This is a matter of grave importance—both to the American taxpayers and to their duly elected representatives in this constitutional body. It deserves careful consideration by all members.

As we debate possible increases or decreases in the funding of various programs included in Medicaid, we must be certain the funding is used wisely and as intended.

A recent issue of the Washington Times included an article by nationally syndicated and widely respected columnist Phyllis Schlafly which suggests that we may not always know the final destination of the money we appropriate to Medicaid. I believe it raises a serious question as to the actual usage of taxpayer money—a question worthy of consideration by the members of this body. I represent Barrington, IL which is referenced in the column, and I am concerned about the information Mrs. Schlafly has shared with the public. It is for that reason I thought it important to share this with the members of the House and have included a copy of the article in the RECORD.

[From the Washington Times, Jan. 18, 1997]

SMOKING GUN IN THE MEDICAID MYSTERY

(By Phyllis Schlafly)

Medicaid, the federal program that provides health care to people on welfare, is one of the biggest problems that the 105th Congress will have to tackle if it is serious about balancing the budget in the foreseeable future. Medicaid costs more than $100 billion a year and is rising far more rapidly than inflation, demographics or poverty can justify.

The smoking gun, which proves why this dramatic increase is taking place, has just surfaced in an amazing letter sent by the Illinois State Board of Education to school district superintendents. Signed by the board's ''Medicaid Consultant,'' this letter describes in detail how public schools can exploit Medicaid to funnel a fresh flow of taxpayers' money into public schools that bypasses all traditional funding sources and accountability.

The letter's enthusiasm for spending this new money on virtually anything the bureaucracy desires is matched only by its arrogance in explaining the deviousness of acquiring it. Stating that ''the potential for the dollars is limitless,'' the letter boasts that ''Medicaid dollars have been used for purchases ranging from audiometers to minibuses, from a closed-captioned television for a classroom to an entire computer system, from contracting with substitutes to employment of new special education staff, from expanding existing special education programs to implementing totally new programs.''

Most Americans think Medicaid is just fulfilling its original purpose of providing health care to people on welfare.

They should think again, because this letter reveals how politicians and bureaucrats, after taxing us for ''entitlements'' for needy people, then conspire to increase the cost by loading on any projects their avaricious hearts desire.

This Illinois State Board of Education letter ''encourages'' local public schools to use the experienced State School Board staff in order to ''maximize federal reimbursement'' of Medicaid dollars and use the ''opportunity'' to bill Medicaid for money already spent in 1994, '95 and '96. The letter describes two ways public schools ''have found Medicaid to be a viable funding source.''

The first initiative provides Medicaid funding through school-based health services. Schools may bill Medicaid not just for therapies, but also for ''social work and psychological services, nursing and audiological services, hearing/vision screenings, and transportation.''

The second initiative allows all schools to claim Medicaid dollars for early and periodic screenings, diagnosis and treatment. The letter states that such services include ''public awareness, i.e., government propaganda, identification and referral, i.e., putting private medical information on a government computer, initial health review and evaluation, initial health review and evaluation, i.e., such as the shocking, unauthorized genital exams given without parental consent to 59 sixth-grade girls in East Stroudsburg, Pa., health provider networking with Planned Parenthood?, and family planning referral to abortion clinics without parental consent?''

In fiscal 1996, $31.7 million in federal funds were paid to Illinois schools for the first initiative and $40.8 million for the second.

Medicaid was set up to cover only people on some form of welfare: either Aid to Families with Dependent Children or Supplemental Security Income (a program for seniors). Medicaid is a federal-state matching program, at a ratio of about 60-to-40.

In 1986, Congress inserted into the law permission for the states to expand Medicaid to cover children in families whose incomes were below the poverty line, whether their parents took welfare or not. That expansion slipped by without the taxpayers discovering it, so in 1990 Congress required states to provide Medicaid coverage to all poor children by the year 2002, and allowed states to extend Medicaid even further to the nonpoor.

This is one reason why Medicaid costs are going through the roof. In 1986, Medicaid cost about $27 million. This year, Medicaid will cost about $105 billion. By 2002, when the mandate is in full swing, Medicaid will cost at least $133 billion.

Many people were puzzled when President Clinton bragged during last fall's campaign that ''he'' had provided health care for an additional 1 million children. Medicaid is how he did it.

No way have Hillary Rodham Clinton, Ted Kennedy and Ira Magaziner abandoned their goal of forcing America to adopt federal health care; they are just bringing it in through the schoolhouse door. When health care is provided by and in the public schools, there is no separating welfare kids from the others. They are all eligible.

The Illinois State Board of Education letter, signed by Jean Rowe, Medicaid consultant, was dated Oct. 8, 1996, but was not made public and has just been discovered. The copy that came into my hands was addressed to the Barrington, Illinois District, which is one of the wealthiest districts in the United States and proves that Medicaid is no longer a program for the ''poor,'' but is the vehicle to saddle us with the federal medical system that the American people have rejected.

FAIRNESS IN MEDICAID FUNDING ACT OF 1997

HON. KAREN L. THURMAN

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 25, 1997

Mrs. THURMAN. Mr. Speaker, today, I join in a bipartisan manner with several of my Florida colleagues to introduce the Fairness in Medicaid Funding Act of 1997. For too long Federal Medicaid dollars have been directed away from States with high poverty rates. Instead, States with low poverty rates have been able to use Federal dollars to finance a significant portion of their program, without added costs to their taxpayers. The Medicaid match formula is meant to alleviate this discrepancy; instead, it aggravates it. The formula used to calculate how Medicaid dollars are allocated is currently based upon a State's per capital income rather than the number of people in poverty.

The Congressional Budget Office has produced increasingly optimistic numbers concerning the rate of growth of expenditures in the Medicaid Program, which may stall more comprehensive reform this year. Therefore, we must act to fix the unfair basic formula that drives the current system.

The Fairness in Medicaid Funding Act changes the way we calculate the Federal match to better reflect the true goals of the Medicaid Program. Under this act, the formula will be recalculated to take into account the number of people in poverty in a State as well as a State's ability to finance program services from State revenues using the State's total taxable resources.

According to the General Accounting Office, ''a formula using better indicators of States' financing capacities and poverty rates * * * would more equitably distribute the burden state taxpayers face in financing Medicaid benefits for low-income residents.'' Based upon the GAO's recommendation, my bill makes the system more fair for beneficiaries, States, and taxpayers.

Enact the Fairness in Medicaid Funding Act of 1997 and help Medicaid do the job it was intended to do.

INTRODUCTION OF THE ACCESS TO EMERGENCY MEDICAL SERVICES ACT OF 1997

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 25, 1997

Mr. CARDIN. Mr. Speaker, I rise today with my colleague MARGE ROUKEMA to introduce the Access to Emergency Medical Services Act of 1997. Companion legislation is being introduced in the Senate by Senators BOB GRAHAM, TIM HUTCHISON, and BARBARA MIKULSKI.

The Access to Emergency Medical Services Act of 1997 would enact a national definition of emergency known as the ''prudent layperson'' definition. The bill would ensure that health plans cover emergency care based on a patient's symptoms rather than the final diagnosis. Enactment of this definition would end the phenomena of health plans denying coverage for emergency care when chest pains turned out to be indigestion rather than a heart attack.

As you may recall, we first introduced this legislation in the 104th Congress. We ended 1996 with 154 cosponsors and had portions of the bill favorably reported by the Commerce Committee and the full Senate.

This year, the legislation has been redrafted to amend the Health Insurance Portability and Accountability Act. The goals of the bill are the same. Again, it would establish the ''prudent layperson'' definition of emergency as the standard for coverage under group health plans, health insurers, and the Medicare and Medicaid programs. It would also forbid any requirement for preauthorization for emergency care. A new addition to this legislation

is that it will go into much greater detail about requirements for health plans and emergency physicians to work together to coordinate any necessary followup care to the emergency visit. A summary of the bill appears at the conclusion of this statement.

In developing this legislation, we once again worked closely with the American College of Emergency Physicians and the Maryland chapter of their organization. I would like to thank them for all of their assistance during this drafting process.

This year we have an important new supporter of our legislation: Kaiser Permanente, one of our Nation's oldest, largest, and most respected managed care plans. I want to underscore the significance of Kaiser's support. As far as I know, this is the first time that a managed care plan has worked to develop a Federal standard for managed care practices. Kaiser has taken this bold step because they agree with us—when a person presents at an emergency room with what they believe is a true emergency, it is in the health plan's best interest to cover that visit, not to penalize their member if the condition does not turn out to be a true emergency.

Kaiser would like our bill to preempt States' abilities to further regulate coverage of emergency care—and we will continue to discuss that issue. Kaiser's perspective is that the best policy would be to have one uniform set of standards on emergency for all States. However, the bill introduced today does not preempt further State action. Our bill is consistent with the rest of the Health Insurance Portability and Accountability Act in that it only preempts State law where that law prohibits the application of the Federal law. States are absolutely allowed to go further.

In addition to Kaiser Permanente and the American College of Emergency Physicians, our legislation is endorsed by a broad spectrum of interests. These organizations include: the American Medical Association, Citizen Action, the American Hospital Association, Families USA, the American Heart Association, the Coalition for American Trauma Care, the American Osteopathic Association, the Center for Patient Advocacy, and the American Association of Neurological Surgeons.

This year's Access to Emergency Medical Services Act is a new and improved version of the legislation we introduced in the last Congress and as you can see, we have already gathered broad-ranging support. Again, this bill would enable those in need to be assured access to emergency medical care—without the fear that their health plan will deny them coverage.

Access to emergency care is fundamental to ensuring a viable health care system. What is at stake here is not an issue of governmental regulation, but an issue of protecting patient safety. I urge each of my colleagues to join me in supporting the Access to Emergency Medical Services Act and help us enact this protection into law.

SHORT SUMMARY—ACCESS TO EMERGENCY MEDICAL SERVICES ACT OF 1997

The bill would amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974 and Titles XVIII and XIX of the Social Security Act. If enacted, this bill would guarantee that consumers are covered for legitimate emergency department visits. For health plans that offer coverage for emergency services, including the Medicare and Medicaid programs, the bill would require payment for emergency services consistent with the ''prudent layperson'' standard. Patients would not be required to obtain prior authorization for emergency services. Health plans would be required to cover and pay for emergency care based upon the patient's presenting symptoms, rather than the final diagnosis. The bill also establishes a process in which the emergency department and health plan work together to assure that the patient receives appropriate follow-up care.

Key provisions of the bill:

Establishes a uniform definition of emergency based upon the ''prudent layperson'' standard. Health plans would be required to cover emergency services if the patient presents with symptoms that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect to result in serious impairment to the patient's health. Health plans would not be required to reimburse for services provided to patients that do not meet the ''prudent layperson'' standard.

Plans would be prohibited from requiring, as a condition for coverage, that patients obtain prior authorization from the health plan before seeking emergency care.

Establishes coverage standards for out-of-plan emergency care to protect patients who, under reasonable circumstances, seek care in an out-of-plan emergency department.

Allows health plans to establish reasonable cost-sharing differentials for emergency care when a patient chooses an emergency setting over a non-emergency setting, or an out-of-plan emergency setting over an in-plan emergency setting.

Provides a process for coordination of post-stabilization care. Treating emergency physicians and health plans would be required to make timely communications concerning any medically necessary post-stabilization care identified as a result of a federally required screening examination. Plans, in conjunction with the treating physician, may arrange for an alternative treatment plan that allows the health plan to assume care of the patient after stabilization.

Health plans would be required to educate their members on emergency care coverage and the appropriate use of emergency medical services, including the use of the 911 system.

There would be no preemption of state law as long as the state law does not prevent the application of the federal law.

In general, requirements of the bill would be enforced in the same manner as the requirements of the ''Health Insurance Portability and Accountability Act of 1996.''

Applies to all health plans that offer coverage for emergency care, whether licensed or self-insured, including the Medicare and Medicaid programs. Effective for plan years beginning on or after 18 months after the date of enactment.

TAKING CHARGE OF YOUR TV

HON. NATHAN DEAL

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 25, 1997

Mr. DEAL of Georgia. Mr. Speaker, the television set has become the primary delivery system for information and entertainment into the average home. Some of this information is objectionable when viewed by young children, but many families feel powerless to control this situation.

Having participated in the critical viewing project sponsored by the cable television industry and the PTA, I want to commend these organizations for their efforts. The ''Taking Charge of Your TV'' video which was developed out of the critical viewing project, offers strategies and solutions to parents and families who want to make the TV a more positive instrument for the delivery of information and entertainment.

COMMUNITY RENEWAL

HON. RON PACKARD

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 25, 1997

Mr. PACKARD. Mr. Speaker, President Clinton has stated that ''the era of big government is over.'' The challenge today is to begin a new era of self-government. The foundation for this renewal must rest on strong families, rejuvenated civic associations, active faith-based and private charities to aid those who fall through the cracks. The cultural challenge for policymakers is to mend the social fabric which binds America.

We need to put the family back together, to improve education, to reduce crime and drug abuse, and to protect families from the appalling violence in our neighborhoods and on television. To to this, we need to find new ways to instill a greater sense of personal responsibility in Americans. We must strengthen civic institutions without allowing for the dependency and loss of mission which often comes with a government subsidy. Empowering citizens to assume the primary responsibility for helping the needy through religious, charitable, and civic organizations is the answer.

Mr. Speaker, we need to get back to the basics. We need to emphasize values and personal responsibility over hand-outs in order to instill the principles of diligence, self-help, and equal opportunity, the qualities which make good workers and prosperous Americans. Community involvement is the key. During the 105th Congress, I plan to work with my colleagues to seek out these opportunities to aid our great Nation in ways the Government and Federal funding cannot.

Last Congress, we brought laudable values to Washington and accomplished a great deal: welfare reform, a smaller government, and cuts in wasteful Washington spending. As we embark on a new Congress, I intend to send more money and power back home so that moms and dads can parent again and build strong families; so that parents and teachers can work together to give our kids the best education they can get; and our communities, once again, become vibrant.

TRIBUTE TO WILLIAM P. SHERMAN

HON. DAVID E. BONIOR

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 25, 1997

Mr. BONIOR. Mr. Speaker, I rise today to pay tribute to Mr. William P. Sherman who retired as director of the Huron-Clinton Metropolitan Authority after 8 years of exemplary service. The park authority operates 13 parks in southeastern Michigan.