DC, and around this Nation. The title of her article: ''Is the Marine Corps P.C.?'' PC meaning political correct.

''Second Lieutenant Ilario Pantano was making a six-figure income as an energy trader with Goldman Sachs in New York when the World Trade Center was attacked. Pantano had friends who worked in the Twin Towers and friends among the firefighters who perished trying to save them.

''This Marine veteran had already served his country in the first Gulf War, set aside his career, which also included work in film and television, kissed his wife and two children goodbye, and headed to Quantico, Virginia, for officer training school.''

I continue Ms. Charen's comments in her article: ''A Marine Corps colleague asked, 'How many guys do you know who would drop 100 grand a year to go sleep in fighting holes in the nasty mud and dust for, what, 25 grand a year?'

''There are a few, and the rest of us owe them more than we can possibly express, which is why it is shocking to learn that Pantano may now be facing murder charges.''

Mr. Speaker, that is why I am on the floor. I want to read from part of a resolution, H. Res. 167, which I introduced the day before we left for Easter:

''On April 15th, 2004, Second Lieutenant Pantano led a platoon in Mahmudiyah, Iraq, that apprehended two Iraqis who were suspected insurgents.

''Second Lieutenant Pantano ordered the suspected insurgents to be detained, then ordered them to search their own vehicle in the event that it contained explosives.

''The vehicle's seats were not bolted down, a tactic commonly used by insurgents to retrieve weapons, and nails and bolts were found in the trunk of the vehicle, items commonly found in improvised explosive devices.

''In response to threatening movements by the suspected insurgents, Second Lieutenant Pantano took action in self-defense that resulted in their deaths.

''Accusations that Second Lieutenant Pantano's actions were something other than self-defense did not surface until almost 2 months after the incident.

''In his Combat Fitness Report dated August 5, 2004, nearly 4 months after the incident, Second Lieutenant Pantano's superior officers gave the following evaluation of his performance from March through July, 2004.''

I am just going to read a couple of these, Mr. Speaker. One, ''He is a Marine who 'leads from the front, always, and balances his aggressive style with true concern for the welfare of his Marines.'

''He was 'ready for increased responsibility,' and was a soldier who the Marine Corps should 'retain, promote and assign to challenging assignments.' ''

Now, ''Therefore be it,'' Mr. Speaker, this is the close of my resolution, ''Second Lieutenant Ilario Pantano, United States Marine Corps, was defending the cause of freedom, democracy, and liberty in his actions of April 15, 2004, that resulted in the deaths of two suspected Iraqi insurgents and that subsequently have given rise to certain charges against him.

''The United States Government should dismiss all charges against Second Lieutenant Ilario Pantano arising from the actions referred to in paragraph (1).''

I hope my colleagues that may be listening tonight will join me or at least look on our Web site or call our office and ask about this resolution, H. Res. 167. I can also say, Mr. Speaker, that his mother, who I have spoken to three times, who is a wonderful lady, has set up a Web site called www.defendthedefenders.com.

Mr. Speaker, in closing, last Friday I went down to Wilmington, North Carolina, where the American Legion was holding a barbecue and a fish fry to help Lieutenant Pantano with his defense. I have never met such a fine young man in all my entire life. He's 29 years old, a beautiful wife and two children. I met them and I hope that my colleagues here tonight and those in the office will look at this resolution, H. Res. 167. We need to stand behind our men and women who are in harm's way in Afghanistan and Iraq.

Mr. Speaker, I close by asking the good Lord in heaven to please bless our men and women in uniform and their families, and I ask the good Lord in heaven to please bless the United States of America and to help us find peace in this world, and May God please, please bless America.

TRIBUTE TO POPE JOHN PAUL II

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

Mr. BACA. Mr. Speaker, I rise to pay tribute to a man who embodied the values of compassion and selflessness.

Serving for the past 26 years as the spiritual and emotional beacon of the Catholic Church, John Paul II exhibited charisma, character, and conviction when carrying his divine message to millions of people across the world.

He passed away this past Saturday at the age of 84 after a courageous struggle.

I join millions of mourning people across the world in honoring his remarkable life and recognizing his wondrous achievements.

Many great men and women have devoted themselves to a single cause or to a group of people. Pope John Paul devoted his efforts to all humanity around the world.

When he was elected Pope on October 16, 1978, he was well aware of the problems occurring not only in the Catholic Church but throughout the world. Communism had a grip on many areas, including his beloved homeland of Poland.

John Paul II had a social and political vision of what the world should be and dedicated himself to changing the reality that we knew.

He inspired incredible change, leading with unwavering faith and exceptional sincerity. His duty to the church was purposeful and his love for mankind was unconditional.

He undertook the goals of sewing the schisms of Christianity, healing the wounds of the Christian-Judeo relationship, and creating a legacy for the world to follow. He left his imprint on all faiths, as well as the scholar world.

As a devoted Catholic, I am honored and privileged to recognize such a special and loved person.

□ 2015

He was my inspirational compass and guided my faith through his unyielding dedication to the tenet of integrity and morality.

Mr. Speaker, today I mourn the passing of Pope John Paul II, but salute and express sincere admiration in his unparalleled life and lasting legacy, and I wrote a poem that I would like to dedicate to John Paul II that's called ''The Spirit of Life Is.''

To live is to believe. To see is to believe. To express is to believe. To feel is to believe. To respect is to believe. To forgive is to believe. To have hope is to believe. To love is to believe. For if you possess these values, you truly can enter the Kingdom of Heaven, and the spirit of life will be within you. For you truly have touched the life of the world around us in making it a better place for humanity, changing the course of history. Your legacy will live in the lives of those who truly believe.''

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

(Mr. PENCE addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

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

(Mr. BURTON of Indiana addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

MEDICARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 4, 2005, the gentleman from Pennsylvania (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY. Tonight Republican Members of Congress will be talking about Medicare. Now, as we are getting into this, what I want to make sure that we first look at here is that many talk about is the Federal Government

doing much with regard to health care? And Medicare, Medicaid, veterans benefits, and other programs that the Federal Government pays for consume a massive amount of the Federal budget. And I wanted to point out, just to begin with, if we can look at this, that about 45 percent of all mandatory spending, all mandatory spending we spend, is on health care, and about 15 percent of all discretionary spending is spent on health care.

If we look at mandatory spending here in health care, we see that the section here which is Medicare is $297 billion, or about 24 percent overall; Social Security disability is in this category here, too, about 6 percent; State Children's Health Insurance Programs, about $5 billion or 4 percent; and Medicaid is $176 billion, or about 14 percent of overall mandatory spending.

So we see that for those seniors and disabled who receive the benefits of Medicare is a large part of the Federal budget and one that has a history of providing good benefits for our seniors; benefits we are proud of, benefits we are pleased to continue to offer them.

But tonight we are going to talk about a number of things happening in Medicare. Some of these will be issues that are staying with Medicare; some will be some positive changes, areas that are growing; some of the new parts that have to do with prescription drug benefits; some some actions on waste, fraud, and abuse; some on new programs that deal with prevention and new physicals for Medicare; and many, many other parts of this we will be talking about tonight.

The overall purpose here is that as we look at the amount of money we spend and the services that we provide, it is Congress' responsibility to be constantly reviewing this and saying can we do it better to provide quality health care that is accessible for our seniors in America? And those who are not seniors yet recognize that about 2.9 percent of wages, half from you and half from your employer, goes to fund Medicare. Thus, every taxpayer is concerned with how this money is spent and what quality is associated with it.

Now, being the first speaker tonight, I want to talk a little bit about one area that I am introducing a bill on to improve Medicare, although it provides a lot of services in many areas of health care. One of those that I believe we need to see some changes in is in mental health coverage.

As a practicing psychologist myself for many years, I recognize that when you integrate the care of mental illness in with other aspects of medical care, it actually is something that reduces the cost of health care and improves health overall.

Let me describe to you now what Medicare does in all this. Currently Medicare beneficiaries pay about a 20 percent copayment for all outpatient health services except for mental health providers, where they have to pay a higher copayment of 50 percent.

According to the National Institutes of Mental Health, nearly 2 million Americans over the age of 65 suffer from depression. The 1999 Surgeon General's Report on Mental Illness found that 20 percent of Americans 55 and older experience mental disorders that are not considered a normal part of aging, such as anxiety, alcoholism, and various other disorders. As many as one in two residents of nursing facilities are at risk for depression.

A June 2002 MED–PAC report, that is the Medicare Payment Advisory Committee that recommends changes to Congress, stated that ''Medicare beneficiaries are apparently having difficulty in obtaining needed mental health services. Despite the availability of proven treatments, one recent analysis found that of those beneficiaries over 65 with need of treatment, 63 percent did not receive it.'' And it goes on to say, ''Beneficiaries face a 50 percent coinsurance for most outpatient mental health services compared with 20 percent for most other outpatient services. Equalizing cost-sharing for outpatient mental health and other outpatient care would reduce the financial barrier to mental health care and provide parity to beneficiaries with mental disorders and those with other illnesses with a small increase in Medicare spending. This change would also simplify Medicare's cost-sharing structure.''

Now, here I am talking about the cost of Medicare and talking about something here which on the surface would appear that we are proposing more spending. And oftentimes when proposals come before Congress, they are scored in terms of what the increased spending would be, but not necessarily scored or reviewed in terms of what the savings would come from this.

Let me describe what happens when you have untreated mental illness. Patients suffering from untreated depression, for example, use health care services more often; pay one and a half to two times more for health care costs that they accrue. They also tend to have increased lengths of hospital stays. Untreated depressed parents tend to have decreased adherence to life-style changes needed for health improvement. Depression also complicates the treatment of those with heart disease. And those with increased psychological stress or depression have increased platelet reactivity to thrombosis or blood clotting, which can complicate heart disease.

Now, as a result of this, I have introduced the Medicare Mental Health Copayment Equity Act to reduce the copayment for mental health services to seniors on Medicare to match the standard 20 percent rate. With such a high amount of seniors afflicted with mental illness, that discriminatory Medicare copayment rate must end.

When we look at ways such as integrating the care for our seniors with something that afflicts so many, such as mental illness and depression, by using such innovative approaches, we can actually save cost and provide better care for our seniors in America.

Now, in addition to some of these things we can look at improving, and we will be talking more about them tonight, a number of aspects, it is important to also recognize that Congress is also being a watchdog of some problem areas for Medicare. What happens sometimes is people see this as a system that they can abuse. Whether it is providers or patients or others, they see this as a way they can get health care that perhaps is not needed, or we have a mechanism that sometimes, quite frankly, just pays too much.

To talk about this issue tonight, I will call upon my colleague, the gentlewoman from Florida (Ms. GINNY BROWN-WAITE), and she will be discussing waste, fraud, and abuse in Medicare, and I yield to her now.

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I thank my colleague from Pennsylvania.

You know, for most seniors Medicare is their only form of health care. Congress must make absolutely certain that not one penny of it is wasted and not one penny is given to those who only want to defraud the system. When Members of Congress voted for the Medicare Prescription Drug Improvement and Modernization Act last year, we voted in favor of important measures to combat waste, fraud, and abuse.

Under the MMA, which I know that the gentleman from Pennsylvania supported, the HHS Secretary was directed to conduct a demonstration of recovery audit contractors in at least two States for 3 years to identify under- or overpayments. This demonstration project allows HHS to identify more efficient ways of working with States on Medicare waste.

The MMA also opened the durable medical equipment industry to competitive bidding. And why did we do that? To ensure that Medicare, that our taxpayers, get the best prices on equipment that patients use. Additionally, the MMA ended overreimbursements for prescriptions and administering costs by replacing the average wholesale price system with a more accurate and verifiable average sales price system.

More importantly, for those of us who worked in favor of the Medicare Modernization Act, we voted in favor of making health care fraud a crime, a serious crime. We voted in favor of punishing those who defraud this precious program. Instead of just slapping them on the wrist, there will be serious penalties. These criminals are defrauding our most vulnerable and our elderly seniors, and they should be very strictly punished.

These measures were very important steps, but more are still needed. The most conservative estimates suggest that waste, fraud, and abuse in the Medicare system is somewhere around $33 billion a year. That is billion with

a ''B.'' Scam artists, however, are using innovative and cunning ways to con Medicare every year. Many use computers to scour the Internet to find holes in Medicare and Medicaid payout systems.

The scam artists register also as providers and then file a slew of claims through the payment system to determine which claims would be automatically approved by Medicare and Medicaid computers. Once these claims are determined, the cons just sit back and they wait for the payments.

Others set up fake medical storefronts. In one case, actually in my home State of Florida, a ''provider office'' was found to be nothing more than a couple of post office boxes, cell phone, and a beeper. The owner vanished when he caught on that Medicare officials were onto him, but not before he collected $2.1 million in payments. They are still looking for him.

Today the Heritage Foundation released their study about waste in various Federal agencies, and guess what? They pointed to the Centers for Medicare and Medicaid, CMS, because of their paying excessive prices for medical supplies and care. They pointed out that in so many instances they paid thousands, not just hundreds of times but thousands of a percent, more than what the VA pays for the very, very same service.

And my colleagues, I am sure, saw this in today's Congress Daily. There is a story in here about how the new chairman of the House Committee on Appropriations is settling in, and that the staff director of that committee is mandating that they go after agencies. And he said, ''The first rule is: There aren't any good government programs anyplace. They are chock-full of fraud, waste and abuse; frittering away millions in appropriated funds. Believe it, focus on it, find it and report on it.'' Obviously, Congress is getting very serious about waste, fraud and abuse in our system, and every Member of this body, I am sure, are very, very grateful for it.

Protecting Medicare against predators should be a bipartisan issue. The last time I checked, there were no Rs or Ds in the word ''solution.'' Guaranteeing the solvency of Medicare has to be a priority of Congress, and we have to begin by ensuring that every penny going to Medicare is being spent on legitimate Medicare benefits. If both sides of the aisle do not work together to protect Medicare, the legacy of this program diminishes with every penny that is lost.

I look forward to working with the gentleman from Pennsylvania (Mr. MURPHY) and the other Members of Congress who are serious about making sure that the Medicare system is a sound system and one that provides necessary health care for our most vulnerable, our seniors.

□ 2030

Mr. MURPHY. Mr. Speaker, I thank the gentlewoman from Florida (Ms. GINNY BROWN-WAITE), and could the gentlewoman repeat how much waste, fraud and abuse is estimated? I believe it is over $20 billion a year.

Ms. GINNY BROWN-WAITE of Florida. I do not want to misquote. It is $33 billion. The most conservative estimates suggest that waste, fraud and abuse in Medicare is somewhere around $33 billion per year.

Mr. MURPHY. Mr. Speaker, what we have to make sure is understanding in a budget that is approaching $300 billion for Medicare overall, and when people are concerned is it providing enough coverage, the issues that the gentlewoman from Florida (Ms. GINNY BROWN-WAITE) brought forth is an area where every senior and their family member can help deal with the spiraling cost of health care.

I have a chart here, and notice how health care costs are spiraling up. Notice the growth in terms of Federal outlays and how much it has climbed over the years. It is quite dramatic. The area of waste, fraud and abuse has grown with it. I would like to advise that one of the messages that we as Members of Congress need to get out to constituents is understand how we can help our constituents find and report waste, fraud and abuse.

Sometimes Medicare fraud is purposely billing for services never provided, billing Medicare and another insurer for services someone never received, for equipment because you received equipment different from what you are billed for, and using another person's Medicare card to get medical care, supplies or equipment, and billing Medicare for home medical equipment after it has been returned.

I have heard of constituents who have reported these kinds of things, and it is important that we do this as a mechanism to save government money, save taxpayer money, and make sure that money goes towards care. People also need to be suspicious. Anytime a provider tells you a test is free, they only need your Medicare number for their records, and the provider may state that the cost to the person with Medicare is free, be wary if tests are being provided and the patient is told they are free, make sure you understand why they are being done and what they are. Or if the provider says Medicare wants you to have the item or service, Medicare does not recommend services, it is up to the physician and health care provider to recommend services. Or if someone says I know how to get Medicare to pay for it, again, the questions family members and Medicare recipients should be asking is I want to know what I really need, and do not be afraid to get other opinions.

Sometimes people say the more tests you have, the cheaper they are; or the equipment or service is free, it will not cost you anything. But be aware, and Members need to educate their constituents that anytime someone is offering that, this is taxpayer money being spent on services that may or may not be needed. And it is important that we encourage Americans to review that and determine if it is medically necessary.

There are ways that you can prevent Medicare abuse, and there are ways you can report this: by contacting the inspector general of Medicare, by looking at the Medicare Web sites to report specific information. It is a way that every American citizen can be a watchdog and can lead to cost savings for Medicare and make sure that care goes to patients.

I would like to turn toward the gentleman from Georgia (Mr. PRICE), an orthopedic surgeon, a good friend to the health care caucus and one who has been very diligent in dealing with health care costs. He will be addressing patient choice and satisfaction with the Medicare program.

Mr. Speaker, I yield to the gentleman from Georgia (Mr. PRICE).

Mr. PRICE of Georgia. Mr. Speaker, I appreciate the opportunity to be here and talk to an issue near and dear to our hearts. As we talk about the challenges that we have with Medicare, as with many programs, what we are attempting to do is to lay out the issue before us and to make certain that we retain those aspects of the program which are so very important and provide for greater health, higher quality health for our seniors, and that we do so in a way that listens to principles. I am fond of going back and talking about principles because I think unless you understand what principles you want to institute, you can get off the mark.

The principles that I like to talk about when I am speaking about Medicare is that we have the highest quality of care that is available, that the cost for that care be absolutely reasonable, that people are not being gouged and you do not have the problems with the waste, fraud and abuse that has been talked about.

And finally, what is incredibly important for Medicare, patient choice. That is patients get to choose who is taking care of them and where they are being treated. Let me just chat a little bit about some of the challenges that we have before us and why we are in the kind of situation we are in.

This chart may look familiar because it is a chart that we have used to demonstrate some of the challenges that our Nation has as it relates to other systems, the Social Security, for example. But the demographic changes that are occurring in our society right now, the aging of our population, that really is the main reason that we have got these challenges within the Medicare system.

As Members see here, today's workers are providing the moneys for the Medicare system, those individuals who are the recipients. So you need a lot of workers to provide the resources with which to care for our seniors. In 1950, there were 16 workers for every

retiree or every senior. This year, there are 3.3 workers for every senior retiree. In a few number of years, there will be two workers for every retiree.

What that means for Medicare is we have an aging population and fewer resources with which to support that population's health care. I think it is important to appreciate that principle. Remember that principle of highest quality, reasonable cost, and choice for patient, and the demographics of our society, the aging of our population, is driving some of the decisions that we make that may violate some of those principles.

What is going on with the cost of health care? The gentleman from Pennsylvania (Mr. MURPHY) had a poster up before that talked about and showed the increasing line of money being spent for health care. That will continue of necessity because of the aging of the population.

One of the problems that we have with Medicare, though, is it is an inflexible system. A number of years ago, we, the Congress, instituted a program called ARBORS, Resource-Based, Relative-Value System, which means we as a Nation will decide how much money we are going to spend on health care for seniors; and regardless of the amount of money that is needed or regardless of the amount of care that is going to be provided, we are not going to violate that. We are going to have a pool of money and pay for the care needed out of that pool. If there is a lot more care that needs to be provided, we have challenges in our system. Remember, we wanted highest quality care, reasonable cost, and choice for patients.

What we have now is a system that oftentimes is being held together just by the altruism of the individuals involved in providing that care, the doctors and hospitals at home, those individuals who are being asked to do more with less, and oftentimes are being asked to do a whole lot more with a whole lot less.

The system we have worked well when there were a lot of workers. However, now when we have fewer workers in this pay-as-you-go system, it becomes more difficult to hold that system together. It is an inflexible system. It is not able to juggle or change with the changes in our society. I want to use as an example of that the debate that has been going on over the last couple of years about a prescription drug plan or a prescription drug benefit in Medicare.

When Medicare was instituted in the mid-1960s, medications, drugs and pharmaceuticals, were not necessarily that extremely important for the care of disease because there were not a whole lot of variants in the type of medications that we had. Oftentimes the treatment for a disease or an illness was in the hospital, which is why Medicare built up as a system that provided primarily for hospital insurance, for hospital care, and provided coverage for the physician as well; but did not have a drug component to it, did not have a prescription drug benefit within the system.

Over a relatively short period of time after the mid-1960s, the explosion in our technology and in our ability to have medications that truly affected the outcome of illness and provided a higher quality of care, and remember one of our principles is that high quality of care, medications just flourished. But the Medicare system stayed absolutely the same. Through the 1980s and 1990s as so many medications were discovered and have been utilized to save people's lives, Medicare was stuck in the mud not providing any prescription drug coverage.

So the President to his great credit put this issue on the table, and in 2003 a Medicare prescription drug plan was introduced. That is important because we have moved now to a health care system that relies a whole lot more on medications than it did in the past.

My purpose in bringing that issue up is that it took us 40 years to get to a point where we had a system that provided for prescription drug coverage. That is a program, a Medicare program, that I believe is inflexible and does not have the kind of capability to change with the needs of patients. One of our principles is patient choice. Patients ought to be able to choose who is taking care of them, where they are being cared for, and what kind of care they are receiving. That brings me to the final point I would like to make.

I think as we move through this discussion, it is imperative that we make certain that the highest quality of care that is being delivered at reasonable cost, those principles, also have the principle of patient choice. When I was a practicing physician, I knew that the important things that patients would talk to me about, if they did not tell me what their wishes and desires were, I could not respond adequately to the kinds of needs that they had. That is patient choice. In an inflexible system, in a Medicare system that is inflexible, it is not possible for patients to be able to exercise their choice.

I believe as we go through this discussion and make certain that we retain a Medicare system that will provide the highest quality of care at the most reasonable cost available, but with patient choice, patient choice is what is so incredibly important, as we allow and provide for patients to be able to have the access to the care that they so need.

Some improvements have been discussed. The gentleman from Pennsylvania (Mr. MURPHY) has talked about a proposal that I think has great merit. I just hope as we go through this discussion that we do not end up in the political name-calling and demagoguery that has been so wont to happen in other issues that we have talked about here. I think if we just stick to the principles of highest quality of care at a reasonable cost and make certain that one of those principles has to be that patients have choice, choice about who is taking care of them, where they are being cared for and the kind of treatment that they are receiving, that we will end up with a program that will be flexible and that will be much more responsive to patients' needs, which in the end is what it is all about.

Mr. Speaker, I thank the gentleman from Pennsylvania (Mr. MURPHY) for the opportunity to participate in this incredibly important and vital issue that means so much to so many Americans.

Mr. MURPHY. Mr. Speaker, I thank the gentleman from Georgia (Mr. PRICE) for his important information about other areas of care. As we continue on this evening, I want to turn to one of our colleagues, the gentleman from Louisiana (Mr. JINDAL), who is an expert on Medicare. He wants to talk about the need to address premium cost and recommendations of the National Bipartisan Commission on the Future of Medicare.

Mr. JINDAL. Mr. Speaker, we come together in this body to talk about a very important topic, our Nation's Medicare program. Medicare has served our country's seniors well. However, this is a program that is in serious need of strengthening and improvement.

I was privileged to serve as the executive director of the National Bipartisan Commission on the Future of Medicare. We spent an entire year looking at the Nation's Medicare program, and we heard from dozens of witnesses. We had countless hearings. I can summarize the challenges facing the program in three ways.

First, we have a Medicare program by any measure that is facing a huge financial challenge, a program that is going to go bankrupt, quite frankly, unless we do something differently.

□ 2045

We can measure that as a share of the GDP, we can look at the ratio of workers to retirees, we can look at that as a share of payroll taxes, or we can look at the life of the trust funds. Quite simply, we have got a Medicare program today that goes from about four workers per retiree, it is going to eventually be at about two workers per retiree, a trust fund that will not last even long enough for the baby boomers to not only finish retiring, but to finish utilizing their health care services.

So the first challenge facing the Medicare program is increasingly we have got a program that is facing solvency challenges. Secondly, we have got a program that, as it is defined today, does not truly cover adequately the health care needs of our Nation's seniors, our parents, our grandparents. We have got a program that covers about half the health care costs of our parents and grandparents. We have got a program that until next year does

not really even begin to cover prescription drugs, does not provide an adequate long-term care benefit; a program that charges over a $800 deductible every episode, every time our parents go to the hospital; a program that until recently did not cover many preventive care benefits and still lags behind the private sector in terms of what is considered first-class medical care; a program that has no real meaningful catastrophic stop loss coverage; in other words, a program that looks largely like the 1960s insurance product it was modeled after. In the private insurance world, we no longer get our physician insurance separate from our hospital coverage. Yet that is exactly what Medicare continues to do today.

So the second challenge facing our program is that it is a program that does not adequately cover the health care needs, does not adequately provide a modern benefits package for our Nation's seniors. We can see that by the fact that 89 percent of our Nation's seniors have something other than just plain Medicare fee-for-service alone. Eighty-nine percent have either some kind of wraparound coverage, supplemental coverage, Medicaid, private HMO coverage, have something in addition to just plain old vanilla Medicare fee-for-service coverage.

The third challenge facing our program is it is a program that has not been run all that efficiently. You can look at that by comparing Medicare's growth rates to the private insurance world, to the other Federal programs that we run, by looking at the billions of dollars, not millions but billions of dollars, we waste every year.

We all have our favorite stories. I know my colleagues have heard from their constituents, and we have heard, about the equipment that Medicare will rent but not purchase even when it would be more cost-effective to buy it. We have heard about the times that Medicare would pay for a patient to go to a physician's office to receive an injectable medication, but would not pay for that same patient to receive those drugs orally. We have heard about Medicare not paying for preventive care, not paying for more cost-effective outpatient-based care. Year after year Congress tries to put a Band-Aid and tries to improve the program and tries to catch up with the latest medical technology, but inevitably we are always a little bit behind what people are getting below the age of 65.

So we have got three challenges being faced by our Medicare program: First, a program that, by any account, faces severe financial challenges; secondly, a program that does not adequately cover the benefits that our seniors deserve and need; and then finally, third, a program that is not all that efficient compared to other programs.

The good news in all of this is that Medicare has done a remarkably good job taking care of our parents and grandparents. We do not need to throw the Medicare program out. Rather, we need to improve it, strengthen it, and get it ready for this next century, get it ready for the baby boomers that are beginning to enter this program.

How do we do that? I would like my colleagues to remember just two numbers that came up during the Commission's deliberations and just two numbers that stand out to me in all the hours of testimony that I listened to. The first number is this: The CEO of the Mayo Clinic testified to our Commission. He said, We count 130,000 pages of rules and regulations. There has been some dispute. Everybody agrees there are tens of thousands of pages of rules and regulations. It does not really matter if you believe it is 130,000, or whether you believe it is 20-, 30-, 40,000. The bottom line is this: Tens of thousands of pages of rules and regulations telling the Mayo Clinic, telling physicians, telling hospitals how they must provide care.

I do not know about you, but to me this debate really comes down to who do we want in control of our health care. I would much rather my physician, my health care provider, working with me to make those decisions. No matter how well-intentioned, I do not want a bureaucrat making my health care decisions for me.

The American Hospital Association talks about the fact they have documented nurses in many hospital settings spend an hour filling out paperwork for every hour they provide care. At the same time, we have a shortage in this country of about 100,000 nursing vacancies, 100,000 vacancies we cannot fill today, and that number is only going to increase, and we are drowning our health care professionals in paperwork.

The second number I ask this body to remember is that we heard from an economist testifying to our Commission basically in the Medicare program that we are trying to set 10,000 prices across 3,000 counties. We call them parishes in my home State of Louisiana. But the bottom line is this: 10,000 prices in 3,000 counties. We do not buy anything else in the Federal Government that way. It makes no sense that that is how we buy medical services. The problem is sometimes we will be too high, and sometimes we will be too low. We heard so many stories about how this distorts the quality of medical care that our parents receive. This distorts their access to services.

We have all heard the complaints from physicians about the inequities of the sustainable growth rate reductions they are going to face. We heard about physicians leaving the Medicare practice. We have heard the stories of patients, we heard it in the Medicare Commission, about patients going to the hospital. We had a patient that told us a doctor wanted to perform a procedure on him. He was in the emergency room thinking he was about to die of a heart attack. Once the physician found out he was in Medicare, the physician said, I don't need to do that service anymore. It turns out Medicare would not pay for that procedure. Not only that, Medicare would not let him pay for that procedure or his private insurance pay for that procedure. I think most of us, if we were in the emergency room, would not want a bureaucrat to make that decision. We would want our physician to make that decision.

That really is the question facing us when it comes to the future of Medicare: Who do we want making our health care decisions? Do we want our physicians working with us, or do we want bureaucrats? It is as simple as that.

The Federal Government runs a different health care program. We run a health care program that has over 300 plans competing to provide coverage. We run a health care program that has had lower inflation rates; a health care program with incredible approval ratings, over 85, 90 percent approval ratings; a health care plan that does provide adequate prescription drugs, is not going insolvent. It is a very simple plan. Members of Congress are allowed to participate. Federal employees, the very employees that design and operate Medicare, are allowed to participate. The simple concept behind the Federal employees' plan is this: We give people choice. The Federal Government pays the majority of the premiums. If somebody wants to buy a little more expensive plan, they pay a little bit more. If they want to buy a more efficient plan, their premiums go down.

We tried this in Medicare some years ago, except Congress said private plans were not allowed to reduce their cost below the government plan. That makes no sense. If a private plan is more cost-effective, of course they should be allowed to lower their prices. Why in the world would we not want our parents and our grandparents to be able to lower their premiums? Fortunately we fixed that, but we have got a lot more fixing to do.

I was pleased today to learn from CMS, I know many of us were, that our seniors, over 90 percent of Medicare beneficiaries next year may have more choices of how they get their health care, may actually have a choice of how they get their health care plans. For those that want to stay in Medicare, they can continue to do that. Nothing has changed. But the good news is more and more of our parents and grandparents are getting more choices.

I know my time is running out, and we are limited in our time tonight, but I think if we remember one thing about the Medicare debate, it is simply this: We must give our parents, we must give our grandparents more choices.

We had a bipartisan Medicare Commission that was chaired by the gentleman from California (Mr. THOMAS) of this body, cochaired by former Senator Breaux of my home State of Louisiana. We came up with good bipartisan findings contained in the cochairman's report. The bottom line is this:

If you remember nothing else but all the numbers and all the facts and all the details, Medicare has done a good job. To make sure it continues to do a good job for our parents and grandparents, let us not be scared of giving them the kind of choices they had before they became the age of 65. If we do that simple thing, not only will it be good for them, it will help us balance our budget, and it will slow down that growth by getting rid of some of those inefficiencies.

Mr. MURPHY. I thank the gentleman from Louisiana not only for the depth of his knowledge in Medicare, but his service before to our country. Certainly if we are able to implement some of the changes he has spoken about so eloquently tonight in changing not only the waste, fraud and abuse, but making Medicare work more effectively, we can make it last longer.

The points made here about when we think about Social Security hitting its financial demise sometime around 2042, when they talk about Medicare, if we do not make some changes to improve the system, again that is what we are talking about, improving the system, it may face its own demise in 2024, some 20 years ahead of Social Security, not because the difference in more people retiring at faster rates and less money going in, but because of the waste, fraud and abuse that is in the system and because of inefficiencies.

It is so important that we work together in a bipartisan way to improve the efficiency of Social Security so that money goes to care for our seniors in ways that we need to make sure they get that care.

I would like to turn to another one of my colleagues for the wrap-up in our session tonight, and that is the gentleman from Georgia (Mr. GINGREY), who is no stranger to speaking on health care issues. He and I chair this conference team on dealing with health care issues. He is as dedicated as they come to working on this.

Mr. GINGREY. I thank the gentleman from Pennsylvania, my cochair on this team, for yielding.

Once again we are bringing to our colleagues, Mr. Speaker, the issue of health care. This is something that we have committed to do, those of us who are in the health care field and interested, as our previous speaker, the gentleman from Louisiana (Mr. JINDAL), who worked in the administration prior to being elected to Congress from the great State of Louisiana and specifically worked within the Medicare system.

There are a lot of people, Mr. Speaker, on our side of the aisle who understand the issue of health care. It is disturbing to me as a physician/Member when I hear the other side in the Social Security debate, as we hear some of these Special Orders in the evening from the other side criticizing the President, criticizing the Republican leadership, the Republican majority for wanting to make some meaningful changes to a 70-year-old system that needs to be brought into the 21st century. Of course, I am talking about Social Security.

But we are hearing from the other side, and I hear this in my district. A lot of times it seems like they encourage people to come to these listening sessions or town hall meetings and say, why are you Republicans so concerned about Social Security when you are not doing anything about Medicare? What they fail to tell these good folks in our districts, usually seniors, that in December of 2003, we historically passed the Medicare Modernization and, yes, Prescription Drug Act, Part D of Medicare, and really made some significant, meaningful changes to this program. Admittedly, Medicare, and Medicaid as well, are very expensive programs, and as our seniors are living longer and, of course, putting more of a strain on the Social Security system, the same thing is happening in Medicare. But to suggest that we in the majority or this President has ignored meaningful changes, modernization indeed, in just this past December of 2003, trying to address that problem, and for us to say that we have done nothing, and to try to divert our attention away now from trying to do the same thing to bring Social Security into the 21st century, I think, is a paper tiger on their side of the aisle.

What we have done, and I thank my colleague from Pennsylvania for putting this special hour together tonight, besides the prescription drug part, which is significant, and I will not spend my time talking about that, but I want to talk a little bit about the modernization part of Medicare in that historic 2003 bill.

Medicare was a little later coming to us than Social Security. Social Security came along in 1935, 1936, and it was not until 1965 that the Medicare bill as part of Social Security was offered to our seniors. It has been a great program, but at its outset it was all about episodic care. Part A was hospital treatment, nursing home, a little bit of home health care; and Part B, of course, the optional part, the premium-based part of Medicare, was for the provider services, the physician or outpatient hospital procedures, durable medical equipment, certain drugs, as the gentleman from Louisiana pointed out earlier, but only those that are administered by an injection, not something that you could get by a prescription.

The original Medicare, and as the argument against it, again, from the other side of the aisle back a year and a half ago, was they are about to take away Medicare as you know it. Well, thank God if we did that. Thank God, and thank the Republican majority, because now instead of treating people when they have a heart attack, when they fall over at home in the shower having had a stroke because their high blood pressure was never treated, never even recognized until it is too late, and then you get into the really, really expensive part of health care, that long-term hospital stay, that ambulance trip to the emergency room, that nursing home stay until you have exhausted all of your benefits, and all of a sudden you end up destitute and covered by Medicaid, no senior wants to be in that situation.

But what we did in the modernization part, most of the attention, yes, was the prescription drug benefit, the optional Part D benefit that was finally delivered by this President, finally fulfilled, a promise that had been made and broken really by so many previous Congresses and administrations.

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But the modernization part, if my colleague will further yield, Mr. Speaker, I wanted to talk about that because we never got the opportunity to just go to the doctor and have a physical exam. As I said, it was always if one has got chest pain, if they got a nose bleed, if they have a stroke, then they get covered under Medicare.

But with the modernization program that we passed in December of 2003, when a person turns 65 and first becomes eligible for Medicare, now Medicare will pay for a complete, a complete head-to-toe thorough physical examination by a primary health care provider, a family practitioner or a general internist; and these are the diagnosticians. A lot of times people will refer to those specialists as diagnosticians; and, indeed, they are. They are the real medical sleuths that can detect disease before the patient has any idea that something is going amiss in their body. I am talking about a slight elevation of blood sugar or a slight elevation of blood pressure or maybe a person is getting a little short of breath and that internist or primary care doctor knows that they need some specific tests to rule out things like coronary artery disease or to institute some prescription medication.

Those physical examinations in the past were not covered under Medicare. It seems ridiculous, but back when we started the system, nobody really thought that that was that important, just as they did not think that prescription medication was so important. But we know now today that if we can detect these diseases as they are starting before the patient has had a significant complication, to treat it, to treat it, as we say, medically with, yes, prescription drugs, that now these seniors can finally afford, and those that are at or near the Federal poverty level, they can literally get prescription medications to treat one of these diseases at its inception by paying $1 or $3 or maybe at the maximum a $5 co-pay for a prescription that may have cost hundreds of dollars if they did not have this benefit.

So I am very pleased to be here tonight as part of this hour, this Special Order, with my colleagues, many of

them health care providers, to remind our colleagues on both sides of the aisle what we have already done in regard to trying to fix the Medicare program and in the process, of course, to provide much greater care, a better standard of care, 21st-century medicine, to our seniors who deserve that and have been waiting really so long for it.

They get that entry-level physical examination so that some of these catastrophic things do not happen to them, and if they choose in January of 2006 to have signed up for the optional part D, as 96 percent have signed up for the optional part B, the doctor part, then I think we are going to see some cost-shifting in this program.

Yes, it is an expensive program. And certainly the prescription drug part is going to be a big expensive number. I do not know exactly what it is, but what I do know is that the number crunchers, whether it is within the Centers for Medicare & Medicaid Services or whether it is the Congressional Budget Office or the Office of Management and Budget from the administration that have given us a number, and we heard $400 billion over 10 years and then we heard $520 billion over 10 years, and now we are hearing 750 or 950. I do not know.

But I do know this, that no credit is given for the possibility, the distinct possibility, that because of the prescription drug benefit, because of the initial complete physical when a senior turns 65, because of the multiple screening tests that are now paid for under Medicare on an annual or every-2-year basis, and I am talking about cholesterol screening, I am talking about pap smears for women to detect early cervical cancer or ovarian cancer, I am talking about colon cancer screening, Flexible Sigmoid tests or colonoscopies, I am talking about osteoporosis screening, doing all of these things, bringing Medicare into the 21st century is going to prevent some of these catastrophic, very expensive things from occurring.

So while we are spending a little bit more money on that and maybe a lot more money finally offering a prescription drug part, we are going to save money on hospitalizations. We are going to save money on fewer days in a nursing home. We are going to prevent people from ending up with a stroke, and, yes, indeed, maybe being in a vegetative state for 15 or 20 years, and we just talked about that last week in the Congress and know how expensive that kind of care is.

So really what we have done, and I am going to close with this, Mr. Speaker, and yield back to the gentleman from Pennsylvania (Mr. MURPHY), but what we have done in modernizing Medicare and not ignoring it, as the other side would suggest, is we have done the right thing, we have done the compassionate thing for our seniors, and we have done the cost-effective thing.

And I thank the gentleman from Pennsylvania (Mr. MURPHY) for yielding to me tonight during this hour and for our continuing to do these health care initiatives on a regular basis.

Mr. MURPHY. Mr. Speaker, reclaiming my time, I thank the good doctor from Georgia for his comments, as well as the gentleman from Georgia (Mr. PRICE), the gentlewoman from Florida (Ms. GINNY BROWN-WAITE), and the gentleman from Louisiana (Mr. JINDAL) for their comments tonight.

And noting that what we have discussed tonight as we recognize that Medicare is a program that albeit is expensive in terms of what it costs the Federal Government and taxpayers to pay for it, we believe it is worthwhile to protect and ensure the health and health care of our elderly; but we also have to note here, as even the best of programs can use better care, in this case the best of care, what we want to make sure that Members do on both sides of the aisle is work towards eliminating waste, fraud and abuse, updating the Medicare program to make sure it is providing that high-quality care, recognizing that there have been changes in how health care is provided since the 1960s when this program began, and we need to make those things work better.

We need to apply some of the changes that were recommended by the Commission on the Future of Medicare. We need to make sure that care is integrated together with examples of what I presented before, with such things as mental health care integrated with other aspects of care; making sure that we improve the system so that we have electronic prescribing that we would reduce the many medical errors that occur, reduce the about 16 million errors that occur on prescriptions every year that are written in part because we still use an old system of paper and pencil where someone may misspell a word or not be able to review it correctly or a physician cannot possibly know all the medications the patient is on, all of those things to be corrected with the major moves that were in the Medicare bill that we voted on a couple of years ago, but will begin to take effect in January of next year.

These are positive changes that I believe will help reduce the thousands of deaths, the millions of errors that occur with prescription drugs, and work for the betterment of health care in America to save lives, to save money, and to improve that.

RENEWABLE FUELS

The SPEAKER pro tempore (Mr. FITZPATRICK of Pennsylvania). Under the Speaker's announced policy of January 4, 2005, the gentlewoman from South Dakota (Ms. HERSETH) is recognized for 60 minutes as the designee of the minority leader.

Ms. HERSETH. Mr. Speaker, I rise today to engage in a dialogue with my colleagues about the policy choices that we must make in the coming weeks and months to address the energy needs and challenges that our country will face in the years and decades to come.

I believe that renewable fuels must play a central role in this debate and in the policy decisions that we in Congress will make this year. I have a strong interest in renewable fuels for several reasons. My home State of South Dakota is a major corn-producing State and one of the top five ethanol-producing States in the Nation. South Dakota alone has the capacity to produce more than 450 million gallons of clean renewable ethanol every year. This fact, of course, gives me a natural interest in renewable fuel production. That, however, is not the only reason I care about ethanol. And each of us who serves in Congress should care about renewable fuels as well.

Renewable fuels provide benefits to the economy, especially those in economically challenged rural years. They benefit the environment, and they enhance our national security. For all of these reasons, Congress should care about renewable fuels, and renewable fuels should be a major component in our Nation's long-term energy policy.

I sought this opportunity to address the House tonight to share with my colleagues important information about renewable fuels and to dispel some myths about ethanol along the way. Ethyl alcohol, or ethanol, is essentially pure grain ethanol that man has been making for centuries by fermenting and distilling simple sugars.

Today, ethanol is a fuel produced from crops such as corn, grain sorghum, wheat, sugar, and other agricultural feedstocks. Most fuel ethanol produced in the United States is derived from corn, and the industry uses a lot of it. The latest figures indicate that more than 10 percent of the U.S. corn crop is utilized to produce ethanol. Because ethanol is produced from crops or plants that harness the power of the sun, it is truly a renewable fuel. We have consistently increased our use of corn to produce ethanol every year in the United States. We are doing so because the demand for ethanol is growing and consumers are realizing its value.

The ethanol industry is growing despite the many myths that have intervened at various points in the historical development of ethanol that misrepresent the technological advancements and the state of the industry today. Some of this misinformation, or disinformation, has been promoted by opponents of the ethanol industry, and some myths have even been propagated by those in academia.

One of the most persistent ethanol myths refers to its energy balance. This myth suggests that the process used to create a gallon of ethanol consumes more energy than that gallon of ethanol contains. And despite overwhelming and irrefutable evidence to