of-pocket if they had the same procedure done in an in-patient hospital. I do not believe that was Congress' intent when the beneficiary copay limitation was first enacted last year.

There is no reason seniors in my district should check into a hospital overnight for a procedure because of the exorbitant copay they would face if it were done on an outpatient basis. HCFA should revise its interpretation accordingly to include all the services provided to a beneficiary in the course of an outpatient visit as envisioned by this year's Medicare ''giveback'' legislation.

CARDIAC ARREST SURVIVAL ACT OF 2000

SPEECH OF

HON. TOM BLILEY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 26, 2000

Mr. BLILEY. Mr. Speaker, I strongly support H.R. 2498, the Public Health Improvement Act of 2000. This package, referred to by many as the ''minibus,'' is composed of a number of different, but all very worthy, proposals designed to improve our public health infrastructure.

The first title of the bill, the Public Health Threats and Emergencies Act, strengthens the nation's capacity to detect and respond to serious public health threats, including bioterrorist attacks and disease-causing microbes that are resistant to antibiotics. Few things are more important than the ability to quickly and effectively respond to outbreaks of infectious diseases and bioterrorism.

Also in the bill, thanks to the good work of the Chairman of the Health Subcommittee, Mr. BILILRAKIS, is the Twenty-First Century Research Laboratories Act. This bill responds to the fact that while our nation possesses the best research institutions in the world, the infrastructure of many of these facilities is outdated and inadequate. The bill authorizes the NIH to make grants to build, expand, remodel and renovate our nation's research facilities.

The bill contains a number of other meritorious provisions. We reform the certification process for organ procurement organizations, providing them with due process and better performance-based measures; we provide better support for our nation's clinical researchers, so that we continue to attract and retain leaders in patient-oriented research; and we require the NIH to enhance research efforts for Lupus, Alzheimer's Disease, and Sexually Transmitted Diseases.

I'd be remiss if I didn't acknowledge the hard work of my colleague, the gentleman from Florida, Mr. STEARNS, on the Cardiac Arrest Survival Act, which is critical life-saving legislation. Sudden cardiac arrest kills more than 250,000 Americans every year. Many of these lives could be saved by immediate defibrillation. In our Committee investigations, we found that counties with defibrillation programs were able to save up to 57% of cardiac arrest victims. The legislation by Mr. STEARNS would protect good Samaritans who use defibrillators to help save the lives of our fellow Americans. It also encourages widespread use of defibrillators by removing the threat of unlimited and abusive lawsuits, and by establishing guidelines for the placement of defibrillators in Federal buildings.

In conclusion, I must note the hard work that went into this bill on both sides of the aisle, and in both bodies. This bill could not have been finalized without the dedication and efforts of Senator BILL FRIST and my colleague MIKE BILIRAKIS, and they are to be saluted, as is the minority. This is a good bill, and I urge my colleagues to support it.

MOTION TO INSTRUCT CONFEREES ON H.R. 4577, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2001

SPEECH OF

HON. BENJAMIN A. GILMAN

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Sunday, October 29, 2000

Mr. GILMAN. Mr. Speaker, I support the motion to instruct on Medicare+Choice being offered by the gentleman from New Jersey.

This motion will allow Medicare+Choice organizations to offer Medicare+Choice plans under Part C of Title XVIII for a minimum contract period of three years and to maintain the benefits specified under the contract for the three years.

At the time the Medicare+Choice Program was being developed, it seemed like a revolutionary concept that would greatly expand services available under Medicare, while keeping overall costs down. Regrettably, for far too many seniors, Medicare+Choice has become a false choice and a cruel joke.

In theory, Medicare+Choice sounded like a good program. Private health maintenance organizations (HMOs) would enter into contracts with the Health Care Financing Administration to provide services to seniors who signed up for membership. These services were included in various benefit plans, the content of which varied with the premium price. The higher the premium, the more services it offered. It bears noting however, that many of the benefits packages initially came with little or no premium cost to the individual senior. Moreover, many of these plans offered extensive benefits for such little cost, including prescription drug coverage. It sounded too good to be true. As history would show, this was precisely the case.

Within the first year, many of the HMOs recognized that providing health coverage for seniors, especially prescription drug benefits, was a highly expensive matter. Once the books were balanced, it became apparent that the cost of providing these services was not being offset by the per patient reimbursement being offered by HCFA. Being creatures of profit, the various HMOs began to take one of two courses of action. They either received permission to drastically raise their premium rates, as much as 1,500 percent in some cases, or they conveyed their intent to HCFA to withdraw their services from areas which they deemed to be unprofitable, usually surburban and rural counties.

My region, the 20th Congressional District of southeastern New York has been devastated by this process. When the Medicare+Choice Program was started, there were approximately six HMOs for seniors in my district to choose from. Today, none remain in Sullivan County, two small plans exist in Orange County and the remaining plans in Rockland and Westchester Counties have sharply raised their premiums.

This is inexcusable. Our seniors deserve to be able to sign up for a plan with the knowledge and comfort that it will not be ripped out from under them after a year's time. The current system simply presents seniors with false hopes.

The fault for this situation lies with: HCFA, for not offering reasonable floor reimbursement rates, the HMOs, for seeking unreasonably high profits above patient care, and with the Congress, for failing to attach any punitive measures to HMOs that pull out of certain counties when they arbitrarily decide they will not meet their projected profit margin.

Mr. PALLONE's motion is a good first step toward solving this problem even though it represents the bare minimum of what the Congress should do to address this crisis. Last year, the Congress sent $1.4 billion in additional funds to HMOs so that they would remain in the Medicare+Choice Program. Yet no accountability provisions were attached. The result was further pullouts this year. The House did the same thing last week with the Balanced Budget Act (BBA) giveback legislation that was incorporated into the tax bill; additional funds for HMOs with no strings attached. I predict this latest action will meet with the same results.

For the sake of those seniors who have been left out in the cold by their Medicare+Choice providers, I urge my colleagues to vote for this motion, and restore some common sense and basic accountability to this broken program.

IN HONOR OF DR. HERBERT B. ANDERSON, PASTOR OF THE BRICK PRESBYTERIAN CHURCH, ON HIS RETIREMENT

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 31, 2000

Mrs. MALONEY of New York. Mr. Speaker, I rise today to pay tribute to Dr. Herbert B. Anderson, the Pastor of the Brick Presbyterian Church in Manhattan, New York, on his retirement after twenty-two years of service to the church. Dr. Anderson will be honored for his many years at the church at a Festival Service of Worship this upcoming November.

Dr. Anderson, recently confirmed to become Pastor Emeritus after his retirement, has dedicated his life to the Presbyterian Church. After graduating from Chicago's McCormick Theological Seminary in 1954, Dr. Anderson began his career as a young pastor at the First Presbyterian Church in Harrison, Arkansas. After five years in this position, he moved onto the Southminister Presbyterian Church in Tulsa, Oklahoma, where he served as pastor for eight years. He then began preaching at the First Presbyterian Church in Lake Forest, Illinois, where he remained from 1967–1978 until he moved to the Brick Presbyterian Church, where he has remained.

Throughout his many years as a pastor, Dr. Anderson has served as a member and leader of numerous religious organizations. Since 1993, Dr. Anderson has been the Chairman of

the Federation of Protestant Welfare Agencies, Inc. He has also worked to promote interfaith dialogue and understanding. In the early 1980s, Dr. Anderson served on the delegations of the Appeal of Conscience Foundation to China, Argentina, and Hungary. In 1975 he traveled to Nairobi, Kenya as the Delegate to the Fifth Assembly, World Council of Churches. Throughout the years, Dr. Anderson's extensive involvement in Presbyterian and interfaith organizations has served as a contribution to the already superior reputation of the Brick Presbyterian Church.

Mr. Speaker, as a member of his congregation, I am confident that the work of Dr. Anderson will have a lasting effect on the Brick Presbyterian Church's congregation, whether it is through our recollection of a particularly memorable sermon by Dr. Anderson, or through the many wedding and baptism ceremonies that Dr. Anderson has presided over. Although Dr. Anderson is retiring, his many contributions to the Brick Presbyterian Church will continue to be appreciated for many years to come.

I congratulate Dr. Anderson on his inspiring career and I wish him an enjoyable retirement.

OMNIBUS INDIAN ADVANCEMENT ACT

SPEECH OF

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 26, 2000

Mr. YOUNG of Alaska. Mr. Speaker, as chairman of the Resources Committee and author of title XV of H.R. 5528 as passed by the House, I wish to make a statement to provide factual background and clarify congressional intent as to the meaning and implementation of that title.

The Secretary of Interior has created allocation pools for acreage entitlements of regional corporations under sections 14(h)(1) and 14(h)(8) of the Alaska Native Claims Settlement Act (ANCSA) and conveyances to one regional corporation under section 14(h)(1) may have the effect of reducing the entitlements of all other regional corporations under section 14(h)(8). Chugach Alaska Corporation (Chugach) currently has significant entitlement remaining under its section 14(h)(1) allocation and the Secretary believes Chugach is overconveyed under its current section 14(h)(8) but allocations under section 14(h)(8) have not been finalized. In the event that any acreage ultimately conveyed to Chugach as a result of title XV would have the effect of reducing the section 14(h)(8) allocations of other regional corporations under current regulations, section 1506(a) provides that such reduction shall be charged solely against Chugach's final section 14(h)(8) allocation, notwithstanding such current regulations, or other applicable law.

SUPPORT FOR H.R. 5543

HON. HEATHER WILSON

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 31, 2000

Mrs. WILSON. Mr. Speaker, the House recently passed a bill to increase the minimum wage, increase the amount Americans can save each year through an IRA, and to improve add funds to Medicare and Medicaid programs. An important part of that Medicare package improves the reimbursement rates for Medicare+Choice. This program offers more choices for seniors to decide what kind of health care plan they prefer. The Medicare+Choice managed care plans usually offer better services and benefits than traditional Medicare—most importantly—they can provide prescription drug coverage to seniors who cannot afford a Medigap policy. In my district, nearly 60 percent of seniors who earn less than $20,000 per year who chose a Medicare+Choice plan. But in my state, Medicare reimbursement for this program is half of what places in New York or Florida receive. And New Mexico's rate is too low for the plans to continue to offer the same quality service. H.R. 5543 will correct that disparity.

This measure is strongly supported by New Mexicans, and I wish to bring your attention to the attached article written by Bob Bada, that clearly illustrates the current situation and need for this legislation and the need for a long term reform of Medicare.

THE DUAL EDGED SWORD OF MEDICARE REIMBURSEMENT—THE MEDICARE PROVIDER AND HEALTH MAINTENANCE ORGANIZATION PERSPECTIVE

(By Bob Badal)

While the nation's booming economy and concomitant boosts in Federal tax revenues over the past six to seven years has extended the solvency of the current Medicare program to 2023, the baby-boom generation soon will begin to enter the program. Paying for the extended range of benefits for this increase in senior citizens will exact a large financial toll. In 2025, 69.3 million elderly and disabled persons are expected to be eligible for Medicare, up from 39 million today. The share of our nation's gross domestic product spent on Medicare is projected to almost double from 2.7 percent in 1998 to 5.3 percent in 2025. Congress passed the Balanced Budget Act of 1997 (''BBA'') to secure the financial stability of the Medicare program by providing an estimated $115 billion in cuts, over five years, in spending to physicians, hospitals, nursing homes, and home health agencies. In addition, the BBA sought to provide alternative network and product choice to beneficiaries via Medicare+Choice plans. Medicare patients, as intended by the BBA, would be able to elect coverage from Preferred Provider Organizations or private insurers, or they could establish a medical savings account, financed by the Health Care Finance Administration (''HCFA''), and purchase a high-deductible insurance policy. With the benefit of hindsight, it is apparent that the BBA, and subsequent amendments, have negatively affected not only the financial stability of Medicare providers, but also the level of choice for the beneficiaries it is mandated to protect. On this point, Senator Pete Domenici R–N.M., Chairman of the Senate Budget Committee stated: ''Seniors in many communities are treated like second-class seniors because their choice and access to care is practically nonexistent. We have created a system of healthcare defined by the 'haves' and 'have nots' ''.

MEDICARE REIMBURSEMENT TO PROVIDERS

The BBA has created a surplus in funds for the Medicare Program over the past 2 years. This surplus is a pyrrhic victory, however. The BBA has reached a surplus by effectively transferring a growing share of the risk to the provider. The Medicare spending cuts called for by the BBA far exceeded the $115 billion Congressional Budget Office (CBO) estimate, and, in fact, will reach more than $212 billion over the five-year life of the BBA. The subsequent Balanced Budget Refinement Act of 1999 served only to restore a modest $15 to $18 billion in payments back to providers. Many providers have been forced into bankruptcy by these draconian cuts, while others have been forced to close their doors.

Cardiac surgeons saw over a 10 percent drop in their reimbursement and anesthesiologists experienced an 8 percent decline. In heavily penetrated Medicare and Managed Care markets, such declining reimbursement can have a serious financial impact on many providers. John DuMoulin, director of managed care and regulatory affairs for The American College of Primary Care Physicians—American Society of Internal Medicine, voiced his concern about the declining Medicare reimbursement schedule by stating that the model was flawed, and called it a ''mixed bag'' of tricks.

In communities like Albuquerque, New Mexico, which has experienced a 15-physician-per-month exodus due, in part, to poor levels of physician-based Medicare reimbursement, access to quality healthcare is becoming a serious concern (New Mexico Hospital Association, January 2000). In addition, as reported in July, 2000, by the American Hospital Association, 10 percent of the nation's nursing homes have filed for bankruptcy protection, and 35 percent of the nation's hospitals are losing money on inpatient services (Healthcare Financial Management, July 2000). Faced with escalating costs of as much as 8–10 percent due in part, to scientific/technological advances, higher drug costs, and increases in union labor nursing costs, hospitals are faced with a dilemma. They are scheduled to receive increases in Medicare reimbursement of 1.1 percent, less than the market-basket rate of inflation in fiscal 2001 and 2002.

Public and provider confidence in HCFA's understanding of the relevancy and possible drastic consequences of their continued pressure on provider reimbursement is not high. To understand the reason why, one need only examine the misguided approach that HCFA has used to determine the initial solvency estimates of Medicare: In 1998, following the passage of the BBA, the General Accounting Officer (GAO) generated new estimates that said that Medicare could remain solvent until 2008. In April 1999, the Bipartisan Commission on the Future of Medicare entered the fray when it issued its report to the nation: Medicare would live until 2015, said the commission. Then in early 2000, the Medicare trustee issued yet another revised estimate for the solvent life of Medicare—2023. That estimate lasted only a few weeks before the trustees admitted they had made a few calculation errors. Medicare would be alive and kicking until 2025. (Healthcare Financial Management, ''Never Underguesstimate the Financial Future of Medicare,'' Jeanne Scott, June 2000).

The formula used by HCFA to calculate physician payment creates extreme oscillations in the reimbursement scale. The swings are due in large part to HCFA's use of a variety of time periods—the current fiscal year, the calendar year and other time frames—to make calculations about physician payment. Part of the problem exists within the new ''sustainable growth rate system'' enacted by the BBA to help control expenditures for physician services under fee-for-service Medicare. The growth rate system calculates the updates to the Medicare fee schedule conversion factor, which is used to set standardized reimbursement for specific service categories. The problem, however, is that HCFA is using projected data on utilization