T. Tommy was born in Tangipahoa Parish, LA. In 1949, he met and married his partner for life, Miss Vicky Martin. T. Tommy declares finding Miss Vicky to be the highlight of his life.

T. Tommy had the opportunity to enjoy several different careers. In 1954, he joined the Grand Ole Opry as a staff announcer and entertainer. His talents allowed him to become widely recognized by all Tennesseans for his Martha White Flour commercials.

In 1978, T. Tommy was elected to the Tennessee State Senate. He represented his district until 1982. Later in 1982 he joined the International Brotherhood of Teamsters as an international representative of drive. T. Tommy retired from this position on June 30, 1995.

During his tenure at the Teamsters, T. Tommy provided me with sound counsel and good advice. I can assure you that the betterment of the hard working men and women was always at the front of his mind.

T. Tommy plans on spending his retirement traveling with Miss Vicky and visiting their 5 children, 11 grandchildren, and 1 great grandchild and another on the way. I want to wish them both the best of luck and prosperity in retirement.

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 1996

HON. JOHN D. DINGELL

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, August 4, 1995

Mr. DINGELL. Mr. Speaker, early this morning, this House voted to approve one of the saddest pieces of legislation it has ever sent forward. We heard the astounding arguments that this Labor, Health and Human Services, Education, and related agencies appropriations bill will maintain, or even increase, funding for health and education programs that are vital to the well-being of our most vulnerable citizens. But these arguments, like the funding decisions themselves, are a sham and a coverup. They coverup the fact that in its allocation of funds to the Labor-HHS Subcommittee, this Republican-led Congress chose to ignore the needs of those citizens to save money for tax cuts for the wealthy, and for spending in the Department of Defense to purchase equipment that even the leaders of that Department stated they do not want or need. For years, that subcommittee has nurtured and supported programs that constitute the discretionary safety net for our children, our seniors living on fixed incomes, and our workers. The grossly insufficient allocation of funds to the Labor-HHS Subcommittee forced Chairman PORTER to snip the threads of that net as if with a chain saw.

But this bill does some very, very bad things as well. It terminates hundreds of programs, including over 60 programs of the Department of Health and Human Services—such as black lung clinics, State trauma care, substance abuse training and treatment, programs that counsel the elderly about their health insurance, the Low-Income Home Energy Assistance Program, programs that provide services to the homeless, nutrition programs for the elderly, and programs designed to reduce the rampant problem of drug abuse among young people. There are many reasons for us to be sad about what this Congress did by passing this bill.

I applaud the dedicated work of Chairman PORTER and Mr. OBEY, for they have done yeoman work under excruciatingly difficult circumstances. I applaud them for increasing funds for the important research activities of NIH. I am pleased that the subcommittee recognized the importance of increased funding for breast and cervical cancer prevention activities at CDC, for childhood immunization, and for other prevention activities.

But I am very concerned that this bill achieved those increases through a very short-sighted approach, and through robbing Peter to pay Paul. I want to focus on just two examples of this.

The bill increases funding for infectious disease programs at CDC, but decreases CDC administrative costs by $31 million. This decrease takes funds not only from such things as office supplies and taxicab rides, but also for salaries and expenses for the researchers, doctors, and laboratory technicians, who are essential to CDC's activities in preventing and controlling infectious diseases and carrying out other critical activities. It also takes money from the budget that provides for CDC epidemiologists and doctors to travel to other parts of the country and the world, where they are often the only source of expertise related to a new, devastating epidemic.

It is already extremely difficult for CDC to recruit and retain qualified scientists and physicians with expertise in infectious diseases. In this era of downsizing Government, the CDC infectious diseases program is losing people faster than it can replace them, and has increasingly limited ability to replace scientists with invaluable and unique expertise. In a March U.S. News and World Report article about CDC, entitled ''Tales from the Hot Zone,'' the deputy director of the infectious disease program stated the problem quite clearly: ''We are losing our expertise.''

In infectious diseases, as in the other areas where CDC on paper receives increased funding, I fear the increase will be seriously undermined by virtue of the fact that this bill limits the agency's wherewithal to maintain the scientific expertise needed to do the job.

Another short-sighted approach to this disastrous budget-slashing exercise is the reduction of funding for the National Institute for Occupational Safety and Health—a reduction that was then applied to allow the supporters of the bill to argue that they had increased funding for CDC. I fear that perhaps NIOSH is being punished because some may believe it is a regulatory, rather than a research agency. NIOSH is not a regulatory agency.

The NIOSH funding cut eliminates the NIOSH training grants program and reduces research activities by over 15 percent. It would eliminate 57 training grants, including 14 university-based educational resource centers which serve as regional resources on occupational safety and health for industry, labor, Government, academia, and the general public.

NIOSH training grants have trained more than 2,700 professionals in occupational medicine and nursing, industrial hygiene, safety engineering, et cetera. These people have been trained to prevent and treat occupational diseases and injuries. There is a severe shortage of certified occupational health nurses and physicians, amounting to only about one physician and five nurses to every 80,000 active workers and 20,000 retired or disabled workers.

NIOSH is the only Federal agency conducting biomedical research on the causes of occupational illness and the only agency conducting applied research to identify, evaluate, and prevent work-related injuries and illness.

At at time when Congress seems so intent that in-depth risk analysis must be associated with regulations, it is absurd to reduce the ability of this agency to ensure that there is sound science and risk assessment to underpin regulatory actions relating to worker heath and safety.

NIOSH works closely with management and labor in its research activities, and currently is engaged in a tripartite agreement with General Motors and the UAW to conduct health and safety research. In a recent letter to the Director of NIOSH concerning this program, the GM vice president for R&D stated: ''we recognize NIOSH's distinct role as a R&D entity which has been very effective in injury prevention research over the last 25 years. This effort has ultimately saved the nation billions of dollars annually in medical costs, and also improved the health and welfare of every American worker and their families.''

These are just two small but significant examples of the many ways in which this funding bill hurts the public health and hurts the people of this country. The House wants to balance the budget—we all agree on that goal. Many agree that all federal programs need to tighten their belts and contribute their ''fair share'' to important budget-reduction efforts. But the budget cutting in this Congress has not been honest, and it has not been fair. The money being saved is much greater than what is needed to balance the budget; it is being saved for tax breaks and unnecessary defense spending. The cuts have targeted the most unfortunate, the oldest and the youngest, and the most needy in our country. Nowhere is that more evident than in this appropriations bill. The ranking member of the Committee on Appropriations said it best in his dissenting views: this legislation ''will make it harder for ordinary people to hold on to a middle class life . . . more difficult for the disadvantaged to get the education and training which they need to work their way into the middle class . . . workers more vulnerable. . . . this bill marks a retreat from our efforts to be one people with common causes and common interests. Surely this Congress in a bi-partisan way can do better.''

MEDICARE AND POINT-OF-SERVICE

HON. BILL K. BREWSTER

OF OKLAHOMA

IN THE HOUSE OF REPRESENTATIVES

Friday, August 4, 1995

Mr. BREWSTER. Mr. Speaker, as we move toward consideration of Medicare reform proposals, I would like to draw my colleagues' attention to a national survey released Wednesday, July 26, 1995. This survey revealed that four out of five Americans age 50 and over said they would not join a Medicare managed

care plan without the freedom to continue seeing their current doctor, a specialist, or other provider when they become ill.

I rise today to speak about the necessity of preserving this freedom of choice as an essential element of any Medicare reform proposal. Many of my colleagues advocate increased use of managed care as one of the necessary steps to save our Medicare system.

This may be true, but we have a responsibility to ensure real freedom of choice for our elderly even within a managed care environment. It should be clear to all of us that unless we preserve these freedoms, Medicare managed care will not work because people will not join.

Americans so deeply value their freedom of choice in doctors that I believe it is essential to include these survey results in the CONGRESSIONAL RECORD, and ask the Chair that full results of the survey be printed in the CONGRESSIONAL RECORD immediately following my statement. I strongly encourage my colleagues to keep them in mind as we move forward to reform the Medicare system.

MEDICARE REFORM SURVEY—JULY 26, 1995,
SUMMARY OF KEY FINDINGS

Between June 30 and July 11, 1995, ICR Research polled a nationally representative sample of Americans age 50 and over on their views concerning Medicare reform. The results carry a plus or minus 3.2 margin of error. The key findings of this survey are as follows:

Roughly three out of four Americans (72 percent) age 50 and older would not join a Medicare managed care program without the freedom to continue seeing their current doctor or turn to a specialist when they become ill.

Fifty-five percent ranked the ''right to choose [their] own doctor or hospital'' most important from a list that included three Contract with America items: ''the right to pray in school'' (20 percent), ''the right to bear arms'' (9 percent) and ''the right to limit the number of terms a member of Congress can serve'' (10 percent).

Fully 82 percent of respondents said that whether a prospective Medicare managed care program allowed them the freedom to choose out-of-network physicians and specialists would be ''critically important/important'' to their decision to join one.

Seventy-two percent of respondents said they would be more likely to join a Medicare managed care program that preserved their freedom to continue seeing their own doctor and guaranteed them access to specialists inside and outside the network—even for a small co-payment—than to join one that covered the cost of their prescription medications, but restricted their freedom to choose their care provider.

Sixty-three percent of all respondents said they would be inclined to join a Medicare managed care program that allows them to continue seeing their current doctor or a specialist, outside the managed care network, for a higher co-payment or deductible.

Even among lower-income seniors (those making less than $15,000 a year), 64 percent said they would choose a Medicare managed care program with the freedom-to-choose feature (for a reasonable co-payment) over a Medicare managed care program that covers the cost of prescription medications. Eighty-three percent of respondents making over $50,000 gave the same response.