

Rob was not survived by his immediate family, but he had many friends, in particular, his life-long friend Mary Eva Candon and his confidant Parker Hallberg.

Mr. Speaker, I ask that this House extend its sympathy and condolences to the many friends of Rob Hodgson.

INTRODUCTION OF THE BREAST AND CERVICAL CANCER ACT BY MARY ANN WAYGAN

HON. WILLIAM D. DELAHUNT

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 18, 1999

Mr. DELAHUNT. Mr. Speaker, standing in front of our nation's Capitol today was Mary Ann Waygan, a woman from Cape Cod, Massachusetts, who joined with Senators CHAFEE, MIKULSKI, and SMITH in introducing the Breast and Cervical Cancer Treatment Act. As an original cosponsor of the House version of this legislation, I would like to share with you her eloquent testimony of those affected by this tragic disease.

STATEMENT OF MARY ANN WAYGAN

Hello, my name is Mary Ann Waygan and I am the coordinator for the CDC Breast and Cervical Cancer Initiative for Cape Cod, Massachusetts.

Before I begin, I would like to thank Senators Chafee, Mikulski, Snowe and Moynihan for sponsoring this legislation. I would also like to thank Senator Smith for his support of this bill.

Clearly, the single largest problem facing the Breast and Cervical Cancer Screening Program today is finding resources and caregivers to provide treatment to the women who are diagnosed with breast or cervical cancer. The lack of treatment dollars is one of the biggest policy gaps in the program—and the problem is only getting worse.

The barriers to recruiting providers for charity care are growing, and funding for the treatment is an ad-hoc system that relies on volunteers, state workers and others to find treatment services. In the community, we go to tremendous ends to find treatment—and raise money to help pay for it. I've organized luncheons, bake sales, raffles—you name it. Anything to raise money for women who could not afford to pay out of pocket for treatment. Despite these efforts, all too often, we come up short.

Funding for treatment through the CDC program is the biggest problem I face as a coordinator and frankly a barrier to screening and detection. Funding for treatment is tenuous at best. Without passage of the Breast and Cervical Cancer Treatment Act, future funding for treatment for these women will remain uncertain.

I want to tell you one story in particular that clearly illustrates the problem some of these women face. A woman who lives in Buzzard's Bay, Massachusetts who was diagnosed with breast cancer through the CDC program.

Arlene McMann is a married woman in her early forties with two teenage sons and no health insurance.

When Arlene was diagnosed with breast cancer through the CDC screening program, she was devastated—not just with the diagnosis, but with the fact that she had no way to pay for the treatment she needed.

Faced with that situation, she and her husband were forced to use the \$20,000 they had been saving for years to pay for their chil-

dren's college tuition. In less than a year, that money was gone. After that, she and her husband were forced to go into debt to pay for her ongoing chemotherapy/radiation treatment and other procedures including a craniotomy and gall bladder surgery. They are now more than \$40,000 in debt, were forced to move into a much smaller house and lost their dream of sending their sons to college without going into further debt.

The additional stress and pressure placed on Arlene and her husband by this situation has turned a difficult situation into an almost unbearable one. To make it even worse, Arlene recently found out that the cancer has spread to her hip, pelvis, lungs and liver.

Through all of this, Arlene has showed tremendous resolve. Despite being in pain and discomfort and forced to use a wheelchair, Arlene desperately wanted to be here today to share her story with you directly. She thought it was important for everyone to understand not just what the cancer had done to her, but what the effect of having to take on this incredible financial burden had done to her physical health, mental strength and family resources.

Due to her condition, Arlene's treatment finally is being paid because she qualified for disability. But to this day, Arlene is convinced that her cancer would not have spread had she been able to afford regular visits to an oncologist.

Arlene's energy and determination to fight this disease and remain positive are amazing. I feel lucky to know her and to have worked with her. I only wish that as the program coordinator, I could have done more—that I could have assured her that any treatment she needed would be paid for and that she wouldn't have to spend time dealing with bank statements, mortgages or packing boxes on top of everything else.

In summary, we hear over and over again that early detection saves lives. In actuality, early detection alone does nothing but find the disease; detection must be coupled with guaranteed, quality treatment to actually save lives.

We must pass the Breast and Cervical Cancer Treatment Act to make sure that screening and treatment always go together.

I would like to thank the National Breast Cancer Coalition for its leadership role in working to get this legislation passed and thank the members of Congress here today for sponsoring and supporting this legislation.

CENTRAL NEW JERSEY CONGRATULATES BRUCE SPRINGSTEEN ON HIS INDUCTION INTO THE ROCK AND ROLL HALL OF FAME

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 18, 1999

Mr. HOLT. Mr. Speaker, I rise today to direct the attention of my colleagues to the induction of central New Jersey's Bruce Springsteen into the Rock and Roll Hall of Fame last Monday.

From central New Jersey to central Europe, you need only mention the name "Bruce," to gain immediate recognition of this man's work. From classics like "Promised Land," "Backstreets," "Tenth Avenue Freeze-Out," and "Thunder Road," Bruce Springsteen's songs hold special memories for all of us. He is a storyteller whose songs are about loyalty,

friendship, and remembering the past. Most of all, his songs are about—and are part of—the real lives of Americans.

In 1973, Bruce released his famous "Greetings From Asbury Park, N.J." album. It was followed by "The Wild, the Innocent and the E Street Shuffle." In 1975 Bruce followed up with "Born to Run" which is widely acclaimed as one of the finest rock and roll albums ever made.

In the late 1970's and early 1980's Bruce and his band continued with a string of modern rock classics—"Darkness on the Edge of Town," "The River," and the multi-platinum album "Born in the USA." In the past few years, Springsteen recorded his most successful solo song ever, "Streets of Philadelphia," earning himself more Grammy Awards and an Academy Award.

Springsteen's most recent record, "The Ghost of Tom Joad" won a Grammy Award for best contemporary folk album, and builds on the work that Bruce began in the 1980's with his critically-acclaimed album "Nebraska," in calling attention to, and building on, America's rich folk music heritage.

Despite his incredible success and worldwide fame, Bruce Springsteen has always stayed true to his central New Jersey roots and to the interest of music fans everywhere. Indeed, in an era of high ticket prices and prima donna stars, Bruce Springsteen has always dedicated himself to providing his fans with affordable, consistent entertainment. He has been dedicated to seeing that his music makes its way into the lives of people. That dedication has rightfully earned him the nickname, "The Boss."

Mr. Speaker, Bruce Springsteen has given a lot to New Jersey, to the lives of music lovers everywhere and to our nation's rich popular culture. We in central New Jersey are rightfully proud to call him a native son and take tremendous pride in his induction into the Rock and Roll Hall of Fame. I am proud to say that Bruce Springsteen is a constituent of mine.

I hope that my colleagues in the House will join me and other central New Jerseyans in extending our congratulations to Bruce Springsteen for this well-deserved honor.

INTRODUCTION OF THE WORK INCENTIVES IMPROVEMENT ACT OF 1999

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 18, 1999

Mr. STARK. Mr. Speaker, I am honored to co-sponsor the Work Incentives Improvement Act of 1999. This bill would remove the barriers to health insurance and employment inherent in the current disability insurance (DI) system, and enable many Americans to return to work. Disabled people have much to offer. It is time that we recognize and encourage them to participate as contributing members of society.

I am especially pleased to support the Medicare and Medicaid provisions of this bill. Without these programs, many people living with disabilities would not have access to the care that is so vital to their health and well-being. Because private health insurance is not affordable or available to them, even after returning

to work, we must keep Medicare and Medicaid available to the working disabled.

There is one segment to the disabled population that I urge my colleagues to give special consideration: End Stage Renal Disease patients.

As you know, there are about 260,000 Americans on dialysis and another 80,000 who are dependent on a kidney transplant (with about 11,500 kidney transplants performed annually). About 120,000 dialysis patients are of working age (between 20 and 64), yet fewer than 28,000 are working.

The "USRDS Abstract of Medical Evidence Reports, June 1, 1996 to June 1, 1997," reveals that 38.1% of all dialysis patients 18–60 years of age were employed full time, part time, or were students before onset of ESRD.

But only 22.9% of ESRD patients in the same age group were employed full time, part time, or were students after the start of dialysis. This 15% (38.1% minus 22.9%) differential is the prime hope for return to work efforts.

Of the transplant patients, most (88%) are of working age, but only about half of them are working.

Section 102 of your bill provides Medicare coverage for working individuals with disabilities—but ESRD dialysis patients already have this protection. For transplant patients, Medicare does not cover their major health need—coverage of \$8,000–\$10,000 per year for immunosuppressive drugs—after 36 months.

Clearly, we should tailor some special provisions to this population.

I would like to suggest a series of ESRD return-to-work amendments that would save total government revenues in the long run. While these proposals may increase Medicare spending, they would reduce Social Security disability and Medicaid spending.

There are just preliminary ideas, and I hope that you and the renal community could refine these ideas prior to mark-up.

(1) A huge percentage of ESRD patients qualify for Medicaid. The disease is so expensive (\$40,000–\$60,000 per patient per year) and the out-of-pocket costs so high that it impoverishes many. For transplant patients, the cost of life-saving immuno-suppressive drugs alone can be \$8,000, \$10,000 or more per year. No wonder many are tempted to avoid actions which would disqualify them for help.

As part of general Medicare policy, I have always thought that we should cover pharmaceuticals and, in particular, indefinitely cover immuno-suppressive. It is maddening to hear the stories of \$80,000–\$100,000 kidney transplants lost, because a patient couldn't afford the \$10,000 per year of medicine.

I think a good case can be made to add to this bill coverage of immuno-suppressives indefinitely, to encourage people to leave Medicaid/Disability and return to work.

(2) Some ESRD facilities do a good social work job helping patients return to work. Others don't seem to even try. We should honor and reward those centers which, on a risk adjusted basis, are doing the best job of rehab in their renal network area.

The honor could be as simple as a Secretarial award of excellence and public recognition.

The reward could be something more tangible—a cash payment to the facility to each

patients of working age who does not have severe co-morbidities which the center is able to help return to work (above a baseline—perhaps 5% of eligible patients). For example, if a center had 100 working age patients, it could receive a \$1000 payment for each patient above 5 who had lost employment and is helped to return to work. This would be a phenomenally successful investment and would particularly compensate the dialysis center for the cost of vocational rehab and social work.

(3) Renal dialysis networks, which are designed to help ensure ESRD center quality, should be able to apply for designation as rehab agencies and for demonstration grants under this legislation.

The law spelling out the duties of Networks has a heavy emphasis on rehabilitation. Indeed, it is the first duty listed:

"... encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs;"¹

I suspect that the 17 Networks vary widely in their emphasis on rehabilitation. Again, the Network(s) that do the best should receive recognition and share their success with the others.

(4) Kidney failure remains a medical mystery. It often happens very quickly, with no warning. But for thousands of others, there is a gradual decline of kidney function. I am told by medical experts that in many cases the descent to terminal or end-stage renal disease can be slowed by (1) nutrition counseling, or (2) medical treatment by nephrology specialists.

I hope that you will make it clear that the Medicaid (or Medicare) funds provided in this program to prevent disability could be used to delay the on-set of the devastatingly disruptive and expensive ESRD. Monies spent in this area would return savings many times over.

Also in the "preventive area," some of the leaders in the renal community are reporting exciting results from more frequent, almost nightly dialysis. Like frequent testing by diabetics for blood sugar levels, it may be that more frequent dialysis can result in a less disrupted life and better chance to contribute to the workforce. We should watch these medical developments and if there is a chance that some additional spending on more frequent, but less disruptive dialysis would encourage return to work, we should be supportive.

(5) Finally, I urge you to coordinate this bill with another proposal of the Administrative—skilled nursing facility employment of aides to help with feeding. As you know, last summer we received a GAO report on the horror of malnutrition and death by starvation in some nursing homes, due to a lack of staffing to take the time to help patients who have trouble eating and swallowing and who take a long, long time to eat (e.g., many stroke patients). A coordinated effort by the nursing home industry and ESRD centers to fill this minimum wage type position would help nursing home patients while starting many long-out-of-work ESRD patients back on the road to work.

Mr. Speaker, these are just a few, quick ideas. I am sure that experts in this field could suggest other steps to ensure that the ESRD program not only saves lives, but helps people have a good and productive life.

A TRIBUTE TO MARY MAHONEY'S OLD FRENCH HOUSE RESTAURANT

HON. GENE TAYLOR

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 18, 1999

Mr. TAYLOR of Mississippi. Mr. Speaker, I rise today to share with my colleagues news of two rather unique accolades for the celebrated Mary Mahoney's Old French House Restaurant in Biloxi, Mississippi.

Since opening its doors on May 7, 1964 in the refurbished Louis Frasier house that dates from 1737, this venerable establishment has been a Gulf Coast culinary landmark serving friends and travelers from near and far. The late Mary Mahoney and her dedicated family built their business on the tenets of excellent cuisine and service as well as an historically authentic Old South atmosphere, which over time has earned them international acclaim.

Among the numerous celebrities whose names grace their guest book are Sam Donaldson, Alexander Haig, Robert Redford, Denzel Washington, Randy Travis, and Dick Clark. During the Reagan Administration, Mary Mahoney catered a ceremony on the White House lawn for President and Mrs. Reagan and their guests.

All were impressed, but none left a more impressive gratuity than author John Grisham. In his recent bestseller, *The Runaway Jury*, Mr. Grisham compliments the restaurant by name and offers the reader a glimpse inside by having the judge in his novel host a fictional lunch for the jurors and court officers at "Mary Mahoney's". Through Mr. Grisham's narrative the reader gets to share in the "crab cakes and grilled snapper, fresh oysters and Mahoney's famous gumbo. * * *" He goes on to write, "By the time the jury was seated for the afternoon session, everyone present had heard the story of their splendid lunch."

Now a newly released book celebrates the restaurant's vivacious founder and guiding spirit. It is entitled, *A Passion for People: The Story of Mary Mahoney and Her Old French House Restaurant*. Written by Mississippi journalist and family friend Edward J. Lepoma, himself a regular in Mary's inner circle of guests, this photo-filled, loving memoir tells of the trials and ultimate triumph of a second generation American with a dream. The dream was that of creating a world class restaurant in Biloxi, Mississippi, where the dining experience would be matched by the warm ambience that told all who visited, "Tonight, you are among friends."

With its quaint art-filled dining rooms, superior wine list, and captivating Southern charm and hospitality, Mary Mahoney's Old French House Restaurant provides a memorable evening for first-time and long-time guests, an excellent backdrop for the novelist, and is a source of civic pride for the citizens of Biloxi and the entire Mississippi Gulf Coast region.

¹ Sec. 1881(c)(2)(A); see also (B) and (H).