with my friend and the Ranking Member of the Committee on Veterans' Affairs, Mr. Evans, that would change funding of the Department of Veterans Affairs (VA) health care system from discretionary to mandatory spending.

We are introducing this bill in recognition of the continually frustrating annual struggles to obtain sufficient funding to provide access to quality care for the nation's veterans in VA health care facilities. The current discretionary appropriations process subjects these veterans' health care needs—needs of the heroes who won the Battle of the Bulge, endured as prisoners of war in Bataan and Corregidor and survived human-wave assaults in the frozen Chosin Reservoir—to annual health funding competition with federal highway funding and sewage treatment projects. This reality alone vividly illustrates the inherent weakness in the discretionary appropriations process for VA health care and the need to reform it.

Mr. Speaker, 2 years ago, we passed TRICARE for Life, a new program to guarantee lifelong health care for military retirees and their families. I was proud to support that program for hundreds of thousands of military families, who are now assured of free health care services sponsored entirely by the government. The bill we are introducing today would extend the same kind of guarantee to the remainder of America's veterans, to assure their continued access to the VA health care system.

H.R. 5250 would establish a formula to fund the VA health care account directly from the U.S. Treasury with a method similar to that used by Congress to provide funding for TRICARE for Life. Veterans' disability compensation payments are already funded through mandatory formulas, and our legislation would apply the same priority to meeting the health care needs of our veterans.

The bill we are introducing today would establish a base funding year, calculate the average cost for a veteran using VA health care, and then index the cost for inflation. Multiplying this average cost by the number of veterans who are enrolled each year on July 1st, would determine the funding allotment for the Veterans Health Administration for the next fiscal year.

It should be noted that H.R. 5250 would neither take away the Secretary's power to manage the VA health care system nor to curtail the Secretary's control of enrollments in VA. And unlike TRICARE for Life, it would not extend benefits to family members of veterans.

Mr. Speaker, for at least the past five years, veterans' usage of VA health care services surpassed Administration estimates. Just this past week, we received a revised workload estimate for FY 2003 from VA showing an increase of 500,000 veteran patients; and that's on top of the 700,000 increase in patients estimated in the budget submission made only five months ago. VA now estimates that there will be 4.9 million unique veteran patients in FY 2003, versus the 3.7 million veterans that had been projected one year ago for FY 2002—a 31.5-percent increase overall.

Mr. Speaker, the continuing rise in demand for VA health care services is driven by many factors, including the growth of new and convenient VA community-based outpatient clinics, improved safety and quality of care, as well as available prescription drug benefits. VA has increasingly become a supplier of prescription drugs to veterans, particularly for senior veterans.

Further evidence of the urgent funding needs of VA health care comes from a new report issued this month by VA measuring the amount of time veterans are waiting for medical services. According to VA's report, there are at least 300,000 veterans waiting for medical appointments, half of whom are waiting 6 months or more; and the other half having no appointment at all. This is the first attempt to measure a situation about which we have all heard from our constituents, and we suspect that the scale of the problem is actually greater, since this estimate only counts those veterans already enrolled in the VA health care system.

Mr. Speaker, we have a sacred obligation to ensure that our nation's veterans receive the honors and benefits that they have earned through their service to this nation. In the past decade, more and more veterans have turned to the Department of Veterans Affairs for medical services, particularly World War II and Korean War veterans. We have attempted to meet our obligation to them by passing record VA budgets for two years in a row. As our colleagues may recall, the House-approved budget resolution for fiscal year 2003 contained a substantial $2.6 billion increase in the funding of medical care for our nation's veterans.

However, the demand for services continues to outpace the supply of federal funding of VA health care. In the supplemental appropriations bill we passed, Congress included $417 million for additional health care funding to try to meet the current year's shortfall, and that was based upon the older workload estimates.

Mr. Speaker, it is becoming increasingly clear that Congress needs to look at new methods and sources for veterans' health care funding, and the Committee on Veterans' Affairs has been seeking additional ways to match resources to the growing demand. Working with the Committee on Armed Services, we attached an amendment to the Department of Defense (DOD) authorization bill that would seek to increase health care resources sharing between the DOD and VA health care systems, and we hope it will see final passage this year. Also we have sought to increase third-party collections through the VA Medical Care Collections Fund with more aggressive oversight and legislative improvements.

In addition, earlier this month the Committee examined ways to improve coordination and allocation of resources between Medicare and VA, since about half of the veterans receiving VA health services are also Medicare-eligible. Yet, despite all of these efforts, VA continues to struggle each year to provide all the funds needed for the tasks it faces in caring for millions of frail, elderly veterans.

Mr. Speaker, with the introduction of H.R. 5250 we hope to begin an important debate on the future of veterans' health care and its funding needs. We will shortly request Administration views on the bill, and cost information from the Congressional Budget Office. We intend to meet with colleagues on both the Committees on the Budget and on Appropriations to obtain their views; and it goes without saying that we will be consulting with veterans organizations in the months ahead in order to learn whether this approach or a combination of other changes will solve this vexing problem confronting America's veterans and the health care system serving them.

We urge all our colleagues to examine H.R. 5250 and work with us to find a means to provide dependable, stable and sustained funding for the health care needs of veterans of our armed forces. They deserve no less from a grateful nation.

RECOGNIZING THE SERVICE OF TONY HALL

HON. JOHN S. TANNER

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Friday, July 26, 2002

Mr. TANNER. Mr. Speaker, I wish to join our colleagues today in recognizing the work of my friend, the Honorable TONY HALL, as he prepares to leaves this House of Representatives to pursue a great endeavor that will call on his practiced leadership skills to help people around the world.

Over the years, Mr. HALL's work in this body has proven that his compassion stretches far beyond the Third District of Ohio. He has shown through his tireless fight against world hunger that he possesses a genuine concern for his fellow man, and I know that quality will continue to guide his work from this point forward.

I am honored to have had this opportunity to work with TONY, who is an exceptional leader, an honorable man and a good friend. All our best wishes go with TONY as he continues his noble work in this new capacity.

HONORING THE 150TH ANNIVERSARY OF THE CITY OF FERNDALE, CALIFORNIA

HON. MIKE THOMPSON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 26, 2002

Mr. THOMPSON of California. Mr. Speaker, I rise today in recognition of the 150th anniversary of the founding of the Victorian Village of Ferndale, Humboldt County, California.

In 1852, brothers Seth and Stephen Shaw and their companion Willard Allen, traveled through the Eel River plain exploring a wilderness of ferns and redwood trees. Desiring to farm the fertile land, they constructed cabins which eventually became the village of Ferndale.

Situated near the Pacific Ocean, surrounded by dairy farms, Ferndale has preserved its architectural heritage, attracting thousands of tourists who cross the historic Fernbridge over the Eel River and step back into another era.

Named one of America's ''Dozen Distinctive Destinations,'' the National Trust for Historic Preservation added Ferndale to its 2002 list of the best-preserved and unique communities in the nation. The Trust cited well-managed growth, a commitment to historic preservation and interesting and attractive architecture as influential in its choice of The Cream City for the designation.

Seeking historically accurate locations, filmmakers have discovered that Ferndale is an ideal place to make motion pictures. The citizens of Ferndale have enthusiastically supported the use of their city as a film site and fill the scenes as ''extras.''

Ferndale will welcome visitors with an old-fashioned birthday party in celebration of this historic anniversary on August 23rd and 24th, 2002. The art galleries, parks and beautiful houses that grace the city make Ferndale a delightful place to live and to visit.

Mr. Speaker, it is appropriate at this time that we recognize the City of Ferndale, California on the occasion of its 150th anniversary.

MEDICARE BENEFICIARY ASSISTANCE IMPROVEMENT ACT OF 2002

HON. JOHN D. DINGELL

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, July 26, 2002

Mr. DINGELL. Mr. Speaker, today my colleagues and I are introducing a bill that will make significant and long-overdue improvements in the programs that provide assistance to low-income Medicare beneficiaries. Medicare provides coverage to all 40 million elderly and disabled beneficiaries, regardless of income, but the cost of uncovered services, premiums, and cost-sharing is a serious burden on those with the lowest incomes.

More than 40 percent of Medicare beneficiaries have incomes below 200 percent of poverty (a little more than $17,000 a year). These low-income beneficiaries are nearly twice as likely as higher-income beneficiaries to report their health status as fair or poor, but are less likely to have private supplemental insurance to cover the cost of uncovered services or Medicare cost-sharing. Poor beneficiaries also bear a disproportionate burden in out-of-pocket health care costs, spending more than a third of their incomes on health care compared to only 10 percent for higher-income beneficiaries.

Medicaid, through what is known as the ''Medicare Savings Programs,'' fills in Medicare's gaps for low-income beneficiaries, providing supplemental coverage to 17 percent of all Medicare beneficiaries. Millions of beneficiaries, however, who are eligible for assistance under the Medicare Savings Programs are not enrolled. For example, only half of the beneficiaries below poverty who are eligible for assistance are actually enrolled. Lack of outreach, complex and burdensome enrollment procedures, and restrictive asset requirements keep millions of seniors from receiving the assistance they desperately need.

The Medicare Beneficiary Improvement Act of 2002 takes a number of steps to address these problems. First, the legislation improves eligibility requirements for these programs. It raises the income level for eligibility for Medicare Part B premium assistance from 120 percent to 135 percent of poverty. This expansion was originally enacted in 1997 but it expires this year; it is simple common sense to make this provision permanent. The bill also ensures that all seniors who meet supplemental security income (SSI) criteria are automatically eligible for assistance. Currently, automatic eligibility is only required in certain states, meaning that beneficiaries in other states may miss out on critical assistance unless they know enough to apply. The bill also eliminates the restrictive asset test that requires seniors to become completely destitute in order to qualify for assistance. Most low-income Medicare beneficiaries have limited assets to begin with—85 percent of beneficiaries with incomes below the poverty level have fewer than $12,000 in assets—but the asset restrictions are so severe, a beneficiary could not keep a fund of more than $1,500 for burial expenses without being disqualified from assistance.

Second, the legislation eliminates barriers to enrollment. The legislation allows Medicare beneficiaries to apply for assistance at local social security offices, encourages states to station eligibility workers at these offices (as well as at other sites frequented by senior citizens and individuals with disabilities), and ensures that beneficiaries can apply for the program using a simplified application form. In addition, this bill will ensure that once an individual is found eligible for assistance, the individual remains continuously eligible and does not need to re-apply annually.

Third, the legislation improves assistance with beneficiary out-of-pocket costs. It provides three months of retroactive eligibility for ''qualified Medicare beneficiaries'' (QMBs). All other groups of beneficiaries have this protection currently. In addition, it prohibits estate recovery for QMBs for the cost of their cost-sharing or benefits provided through this program. The fear that Medicaid will recoup such costs from a surviving spouse is often a deterrent for many seniors to apply for such assistance.

Finally, the legislation funds a demonstration project to improve information and coordination between federal, state, and local entities to increase enrollment of eligible Medicare beneficiaries. This demonstration would help agencies identify individuals who are potentially eligible for assistance by coordinating various data and sharing it with states for the purposes of locating and enrolling these individuals. In addition, the legislation provides grant money for additional innovative outreach and enrollment projects for the Medicare Savings Programs.

All told, this legislation should go a long way in making sure that the Medicare Savings Programs are working as they should to provide assistance with health care cost-sharing and premiums for vulnerable low-income seniors. As Congress addresses Medicare issues this year, we must ensure that in addition to addressing provider payments, we also address these important beneficiary protection issues as well. I look forward to working with my colleagues to pass this legislation.

H.R. 5250—VETERANS HEALTH CARE FUNDING GUARANTEE ACT OF 2002

HON. LANE EVANS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 26, 2002

Mr. EVANS. Mr. Speaker, today, I want to end my support as an original cosponsor of the ''Veterans Health Care Funding Guarantee Act of 2002'' being introduced by the Chairman of our Committee, CHRIS SMITH. The bill, supported by all of the major veterans' service organizations, would create a mandatory spending stream for veterans' health care and medical construction in the Department of Veterans Affairs.

VA medical care is one of the biggest domestic discretionary accounts in the federal budget. While Congress has historically improved upon inadequate Administration budget requests, VA has still suffered from ebbs and flows in its funding streams that often have little to do with the number of veterans served or the cost of the services they receive. We, in Congress often must work within artificially constrained budget limitations that do not allow the growth in funding VA needs or our veterans deserve.

This has been particularly difficult in recent years in which the growth in veterans seeking care in the system, often for the first time, has been unprecedented and unpredictable. A mandatory funding stream, such as that which the Chairman of our Committee proposes, will bring increased stability and predictability in funding the health care system designed to meet the needs of our nation's veterans.

The Chairman's bill would use medical inflation and growth in the VA's enrollment to ensure that these uncontrollable factors are appropriately addressed. The bill would also require a one-time ''bump'' of twenty percent in the appropriation to adjust VA's baseline, deemed by our major veterans' service organizations to be significantly under-funded for the last several years.

Our veterans' health care system is struggling to accommodate significant growth in use by veterans. Finding that VA is a source of inexpensive prescription drugs, aging middle-class veterans have recently enrolled in record numbers. About five years ago, lower priority veterans (those who are not service connected or medically indigent) constituted about 2–3 percent of the veterans' patient population; they now constitute about 30 percent of the 6 million veterans enrolled in the system.

Appropriations have simply not kept pace with veterans' increased demand for VA health care. As a result VA has unmanageable waiting times and is neglecting its core population—the veterans with service-connected conditions, with certain exposures or service or the veterans who are considered medically indigent. I recently received data from the Secretary of Veterans Affairs that indicates that there are more than 300,000 veterans either waiting for their first VA appointment or who have waited longer than six months for care. I believe that all veterans deserve access to their health care system, but we cannot pretend that they have this access simply because we allow it. The system must be funded to ensure that it is able to meet the demand veterans produce.

I believe the Chairman's bill will address the problems Congress has chronically been unable to redress. I applaud his innovation and look forward to working with him on this bill.

PERSONAL EXPLANATION

HON. LUIS V. GUTIERREZ

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 26, 2002

Mr. GUTIERREZ. Mr. Speaker, I was unavoidably delayed on June 26th and was absent for a journal vote. I would like the record to reflect that had I been present, I would have voted ''yea'' on rollcall vote 261.

I was also unavoidably absent from this chamber on July 12, 2002. I would like the