesses to sell their products overseas. Each year, the Bank services about 2,000 new small business transactions, and is involved in more than 10,000 small business transactions.

Although the overall funding for the Bank was reduced by $1 million, the Committee did approve a crucial $5 million increase in the Bank's Administrative budget that will enable the Bank to modernize their computer systems and to insert personnel into key markets to help American businesses sell overseas. This modernization is absolutely necessary at this time to ensure that the Bank is Y2K compliant. New systems and personnel will also help the bank reduce turn-around time on decisions for both small and large U.S. exporters.

The gentleman's amendment would prohibit the Bank, as well and the Overseas Private Investment Corporation and the Trade Development Agency, from entering into any new obligations. This extremely dangerous amendment plays right into the hands of our European and Asian competitors, who will not cease to subsidize and finance the deals that their companies make simply because we will have chosen to do so; rather, this amendment will make it even more difficult for American exporters to compete in the combative worldwide marketplace, cutting U.S. jobs in the process.

This amendment may save a few dollars, but I assure my colleagues that the costs in lost exports and lost jobs far outweigh any savings we may incur. I urge my colleagues to fight to preserve American jobs and vote against this amendment.

IN SUPPORT FOR THE PATIENTS' BILL OF RIGHTS

HON. EARL POMEROY

OF NORTH DAKOTA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, August 3, 1999

Mr. POMEROY. Mr. Speaker, today I am signing the discharge petition for the purpose of forcing floor consideration of the Patient's Bill of Rights.

I have held back from this action before this time out of my expectation the House Speaker would have brought this issue—if not this bill—forward before the August recess.

I am disappointed the majority leadership has broken its commitment to have House action on this matter this week. The Senate has acted. The American people want Congress to act. Because the indefinate House delay is irresponsible and very unfortunate I am signing the discharge petition. I hope all minority members who have yet to sign will join me in this action. I further hope that we will be joined by a sufficient number of Republicans who understand that it is time to act, in order to finally force House action on this issue.

EXPLANATION OF OMNIBUS LONG-TERM HEALTH CARE ACT OF 1999

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, August 3, 1999

Mr. STARK. Mr. Speaker, Representative MARKEY and I have introduced the Omnibus Long-Term Health Care Act of 1999. We are joined by Representatives MCGOVERN, MCDERMOTT, MOAKLEY, OLVER, CAPUANO, and GORDON.

The following is a detailed outline of the provisions of this legislation. We invite members of the House to join us in cosponsoring this legislation. We invite the public to suggest refinements and additions to the legislation to make it more comprehensive, workable, and effective legislation to help the millions of Americans facing the problems of obtaining quality long-term health care.***HD***Title I: Long-Term Care Giver Tax Credit

Title I of the bill provides a $1000 tax credit similar to the one described by the President in his State of the Union address. Our proposal has several notable differences. First, our tax credit is completely refundable, and there is no distinction between care for an adult or a child. If the credit is not refundable,

it will fail to help those families in greatest need of help.

To be honest, $1000 is not that much money for long-term care, but it does provide a family with modest relief that they can use as they see fit. That is why we have structured the bill to ensure that those who most need the support will receive the refund.

Another important distinction between our proposal and the President's is the treatment of children with long term care needs. The President's proposal would limit the tax credit to $500 for children with long term care needs. We do not agree with this policy. The long-term care needs of a disabled child are just as expensive and emotionally and troubling as they are for an adult.

Our legislation also has a broader definition of individuals with long-term care needs. The President's proposal includes individuals who require assistance in to perform activities of daily living (bathing, dressing, eating, continence, toileting, and transferring in and out of a bed or chair). This is a good start but does not include people with severe mental health disabilities or developmental disabilities who cannot live independently.

Finally, our legislation limits the amount of the refund for the wealthy, not the poor. In our bill, reductions in the refund begin at the upper income levels, not the lower income levels. The full refund is available up to income of $110,000 for a joint return, $75,000 for an individual return, and $55,000 for a married individual filing a separate return. Above these levels, the refund is decreased by $50 by every $1,000 over the threshold level.***HD***Title II: Long-Term Care Medicare Improvements

Title II of the legislation addresses a range of reforms and improvements to Medicare benefits. The goal of this title is to provide adequate long-term coverage to patients with chronic health care needs. We believe that we can adjust Medicare benefits so that people can continue to live in their homes and communities, and enjoy the contact with their families and friends. These proposals are cost effective as they rely on services in facilities other than hospitals and skilled nursing facilities, and allow people to continue to live in familiar surroundings with their family.

1. LONG-TERM HOME HEALTH AIDE BENEFITS

The first section extends Medicare Home Health Aid-Type services to chronically dependent individuals. This section establishes a new ''long-term'' home health benefit to maintain people with chronic conditions at home rather than in more expensive settings. Many people can no longer take care of themselves because physical or mental disabilities impair their ability to perform basic activities of daily living (ADLs), including eating, bathing, dressing, toileting, transferring in and out of a bed or chair, and continence. These are activities that we all take for granted. The inability to do any of these independently is distressing for the patient and a clear indication of the extent of the impairment.

This provision allows individuals who suffer from a chronic physical or mental condition that impairs two or more ADLs to receive in-home care. To help contain costs, the provision would require competitive bidding of these services.

2. ADULT DAY CARE

The second section of this title's reforms is a provision for Medicare Substitute Adult Day Care Services. This provision would incorporate the adult day care setting into the current Medicare home health benefit. The provision allows beneficiaries to substitute any portion of their Medicare home health services for care in an adult day care center (ADC). Adult day care centers provide effective alternatives to complete confinement at home. Many States have used Medicaid funding to take advantage of ADCs for their patients.

For many, the ADC setting is superior to traditional home health care. The ADC can provide skilled therapy like the home health provider. In addition, the ADC also provides rehabilitation activities and means for the patients. Similarly, the ADCs provide a social setting within a therapeutic environment to serve patients with a variety of needs.

To achieve cost-savings, the ADC would be paid a flat rate of 95% of the rate that would have been paid for the service had it been delivered in the patient's home. The care would include the home health benefit and transportation, meals and supervised activities. As an added budget neutrality measure, the title allows the Secretary of Health and Human Services to lower the payment rate for ADC services if growth in those services is greater than current projections under the traditional home health program.

This program is not an expansion of the home health benefit. It would not make any new people eligible for the Medicare home health benefit. Nor would it expand the definition of what qualifies for reimbursement by Medicare for home health services. This legislation recognizes that ADCs can provide the same services, at lower costs, than traditional home care. Futhermore, the legislation recognizes the benefits of social interaction, activities, meals, and a therapeutic environment in which trained professionals can treat, monitor, and support patients.

The legislation also includes important quality and anti-fraud protections. In order to participate in the Medicare home care program, ADCs must meet the same standards set for home health agencies. The only exception is that the ADCs would not be required to be ''primarily'' involved in the provision of skilled nursing services and therapy services. The exception recognizes that ADCs provide services to an array of patients and that skilled nursing services and therapy services are not their primary activity.

Here is an example of how the system would work. A physician prescribes home care for the patient. Next, the patient and his or her family decide how to arrange for the services. They could choose to receive all services through home care, or choose a mix of adult day care and home care services. Therefore, if the patient required three physical therapy visits and two home health aide visits, the patient could receive the physical therapy at the ADC while retaining the home health aide visits. When the patient goes to the ADC, he or she will receive the physical therapy and other benefits the ADC provides. All of these services would be incorporated into the payment rate of 95% of the home setting rate for the physical therapy service. This plan offers a savings for Medicare and an improved benefit to the patient.

3 HOME HEALTH CASE MANAGERS

The third section of this title makes a number of improvements in the quality of services provided through home care. First it establishes a case manager who will oversee the provision of home health care. This section of the legislation will ensure that those in need of long-term health care will receive necessary and cost effective care.

The Balanced Budget Act of 1997 (BBA) implemented a number of policies designed to slow the growth of a health benefit that was doubling in cost every three or four years. Prior to the BBA, the incentive to home health agencies was to over-use services to boost profits. In the BBA's prospective payment system (PPS), the incentive will be the opposite and there are real concerns about potential under-utilization of services.

The Medicare Home Health Case Manager legislation would ensure that an independent case manager evaluates the patient's needs and service level. The case manager will be financially independent of the home health agency and would be paid through a Medicare fee-schedule, independent of the amount or type of care the patients receive. The legislation would also provide the Health Care Financing Administration (HCFA) with the flexibility to investigate the effectiveness of reimbursing home health case managers on a competitively bid basis.

This type of case manager program is endorsed by the Medicare Payment Advisory Commission (MedPAC), a Commission appointed by Congress to provide expert advice on Medicare and Medicaid policy. In their March 1998 report to Congress they recommended that such a case manager be adopted for the home health benefit. Their report states:

> Such an assessment would help to minimize the provision of services of marginal clinical value, while ensuring that patients receive appropriate care. *Requiring case management of long-term home health users could improve outcomes for individuals with long-term home health needs and at the same time slow the growth of Medicare home health expenditures.* (Emphasis added).

In addition, there are real-life examples of case management systems saving money and improving care. For example, Maryland's Medicaid program has a high cost user initiative which in FY 96 saved the state $3.30 for each $1 spent—a savings of 230%. The Health Insurance Association of America also commissioned a study of its member plans and found that rehabilitation/case management programs return an investment of $30 for every $1 spent.

Therefore, this section would achieve two important goals. First, it saves money. Second, the program ensures that patient's needs are met. Patient's care should be determined based on an objective and independent evaluation of the patient's condition, not the bottom line of a health care corporation.

4. COORDINATED CARE

Another section recognizes that there are many medical conditions, such as congestive heart failure, that create severe long-term care needs that need coordinated, comprehensive care. Many people suffer an acute condition that leaves them weakened and in need of health care long after the acute phase of the condition passes. Currently, Medicare does not adequately cover an expensive recuperation that can last for months. This section directs the Secretary to identify 10 medical conditions, clustered by diagnostic related groups (DRGs) that consistently require intense follow-up care. Along with the 10 DRGs, the

Secretary would determine reasonable costs to cover comprehensive case management, caregiver education and training, and other general assistance. Our proposal requires the Secretary of Health and Human Services to identify those medical conditions, clustered into logical DRGs that represent the most expensive home health services, most consistently require home health services, and require the longest period of convalescence. Using these DRGs, the Secretary will be able to develop a better system of coordinating care and helping families.

5. OTHER HOME HEALTH SERVICE IMPROVEMENT

Adopting a provision from Rep. Jim McGovern's bill, we propose an outlier policy. In brief, this provision requires that HCFA develop a home health agency outlier program, so that agencies do not avoid the money-losing, harder to care for cases. We also propose to strengthen the provisions in the BBA that require hospitals to give more objective information to patients about the full range of post-hospital services, and not just direct patients to their hospital-owned services. Finally, we give more flexibility to the ''homebound'' rule.

6. HOSPICE IMPROVEMENTS

Another section provides broad revisions and improvements to the hospice care benefit. Hospice care includes interdisciplinary professional services for patients whose health condition will not benefit from cure-based treatments. Hospice care, which may be offered in the person's residence or a skilled facility, provides palliative care to reduce pain and enhance the patient's quality of life. For those patients in the terminal phase of their life, hospice care offers final comfort for the patient and the patient's family. The current rules governing hospice care offer physicians few incentives to recommend this alternative for their patients.

In a 1999 report to Congress, MedPAC commented that,

Another vulnerable population is the nearly 2 million Medicare beneficiaries who die each year. Too many of their physical, emotional, and other needs go unmet, although good care could minimize or eliminate this unnecessary suffering. Even hospices—which pioneered care for the dying—help only a fraction of patients and are often used far later than they should be. Ensuring that beneficiaries receive human, appropriate care at the end of their lives should be a priority for the Medicare program.

The consequence of our current medical practice is that patients remain in more expensive treatment facilities and do not receive the palliative care they require. This section of the bill offers three specific improvements.

First, the legislation would direct the Secretary to designate DRGs that indicate a chronic and terminal condition that are most likely to lead to death, and for which hospice care may provide assistance. These DRGs would then be used as a part of the patient's discharge planning. The intent of this section is to ensure that patients receive a complete review of their treatment and care options, including hospice options in the patient's community.

A second solution is to ensure that information regarding hospice care becomes a part of physician training. This section does not require that physicians become proficient in the medical practice of hospice care, only that they become more aware of its services as an option for terminally ill patients.

The legislation would also include hospice care within the federal employees health benefits program (FEHBP). We hope that by including this benefit for our nation's federal employees, we will set a standard for other insurance providers. The net result would be that more patients will obtain necessary hospice care during the final days of their lives.

7. HELP FOR LOW-INCOME SENIORS AND DISABLED

Another section of this title will help all lower-income Medicare beneficiaries—and the chronically ill, the disabled, and the frail 'old-old' who tend to be those with the least income. This amendment is a repeat of a bill introduced by Rep. McDermott and Stark (HR 1455) which coordinates SSA and IRS data to presume that individuals who show income below the poverty level are eligible for the QMBy and SLMBy programs and presumptively enrolls them in those programs. Today about 40% to 50% of those who are eligible for these programs which pay Medicare's premiums, deductibles, and copays, fail to enroll. Presumptive enrollment will provide hundreds, even thousands of dollars of help per year to our nation's poorest, most vulnerable citizens.***HD***Title III: Nursing Home Improvements

Title three of the legislation provides a number of reforms to laws and regulations governing skilled nursing facilities. Earlier this year, the General Accounting Office released a report that several members of Congress and Rep. Stark requested. That report, ''Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS–99–46)'' indicated that more than 40 percent of the skilled nursing facilities did not comply with fundamental quality standards. In many cases, these deviations from quality standards represent an egregious threat to the health of patients living in nursing homes. At least 25 percent of the homes reviewed violated standards that eventually created actual harm to the residents.

Currently, 1.6 million elderly live in skilled nursing facilities. These people are among the sickest and most vulnerable segment of the population. A major portion of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) brought sweeping reforms to the nursing home industry. That legislation did much to improve and ensure the quality of health care provided in skilled nursing facilities. Fortunately, the majority of skilled nursing facilities responded well to these changes and continue of offer quality care for their patients. Unfortunately, a sizable minority of skilled nursing facilities continues to place profits ahead of quality care. Because of the continued failure of these providers, we must give the states and health care regulators the legal tools to bring these providers into line or remove them from the system.

This title provides several important modifications and additions to the OBRA-87 legislation. First, all skilled nursing facilities will be required to conspicuously post in each ward of the facility a list of the names and credentials of the on-staff employees directly responsible for resident care and the current ratios of residents to staff. This simple requirement will allow families and the nursing home ombudsman program to determine whether the facility provides adequate staff to attend to the residents'' needs. In addition, the legislation would direct the Secretary of Health and Human Services to issue guidelines for adequate staffing for skilled nursing facilities.

The second provision of this title gives states alternative punitive measures to use with repeatedly noncompliant nursing facilities. One of the distressing trends identified in the GAO report is a phenomenon they describe as a ''yo-yo'' effect. A nursing facility will correct the problem and avoid the fines or penalties. Once found to be in compliance, the facility will slip back and provide substandard services until cited again by regulators.

Our proposed legislation offers two fixes. First, the legislation would allow states to recover the expense of resurveying and reinspecting the skilled nursing facility where there has been a substantial violation of the regulations. Second, the legislation would prohibit the facility from including the costs of the resurveying and reinspection in its reasonable costs figures. In other words, they cannot pass the bill of rectification onto Medicare or Medicaid. This proposal is a clear financial disincentive for homes to practice a yo-yo management and adds an important regulatory tool for the states.

The third major initiative in our legislation is the requirement of criminal background checks. Skilled nursing facilities would be required to conduct a criminal background check of all employees and would be prohibited from hiring any person who has been convicted of patient or residence abuse. This portion of the legislation makes clear that we do not want felons who have a history of abusing others working with one of the most vulnerable groups of people in the nation.

Finally, the legislation requires skilled nursing facilities to report cases when an employee has harmed a patient or resident. The legislation calls for revising the current Nursing Aide Registry. Under our legislation, the new name of the data base will be the Nursing Facility Employee Registry and will list any nursing facility employee who has been convicted or had a finding of abuse or neglect of a patient.***HD***Title IV: Long-Term Care Insurance

Title four of the legislation addresses long-term care insurance. The first chapter encourages long-term health care policies for federal and nongovernmental employees. The second chapter extends the consumer protection standards contained within the Health Insurance Portability and Accountability Act to all long-term care policies.

First, it directs the Office of Personnel Management to provide for the sale to the general public of group long-term care insurance policies that are offered to federal employees.

The legislation keeps separate the premiums and costs of nongovernmental employees from governmental employees, thus protecting the federal employees from potential adverse cost impacts. In other words, non-government employees could pay a higher premium if the cost of underwriting that population is higher than the cost of underwriting federal employees. It is our hope, however, that by helping create a group market and offering economies of scale, this provision will help nonfederal employees obtain lower cost policies.

The next section extends the consumer protection standards contained within the Health Insurance Portability and Accountability Act to all long-term care policies. Currently, these standards apply to only tax-qualified policies. Without these protections, some insurance providers may be tempted to provide long-

term care policies that do not provide the level of financial protection that consumers need. Because of the expense of these policies, the consequences of purchasing inadequate insurance, and the difficulty of understanding these policies, we need to ensure that reasonable quality standards protect consumers from buying inadequate and inappropriate long-term care policies.***HD***Title V: Reauthorization of the Older Americans Act of 1965

Title five of the legislation is an extension of the Older Americans Act of 1965, as proposed by the President to include grants for care giver assistance.***HD***Title VI: Early Buy-in For Medicare

Title six of the legislation would provide caregivers an early option to join Medicare. This important portion of the bill would provide increased access to health coverage for Americans who are the primary caregivers for family member with long-term care needs.

Many Americans must quit job or retire early to care for a family member who has long care needs. In addition, they tend to range in age from 55 to 64. Consequently, health insurance companies refuse to insure them or charge huge premiums. Our proposal would cover nearly five million early caregivers who face the prospect of being uninsured and who are helping all of us by keeping other individuals out of taxpayer-subsidized institutions. This provision allows qualifying individuals to receive Medicare coverage when they leave their employment to provide long-term care for a spouse or relative.***HD***Title VII: Long-Term Care Giver Social Security Credit Protection

Title seven also protects the future retirement income of caregivers who leave their employment to offer long-term care. This title does two things. First, it ensures that caregivers will continue to receive their Social Security credits while they are caregivers. Second, while the caregiver is unemployed he or she will be credited with the arithmetic average of his or her previous three years of employment as a contribution to income.

FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS ACT, 2000

SPEECH OF

HON. LORETTA SANCHEZ

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, August 2, 1999

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 2606) making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2000, and for other purposes:

Ms. SANCHEZ. Mr. Chairman, today the House considered the Foreign Operations Appropriations Bill for fiscal year 2000. One issue of great concern to me was the absence of funding for the Community Adjustment and Investment Program (CAIP) in this appropriations bill. The CAIP is a way of helping communities that are negatively impacted by NAFTA.

With NAFTA came hard times for many areas around the country. Businesses moved operations to Mexico, leaving thousands of Americans without jobs and many communities in economic distress.

The CAIP program allows NAFTA affected communities to receive funding for job training and investment capital for job creation. Providing workers with the skills to acquire new jobs, and providing the communities with the funding to establish new enterprises, will help to bolster the economies of many NAFTA impacted areas. President Clinton understood this when he requested that the CAIP receive $17 million in his fiscal year 2000 budget.

NAFTA was supposed to increase economic prosperity for everyone involved in this agreement. The least we can do in Congress is to make sure that those American workers who were negatively impacted by NAFTA have a chance to succeed as well. The CAIP is a program which helps to achieve that goal.

I am hopeful that my colleagues will realize the importance of CAIP and ensure that it will receive funding when this bill goes to conference.

A TRIBUTE TO MANUEL A. ESQUIBEL

HON. CALVIN M. DOOLEY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, August 3, 1999

Mr. DOOLEY of California. Mr. Speaker, I rise today to pay tribute to Manuel A. Esquibel, who is retiring this month from his position as City Manager of Selma, California. He has dedicated his life to improving the quality of life for Selma residents.

Mr. Esquibel was born and raised in Colorado, and earned a degree from the University of Southern Colorado. He has served in local government for over 25 years, holding the positions of Assistant City Manager of Pueblo, Colorado, and later City Manager of Lindsborg, Kansas.

In 1990, Mr. Esquibel began his current position as City Manager of Selma, California. During his tenure in Selma, he has developed an effective community team approach and a motivational management style, generating excellence among city staff members.

Mr. Esquibel has been a leader in promoting economic development in Selma, participating in the ''Team Selma'' program, which led to the creation of over 3,500 new jobs. During his term as City Manager, Selma has received regional, state, and national recognition in the promotion of economic development. Mr. Esquibel played a critical role in planning President Clinton's successful visit to Selma in 1995.

Mr. Esquibel's tremendous dedication to Selma is surpassed only by his dedication to his family. He and his wife, Beverly, have two children—Renee and Tony—and four grandchildren.

Mr. Speaker, I ask my colleagues to join me today in congratulating Manuel Esquibel for his tireless service and countless contributions to the City of Selma. We wish him nothing but the best as he retires from a long and successful career in public service.

A TRIBUTE TO THE LATE STANTON CRAIG HOEFLER

HON. GARY G. MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, August 3, 1999

Mr. GARY MILLER of California. Mr. Speaker, I rise today to honor the late Mr. Stanton Craig Hoefler, who passed away on February 17, 1999 of natural causes. Born in San Francisco on February 18, 1924, Mr. Hoefler attended Lowell High School and joined the Army Air Corps in 1942 where he flew with the ''Mighty 8th'' as pilot in command of a B–17 bomber over Germany. He completed his tour and later flew photo-recon aboard P–51's.

In 1976, Mr. Hoefler became the curator of the Yanks Air Museum where he was responsible for the restoration of many Golden Years and World War II airplanes. Among these are the Curtiss Jenny, Ryan B–1, Stearman 4–D, AT–6, F6f ''Hellcat'', P–38 ''Lightning'', P–40 ''Warhawk'', P–47 ''Thunderbolt'', the P–63, and the Dauntlas SBD to name just a few. He became an expert in the aircraft restoration field and his accomplishments have been featured in aviation periodicals around the world.

Stanton Craig Hoefler is survived by his wife Phyllis of Phillips Ranch, five children, and nine grand-children. Memorial services were held on February 25, 1999 at the Yanks Air Museum in Chino Hills, CA.

Mr. Speaker, he will be sorely missed.

KING HASSAN II OF MOROCCO—AN APPRECIATION BY DR. JOHN DUKE ANTHONY

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, August 3, 1999

Mr. LANTOS. Mr. Speaker, on July 23, His Majesty King Hassan II of Morocco passed away and his son, Sidi Mohammad ben Al Hassan assumed the throne of Morocco.

I would like to call the attention of my colleagues to a particularly thoughtful and insightful essay on the role of King Hassan and his positive impact upon Morocco. The essay—''The Passing of Morocco's King Hassan II''—was written by Dr. John Duke Anthony, the president of the National Council on U.S.-Arab Relations, secretary-treasurer of the U.S.-Gulf Cooperation Council Corporate Cooperation Committee, and a distinguished American scholar of Middle Eastern affairs.

Mr. Speaker, I ask that Dr. Anthony's essay be placed in the RECORD, and I urge my colleagues to reflect upon his discerning appreciation of the role and significance of the reign of King Hassan II.

THE PASSING OF MOROCCO'S KING HASSAN II

(By Dr. John Duke Anthony)

In the history of America's foreign affairs, a long-running chapter with Morocco, one of our country's oldest and most important allies, closed and a new one opened this past week.

The King of Morocco, the first country to recognize the fledgling U.S. republic during the Administration of President George Washington, was laid to rest.

As anticipated, accession to the kingship of King Hassan II's eldest son and Heir Apparent, the 36-year old Moulay, now King,