

WISHING DR. DAVID STRAND OF ILLINOIS STATE UNIVERSITY A HAPPY RETIREMENT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. EWING) is recognized for 5 minutes.

Mr. EWING. Mr. Speaker, I rise today in honor of a very good friend of mine, Dr. David Strand, to recognize his pending retirement as president of Illinois State University in Bloomington, Illinois. I would be remiss not to come here today to honor Dr. Strand, for throughout his long and distinguished tenure, spanning from 1978 until 1999 at the university at Normal, Illinois, Illinois State University, Dr. Strand has helped shape the lives of thousands of young men and women. Over the years graduates of Illinois State University have traveled far beyond the borders of Illinois and have spread out around the country to become some of the best and the brightest in their respective fields.

As doctors, lawyers, educators, business professionals and civic leaders, these men and women have gone on to help shape the United States into the prosperous, peaceful and strong Nation we are today. Dr. David Strand through his years of service helped make this happen, and for this we, as a Nation, owe him a debt of gratitude.

Mr. Speaker, too often we fail to realize the importance of talented educators like Dr. Strand. Not only has Dr. Strand maintained the integrity and high academic standards for the university, but as a classroom professor, a professor of education, David has mentored countless young teachers, those men and women who will in kind touch thousands of other young lives. Those teachers and their students will secure the future of our Nation far into the next century, this in part due to the efforts of Dr. Strand.

As a community leader, David has made a permanent mark on his community and our State. He has worked with the public libraries, the community concert association and the Boy Scouts, just to name a few. He has been honored on many occasions by numerous organizations for his many community and professional accomplishments.

Mr. Speaker, I am pleased to rise and recognize David Strand for the contributions he has made to Illinois State University and the Bloomington/Normal community. David Strand is indeed an administrator, an educator and citizen that we, as a Nation, can and should with one voice say "Thank you."

Mr. Speaker, I enter this statement into the CONGRESSIONAL RECORD so this and future generations of Americans can be aware of the numerous contributions of a man I am honored to call a friend, Dr. David Strand of Bloomington, Illinois, and I wish Dr. Strand a happy, healthy and enjoyable retirement.

Mr. Speaker, I rise today in honor of my good friend, Dr. David Strand, to recognize his

pending retirement as President of Illinois State University in Bloomington, Illinois.

I would be remiss not to stand here today honoring Dr. Strand, for throughout his long and distinguished tenure spanning from 1978 until 1999 with Illinois State University, Dr. Strand has helped shape the lives of thousands of young men and women.

Over the years, graduates of Illinois State University, have traveled far beyond the borders of Illinois, and have spread out around the country to become some of the best and brightest in their respective fields.

As doctors, lawyers, educators, business professionals and civic leaders, these men and women have gone on to help shape the United States into the prosperous, peaceful and strong nation we are today. Dr. David Strand, through his years of service, helped make this happen, and for this, we, as a nation, owe him a debt of gratitude.

Mr. Speaker, too often, we fail to realize the importance of talented educators like David Strand. Not only has Dr. Strand maintained the integrity and high academic standards for the University, but in the classroom, as a Professor of Education, David has mentored countless young teachers—those men and women who will, in kind, touch thousands more young lives. Those teachers, and their students, will secure the future of our nation far into the next century. This is, in part, due to the efforts of Dr. Strand.

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Mr. Speaker, I requested that this statement be entered into the CONGRESSIONAL RECORD so that this, and future generations Americans can be aware of the numerous contributions of a man I am honored to call "friend"—Dr. David Strand of Bloomington, Illinois.

I wish Dr. Strand a happy, healthy and enjoyable retirement.

MEDICARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from Washington (Mr. McDERMOTT) is recognized for 60 minutes as the designee of the minority leader.

Mr. McDERMOTT. Mr. Speaker, I welcome this opportunity to talk today about Medicare.

This is a program that we hear lots about in the news and in political campaigns, and people talk about it as though they all understood what they were talking about. I would like to talk a little bit about the program today and then talk about what all the excitement is about, what people are talking about, why they are talking.

The first thing that needs to be said about Medicare is that it is a success.

People will talk about it: It is about to fail, it is going to collapse, it is the end of the world. But if you were active politically before 1965, the situation was very much different for senior citizens in this country.

I put this graph up because I think it is important to remember what it was like before Medicare. In 1965, 54 percent of senior citizens did not have health insurance. Less than half the people in this country had health insurance when they got to be 65. Today, in 1999, 99 percent of senior citizens are covered.

Now what that has done for not only the senior citizens, but their children and their grandchildren, has been enormous because it has had an impact on them both from a financial standpoint, but also from the standpoint of the security of knowing that, as a senior citizen, you have health care benefits, and you do not have to go to your kids and have your kids take care of you, and for that reason it has been an enormous success.

There are 39 million elderly and disabled people in this country who are on the Medicare program. We spent about \$207 billion in 1997, and that is the last year we have good solid figures for; that is about 11 cents out of every Federal dollar goes for taking care of senior citizens in this country, and it amounts to about \$1 and 5 of every dollar spent on health care in this whole country.

Now let me put up the second one here. Part of the reason why we have so much discussion about Medicare is it is such a big program. If we look at the Federal budget, and we can do a short budget course here, the biggest element of our budget is Social Security which takes 22 cents out of every dollar. Defense takes 15 cents out of every dollar, and then we come to the interest on the debt which is 11 cents on every dollar, and Medicare, 11 cents out of every dollar. So, Mr. Speaker, it is the third largest or fourth largest expenditure in the Federal budget. We spend 6 percent on a program called Medicaid, which is a State program for poor people's health, and all the rest of government is 35 percent.

So Medicare is an enormous program that is used by, as I say, 39 million people, both the elderly and the disabled.

□ 1715

You hear or read in the newspaper that Medicare is going to go broke, and you say to yourself, well, how could a program that is that valuable to so many people, spends that amount of money, how could it possibly go broke? What is it about this program?

I want to explain it, because it is easy when you are watching television and listening to people or reading the newspaper to not really understand what Medicare is. Medicare is actually two programs. The first program is Part A.

Now, in 1965, the problem was that they looked out and they said, "Senior

citizens don't have any hospitalization, so we ought to put together a program for hospitalization for seniors." So Part A covers inpatient hospitalization, it covers skilled nursing facilities and it covers hospice care; and beneficiaries, senior citizens, pay a deductible and then they pay a certain amount of cost-sharing. They pay 20 percent of the bill when it comes, when they are in the hospital.

Now, when they were passing this bill through the House, it started out just as Part A. As it went along, Members of the House said, "This is dumb. Why are we passing a bill that will pay for senior citizens to go into the hospital, but do absolutely nothing for their doctor bills?"

So somebody said, well, "Let's add Part B." Part B includes the physician's cost, that is the doctor's payment, the laboratory costs, x-rays, outpatient services, mental health services, and Part B is paid for from the beneficiaries. Senior citizens pay a premium. Every senior pays \$45.50 a month as part of their cost, and then they also pay the cost-sharing of various parts, 20 percent or whatever.

Now, here comes what the real problem is: How do we pay for that? Well, of course, the beneficiaries are paying something, but most of what is paid in by people, in Part A, 89 percent of the money comes from payroll taxes. That means everybody who is working is putting money into Part A. It is called a trust fund.

Over the years with that trust fund, we increased the amount. Everybody who is working pays 1.45 percent of your earnings into the trust fund, and the employer pays 1.45 percent of your salary into the trust fund. Those are the payroll taxes that are on your stub. So senior citizens' health care is being paid for by the workers today.

It used to be there were four or five workers for every senior citizen. In the future it is going to get down to the point where there are about two people working for every senior citizen drawing benefits out of this program. So when people say that the Medicare is going broke, they are saying that there are not going to be enough workers paying payroll taxes to pay for the benefits for hospitalization. It is only that part, Part A of Medicare, that is going broke or is not going to have enough money.

Now, on the other side, on Part B, on this side you remember I said everybody pays a \$45.50 premium, so about 22 percent of Part B is paid by the premiums, by senior citizens themselves. They pay for it. Then 76 percent of it comes out of the Treasury of the United States.

Now, nobody can tell me that the Treasury of the United States, the richest country on the face of the Earth, is going to go broke. So when people talk about Medicare going broke, they are talking only about this part and not about Part B, because this part is not. There is no way we are not

going to pay for the health care of our seniors in this country.

Looking at the last slide again, one of the ways in which we have dealt with this problem in the past has been to make adjustments in the Medicare program. We have made adjustments every year since 1965.

Every year a group of people called the trustees sit down and say, "What is the status of the trust fund, Part A?" They will say, "Well, it is going to go broke in 2 years," or, "It is going to go broke in 16 years," or, "It is going to go broke in 5 years." The Congress then meets every year and makes changes.

In 1987 we made a lot of changes. We said one of the things we are going to do to take the pressure off of Part A is move home health care from the payroll tax part over on to the general fund of the United States Government, the General Treasury. We have done that many times in the past.

Medicare does some other things which do not show on this chart because they are not related to senior citizens directly. Since this is the major medical program of the Federal Government, anytime we want to do something for senior citizens in this country, or for health care generally, we had a tendency in the past, before I got here in 1988 at least, to stick the program in here.

For instance, the financing of medical schools, it is called Graduate Medical Education, GME. We put that into Medicare, and everybody who goes into a hospital has a certain amount of their payment which is for the Graduate Medical Education. It pays for the interns, the residents, all the medical staff in the hospital.

We have also a program in there for all the hospitals that take care of people who do not have any health insurance. If someone in this country is sick, they pick them up, they take them to the hospital. The hospital cannot say, "No, we are not going to take care of you, take them out and leave them in the parking lot." They have a responsibility to take care of them, so they take care of them. Then where do they get the money to pay for that? Well, the money to pay for that comes out of something called DISH payments. It is the disproportionate share of people who do not have insurance. So we put that program in.

We have loaded up Part A with all these kinds of programs to make sure that we took care of what was a major medical need for the entire country. In this country, for instance, if you have your kidneys fail and you need to have dialysis or a kidney transplant, you are put right into this program. Everybody in this country who has kidney problems or kidney failure ultimately winds up in Medicare.

We have about 100,000 people who are covered by this program. If the program did not exist, they would have died. When I came out of medical school in 1963, if your kidneys failed,

that was about it for you. Then they developed the dialysis machine and then kidney transplants, and, as those things developed over the course of time, they were added to the Medicare program. So it has been a program that has been adjusted every year for years and years and years, and has functioned very well.

It is not a generous program. It certainly is not a program that does not have a problem here and there, but it has raised the life expectancy of our senior citizens. It has taken away their fear about their ability to pay for their health care. It has taken the pressure off their children.

Their children, people my age, my mother is 89 and she is on this program. My father, 93, just died a few months ago. People like me, when I had to choose, shall I take care of my mother and father or put my kids through college, I did not have to make that choice, because Medicare took care of my mother and father, and I could pay attention to my kids. Medicare has simply wiped out the responsibility for most of us to take care of our parents or our grandparents, because Medicare has been so successful over the course of the years.

Now, the question comes, if there is a problem in Medicare, what should we do? Should we try and modernize the present system and continue to guarantee seniors what every senior citizen in this country has; that is, a list of benefits; or should we make a fundamental restructuring, throw away the old system or ease it out the door, so-to-speak, and bring in a new one, either for universal coverage or to a defined contribution?

These are two terms that anybody who is going to discuss Medicare really ought to understand. A defined benefit says that everybody who has the program, every senior citizen, whether they live in South Carolina or Texas or Washington State or New York, everybody gets the same benefits. It does not make any difference where you are.

This is an American plan. It says we are going to be fair to everybody; no matter who you are, where you live, what you look like, how much money you have, whatever, you are going to get the same plan. That is why Medicare has been so successful and has so much popular support for it, because people understand it is a fair program that covers everyone.

Now, if you are going to make a restructuring and you are going to in any way take away that defined benefit and replace it with simply a defined contribution, that is, then instead of guaranteeing people that they are going to get all the things that they presently get, you say to them, here is a voucher, here is X number of dollars, you take that money and go out and buy yourself a plan.

Now, I sat on the Medicare Commission for the last year, and what we talked about for that year was something called a premium support plan. I

want to talk a little bit about that, but I see my good friend the gentleman from Texas (Mr. GREEN) is here, and the gentleman has some ideas. Tell me what you are thinking about.

Mr. GREEN of Texas. Mr. Speaker, I appreciate the chance to speak this evening. I thank the gentleman for not only his service on that Medicare Commission, but also for tonight, for this special order and some of the information you are imparting. I hope there are a lot of people out there listening, and those of us still in our offices will know, because what you are talking about with the difference in the defined benefit plan versus defined contribution was really one of the cutting edges on which you were talking about as a member of the Medicare Commission.

I know you talked about it earlier, but protecting Medicare should be on the top of not just the Democratic agenda, but all our agendas. Ninety-nine percent of our seniors are relying on this program for some type of medical assistance. You talked about some success we had. Over 39 million elderly and disabled Americans, 35 million elderly and 5 million disabled, receive Medicare. Before Medicare, almost half of the elderly were uninsured.

That was the fault of the market. No one could afford what the private sector wanted to charge a senior citizen for insurance. People could not afford it. That is why Medicare was created, and that is why it is so important that we talk about the policy debate like you are mentioning and we talk about how important the Medicare program is, because, to me, it ranks right up there with defense of the country, the Social Security system, education of our children and Medicare for our senior citizens.

It has been so successful. The life expectancy of people over 65 has increased over 20 percent, from 79 to 82 years in such a short time. Access to care has increased by one-third. Seniors are seeing doctors almost 30 percent more than they did before Medicare. Poverty has declined, because, again, we have a program that they do not have to spend themselves poor to have health care. There are seniors who have very little income who cannot afford the high cost of medical assistance, if it was not for Medicare.

The program is critical for those who face disability, as I mentioned. The gentleman talked about the dialysis, the kidney failure, the success we are having now under Medicare if you have kidney failure. At one time you were just sent home to die. Now you can actually live with dialysis that is available through Medicare.

We search for ways to protect the future of the program. It is estimated that approximately 35 percent of Medicare beneficiaries have no prescription drug benefit. I know a lot of people in my district have joined Medicare HMOs simply because that is what they needed. They needed some type of prescription drug benefit, so they joined HMOs.

The problem is we now see a lot of the health maintenance organizations, HMOs, withdrawing from the market because they got in and thought they would make more money. I thought they were making plenty.

□ 1730

But they thought they would make more money, so they are drawing from certain portions of the market, rural areas; not necessarily from Houston where I am from, but I know it is happening in other parts of Texas.

We did a study in the district I represent on prescription medication and the almost double and sometimes triple the cost of prescriptions for senior citizens. I know when the gentleman was on the commission, that was one of the things that the commission members agonized over and said well, if we are going to reform Medicare, let us see if we can expand fee-for-service Medicare, where one does not make a decision to go to managed care just because someone needs the help, to have a copay on prescription drugs. That is pending legislation, and I hope Congress will consider it when we are dealing with Medicare.

I use an example, and I have said this thousands of times in my own district. My dad is 83 years old. I did not know his father. His father died before I was born. That was during World War II. My dad, though, his success is because he has had adequate health care since he has retired, since he has been 65, and so we are seeing that longevity individually and as a group, as I mentioned.

So that is what the benefits of Medicare are, and that is why it is so important. That is why I wanted to see the commission successful. But I did not want to see it successful with what I would see would take away Medicare from the guarantee that we have. It does not pay for everything; the gentleman and I know that. Prescription drugs is a great example; glasses. It does not pay for everything. I saw a bill that my mother-in-law receives from a physician and there are things that Medicare does not pay for. She has to pay for that. We understand, though, that it pays for so much and it pays for so much security for seniors to go to the doctor.

That is why I am proud to be with the gentleman tonight, and the gentleman's explanation of the defined benefit versus defined contribution. That is where the rubber meets the road, because in a district like I represent that is predominantly blue collar, they do not have that kind of income. Of course, I do not see how many people could afford, if we disregarded or eliminated Medicare right now, they could not go to the market and buy insurance. An actuary would say, if I am 67 years old, how much do you think they would want per month from me, \$3,000 a month? How many people can afford that? The free market system is not available for Medicare recipients, for senior citizens, because it just cannot

work. I think some people on the other side maybe have forgotten that, that the reason that we have Medicare is because one cannot use the free market system.

If I was in the insurance business, I would not want to sell to a senior citizen. They are going to have a lot of claims; they are elderly. We cannot make that kind of money unless we have a Medicare-type program. So again, I thank the gentleman for his service on this commission, but also for this evening and this afternoon for requesting this time to talk about it.

Mr. McDERMOTT. Mr. Speaker, one of the interesting things the gentleman is talking about is how much money senior citizens pay out-of-pocket. The average senior citizen spends \$2,500 out-of-pocket.

Now, if we think about that, \$2,500, that is a lot of money, but for those of us who are working it may not seem like very much. But if we think about it, almost half the seniors in this country have incomes less than \$15,000, and there are almost 10 million widows in this country who live on less than \$8,000 a year. So if someone is a widow and their husband had a job, and they were living on Social Security and the husband died and they get the residual benefit, that person is therefore making about \$8,000; if that person has to take \$2,500 out-of-pocket today, that leaves that person with \$5,500 to live on.

Now, if we think it about, how in the world, I do not know what it is like in the gentleman's city, but I will tell my colleagues in my city \$5,500 does not go very far when one has to get a house to live in and some food and pay for lights and telephone and maybe some clothes. So we are talking about a very hard life for these people if we say we are going to have to get more money out of them, which is what really this premium support program does.

Mr. Speaker, two-thirds of the savings from the Breaux-Thomas proposal was additional money taken from the beneficiaries. We are talking about half the senior citizens living on less than \$15,000 a year.

So that is why it is very important to talk about who senior citizens really are, as though somehow we get the idea that they have this free ride on health care and they are just rolling in dough somewhere, that is not true. The facts simply are not there, particularly when Medicare does not cover prescription drugs. Anybody who looks at our program, or the program of most employers covers prescription drugs, but Medicare does not. That is why the President said, that is one of the benefits that ought to be added. If we are going to modernize the current system the way we do it, at least we have to put in prescription drugs.

So I appreciate the gentleman coming down.

I see another one of my colleagues, the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I just wanted to thank the gentleman again for all that he has done to try to shore up and, as the gentleman says, make the case as to why we have to modernize Medicare. I know that the gentleman served for a few years on this Medicare commission. I want to commend the gentleman because the gentleman refused to accept this Breaux-Thomas proposal. I know we are hearing that it has been introduced in the House and there is an effort to try to push it here in the House of Representatives, but I am glad that the gentleman and enough of the other members of the commission voted against that, because otherwise it would have had the sort of stamp of approval, if you will, of the Medicare Commission, and it did not because it is not a good idea.

I totally agree with what the gentleman said about modernizing the current system. When I talk to seniors and to people who have been involved in Medicare over the years, they explain to me, and the gentleman might want to comment on this as well, that when Medicare started out, prescription drugs and some of the other things that are not covered really were not that important. In other words, there were not as many drugs available, people did not rely on drugs so much; they were not so much a part of sort of the preventive nature that they are today. It did not exist maybe 30-some years ago or when Medicare first started in the 1960s. The reason we need to modernize is because there were a lot of things that were not covered when the program started, like prescription drugs, that now have taken on vast importance. Therefore, we need to look at the system again to try to come up and see what is not covered.

One of the things that I hear from my senior citizen constituents so often is that most of them, or at least most of the ones that contact me, do buy some kind of Medigap coverage because of the gaps in the coverage in the current system. But the Medigap policies and the premiums for those are also going up significantly.

I saw some information about the increased premium costs for Medigap in the New York-New Jersey metropolitan area. They were much higher than inflation, significantly; sometimes 13, 14 percent increases on an annual base. So we do need to modernize. But what the gentleman is pointing out and what I think is most important is let us modernize in a way that expands the benefit package, add prescription drugs, try to be conscious of the costs that so many seniors are incurring out-of-pocket.

I just want to say that some of the things that some of our colleagues on the other side have put forth, and I am not saying they are all that way, but some of the things that I have heard about increasing the age limit before one is eligible for Medicare, or means testing. Mr. Speaker, means testing

may sound good to some people saying well, if one has a little bit more money, maybe one can pay more. I see Medicare as sort of like a contract, sort of like Social Security. People knew that they were going to get Medicare by paying into the system over the years, and it does not seem fair to me now to say at this stage well, okay, if you are above a certain income you have to pay more, maybe to the point where you do not get Medicare coverage at all and you have to pay completely out-of-pocket.

The other thing I wanted to say, and I am so glad that my colleague from Washington got into this, and that is that this Breaux-Thomas proposal, when we listen to some of the advocates for it, they make it sound so rosy, like it is such a great thing; it is going to save money for the Federal Government. One is still going to get the same benefits, the costs out-of-pocket are not going to go up. It is a lot of baloney.

The way I have looked at this thing, and I know we have talked about it before, the gentleman and I and others on our side of the aisle, just the opposite is true. The way I understand it, there will not be a defined benefit package, so it will not be clear at any given point that certain types of things would be covered, including prescription drugs. In addition, if one is in a fee-for-service plan, which most people like, where they basically can go to any doctor they want or they can go to whatever hospital they want or whatever emergency room, and the doctors just get paid out of Medicare, well, what they are going to do with this Breaux-Thomas proposal is say that if one is in a fee-for-service program, one is going to get a voucher and the Federal Government is only going to pay a certain amount. If the fee-for-service program, the premium for that program is above whatever the amount is that is established by whoever is in charge of this program in Washington, if one's fee-for-service plan is more than that, one is going to have to pay that difference out-of-pocket, so costs are going to go up for anybody who is in a fee-for-service program. What that means is unless one is a little wealthier, one is going to have to be pushed into managed care because one will not be able to pay and afford the traditional fee-for-service program; one is going to have to opt for a managed care plan.

A lot of people around the country, if they are in rural areas or in certain parts of the country, they do not have managed care plans, number one. In addition to that, many of my constituents are not happy with their HMO or managed care. Many of the HMOs in New Jersey have actually dropped out of Medicare and dropped the coverage, and seniors have been left where they have to look around and try to find some other coverage because the HMOs have gone bankrupt.

So pushing everybody into managed care may sound like a good idea to save

money for the Federal Government, but it is not a good idea for senior citizens.

Mr. McDERMOTT. Mr. Speaker, the gentleman from New Jersey raises an interesting question. The Breaux-Thomas plan, when they figured out the finances of it in the Medicare Commission, only extended the life of the plan 2 years. The President, when he said we should put 15 percent of the surplus into the Medicare program, extended the life of the plan by 10 years. So the savings from this so-called defined contribution program, premium support, are really quite small, and the disruption is I think what people really do not understand.

Mr. PALLONE. Mr. Speaker, the gentleman makes a very good point, and that is, again I use the term baloney, because the advocates of this Breaux-Thomas plan are saying to us that it is going to save the Federal Government money, and I do not even believe it is going to do that, ultimately. I think the gentleman makes a very good point.

I am very supportive of the idea of using the surplus, 15 percent I guess is what the President has proposed, to shore up the Medicare program. I know that that is one thing that the Republican leadership has absolutely refused to accept, that they would use that 15 percent of the surplus.

Mr. McDERMOTT. Mr. Speaker, they never even gave us the figures on the Medicare Commission. We said, let us figure what impact would this have on the program, if we adopted the President's proposal of taking 15 percent of the surplus over the next few years and putting it into Medicare, and they would never have the staff even figure it out, because they were determined to move away from the present system and go to this premium support system where they just simply handed vouchers to everybody and then they have to make up the difference.

If we think about old people and we say well, if they have a voucher and they cannot buy what they need because of where they live is a high-cost area, where do they get the extra money? If they cannot take it out of their own pocket, they turn to their children or they do without.

Mr. PALLONE. Exactly, Mr. Speaker.

Mr. McDERMOTT. That should not be the result of what we do when we reform Medicare, is wind up with senior citizens being forced to either turn to their kids or do without, because not everyone has kids. My mother has four kids. We all live in Seattle. Everybody has a job, everybody is working. So my mother would be able to turn to us and we would gladly give her some extra money, but not everybody has four kids who are working, who can give them money. Or they may have four kids who are working, but they are trying to help their kid go to community college or whatever, and they do not have it to spare. So the middle class,

the middle age person is going to wind up saying to themselves, should I help mother or should I help my kid?

Mr. PALLONE. Which is a terrible situation to be in, Mr. Speaker.

What I see happening with this Breaux-Thomas proposal, and I think also what the gentleman is trying to do when he says modernize the current system is just the opposite, which is that we do not want Medicare, which is a promise that if one is going to be 65 and one is going to be a senior citizen, that one is going to have their health insurance covered, we do not want it to become a system now where certain people get the benefits now and others do not, depending upon their income, or that the age goes up. We want to make sure that the promise is kept, that when one is over 65, that one is going to be a part of this program, that it is going to be a universal program that benefits everyone equally.

□ 1745

I think when the gentleman suggested that he wants to modernize it, he is concerned that already over the last 20 or 30 years that some of that has sort of disappeared, because certain benefits are not covered or we have to take more money out of pocket.

As the gentleman says, let us move in the opposite direction. Let us not move, as the Breaux-Thomas bill says, towards making even greater discrepancies between rich or poor, or based on age, but let us try to make it so we modernize the system and everybody gets the same coverage, and it is universal. I thank the gentleman.

Mr. McDERMOTT. Mr. Speaker, I see our colleague, the gentleman from Minnesota, is here, and I will bet I know what he is going to talk about. He comes from an area where some of the problems we have already been talking about have really impacted. It is an area where the payments are not high enough for managed care to go in. He also has larger rural areas where there are not managed care programs.

Am I close to being right, I would ask the gentleman? I yield to the gentleman from Minnesota (Mr. MINGE).

Mr. MINGE. Mr. Speaker, I thank the gentleman for yielding. We share a common concern. The State of Minnesota, like several other Midwestern States and the State of Washington, has had a relatively efficient low-cost health care delivery system for many years.

When the Medicare program was created, I understand that they looked at the cost of health care for the average citizen or senior citizen in the county in which the person resided and said, if you would like to have a managed care program, we will provide a sum of money monthly to the firm that is providing managed care coverage for your health care.

So these areas of the Midwest or Washington started out at a relatively low monthly rate, whereas other areas of this country that did not have a low-

cost, efficient delivery system, effective system for health care, had a high monthly average rate that seniors were paying for health care, and they were then offered the opportunity to go into a managed care program where the companies had this high, they call it AAPCC rate, as I understand it.

Mr. McDERMOTT. It is part of alphabet soup. It stands for average annual per capita cost of health care.

Mr. MINGE. Average annual per capita cost. And one thing I know that the gentleman and I have discussed several times is that over the years this discrepancy between what we experienced certainly in some of the rural areas in the State of Washington and what was experienced in other areas of this country became quite unfair.

I understand that in some areas of this country the managed care programs that seniors enrolled in would cover prescription drugs, eyeglasses, hearing aids, even the cost of transportation to the doctors' office. In our areas, we did not have that.

I am wondering, did the Breaux-Thomas Commission really look at this fundamental inequity that we have tried to end in the Medicare program, and did they have a way to end it? If they did not, is that not something that really the Commission should have undertaken?

Mr. McDERMOTT. As we see, I say to the gentleman from Minnesota, this is exactly the point. They did not have any reason to look at it. They did not care. They said, we are going to give a defined contribution. We are going to give the same amount of money to everybody in the country. If they can buy a lot of things in one place with it, they can get prescription drugs and eyeglasses, that is fine. Wonderful. If over here they cannot, well, that is the luck. If someone happens to live in a poor county, we do not care.

That is what is wrong with the defined contribution. That is why we have to stay with a defined benefit. We should define a program where if we are going to give prescription drug payments, it should not make any difference where one lives in Windom, Minnesota, or in Los Angeles, California, or Miami, Florida, or New York City, but someone should have the same set of benefits, no matter where they are. Anything less than that is not fair.

But the defined contribution just closes our eyes. It just says, I do not care. I do not see the differences. I am giving you all the same amount of money, so what are you complaining about?

Mr. MINGE. So it sounds like the discrimination that we have suffered from in our rural areas in the State of Washington would perhaps have just been flipped and we would have had discrimination in the other direction, and instead of solving a problem, we would have created another problem of discrimination among different areas of this country.

Mr. McDERMOTT. Yes.

Mr. MINGE. I am impressed with the gentleman's knowledge of geography. Actually, the community of Windom, Minnesota, is both in my district and where I have had a district office for over 6 years, and it is one of these communities that has an excellent hospital, it has doctors who are well-trained and provide first-class health care service, but at the same time the seniors in a community like that are unable, due to the current inequities in the system, of having the same level of benefits that seniors have let's say in Arizona.

One reason that this has been particularly harsh and difficult for many of us to accept or to understand is that if our more affluent senior citizens have the wherewithal to go to Florida or Arizona for the winter, they can become members of a managed care program and have all of these benefits that their less prosperous brethren who have to stay in Minnesota for that cold winter are not able to obtain.

So there is just a real disconnect when we think of trying to reform a health care system and somehow not being sensitive to the inequities of that type.

I really commend my colleague, the gentleman from Washington, for his work on the Commission. I know he came to Minnesota as part of the Commission activities, and I would certainly, with the gentleman, like to see a Medicare reform program both advocated by the Commission and embraced here by Congress, so we could chalk it up as one of the challenges that is on our plate that we really have a responsibility to address. I thank the gentleman for yielding to me.

Mr. McDERMOTT. The gentleman is welcome. I think that it is—I appreciate the gentleman's coming down and sharing his thoughts with us today, and I think that what people have to begin to look at is the specifics.

When somebody says premium support is a good idea, that sounds as if, as the gentleman says, it is a very attractive idea. Everybody gets the same amount of money all over the country. But as we know around here, the devil is always in the details, and the details of this program are, I think, the reason I wanted to come out here and talk about it, because sometimes issues go through the House of Representatives and they are sort of like bumper strips: If we can make a good slogan, then we think we understand. But if we actually look at what this program does and what they are talking about, we realize that it is not so good.

For instance, let me give one example. A senior citizen in Part B, that is the doctor's part, the doctor payments, pays a \$100 deductible. So if he goes to the doctor the first time, whatever it costs he has to pay it himself until he gets the \$100 deductible paid for, and then Medicare kicks in and covers the rest of the time.

If he goes all year and never goes to the hospital, all he would have to pay

is that \$100 deductible. Now, if he happens to get sick and goes in the hospital, the first day he is in the hospital he has to pay for, \$746. So if somebody goes and sees the doctor during the year and has 1 day in the hospital, their deductible for the whole year would be \$864.

Part of this defined contribution plan, this premium support idea is, well, that is too much, \$746. Let us cut it down to \$400. That sounds like a good idea until we figure if we never go into the hospital, suddenly our deductible has gone from \$100 to \$400, because we are going to have to pay every penny of our doctor's bills until we get up to \$400.

I do not think that is a very good deal for a lot of old people. It would be a good deal if they wind up being sick and have to go into the hospital, but if they do not, if they just go and see the doctor, they are going to wind up paying \$300 more.

Now, to figure what \$300 is, that is about 10 bags of groceries, which, remember, we are talking about old people who are living on \$8,000 a year, and we are saying they have to pay \$300 more in premiums. How can that be a good deal?

That is why what I do not like about the Breaux-Thomas program is that two-thirds of the new money comes out of the pockets of the beneficiaries. It does not come from savings in efficiency in health care delivery, but rather, it comes right straight out of the beneficiaries.

Mr. MINGE. The gentleman has raised another point that I think is certainly important for us to emphasize. That is, the gentleman talks about groceries. I know that in talking with both physicians and with seniors in my area, that often seniors are making a choice between groceries and prescription drugs.

I hear this over and over. They are amazed at the cost of prescription drugs. They are struggling with how they can find the resources to pay for this, and often they feel that they have to make a decision, are they going to obtain those drugs which are necessary for the maintenance of their health, or are they going to short themselves on the grocery side?

Those are their two big sort of inflexible expenditures from the point of view of the larger public. Neither one is really a flexible expenditure. I would like to join the gentleman in really urging my colleagues to take up this question of prescription drugs and how do we deal with it in the Medicare program, and not see the program stumble on the financial side any further. It is really an enormous challenge, and I again would like to thank the gentleman for his work.

Mr. McDERMOTT. I had an experience myself with this whole issue of prescription drugs. The gentleman reminds me of it. I had an ear problem, and I went to see the doctor and he gave me a prescription, as you get

when you go to the doctor. I went down to the pharmacist, and I know him, and he said to me, Jim, sit down. So I sat down, and I said, why are you asking me to sit down?

He said, well, this prescription that is for 2 weeks, medication for your ear, costs \$385. Now, for most people \$385 is a lot of money, and if you are one of these widows we are talking about, or the average senior citizen who lives on less than \$15,000 in income, \$385 is a lot of money.

He said, people come in here all the time, and they will stand there and they will say, well, why do you not give me half the prescription? Now, that means what they are doing is going home and taking half of the medication that has been prescribed for them. If they do not get better, they wind up having to go back to the doctor. And the doctor says, did you take the medication? They say, well, yes. But in fact they are not telling the doctor that they only took half of the prescription because that is all the money they had in their bank account or in their pocket or whatever, or they had to pay their rent or something else with the money that they did have.

This kind of dilemma for senior citizens is absolutely unacceptable, and it is why the President has taken the position that in modernizing the system as the President wants to do, first of all, he wants to put 15 percent into the program from the surplus, and secondly, he wants to have a prescription benefit.

Now, my colleague, the gentleman from New Jersey (Mr. PALLONE) raised the issue of how prescription drugs have increased in usage in medicine. When I got out of medical school in 1963, which was a couple of years before Medicare started, usually when people went to the hospital they would stay 3, 4, 5, 6 days, and if you had a hernia or you had a baby or most anything, it was not uncommon to stay in the hospital 3, 4, 5 days.

Today if you get to stay overnight you have got something pretty serious, because most things are done in 1 or 2 days in the hospital. In fact, the reason we passed a bill out here on the Floor making it absolutely the doctor and the mother's decision was that many of the HMOs had said that if a woman delivered a baby at 8 o'clock in the morning, she ought to go home at 6 o'clock at night with the baby under her arm. She was not even given one night in the hospital.

That pushing people out of the hospital has created two of the problems that we are now struggling with in Medicare. One is that prescription drugs, that is, people get pain medication and they get a variety of drugs, and they are supposed to go home and take care of it, sort of medicating themselves. And the second thing is that we wind up with lots of home health care.

Mr. Speaker, the home health care program is there because we do not

keep people in the hospital. If one keeps somebody in the hospital, my father was 90 years old when he had his gallbladder taken out. When it was taken out, he was sent home 3 days later.

□ 1800

Now, there is my mother, she is 89 years old, and she is supposed to take care of a 90-year-old man who has just had a major surgery. That is obviously not reasonable.

So we have designed a system in this country of home health visits. We have visiting nurses who come into the home and see people, maybe once, sometimes twice a day, to be sure that the bandage is changed or that the blood pressure is taken or whatever is necessary to make it possible for somebody to recuperate at home. If we did not do that, they would wind up back in the hospital at \$600 or \$700 or \$800 a day. So there is a savings in putting people out in their home. It is more comfortable. It is more pleasant to be in our own home surroundings, but we may need some additional help.

Now, that program has been used all over this country in different ways. In the State of Washington and the State of Minnesota the average number of visits for any case is about 35 visits. In the State of Louisiana it is 170 visits. Now, we may ask ourselves, well, what is different with people in Louisiana from people in Washington or Minnesota? Well, the fact is that in those States where they have these long and large number of visits, they have been using the program to keep people from having to go into nursing homes. They have been delivering long-term care in the home, using the Visiting Nurse Service.

So the Congress gets all excited that here is this cost going out of sight within home health care and they say, well, we have to stop this. So what do they do in this defined contribution program; one of the ways they save money? They slap a 10 percent copay on anybody who has a visit at home. Right now there is no copay for a home health care visit.

What they are saying is, if the hospital throws someone out as quickly as they can, gets them home, then we will start taking 10 percent out of their pocket rather than the government paying for it. So what is happening here in this defined contribution is that we are giving only so much and everything else comes out of the individual's pocket. And if that individual does not have it in their pocket, well, that is tough. And we are going to have lots of people in this country who are not going to have the capability to take care of this additional cost to them as individuals.

Now, the Congress passed some years ago a bill to give people some help if they could not afford to pay the deductibles. It is called SLIMBY. That is just another one of the alphabet soup names for a program for old people,

who do not have enough money, can go and get some help. But guess where they put that program to make it easy for old people? They put it down at the welfare office. They say to old people that all they have to do is go down to the welfare office and ask for some help.

Now, old people have got pride. Old people have worked hard all their life, they have taken care of themselves, they have paid their bills, they have raised their kids, they have paid their taxes and, at the end of life, when they cannot pay the deductibles on this program, they have to go down to the welfare office and ask for some help to pay for that.

Now, I proposed in the Medicare Commission something that I have been proposing before in the Committee on Ways and Means; that when someone registers for Social Security, and their income is known at that point, that when they are 65, if they do not have enough income to pay those deductibles, then they should be registered immediately in the program for help to pay for their deductibles. That was resisted in the commission. They left it down there in the welfare office. And I know senior citizens in my district who will not go down there because it makes them feel ashamed of themselves to have to go down and beg at the welfare office.

So if we are going to modernize this program and we are going to raise the deductibles and so forth, we have to make it user friendly for senior citizens who are living on less than \$15,000 a year. We cannot expect them to say, well, I think I will go down to the welfare office and get some help.

We teach people in this country to be independent, to take care of themselves. We value that as a country. And the people who we are talking about right now are the people who lived through the Depression. They brought this country back from the Depression. They took us through the Second World War and they took us through the Korean War. Now we are saying to them that they did not do enough then and so we are going to make them go and beg for some more help just because they do not have anything more than their Social Security.

From my point of view that is not a good system. And when we modernize it, we have to make this an automatic benefit for people who are not capable of paying for it.

Now, there is an issue that the gentleman from New Jersey (Mr. PALLONE) raised, and that is this whole business of so-called means testing. "Means" means how much money we have. When we say somebody is a person of "means", it means he has money. So what some people say about Medicare is that what we ought to do is put a means test. Everybody, let us say above a certain point, should not get Medicare. They should just buy their own health insurance because they have enough money.

Now, we can say to ourselves, yes, that makes sense; why do we not do that? Well, where do we want to put that? Do we want to say that everybody who has \$100,000 in income when they are 65, that they should buy their own insurance? Well, \$100,000 is a lot of money; right? They ought to be able to handle it. Well, maybe we are a little short on dough here in the Congress so we lower the means test down to, say, 75,000; and the next year we are a little short on money and we say, well, let us take it down to 50,000; and the next year we are a little shorter and we get it lower.

The problem with the means test is that what it does, it creates two groups of people in this country, those people who get the benefit and those people who do not. I personally oppose a means test. I think if we come into this country and we pay our taxes and we participate to the best of our ability, we ought to get the program.

I feel the same way about Social Security. I do not care how much anybody has. If they paid into the Social Security system, they ought to get their money out. They ought to get their fair share out.

The reason is, and this is a principle of both Medicare and Social Security, they are social insurance programs. Just like our fire insurance we have in this country. We made the decision, I think it was in 1759, in Philadelphia, to have the first fire department. We said, we cannot save our own homes, so let us all, all of us in Philadelphia, get ourselves together, get a horse and wagon and some barrels, some water and some ladders, and if a house catches on fire, we will go put it out.

That is a social insurance system. That is what fire insurance is. Nobody wants to take advantage of that. Nobody says, well, gee, I hope my house catches on fire so I can get back some of the money that I have paid in in taxes to the fire department or to my fire insurance plan. Nobody wants to get their money back, but we have it there so that if a disaster strikes us, we have coverage.

If anybody stood up on the floor of the House here and said, I think if an individual's house has not caught on fire in the last 5 years they should not have to have fire insurance or pay any taxes for a fire department, we would think they were crazy. We would think they had lost their mind, because we know that nobody knows whose house is going to catch on fire and that is why we have this social insurance fire policy in our pocket.

Same thing is true about roads. We figured out we could not do roads by ourselves, that we had to do them as a national program. That is what Dwight Eisenhower did back in the 1950's, was to establish a national interstate system. And so we collect all the gasoline tax and we put it out there and we take care of the highways in this country.

We do the same thing with schools. We realized that in order to have a de-

mocracy, we needed to have an educated electorate, and so we have a system of schools.

Well, the same thing happened in the 1930's, when there was no money for people to live on and there were a lot of old people who had no pensions. We said we have to have a Social Security System, and Franklin Delano Roosevelt came in this room and said, we ought to have everybody have an account, and so everybody has a number. 000-00-0000 is my number. And everybody has an account. We put in our money every month, and when we get to be 65, there it is for us.

None of us knows how rich or how poor we are going to be when we get to be 65. We all hope that we will be very successful and be able to take care of ourselves without that Social Security money. But when we look at senior citizens and realize that 50 percent of senior citizens live on \$15,000 or less, which is about the Social Security benefit in this country, we realize that for half the senior citizens, when they get to the end of life, that is all they have. They did not know that when they were 15 or 20 or 25 or 40 or whatever. But they put their money in, and when they got there, they had it.

The same is true about Medicare. That is why this is such an important program. There is a fascinating fact about this whole program which I think really drives it home to me as a physician, and I have seen it. We spend 70 percent of the money on 10 percent of the people, 10 percent of the senior citizens in the Medicare program. And none of us knows whether we are going to be a part of that 10 percent. That is why we have to protect the Medicare program with a defined benefit for everyone.

SOCIAL SECURITY REFORM IN THE 106TH CONGRESS

The SPEAKER pro tempore (Mr. HEFLEY). Under a previous order of the House, the gentleman from Minnesota (Mr. MINGE) is recognized for 5 minutes.

Mr. MINGE. Mr. Speaker, in the last week there have been some very disturbing announcements about the status of Social Security reform in the 106th Congress, and I would like to express my severe disappointment that the majority leader in the Senate and possibly the Speaker of the House has backed away from a commitment that we ought to have here in Congress to make Social Security reform the number one priority for the 106th Congress.

I do not think that there is a Member of this institution, nor are there many in this entire country, who is not aware of the importance of addressing the financial crisis that is looming for Social Security unless we take steps to change the program and make it financially secure for the foreseeable future.

We can do this by modest changes here in 1999-2000; changes that we could implement over several years. They