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

patterns and associated healthcare provider costs rather than current actual data in establishing each year's sustainable growth rate. ''Deliberate use of sustainable growth rate estimates that are based on knowingly flawed projections—even after actual data have become available—is arbitrary and capricious,'' the AMA said in a March 4 letter to Harriet S. Rabb, general counsel for Health and Human Services. (Government and Medicine, ''Data driving swings in Medicare pay,'' Susan J. Landers, AMNews staff. May 17, 1999).

HEALTH MAINTENANCE ORGANIZATIONS AND MEDICARE+CHOICE REIMBURSEMENT FROM MEDICARE

Before the BBA was passed, Medicare beneficiaries essentially were limited to a choice between traditional Medicare coverage under Part A and Part B or HMO coverage. HCFA paid most Health Maintenance Organizations (''HMO'') under the Medicare risk-based system. Under this approach, HCFA generally paid an HMO a prospective amount equal to 95% of the average adjusted per capita cost (AAPCC) of providing traditional coverage to Medicare beneficiaries in the county in which they resided. This amount was adjusted to reflect geographic differences in utilization and practice parameters, as well as certain demographic characteristics of enrollees, such as gender, institutional status, and age. Payment to most HMOs was risk-based in that it was fixed, regardless of the total costs incurred by the HMO in furnishing care to an individual beneficiary. The Medicare payment rates to HMOs varied significantly across the country. Thus, HMOs more actively pursued Medicare enrollees in areas where HMO rates tended to be higher, typically in larger cities. Conversely, market penetration by HMOs was limited in other areas, particularly in rural areas, where Medicare payments to HMOs were lower. Since Medicare HMO plans have traditionally offered enhanced benefits—such as prescription drug coverage and routine physicals—to their enrollees, the lower availability of managed care options in rural areas meant that many rural beneficiaries did not have access to the same benefits as urban beneficiaries did. (ProPac, Medicare and the American Health Care System: Report to the Congress, June 1997; and PPRC, Medicare Managed CARE: Premiums and Benefits, April 1997).

Under the BBA, Medicare+Choice plans would receive aggregate payments for the year based on their geographic location and the demographic characteristics of their enrollees. The BBA establishes that each county's payment is determined as the greater of (1) a local/national blend rate, (2) a national floor, or (3) a minimum update rate set at 2 percent above the previous year's rate. (Project HOPE Center for Health Affairs, ''Changes to Medicare risk plan payments as a result of the Balanced Budget Act of 1997; implications for budget neutrality [abstract],'' Schoenman, 1998). In addition, the BBA, through the use of a risk-adjustment payment, attempts to reflect the relative health status of managed care enrollees, with plans getting more money for their sickest beneficiaries. Because this risk adjustment model is based solely upon impatient hospital utilization gathered from Medicare risk contractors, there are some genuine concerns regarding the administrative costs of gathering this data for HMOs, as well as concerns regarding inappropriate incentives.

With the passage of the Balanced Budget Act, changes in the Medicare program requirements were designed to attract more managed care plans to the program. These changes have resulted in new plans in some areas, but the payment reforms in the BBA, coupled with new regulatory requirements, have already had the unintended effect of discouraging other health plans from participating, resulting in fewer choices for Medicare beneficiaries overall. In 1999, the number of Medicare risk plans declined in response to changes in public policy under the BBA. An estimated 450,000 seniors were affected in 1999 as 54 health plans announced their intent to reduce the size of the markets they served, and 45 did not renew their contracts with HCFA. In January of this year, another 41 Medicare+Choice plans announced their intentions to leave the Medicare market, with 58 additional plans announcing a reduction in their service area. In addition, many HMOs that remain have raised premiums or cut benefits to beneficiaries, including prescription benefits.

CONSEQUENCES

When Providers and Medicare+Choice plans pull out of markets on such a grand scale, the implications for seniors are tremendous. Access to care, continuity of care, cost of healthcare services, and provider/Medicare HMO (both inpatient and outpatient) ''flight'' are the paramount concerns of most Medicare beneficiaries (Modern Healthcare, ''The exodus escalates, Medicare+Choice market pullouts to nearly double in 2001,'' Benko, July 3, 2000). As Medicare reimbursement to providers continues to fall far short of rates obtainable from private payers, providers will increasingly refuse to serve Medicare patients and/or will reduce the quality of services rendered to them. (Economic Commentary, ''Medicare: Usual and Customary Remedies Will No Longer Work,'' April, 1997). For some providers, this decrease in reimbursement may prove to be too costly, forcing them out of business all together. Declining Medicare reimbursement to HMOs has had a similar effect, and has proven to be even more costly to Medicare beneficiaries than Medicare cuts in provider reimbursement. A study by the Barents Group, Westat, and the Henry J. Kaiser Family Foundation, performed in 1998, providing data on 2,163 Medicare beneficiaries who were involuntarily disenrolled from their Medicare risk HMO, confirms the implications of Medicare's declining HMO reimbursement methodologies, and subsequent decreases in Medicare contracted HMOs. The study identified seven areas of concern:

Benefit Reductions: Eighty-four percent of beneficiaries reported prescription drug coverage in their former HMO, but only 70% reported coverage after their plan withdrew. Beneficiaries most likely to have lost one or more benefits also were those most likely to have health problems and least able to pay for those benefits. The disabled under age sixty-five, those age eighty-five and older, and the poor and near poor were more likely to have moved to traditional Medicare with no supplemental coverage and were most likely to report losing benefits after the transition.

Increased Out-of-Pocket Costs: Four of every ten beneficiaries reported paying higher monthly premiums after their Medicare HMO left the market, with the share of beneficiaries paying no premiums for supplemental benefits declining from 67 percent to 53 percent and the share of beneficiaries reporting premiums of $75 or more a month rising from 3 percent to 21 percent. Joining another Medicare HMO, however, does not appear to protect beneficiaries against premium increases or cost concerns. One quarter of those who joined another HMO reported paying higher premiums after switching HMOs and said they expect to have higher doctor and hospital expenses.

Continuity of Care: Most beneficiaries (91 percent reported having one person they think of as their personal doctor or nurse. However, 22 percent of beneficiaries said that they had to find a new personal doctor after their plan withdrew, and 17 percent had to find a new specialist. Beneficiaries in traditional Medicare with no supplemental coverage were much less likely than others were to report having a personal doctor after their plan pulled out and more likely to report having to change specialists. For markets where provider financial viability is already threatened by high percentages of uncompensated care and dwindling commercial insurance payers, continuity of care is further diminished.

Impact on Patient Interactions: Time spent with Medicare patients on each visit is being reduced, and multiple visits for multiple problems are being required. Some physicians selectively refer the more difficult, costly cases to other physicians. Videos are being substituted for face-to-face patient counseling and education.

Cutting Amenities: Services for the convenience of patients are being dropped, such as arranging for community services, in-office phlebotomy and x-ray services, and incidentals such as post-procedure care kits. Screening and counseling are being curtailed. Satellite offices are being closed. Telephone consultations are being reduced, with office staff returning more telephone calls from patients.

Impact on Access: Medicare patient loads are being reduced, limited or eliminated. Some physicians accept Medicare patients only by referral. Money-losing services, especially surgical procedures, are not being offered to Medicare patients. Simple procedures formerly performed in the office are done in outpatient facilities. In addition, access to specialists is decreasing. Specialists refer patients back to primary care physicians as soon as possible, and are less willing to become primary physicians for their chronically ill patients. ''Reimbursement generosity from private insurance relative to that from Medicare negatively affects physicians' assignment rates, implying that the elderly's access to health care and/or the financial burden is likely to be jeopardized by further reductions in Medicare reimbursements.'' (Journal of Aging Social Policy, ''Physician case-by-case assignment and participation in Medicare;'' Zhang, 1997).

Technology lags: Many providers are not renewing or updating equipment used in their office, but shifting to hospitals to perform Medicare procedures. Purchases of equipment for promising new procedures and techniques are being postponed or canceled.

SOLUTION

How should we design Medicare if we had it to do over again? To restore the viability of the program's promise to future generations, and to prevent the drop in access of quality, cost effective healthcare for beneficiaries, the American Medical Association's approach makes sense. Medicare funding, states the AMA, must be shifted from the pay-as-you-go system to one in which beneficiaries have a larger responsibility to provide health insurance for their own retirement health care during their working years. Shifting out of a tax-based, pay-as-you-go system to a system of private savings can assure that all working Americans have access to health care in retirement. This does not means, however, that government would not have a major role to play. The government would continue to make a substantial contribution toward the purchase of insurance for the elderly and it would enforce requirements for individual saving. From a financial standpoint, greater individual funding of retirement health care has at least five advantages over a government-based system:

A private system would allow individuals to freely choose the types of health care plans that meet their particular needs.

Individual funding would remove federal budgetary considerations and the accompanying extraneous budgetary issues from government policy toward the system.

Much of the funding of a private system would be invested in economic activity in the private sector, rather than in unfunded federal debt that must be repaid by subsequent tax revenue.

A higher rate of return is possible with investment of funds in private sector economic activity than in government debt instruments.

And, above all else, provider as well as Medicare+Choice HMO reimbursement would be appropriately set at free market competitive levels, as established by the consumer. (Rethinking Medicare: A Proposal from the American Medical Association—''Solutions for Medicare's Short-term and Long-term Problems'', February, 1998).

CONCLUSION

It is somewhat paradoxical to think that providers of healthcare and their long-time adversary, the HMO (or in this case, the Medicare+Choice HMO), actually may have something in common. Providers of healthcare and managed care organizations agree that the Health Care Financing Administration, and its reimbursement methodologies, have eliminated some of the incentive for providing quality, cost effective access to care for beneficiaries. Nevertheless, because there is only a finite amount of dollars that HCFA can provide to the delivery of healthcare for beneficiaries, any short-lived alliance between providers and HMOs breaks down. Both parties will continue to fight over available healthcare dollars. Worse yet, as the population ages and the number of Medicare beneficiaries grows—leading to a subsequent decline in Medicare tax revenues per beneficiary—the battle for government healthcare funding will increase.

Most health care groups and analysts believe Congress will allocate some additional money to Medicare fixes this year. The large budget surpluses, the greater-than-expected savings from 1997 Medicare cuts, and the data supporting providers' and managed cares' claims of financial pain make it difficult for lawmakers to ignore the problems. ''I think the surplus makes it easier to make corrections and to make a larger amount of corrections,'' said Rick Pollack, executive vice president for the American Hospital Association. Bob Blendon, a health policy and political analysis professor at Harvard University, however, states that members of Congress ''. . . may be concerned about paying for tax cuts and a Medicare prescription drug benefit, as well as ensuring that Medicare cuts won't have to be reinstated if the surplus disappears.'' Despite the cautious optimism among providers, in a highly charged political environment like a presidential election year, the issue remains undecided and unresolved, and the deterioration in service continues apace.

Aetna U.S. Healthcare: 23 counties in 14 states, 355,000 lives.

Humana: 45 counties in 6 states, 84,000 lives.

Foundation Health Systems: 18 markets in 6 states, 19,000.

Oxford Health Plan: 6 Louisiana parishes, 5,900.

Gulf South Health Plans: 5 Louisiana parishes, 4,000.

United Healthcare: Bristol County, R.I., 1,700.

Additional Pullouts pending:

Cigna Corporation, Philadelphia Pennsylvania, announced last month that it is leaving 13 of its 15 Medicare HMO markets, affecting about 104,000 members, effective January 1, 2001. Cigna cites Medicare payment reductions mandated by the BBA have made it difficult for MCOs generally to offer benefits cost effectively. (Healthcare Financial Management, July 2000, ''Cigna Drops Most Medicare HMOs'').

Carefirst Blue Cross and Blue Shield reports its intent to close Maryland's largest Medicare HMO by year-end, displacing 32,000 members. Carefirst blames the government's skimpy reimbursement rates, which it says aren't keeping pace with medical cost increases.

Pacificare's Secure Horizon plan will uproot 20,300 lives when it exits 15 markets in Arizona, Colorado, Texas and Washington. The company has been changing its benefit offerings and boosting members' premiums and copayments in an effort to offset reduced government payments. ''For us to remain viable in the long term, congressional action is needed. We've been urging Congress for over two years to increase funding for the Medicare+Choice program,'' says Robert O'Leary, CEO Pacificare. (Modern Healthcare, July 10, 2000, ''More Plans dropping Medicare HMOs'').

IN HONOR OF COMMANDER CHRISTOPHER JENKINS OF THE NEW YORK COUNTY AMERICAN LEGION

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 the late Christopher Jenkins, the former American Legion New York County Commander, who passed away this past summer. Mr. Jenkins, the first African-American ever to become the Commander of the New York County American Legion, was an outstanding veterans' activist and leader in the Harlem community.

A member of ''the Greatest Generation,'' Mr. Jenkins served in the U.S. Navy during World War II. Originally from Savannah, GA, Mr. Jenkins moved to Harlem after his military discharge and began a career with the New York City Department of Sanitation. He became a Legionnaire at Harlem's Colonel Charles Young Post No. 398 in the late 1940's. He was elected the Post Commander in 1958 and was later reelected to this office more than 15 times. He was then elected New York County Commander in 1975 and served until 1976. From 1992 to 1993 he served as the First District Commander, Department of the New York American Legion. In 1995, he was elected Vice Commander of the Department of the New York American Legion, remaining in this office until his retirement from the Legion in 1996.

Aside from his work with the local American Legion post, Mr. Jenkins was an extremely well-liked leader in his Harlem neighborhood. He was the founder of the Jackie Robinson Senior Citizen Center's Chorale Group and active in numerous community and religious organizations.

Mr. Speaker, I salute the laudable accomplishments and community activities of Christopher Jenkins. A proud, loyal, and dedicated leader, Mr. Jenkins' gracious and friendly personality, his involvement in the American Legion, and his leadership in the Harlem community, will be sorely missed.

PERSONAL EXPLANATION

HON. NEIL ABERCROMBIE

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 31, 2000

Mr. ABERCROMBIE. Mr. Speaker, on Sunday, October 29, 2000, I was unavoidably detained and I was unable to vote on three rollcall votes. Had I been present, I would have voted as follows: Rollcall 574—Approval of the Journal—''yes''; rollcall 575—One Day Continuing Resolution—''yes''; and rollcall 576—Pallone Motion to Instruct Labor-HHS Appropriations Conferees—''yes.''

On Monday, October 30, I was unavoidably detained and I was unable to vote on the seven rollcall votes taken. Had I been present, I would have voted as follows: Rollcall 583—Technical Corrections to Minimum Wage Legislation/St. Croix Island—''yes''; rollcall 582—Previous Question—''no''; rollcall 581—Rule to Allow Additional Continuing Resolutions—''yes''; rollcall 580—Previous Question—''no''; rollcall 579—Hour of Meeting October 31 at 6:00 p.m.—''no''; rollcall 578—Passage One Day Continuing Resolution—''yes''; and rollcall 577—Approval of the Journal—''yes.''

IN HONOR OF THE NATIONAL ASSOCIATION OF CUBAN-AMERICAN WOMEN

HON. ROBERT MENENDEZ

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 31, 2000

Mr. MENENDEZ. Mr. Speaker, I rise today to honor the National Association of Cuban-American Women (NACAW) for promoting excellence and achievement for minority women.

NACAW's philosophy and focus has helped create the support that is essential for building a strong community. With an understanding that the individual is the building block for the success of every community, NACAW has provided excellent support and guidance for Cuban-American women, and for the community as a whole.

In pursuit of its goals, NACAW has developed a comprehensive agenda:

to work with other women's organizations to develop a strong national platform in response to common concerns;

to serve as a forum for Cuban-American women and other minority women to ensure their participation and representation in national organizations;

to increase awareness of education and career opportunities for Cuban-American women and other minority women;

to promote participation of Cuban-American women in Hispanic community service activities;

and to accurately portray the characteristics, values, and concerns of Cuban-American women.

Since its founding, NACAW has sponsored a variety of important programs:

NACAW's Educational opportunities Center disseminates information about post-secondary programs, scholarships, and financial aid sources.