40TH ORDINATION ANNIVERSARY OF FATHER STANLEY CZARNOTA

HON. DICK CHRYSLER

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 24, 1996

Mr. CHRYSLER. Mr. Speaker, I rise today to commend Father Stanley Czarnota.

Father Stanley Czarnota was born in Wolka, Poland, in January of 1933 in a small village located along the largest river in Poland. He is the youngest child of Frank and Helen, and he has two sisters, Mary and Jessica.

Father Czarnota graduated from high school in 1951 and then attended Catholic Lubin University. In 1956, he received his degree in theology and was ordained a priest on December 22, 1956. He worked in Poland as an assistant pastor and then pastor at Borowicz, located near the Russian border.

Relatives from both Fr. Czarnota's mother's and father's family reside in the United States. His father spent 10 years in Michigan before returning to Poland. In 1976, Father Czarnota's family came to America and fell in love with this country. After receiving permission from his bishop in Poland, Father Czarnota applied for permanent residence in the United States. He was accepted in the Lansing dioceses and began working in this area. On August 6, 1981, he became a citizen of the United States of America. He described the event as ''an unforgettable day, a very special day in my life, a day I will never forget and will always treasure.''

Father Czarnota has always stated that he had the marvelous opportunity to repay this country for adopting him by accepting a commission in the U.S. Navy on May 15, 1988. On September 29, 1996, Father Czarnota will celebrate his 40th ordination anniversary as a priest.

A former commanding officer in the Navy stated, ''Father Stanley no matter where he works has left a very important message with many people. No matter what task, and there are many in various areas, his work with the youth or older community have left a healthy and lasting impression of encouragement and always going out of his way to improve or be helpful with the individuals when needed.''

Father Stanley Czarnota is well known in Flint, Ann Arbor, Detroit and Lansing for his work with the refugees from Poland. His work has been fulfilled when he saw newcomers pursue their dreams in America and succeed in many fields of work, not only for themselves, but also for their families.

His motto is quite simple: ''Don't worry, be happy.''

THE MANAGED CARE ORIENTATION AND MEDICAL PROFILE ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 24, 1996

Mr. STARK. Mr. Speaker, I am pleased to introduce ''The Managed Care Orientation and Medical Profile Act.''

For the past decade, the Medicare and Medicaid programs have been joining the national movement to managed care. Medicare enrollment in capitated Health Maintenance Organizations (HMOs) jumped from 441,000 members in 1985 to almost 3.5 million beneficiaries as of March 1996. Medicaid enrollment in managed care has been more dramatic as States have received Federal waivers to enroll almost all of their Medicaid recipients in HMOs.

The growth in managed care is largely due to the aggressive marketing practices of managed care plans. HMOs place financial incentives on door-to-door agents to enroll as many new members as the plans can handle. Medicaid HMOs even stake out food stamp offices targeting would-be enrollees with free gifts and high pressure tactics.

Unfortunately, these practices put some of our most vulnerable populations at severe risk. Consumer advocates have reported that Medicare and Medicaid beneficiaries are often enrolled without understanding what they are signing. Some unscrupulous health plans even prey on non-English speakers or the mentally handicapped. As a result, many new enrollees are left clueless as to how their health plan works or how to access care while the HMOs begin receiving payments from the government for care they are not providing.

Once an individual is enrolled, Medicare sends the HMO somewhere between $300 and $700 per month (depending on the region of the nation) to maintain the health of that person and to treat them when they are sick. In many cases—perhaps most cases—Medicare can spend thousands and thousands of dollars on behalf of an enrollee before that person ever visits the HMO. In the meantime, the health of the enrollee can actually be deteriorating and more serious problems can be developing.

The legislation I propose today address this problem by making HMOs more accountable for the lives they enroll. In order to enroll new patients, HMOs would have to fulfill the following requirements before payment begins:

First, conduct an orientation meeting with the new enrollees introducing them to managed care and clarifying where to access care, which benefits are covered, and all payment structures including deductibles and copayments.

Second, conduct a preventive screening as defined by the Secretary and an immunization assessment for children.

Managed care claims to be effective because it works with the patient to ''manage'' health and prevent illness. When the government is paying the bill, we ought to demand that plans live up to this promise by mandating the orientation and medical profile before their payment begins. In the medical profiling encounter, the HMO can begin to work with the enrollee on issues such as diabetes, lack of immunization, obesity, smoking, alcoholism, pre-cancerous skin conditions, high blood pressure—the whole range of potential health problems that a good HMO should know about their enrollees and be working to improve.

The August 1996 issue of New York's United Hospital Fund newsletter ''PolicyLine'' shows why the idea of requiring a meeting and work-up before we start paying HMOs makes a great deal of sense:

> Even if specifically required to assume certain public health responsibilities, however, managed care plans may not yet have the experience or systems to fulfill their responsibilities, as experienced in Wisconsin demonstrates. Five years into its managed care initiative, Milwaukee experienced a measles epidemic. According to Paul Nannis, Milwaukee Commissioner of Health, the city had 1,100 cases of measles in 1990, mostly among disadvantaged preschool-aged children. Eighty-three percent of these children were in HMOs; three of them died. Subsequent analysis revealed that of all the preschoolers enrolled in the HMOs, two-thirds were not appropriately immunized. In the wake of this crisis, the department of health provided 20,000 shots in a ten-week period, 55 percent of them to children enrolled in HMOs.
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> In analyzing the events that led to the crisis, Mr. Nannis said that the independent practice associations that were operating as managed care organizations had not fundamentally altered the way they delivered primary care services. Simply renaming the existing system managed care and changing the reimbursement process for physicians who continue to practice medicine the same way they always have done does not magically manage anybody's care, said Mr. Nannis.

While the Milwaukee example refers to a Medicaid managed care type program, I believe its lessons apply more broadly. As the article continues, Mr. Nannis is quoted as saying

> * * * public health agencies [read: HCFA] and HMOs need to be at the same table before initiatives start. Managed care plans should be expected to provide uniform data on enrollees including prevalence and cause of mortality, morbidity, and disability; timing and frequency of immunizations; and effectiveness of interventions.

HMOs and managed care can be a wonderful thing for the health of the American people—but only if people know how to use their HMO and only if their HMO works with them to prevent the minor problems of today from becoming the medical catastrophes of tomorrow.