Blue Cross would like to convert all of its business, acknowledge that as much as ⅓ of the premium dollar goes to ''administration'' rather than patient care.

Faced with a diminishing piece of the premium dollar pie, physicians and hospitals dependent upon managed care dollars for survival are constrained to deny care to those in need. Primary care physicians are compensated by ''capitation,'' meaning that they receive only a fixed monthly fee for caring for each patient. This fact has resulted in California in a lot more medicine being practiced by telephone. In addition, in many plans, a significant percentage of the primary care physician's capitation payment is withheld, with all or a portion of the sum returned to the physician at year's end, depending upon the ''loss experience'' of the group. And what ''loss experience'' means is simply that the more patients referred for tests, consultations, surgery, etc., the greater the loss experience. So there are powerful financial incentives built into the system for primary care physicians who act as ''gatekeepers'' for referrals, to deny care. In addition, managed care bureaucracies keep track of each primary care physician's financial track record, and have the right to terminate a physician whose loss experience is not to their liking. Managed care organizations are under no legal obligation to inform consumers of these facts when giving them a sales pitch to join an HMO. And if you look at the situation here in California, insurance companies have been aggressively advertising Medicare HMO products with offers that seem too good to be true. But in the end, in practice, what for-profit managed care organizations really do is to siphon money away from medical care, and redirect those dollars into multimillion dollar CEO compensation packages and huge bureaucracies. Do Medicare HMO's save the Federal Government any money over the existing system? Look for any proof of that; there isn't any.

When I look at the Republican proposals for Medicare reform, what I see first is that the deductible will be made so large as to make the overwhelming majority of Medicare recipients join for-profit HMO's who promise them a ''no-deductible'' plan. The business of other options such as medical savings accounts, etc. will never amount to anything in reality. I cannot understand why my buddies in the AMA cannot see that. If the California experience with HMO's is any indicator, there will be a merger and acquisition frenzy as larger HMO's swallow up smaller ones. More and more dollars will be spent on these mergers rather than patient care (When, for example, Health Net and Qual-Med merged, certain members of their respective boards of directors shared $110,000,000 in stock and cash ''compensation''). What will result is an oligopoly of three or four huge insurance companies controlling all medical care. And the primary factor determining success or failure in any competition in this marketplace will not be quality of care, but simply the profit picture of the company, which is inversely related to expenditures on patient care.

It is for these among other reasons that I am highly wary of the Republican plan. I strongly suspect that the Republicans are primarily doing the bidding of a few huge insurance companies who plan to be the major players in the Medicare marketplace once it is ''privatized.''

From this perspective, I am also highly suspicious of the provision in the proposed legislation to limit noneconomic malpractice litigation awards. This may surprise you, coming as it does from a physician. But according to my malpractice insuror, in California the largest growth area in medical malpractice suits is in litigation against the formerly-low-risk-specialty of primary care for failure to timely diagnose and refer to specialists. Does this mean that managed care in changing practice patterns in primary care as regards the timeliness in which patients are referred for specialty care? I don't think that it takes a brain surgeon to figure that one out! Lawsuits filed against physicians are inevitably filed against the HMO's as well, and particularly after the 75+ million dollar judgment against Health Net in the marrow transplant denial malpractice case, the HMO's are quite aware that they have become the ''deep pockets.'' From this perspective, I view such malpractice reform as contained in the Republican proposals primarily as a license for HMO's to be negligent, confident in the notion that a maximum $250,000 liability in almost all cases represents a relatively small cost of doing business. As more and more doctors become virtual employees of for-profit HMO's, they will realize that malpractice reform was primarily meant to benefit their employers!

Right now Medicare works well, returning a high percentage of dollars spent in actual benefits to recipients. The increased spending on Medicare is primarily a function of the aging of the population and the fact that advances in medicine have made possible the successful treatment of many conditions not amenable to such treatment in 1964. While I would agree that the system requires reform, I would caution you that the Republican plan is simply a scheme for diverting billions of Federal dollars earmarked for Medicare recipients into the hands of a few at the expense of many. If you are unsure of this, just try to introduce some elements into the legislation that would insure that a certain percentage of Medicare dollars are to be spent on patient care, and not diverted by profiteering insurance giants. You will find that your Republican colleagues will be spouting all kinds of pure garbage in defense of their true benefactors, who would love to be an unregulated industry!

Sincerely,

MARC A. LEVINA, M.D.

Mr. Speaker, I now yield to the gentlewoman from Florida [Ms. BROWN].

Ms. BROWN of Florida. During the August recess I conducted 14 town meetings where I talked to over 3,000 of my constituents, and we in Florida understand that the $270 billion that the Republicans are cutting out of the Medicare budget to save it, we understand just what kind of savings that is, and in fact the 10 years I served in the Florida House we had a saying for it: That dog don't hunt.

Now I have a contract that I signed yesterday in Orlando, and I signed it with the people of the Third Congressional District, but let me be clear. I signed it with the people of Florida and the seniors of the United States, and my commitment is to them. We do not like that reverse Robin Hood that has been going on since the 104th have taken over. You know what I mean, robbing from the poor and working people to give a tax break to the rich, and I know that you all do not like that word ''cut.'' Well, I have got a better word for you. Try ''gut.'' You are gutting the program.

Ms. PELOSI. Mr. Speaker, I thank the gentlewoman for her remarks, and I ask our colleagues to vote ''yes'' for Medicare and ''no'' for tax cuts.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida [Mr. SCARBOROUGH] is recognized for 5 minutes.

[Mr. SCARBOROUGH addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

THE FACTS OF THE REPUBLICAN MEDICARE PROPOSAL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Pennsylvania [Mr. FOX] is recognized for 5 minutes.

Mr. FOX of Pennsylvania. Mr. Speaker, the fact of the matter is, Mr. Speaker, despite the comments you may have heard tonight from others on the House floor, Republicans do care, care so much for seniors, that we, in fact, passed on the House floor earlier this year rescinding of the 1993 tax on Social Security. We now have legislation we have adopted here in the House which will allow seniors under 70 to make more funds than the $11,280 they have been capped at without having deductions from their Social Security.

Now let us look at perspective when it comes to Medicare discussion about how we got to this point. It was the President's trustees working with others who came out with a report in April which said that Medicare, if nothing happens with the program, will go bankrupt by the year 2002. You may say, well, how did we get to this point with health care going up 4 percent a year and Medicare going up about 10 or 11 percent a year? How did we get to that point? Well, the facts are we got to this point because we have $30 billion a year in fraud, abuse, and waste. We also have 12 percent of the costs of Medicare just going to paperwork.

So you say to yourselves, What's the solution? The solution is we cannot do nothing. We have to make sure the system is solvent and we have access to quality health care for our seniors. So what we have to consider is a program which would give seniors choice, continue their fee for services, if that is what they would like; the managed-care option, if they would like to have that, which would include such items as pharmaceuticals or dentures, eyeglasses, hearing aids. Also we have the possibility of the Medisave account whereby each subscriber now would get $4,800 toward their health care costs. If they do not use it all, keep the funds they do not use or roll it over until the following year.

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One of the biggest problems has been the fraud, abuse, and waste. Under legislation which has been introduced by the gentleman from New Mexico [Mr. SCHIFF] and the gentleman from Connecticut [Mr. SHAYS], the penalties for fraud, abuse, and waste will be increased.

For the first time in the history of the Congress, we have had crime of health care fraud as an offense of the Federal Government, a 10-year maximum jail sentence. The provisions of the bill would in fact define the crime of illegal remuneration with respect to health care benefit programs. It would define the crime of willful obstruction of criminal investigations of health care offenses and would, for the first time, make sure that we get a coordinated effort of the Federal Government in stopping the fraud, abuse and waste.

If we can attack that particular problem, we will find that Medicare will be strong, it will be solvent, and it will be here for generations to come.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio [Mr. BROWN] is recognized for 5 minutes.

[Mr. BROWN of Ohio addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

COMMONSENSE MEDICARE REFORM

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan [Mr. STUPAK] is recognized for 5 minutes.

Mr. STUPAK. Mr. Speaker, what I would like to do, I am on the Committee on Commerce and will be on the floor most of the day tomorrow arguing Medicare. I can go on all night about the inequities in the Republican plan, but what I would like to do tonight is submit my statement for the RECORD, and yield the balance of my time to the gentlewoman from Florida [Mrs. THURMAN].

Mr. Speaker, I include my statement for the RECORD as follows:

Mr. Speaker, a week ago, I introduced the Common Sense Medicare Reform. the new majority in Congress claims that it is necessary to cut $270 billion in order to save the Medicare Program. This is simply ludicrous. The Medicare trustees say that the Federal Government must devote $89 billion—not $270 billion. What's really going on here is the majority is attempting to steal $270 billion from the Medicare trust fund in order to keep its campaign promise by giving a $245 billion tax cut to the wealthiest 1 percent of Americans.

Actually, the Medicare trustees say that the Federal Government must devote $89 billion—not $270 billion—to save Medicare from bankruptcy. There must be changes and adjustments to Medicare, but it's irresponsible to gut a program which 37 million senior citizens depend on for health care coverage. My legislation takes the best ideas from the Republican proposal and the Democratic plan to improve the Medicare Program in a bipartisan manner.

The first thing we must do to save Medicare is to aggressively fight waste, fraud, and abuse in the Medicare Program. Ten cents of every dollar spent on Medicare is consumed by fraud and waste. Some health care providers charge the Medicare Program many times more than what these goods and services would cost on the open market. For example, Medicare rents, you can't buy it, but rent pressure reducing mattresses for approximately $650.00 per month and comparable alternate pressure reducing mattresses can be purchased for $168.95. Foam rubber egg shell mattresses can be purchased for $19.95, yet Medicare pays $29.95. The Medicare Program pays $280 for oxygen concentrate, while the Veterans Administration, another Federal agency, pays only $123 for the exact same product. Savings from the oxygen concentrate alone could save us $4.2 billion over 5 years. These three examples alone demonstrate how billions of dollars are robbed from the Medicare trust fund.

We can find the money we need to save Medicare. In 1994, more than $8 billion was recovered in fraud and waste by Medicare providers, and it is expected that $10 billion will be recovered in 1995. We can save $93.5 billion over the next 7 years by actively detecting and prosecuting waste, fraud, and abuse, and this amount is more than enough to save Medicare according to the trustees' report.

The Republican Medicare bill proposes to legalizes fraud committed by health care providers by making it more difficult to prove fraud and to recover Medicare funds. Conversely, my bill provides more and better tools to fight Medicare fraud by increasing the powers available to law enforcement. It will strengthen civil penalties for kickbacks, provide grand jury investigations, and increase subpoena authority. Both the OIG and the Justice Department endorse the fraud-fighting tools that are contained in my bill.

Currently, any money saved from Medicare is returned to the U.S. Treasury. My legislation requires that any funds recovered through cuts or savings be automatically returned to the Medicare trust fund. Your Medicare money should not go to the U.S. Treasury to pay for tax cuts for the wealthiest Americans and large corporations—it should be used to save Medicare.

I firmly believe that before we gut Medicare and implement radical and untried managed care programs, we should test the feasibility of these new programs on a voluntary basis. I propose that we look at managed care programs and health care service networks on a 5-year trial basis. We must make sure that such pilot programs will save money, provide quality care, and prolong the life of Medicare while giving seniors greater health care benefits and choices. Programs such as provider sponsor organizations [PSO's] and provider sponsor networks [PSN's] may be particularly useful and effective in rural areas. In northern Michigan, we are on the cutting edge of providing maximum benefit for our health dollar through cooperative efforts. I won't gamble with your health care. Let's make sure that the proposed changes improve Medicare, rather than destroy it.

My legislation also directs that a Baby Boomer Commission be appointed to study alternatives for the best way to address the large influx of recipients who will be eligible for Medicare beginning in the year 2010. The Commission will work with Medicare trustees to ensure there will be funds available to provide health care coverage for the baby boomer population. In addition, the Commission will hold public hearings all across the country so you will have input on any proposed Medicare changes.

Lastly, I advocate the use of a single-page Medicare claim form to increase administrative efficiency. We can simplify the Medicare system for beneficiaries and providers, while saving money from increased efficiency and cutting down on fraud.

People should not have to pay more money to receive less coverage and lose their choice of doctors. The Republican majority should not raid the Medicare trust fund to give tax cuts to the wealthiest Americans and multinational corporations. Instead of stealing money from the Medicare System, we need to put money back into the system to keep it solvent for current and future recipients. Let's not gamble with the health of our senior citizens.

You can see why the Republican majority refuses to make my bill in order because it is common sense.

Mrs. THURMAN. Mr. Speaker, I thank the gentleman from Michigan for yielding.

Mr. Speaker, I want to do this from a different standpoint of looking at what I think is going to happen to Florida residents. First of all, I want Florida residents to understand that they are looking at the $38 billion cut between Medicaid and Medicare, and this is to pay for a tax cut for the very wealthy.

Mr. Speaker, Florida stands to lose more than $38 billion in Federal funds under the Republican plan to cut Medicare and Medicaid to finance a tax cut for the wealthy.

Now, I would like to introduce you to a wonderful couple from my district who worked hard all their lives and looked forward to retirement.

But, like many elderly, they fell ill. While the wife struggles with illness herself, she has had to care for her sick husband.

Recently, she came to me for assistance. It seems no one could help her secure a place in a nursing home for her husband. Thankfully, we were able to do that for them. But I worry about how this family will be impacted by the cuts in Medicare and Medicaid.

First, under the Republican Medicare cuts, the ill wife will lose the security of her Medicare coverage. Yes, the Republicans are promising choice to my constituents.

But the truth is, should my constituent want to stay in her current fee-for-service plan with her trusted doctor, she will be forced to pay over $1,000 a year in premiums by the year 2002.

How can a plan promising choice produce such terrible results? It is because of what the Republicans are not telling seniors.