STATEMENT TO SUBCOMMITTEE ON PERSONNEL, SENATE ARMED SERVICES COMMITTEE

HON. EDDIE BERNICE JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, September 27, 1996

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, for the last 2 months, I have assisted my constituents, Charles and Annette Casto, in attempting to locate information regarding the death of their son, L. Cpl. Anthony A. Casto, U.S. Marine Corps. After a hurried investigation, the Marine Corps concluded that Anthony Casto died as a result of suicide. The few material possessions given to the family, brief and uninformative talks with senior military personnel and the investigative branches involved in the process, yielded more questions and uncertainties than answers to Anthony's death.

The families which appeared before the subcommittee were in concurrence that the military's death investigation process is fractured. Currently, separate entities come to conclusions on a single death and withhold information underlying their conclusions. This is the antithesis to freedom of information and contrary to families' legitimate expectations that services will be forthcoming and truthful about the cause of a loved one's death.

All governmental entities and departments are accountable to the citizenry. I am not overzealous when I say that, just as we expect our government to be effective, it should be standard that it is also compassionate when dealing with the families of those who sacrifice their lives for our country. Unfortunately, the personal experiences of families of deceased military personnel illustrate a different picture. Though the people and places were different, there was a common theme that the investigative process treated families as outsiders, not obligated to knowing how their sons and daughters died while serving our country.

I know that the members of the subcommittee listened to the stories on September 12 with sincere interest, professionalism, and sympathy. However, I ask that the subcommittee lead this Congress in a first, but major step, in reforming the military death investigation process to transform it into one that is efficient, responsive, accountable and most importantly, one that is respectful and compassionate to our deceased servicemen and women's families.

HONORING ALVIN R. BELL

HON. MICHAEL G. OXLEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, September 27, 1996

Mr. OXLEY. Mr. Speaker, I am proud to recognize Alvin R. Bell a constituent of mine who participated in CIVITAS@Bosnia-Herzegovina, an intensive program to train local teachers in education for democracy. Mr. Bell was part of a team of 18 American educators and 15 teachers from the Council of Europe who were assigned last July to key cities throughout the Federation of Bosnia and Herzegovina.

The summer training program was developed by the Center for Civil Education as part of a major civic education initiative in Bosnia and Herzegovina. The goals of the program are to help prepare students and their communities for competent and responsible participation in elections and other opportunities in the political life of their communities. Achieving this goal will contribute to the reconstitution of a sense of community, cooperation, tolerance and support for democracy and human rights in this war torn area.

I am also pleased to announce that the curricular materials being used for the program in Bosnia and Herzegovina have been adapted from the We the People * * * the Citizen and the Constitution and Project Citizen programs that have been very successful in may congressional district. Initial reports evaluating the summer program indicate the materials and teaching methods were enthusiastically received and can be adapted for use in classrooms throughout Bosnia and Herzegovina.

Alvin Bell is a teacher at Findlay High School in my hometown of Findlay, OH. Over the years Mr. Bell has brought five different teams of students to Washington, DC to compete in the We the People * * * the Citizen and the Constitution national finals, an academic competition involving simulated Congressional hearing to test the knowledge of your youth in the U.S. Constitution and Bill of Rights.

Mr. Speaker, I wish to commend Alvin Bell for his dedication and commitment during the CIVITAS@Bosnia-Herzegovina summer training program. His work, is helping to achieve the overall objective to building support for democracy in Bosnia and Herzegovina.

THE BREAST CANCER PATIENT PROTECTION ACT OF 1996

HON. BERNARD SANDERS

OF VERMONT

IN THE HOUSE OF REPRESENTATIVES

Friday, September 27, 1996

Mr. SANDERS. Mr. Speaker, I am pleased today to join with Representative ROSA DELAURO in introducing ''The Breast Cancer Patient Protection Act of 1996'' to require insurers to pay for a minimum 2-day hospital stay for a mastectomy and a 1-day stay for a lymph node removal, unless the doctor and patient decide less time is appropriate. The legislation responds to a recent trend by insurers who are refusing to pay for an overnight stay for a woman with breast cancer who has had a mastectomy, the surgical removal of a breast, unless the doctor can prove it is ''medically necessary.''

While medical societies have no established guidelines on how long a woman should stay in the hospital following a mastectomy, doctors have argued that women need to stay 1 to 2 nights after such surgery. Surgeons have told me that the large majority of women would not do well going home the same day after such a surgery. It is unbelievable to me that the insurance industry is now considering mastectomy an ''outpatient procedure'' and denying women overnight stays.

After a mastectomy, a women has a large wound, still-attached drainage tubes and intravenous fluids, and, often times, excessive pain. Overnight stays allow doctors to address many of the problems that can arise in the 12 to 24 hours following surgery and allow women the time to learn how to care for the wound, handle the paint that accompanies such surgery and recover from the emotional trauma that can result from the surgery.

Outpatient mastectomies are disturbing new part of a growing trend in the insurance industry to deny care or truncate stays. First they denied insurance to victims of domestic violence, then they sent mothers and their newborn home within hours following a birth and now women with breast cancer are being denied the ability to have a very difficult surgery with some degree of dignity.

I have played an active role in ensuring that victims of domestic violence are no longer discriminated against in the health insurance industry and in guaranteeing that mothers and newborns are not sent home before they are ready to go. To that end, I will remain steadfast in my commitment to protect breast cancer patients from premature discharges from the hospital.

I am pleased that the National Breast Cancer Coalition has given its support to ''The Breast Cancer Patient Protection Act of 1996.'' I look forward to working together with the Breast Cancer Coalition, surgeons and medical societies to protect safe and appropriate care for cancer survivors.

The truth of the matter is that insurance companies are trampling on the sacred doctor-patient relationship and it must stop. The decision about when a woman should leave the hospital after a mastectomy should be made between the doctor and the woman, not by insurance companies bent on profits.

Congress must restore the doctor-patient relationship once and for all, and I am doing everything I can to see that that happens. In the meantime, this critical measure will protect thousands of women who confront breast cancer surgery from being forced out of the hospital against their will and against the best advice of their doctor.

TRIBUTE TO REV. EDWARD O. HUG

HON. MARCY KAPTUR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, September 27, 1996

Ms. KAPTUR. Mr. Speaker, I rise today to pay tribute to a man of true faith—longtime servant of the church and our larger community in the greater Toledo area, the dear and beloved Rev. Edward O. Hug. He generously bestowed upon our community, particularly in the Catholic parishes throughout northwest Ohio to which he devoted his life for 47 years gentleness, dedication, and spiritual depth.

A man of God, Father Hug ministered to thousands, providing counsel, direction, and solace. His final parish was my own, Little Flower Catholic Church in Toledo.

As we remember Father Hug, his life, and his work and reflect upon his passing, I would like to quote from what has been regarded as one of Father Hug's finest sermons. In discussing life's passages, Father Hug told his congregation, ''we should never be afraid of dying. When a baby comes into this world, the baby says 'I'm afraid to be born.' Then he comes out into the world and sees all the friendly faces and realizes the world is a wonderful place.'' It's the same with death. We're all afraid of dying, but when we die, we are

entering a new life. And it's the most wonderful place to be.'' Upon his own death, to which he professed to look forward, Father Hug's words echo. We know that he is at peace after a long and heroic struggle, and he is happy.

Our entire community expresses heartfelt gratitude for the life and beneficence of Father Edward Hug. No man could have given others more. We extend our prayers to his family, his brothers Father Fritz and Father Relmond Hug, also men of the church, and Eldred Hug, his devoted sisters Virginia Kunisch and Marlene Alter, and the entire Hug family. Godspeed.

INCREASING ACCESS TO MEDICARE SERVICES

HON. RICHARD J. DURBIN

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, September 27, 1996

Mr. DURBIN. Mr. Speaker, I am introducing legislation today, along with Congressman JOHN ENSIGN, to create a demonstration program to waive, for selected diagnoses, the Medicare rule requiring a 3-day hospital stay before Medicare will cover services in a skilled nursing facility. There is growing evidence that, for selected diagnosis-related groups or [DRG's], a waiver could save money by allowing care in a less expensive setting.

The legislation would require the Secretary of Health and Human Services to cover services in skilled nursing facilities for at least five DRG's that involve medical conditions that do not need inpatient care and that are not likely or are least likely to result in any net increase in Medicare expenditures. Over the course of time, the Secretary would be able to add to the list of DRG's for which the 3-day stay rule is waived.

The Secretary would monitor this demonstration program to determine the impact of the program on overall Medicare expenditures. If this experiment is successful, it will increase access to Medicare-covered services without an increase in costs.

I expect that, if the DRG's are carefully selected based on evidence of which medical conditions could be treated less expensively in skilled nursing facilities, there will be no increase in total Medicare expenditures and there might even be budget savings. However, in case that expectation is not met, the legislation includes explicit language to ensure budget neutrality.

If this demonstration program, as a whole, causes an increase in overall Medicare spending, payments to skilled nursing facilities will be reduced by a corresponding amount in the following year to make up for the losses. This provides a fail-safe mechanism, supported by the skilled nursing facility industry itself, to ensure that the measure does not cause new Federal outlays. Moreover, the Secretary would be authorized to remove DRG's from the waived list that result in an increase in overall Medicare spending.

If, as I hope, this demonstration program is successful and overall Medicare costs do not rise as a result of the 3-day stay waivers, the legislation directs the Secretary to actively consider adding other DRG's to the waiver list that could be added without increasing total Medicare costs.

While I do not expect Congress to move forward on this measure in the waning days of this legislative year, I believe this idea deserves careful consideration. I am introducing it now in the hope that we can lay the groundwork for this type of budget-neutral reform in the next Congress.

H.R. 4244

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. WAIVER OF 3-DAY PRIOR HOSPITALIZATION REQUIREMENT FOR COVERAGE OF SKILLED NURSING FACILITY SERVICES FOR CERTAIN DRGS.

(a) IN GENERAL.—By not later than October 1, 1997, the Secretary of Health and Human Services shall provide for coverage, under section 1812(f) of the Social Security Act, of extended care services for individuals with a condition that is classifiable within a diagnosis-related group selected under subsection (b).

(b) SELECTION OF DIAGNOSIS-RELATED GROUPS.—For purposes of subsection (a) and subject to subsections (c) and (d), the Secretary—

(1) beginning with fiscal year 1998, shall select at least 5 diagnosis-related groups (as established for purposes of section 1886(d)(4)(A) of the Social Security Act that—

(A) relate to conditions that do not require treatment through receipt of inpatient hospital services, and

(B) are not likely (or are least likely) to result in any net increased expenditures under title XVIII of such Act; and

(2) for subsequent fiscal years may select additional diagnosis-related groups that meet the requirements of subparagraphs (A) and (B) of paragraph (1).

(c) RECOVERY OF EXCESS EXPENDITURES.—If the Secretary determines that the application of this section in a fiscal year has resulted in any increase in aggregate expenditures under such title for the fiscal year above the amount of such expenditures that would have occurred in the fiscal year if this section did not apply (taking into account any reductions in expenditures resulting from the elimination of or a reduction in the length of hospitalization), the Secretary—

(1) shall, notwithstanding any other provision of law, provide for a reduction in the amounts otherwise payable under part A of such title for post-hospital extended care services in the following fiscal year by such proportion as will reduce aggregate Federal expenditures in such fiscal year under such part by the aggregate amount of such a increase in the previous fiscal year, and

(2) may rescind the selection of any diagnosis-related group if the application of this section with respect to such group has resulted in such an increase in expenditures under such title.

(d) CONSIDERATION OF ADDITIONAL SELECTIONS.—The Secretary shall actively consider the selection of additional groups under subsection (b)(2) if the Secretary determines that the application of this section has resulted in a net reduction in expenditures under such title.

REAUTHORIZATION OF THE PUBLIC HEALTH SERVICE ACT

HON. BILL RICHARDSON

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Friday, September 27, 1996

Mr. RICHARDSON. Mr. Speaker, I rise in strong support of our community health centers and this reauthorization bill.

I have introduced this piece of legislation in the House as H.R. 3180. Although time constraints prevented the House Commerce Committee from moving this bill through the committee this year, I am extremely please that the House will have the opportunity to vote on this important reauthorization.

This bill will consolidate community health centers, migrant health centers, health care for the homeless and health care in public housing projects under one authority as requested by the administration and as supported by the health centers.

Health center programs have been highly successful in delivering primary health care to the Nation's most needy inner city and remote rural over the last 30 days.

These centers have improved health, have high-confidence ratings from the people they serve, and have produced Federal savings by lessening the use of more expensive Federal provided health care.

In New Mexico, Federal health centers serve over 150,000 patients each year. My State has 56 clinics in 27 of our 33 counties. In most areas these clinics are the sole providers of health care in the county. These clinics are usually also the only providers with a sliding fee scale, which means they provide both geographic and economic access to health care for many uninsured or geographically isolated New Mexicans.

Community health programs are a vital part of health delivery to underserved communities across the country and a model of a Federal program that works.

However, over the last 30 years the health care industry in our country has undergone significant changes. This is why I believe we must—through reauthorization—give the health center programs the flexibility and streamlined efficiency to survive in today's health care marketplace.

This authority would support the continued development and operation of local, community-based systems of health care to address the needs of medically underserved communities and vulnerable populations.

At the same time, my legislation frees these centers from unnecessary and burdensome requirements. This bill will: First, make the grant process more flexible, simpler, streamlined, and less burdensome for communities receiving health center awards; second, reduce the Federal administrative costs associated with administering the programs; and third, assure continued Federal support—in these times of tight budgets—for health centers by consolidating the funding previously requested under separate authorities.

In addition, this legislation addresses the rapid expansion of managed care and gives our health centers the ability to complete in today's health care marketplace. This bill will create grants for health centers to plan and develop networks with health maintenance organizations or form their own networks with other physicians and hospitals.

Further this legislation will reauthorize the Rural Health Outreach, Network Development, and Telemedicine Grant Program to focus on the development of coordinated, integrated health care delivery systems in rural areas using advanced technologies.

I believe this bill is the most comprehensive approach to reauthorizing public health centers. This legislation has the support of the public health centers and would allow our public health centers to continue providing top