

EXTENSIONS OF REMARKS

HEARING ON "URANIUM CONTAMINATION IN THE NAVAJO NATION"

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 23, 2007

Mr. KUCINICH. Madam Speaker, I submit for the RECORD a copy of my opening statement delivered before the Committee on Oversight and Government Reform on October 23, 2007 on Uranium Contamination.

I want to thank and commend the Chairman for holding this hearing. Native Americans have borne a disproportionate burden of the toxic legacy from this country's pursuit of nuclear weapons and nuclear power. This is a topic that has been important to me for a long time. In this classic environmental justice story, we can see how long disadvantaged peoples have been burdened with inhumane levels of contamination. And we see how long it can take just to begin to undo the damage that such contamination brings.

The stories we will hear today will also make clear that quests for power—be they political or electrical—have no respect for life and exact an unacceptable cost to human health and the environment. The EPA guesses there are about 520 abandoned uranium mines in the Navajo nation and 1,200 abandoned mines in the area. The Navajo nation is home to 5 old uranium mills. Each of the mill sites and the mine sites represent a potential groundwater contamination site in addition to being sources of air and soil contamination.

There are many potential exposure routes. Children play in the water that accumulates in the radioactive tailing piles. Homes and hogans are built out of materials that are radioactive. Wind-blown dust from the tailings is inhaled. Groundwater is contaminated with uranium and its daughter products. Wildlife and plantlife concentrate the contamination and become food for other wildlife or for Navajo living off the land.

Uranium can be toxic in two ways. First, its properties as a chemical confer an ability to irreversibly destroy parts of the kidney when acting in isolation. But, like lead and mercury, it is a metal which interacts with uranium in the human body. Native Americans are known to experience disproportionately high levels of lead poisoning. And when uranium and lead both make their way into a person, the toxic effect on the kidney could be additive or even synergistic.

Uranium is also toxic because it naturally decays into other elements like radium, thorium and radon, each of which is also radioactive. Radon alone is the number two cause of lung cancer in the U.S. behind smoking.

The industrial process of extracting and concentrating uranium uses a host of other highly toxic compounds like various acids and cyanide, which are common mine tailing contaminants. And of course there are the other elements that co-occur with uranium like arsenic and fluoride which are left behind when the uranium is refined. Each of these compounds bears its own list of health effects. And each combination of two or three or more of these compounds brings their own set of health effects. It could take

generations just to completely understand the health effects of the contamination at all of these sites in question.

Making things worse, it is a formidable challenge just to understand the magnitude of the contamination—so much so, it hasn't even been done yet. No comprehensive review of groundwater contamination at all of the mine sites has been done. No comprehensive review for the presence of elevated levels of radiation in Navajo houses has been done even though dozens are known to have been built with radioactive materials. No comprehensive review of the health effects of the contamination from the mines and mills has been done. There is no way we can begin to address the problem if we can't define it.

One estimate I've heard is that the entire cleanup could cost around \$500 million. That seems unrealistically low. Efforts just to clean up the groundwater at three of the old mill sites on the Navajo nation are predicted to take 20 years. Already, the contamination has spanned generations and will span many more if we continue the current pace of cleanup.

Some effects can't be cleaned. Before the mines were opened, the Navajo way of life was heavily dependent on natural resources, which fostered a healthy respect for their environment. Not only did they rely on it for clean water and abundant food, but they incorporated it into their customs, their religion, and their way of life. Carol Markstrom and Perry Charley pointed out in their chapter of *The Navajo People and Uranium Mining*, that the contamination of livestock, of the medicinal herbs they used, and the water bodies their children played in, changed the view of the land. It was embraced and used as the conceptual center for their way of life. After the contamination, they feared it. It is hard to imagine how destabilizing it would be if we thought radioactive contamination permeated all that we rely on to be clean and safe.

Now, almost 60 years after the first uranium contamination began, there are corporations who want to reopen some of these very same mines and extract more uranium for nuclear power plants.

Never mind the contamination already created that we're still trying to define, let alone clean up. Never mind the permanent social damage inflicted by this contamination. Never mind that nuclear power is nowhere near economical. Never mind the lack of a viable and safe storage facility for the waste that will continue to be toxic for thousands of years.

I look forward to hearing from our witnesses about plans for cleaning up the contamination in shortest possible timeframe. And I stand ready to do whatever I can to not only help this process along, but to make sure we don't do anymore damage by failing to learn our lessons from the past.

IN MEMORY OF FLAVE
CARPENTER

HON. MIKE ROSS

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 23, 2007

Mr. ROSS. Madam Speaker, I rise today to honor the memory of Flave Joseph Carpenter

Sr., formerly of Arkadelphia, Arkansas, who passed away October 15, 2007, at the age of 89.

Flave Carpenter spent his lifetime dedicated to his family, his community and his country. He was born in Clark County and his affinity for the region he called home can be measured by the enormous contributions he made to all the people and organizations he championed throughout his long life. He lived life to the fullest and would always say yes when he was called upon to help.

Flave Carpenter spent 28 years serving in the military, which encompassed tours in World War II and Korea where he was honored with multiple decorations including two Purple Hearts, two Bronze Stars and a Silver Star. Upon retirement, he returned to Arkadelphia where he took his enthusiasm for serving his country and shifted it into public service. Over the years, he gave everything he had to the city of Arkadelphia and Clark County by serving as the executive director of several local businesses and organizations. He was appointed by then-Governor Dale Bumpers to the Arkansas Parks and Recreation Commission and was later elected chairman of the Arkansas Chamber of Commerce Directors. His passion for public service was rewarded in 1984 when then-Governor Bill Clinton inducted him into the Arkansas Parks and Tourism Hall of Fame. In 2002, he received the esteemed Lifetime Leadership in Economic Development recognition by the Arkansas Economic Developers.

In addition to his civic leadership, Flave Carpenter was also a man of devout faith. He was a member of the First Presbyterian Church where he served as deacon and elder. He also enjoyed the outdoors and the camaraderie that came with hunting, experiencing nature and the numerous recreational opportunities the State of Arkansas offered.

I send my deepest condolences to his three children, Diane McKenzie of Colorado Springs, Colorado, Jan Davis of Brazil, South America, and Flave Carpenter Jr., of Searcy; his sister Carolyn Jane Berry of Arkadelphia; and to his numerous grandchildren, great-grandchildren, nieces, nephews and friends. Flave Carpenter will be greatly missed in Arkadelphia, Clark County and throughout the state of Arkansas, and I am truly saddened by this loss.

THE FUTURE OF MEDICARE

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 23, 2007

Mr. KUCINICH. Madam Speaker, I submit for the RECORD a copy of my speech delivered at the summit on the future of Medicare on October 19, 2007.

Good afternoon. I want to thank each of you for coming to discuss one of the issues that reflects the values of this country—health insurance for retirees and the disabled. I want to especially thank the Senior

• This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

Voice Coalition, a group of organizations and passionate individuals who are truly the grassroots leaders in organizing around issues affecting seniors in our community. Before I begin, please know that while there are many issues of importance, we will only be talking about Medicare at this summit today. If there are other issues on your mind, I would be happy to discuss them with you if there is time after.

Many of you recall that I held 13 town hall meetings in 2005 during the Social Security privatization debate. At these town halls, I presented detailed information on the reasons why I rejected the notion advocated by the President and some in Congress that there was a "crisis" in the solvency of the combined Old Age, Survivors, and Disability Insurance Trust Fund. We were told that to correct this manufactured crisis, the best solution was to privatize Social Security. Even if there was a "crisis," which did not actually exist, according to both the Social Security Administration and the Congressional Budget Office, the worst solution would be to drain the trust fund more quickly and therefore undermine the entire program.

Folks, we are on the verge of a very similar debate today with Medicare, our nation's other social insurance program. There is a symbiotic relationship between Social Security and Medicare. But unlike with Social Security, much of Medicare has already been privatized. Today I want to explore that with you by looking at two different Medicare programs that have been the cornerstones of efforts to privatize Medicare to see how they have performed. First, we'll look at the Medicare prescription drug plan, also known as "Part D," which leaves enrollees no choice but to go through the extraneous insurance companies. Second, Medicare Advantage shoe horns in the option to have private insurance industry middlemen to dole out health care according to what is profitable.

PART D

In 2003 came the single biggest Medicare privatization effort to date, the Medicare Modernization Act. It passed the House of Representatives only because the then-Majority party held open a 15 minute vote for over three hours in the middle of the night so they could strong-arm their way to a passing vote. Not only did it create an entirely private, chaotic prescription drug program, but it also dramatically increased subsidies to Medicare Advantage plans.

Several of us in Congress warned of what we were buying into with Part D. We warned against the forced inclusion of the unnecessary middleman—the insurance industry—and its likely effects on cost and access to meds. We warned about CMS' inability to negotiate drug prices like the VA does. We warned of a benefit that was far too complex. We warned of the now famous doughnut hole that left people without coverage for a period of time even though they were still paying premiums. We supported a bill that created a new prescription drug benefit that did away with all those problems by keeping the insurance industry out of the benefit and letting Medicare administer it.

As you know, we were not alone in our fight. At the time, the Center for Economic and Policy Research released a study showing that even if we took the modest step of allowing Medicare to negotiate drug prices, we would save so much money that we would be able to cover every single beneficiary with no co-payments, no deductibles, and no premiums . . . and still have \$40 billion dollars left.

Oversight and Government Reform Committee report on Part D.—I am sad to say that we were right. Just this Monday, the Committee on Oversight and Government

Reform released a study, which was requested by a handful of my colleagues and me, on the performance of Part D so far. It found three things. First, it confirmed the most obvious concern; that administrative costs are far higher than they should be. This was expected because of the forced inclusion of the insurance industry in the benefit. The insurers reported administrative expenses, sales costs, and profits of almost \$5 billion in 2007—including \$1 billion in profits alone. The administrative costs of the privatized Part D program are almost six times higher than the administrative costs of the traditional Medicare program.

The second finding was that the insurance industries were not doing a good job of negotiating with the pharmaceutical companies to lower prices. One of the main rallying cries of the Part D privatization effort was that the private insurers could be more effective negotiators than Medicare. Turns out to not be true. Now, instead of negotiating for lower prices, the insurers negotiate for rebates from the drug companies, which is what the Part D law calls for. The committee investigation found that drug price rebates negotiated by the insurers reduce Medicare drug spending by just 8.1 percent. In contrast, rebates in the Medicaid program reduce drug spending by 26 percent, over three times as much. Because of the difference in the size of the rebates, the transfer of low-income seniors from Medicaid drug coverage to Medicare drug coverage will result in a \$2.8 billion windfall for drug manufacturers in 2007. Furthermore, the insurers receive no rebates or other manufacturer discounts for three-quarters of the drugs used by seniors.

And the third finding was that when insurers do actually get a rebate from the drug companies, rather than passing the savings on to seniors in the form of lower prices, they keep the money for themselves! This year alone, the private insurers will receive \$1 billion in rebates on purchases that seniors pay for out of their own pockets, thanks to the doughnut hole. But beneficiaries continue to pay premiums.

Unpredictability in Part D.—Another problem with Part D as it has been implemented is that stability is lost. Much like with corporate pension scandals, instead of receiving a guaranteed benefit, those enrolled in Medicare Part D only receive a guaranteed bill to pay. Instead of being able to have peace of mind when it comes to whether or not drugs prescribed by a doctor will actually be covered, a state of financial nervousness and uncertainty is par for the course with Medicare Part D. A consumer's Union study found that most insurers raise the cost of their drugs during the year—in one case by 28 percent. The same uncertainty is present in predicting which month beneficiaries will hit the doughnut hole and be forced to pay all your drug costs as if you had no benefit at all.

Clearly, Part D is more of a benefit for the pharmaceutical and insurance industries than retirees and the disabled. The Part D provisions of the Medicare bill alone guaranteed \$139 billion in guaranteed profits for the pharmaceutical industry, which amounts to 61 percent of the total spending in the bill for prescription drugs, according to Boston University School of Public Health. Even so, Part D is not where the real money is. The real money is in the Medicare Advantage, the HMOs, PPOs, PFFSs and other alphabet soup of private plans offered through Medicare as an alternative to traditional Medicare. I'd like to talk a bit about these plans now.

MEDICARE ADVANTAGE

Medicare Advantage plans have been in existence for several years now, but the 2003

Medicare Modernization Act has drastically accelerated privatization. Lets take a look at how the plans have done, starting with how they deal with customers. I'll start with their efforts to sign you up and then we'll see how they treat you after you're already on the plan and are requesting coverage.

Marketing.—An October 7 article in the New York Times conducted their own review of 91 federal audits of privately run Medicare plans—both Medicare Advantage Plans as well as Part D plans. They found that "tens of thousands of Medicare recipients have been victims of deceptive sales tactics." They also found that "since March, Medicare has imposed fines of more than \$770,000 on 11 companies for marketing violations and failure to provide timely notice to beneficiaries about changes in costs and benefits." I want to read you two other quotes from that article to round out the picture. "In July, Medicare terminated its contract with a private plan in Florida after finding that it posed an 'imminent and serious threat' to its 11,000 members." "Medicare officials said that compliance problems occurred most often in two areas: marketing, and the handling of appeals and grievances related to the quality of care." That stands to reason since that is where the profit is made.

Humana is a good case study. Humana, which is the second-largest provider of Medicare Advantage plans, was required to fulfill corrective action plans for 300 different violations. The Center for Medicare and Medicaid Services or CMS administers Medicare. Their audit results for Humana included findings that marketing agents were not trained or supervised, enrollees were not informed of changes to plan formularies (list of covered drugs), and enrollees were not provided with explanations for claims denials or appeal rights when their claims had been denied. This is the same company that gained 4 million new policy holders and reported to stockholders in April that it had amassed "record-breaking revenues," according to an article in "The Nation." Keep in mind that this company pays its agents a commission five times greater for enrolling individuals into their Medicare Advantage plan than the commission they receive for enrolling them into a stand-alone prescription drug plan. Similar arrangements are true for other leading insurers like United Health Care, Aetna, and Blue Cross and Blue Shield. But why would they do that?

Big insurance companies are quite eager to sign up people for Part D plans. But Part D plans are nothing compared to the profit to be made in Medicare Advantage. So insurers offer low price Part D plans in order to get their foot in the door with those who were on traditional Medicare. Then they aggressively marketed their Medicare Advantage plans, too often using the unscrupulous tactics I just described. Such marketing tactics are especially effective when the plans are so complex, the customer is easily fooled. In Humana's case, the tactics worked. They were a relatively small company before the prescription drug plan and the Medicare Advantage push. But they were able to get 100,000 people to move to Medicare Advantage plans. An insurance consultant said "an additional 100,000 people contributing to top line revenue is not insignificant—it's an extra billion dollars."

Customer Service.—Now that's just the marketing. What do they do when they have you? The New York Times article found that both Medicare Advantage and Part D enrollees "had claims improperly denied by private insurers." Some examples of other problems found include "the improper termination of coverage for people with H.I.V. and AIDS, huge backlogs of claims and complaints, and a failure to answer telephone

calls from consumers, doctors and drug-stores.”

WellPoint, an Indianapolis-based company that covers 360,000 members under Medicare, had a backlog of 354,000 claims under its Medicare plans. Auditors logged an average wait time of 27 minutes to answer enrollee phone calls and a 16-minute wait time to respond to provider calls. Of the more egregious offenses, Sierra Health, based in Las Vegas, wrongfully terminated drug coverage for 2,300 HIV-positive Medicare Advantage enrollees, improperly claiming they had defaulted on plan premiums.

Fewer options, not more.—Medicare Advantage advocates often speak of the greater choice in their plans as opposed to traditional Medicare. I don't think you can have more choice than to be able to choose from any doctor, which is the case with traditional Medicare, but we'll take a look anyway.

As with Part D plans, there are countless stories of beneficiaries seeing changes to their plan midyear, including cost increases, dropping certain drugs from formularies, or doctors dropping out from frustration with the plans. In fact, Medicare Advantage plans talk a lot about their extensive network of doctors but customers frequently find that when try to go to one, the docs won't take Medicare Advantage customers. Many doctors don't like it because of the low pay and because of the insurance industry second-guessing their diagnoses and choices for providing care. Even though all these changes can be made at any time in the enrollment cycle, beneficiaries can only switch plans once per year.

Some argue that Medicare Advantage offers a better quality of care than traditional Medicare. The Congressional Budget Office disagrees, stating “though Medicare Advantage plans cost more than care under the fee-for-service program does, on average, they would be more cost-effective if they delivered a sufficiently higher quality of care . . . The limited [quality] measures available suggest that Medicare Advantage plans are not more cost-effective than the fee-for-service program.”

Those enrolled in Medicare agree, as traditional Medicare beneficiaries are less likely to have problems accessing specialists, according to MedPAC.

Out of pocket costs.—Medicare Advantage insurance companies make money when they shift the costs onto you and me. One of the ways they do that is by providing incomplete insurance or underinsurance. They can offer meager coverage in specific unnoticeable areas that only matter if you get the illness that isn't covered well. Because Medicare Advantage plans are not required to be standardized—meaning different companies are not required to offer the same plan structure and compete only for price—these companies can skew their plans to maximize their profits and decrease benefits. One tragic result is that people in more need of services, especially those in need of physician-administered chemotherapy drugs and dialysis services, pay more under Medicare Advantage than they would under traditional Medicare for less service. Their out-of-pocket costs are unexpectedly and dangerously high. This is one of the biggest health care problems that we don't hear enough about. About half of all bankruptcies in this country are related to medical bills. Of those medical bankruptcies, 75 percent of the people had insurance before they got sick. But because their insurance still allowed them to go bankrupt, it was clearly lacking. Profitable, but lacking.

For those of you that have seen Sicko, the Michael Moore movie about health care, you know that another way insurance companies

make money is to deny benefits, which is done in spades under Medicare Advantage. The Medicare Rights Center who collects many Medicare Advantage complaints told the story of an 80 year old man enrolled in a private Medicare plan called HealthSpring. He had a heart attack and went to the hospital. All of his claims were denied because he didn't get prior authorization from the plan to enter the hospital. His hospital bills now top \$87,000 dollars.

Propping Medicare Advantage up.—You would think that since Medicare Advantage beneficiaries are getting such an inferior product, that it would cost less. It is not so. As with Part D, Medicare Advantage is far more costly than traditional Medicare. Both the Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office (CBO) report that for 2007, it costs taxpayers 12 percent more (on average) to cover beneficiaries enrolled in private Medicare Advantage Plans than under traditional Medicare. That is an extra \$149 billion over 10 years. The Chief Medicare Actuary has said that the beneficiary enrolled in traditional Medicare pays an extra \$24 per person this year because of overpayments to Medicare Advantage. This overspending also cuts years off the life of the Medicare trust fund and diverts money away from hospital and acute care services. While the Social Security trust fund can pay 100 percent of benefits until at least the year 2041 without any changes whatsoever, the Medicare Hospital Insurance (or HI) Trust Fund can pay 100 percent of claims only until the year 2019, based on current actuarial assumptions, in large part because of privatization.

Not only is the program inefficient, but it is growing steadily. According to the Congressional Budget Office, 18 percent of current Medicare beneficiaries are enrolled in a Medicare Advantage plan. This number is expected to increase to 26 percent by 2017. The biggest growth—about 650 percent since 2005—has been in enrollees in the private fee for service plans which have enjoyed exclusive access to major subsidies from Congress as well as exceptions to standards of quality care. Unfortunately, the fastest growing type of plan is also the least efficient of all Medicare Advantage plans. They cost, on average, 19 percent more than traditional fee for service Medicare. Where does all that money that should go to health care, actually go? MedPAC found that half of the overpayments go directly to profits, marketing, and administrative costs. That's worth repeating. Half of the overpayments go directly to profits, marketing, and administrative costs.

These private fee for service plans aren't the only ones to get corporate welfare. The PPO “stabilization” fund is a slush fund designed to encourage growth of new regional PPOs of 10 billion dollars over 10 years. That's in addition to general subsidies for Medicare Advantage plans. But in 2006, 88 percent of beneficiaries had access to a regional PPO. So subsidies for growth are unnecessary. Even MedPac recommended eliminating the slush fund.

I mentioned earlier that Medicare Advantage Plans are lucrative for insurance companies. UnitedHealthcare will make about 11 percent of its net income for 2007 from Medicare Advantage. That number is 66 percent for Humana. Between 2005 and 2006, when a lot of these subsidies took effect, United and Humana saw increases in revenue of over 50 percent. WellPoint saw an increase of 27 percent. When there is so much money at stake, it is very cost effective to have not only a big marketing push, but also a strong lobbying army to make sure your Congressional subsidies don't go away. That is what they do.

GENERAL DISCUSSION

There is a race in the health insurance world to determine who can provide the lowest quality benefits for the highest possible cost that consumers, companies, and the government will accept.

Seniors and disabled individuals who have contributed to Medicare from a lifetime of work deserve to have simple, clearly defined benefits which do not change from month to month, year to year. We should not be paying companies exorbitant administrative costs and overpayments that maximize profit margins in order to put beneficiaries, benefits at risk. All of this is the case with the private Medicare Advantage and Medicare Part D, and it should be stopped.

The best, most efficient way to ensure all Medicare beneficiaries will always have real, reliable, and complete benefits is to end private involvement in Medicare. That's why I, along with John Conyers of Michigan, coauthored the Expanded and Improved Medicare for All Act, H.R. 676, back in 2003. HR 676 captures the enormous savings to be had if Americans had health care provided through Medicare and uses them to cover everyone for all medically necessary services with no copayments, no deductibles and no premiums. This bill would strengthen Medicare by removing the for-profit interests, decrease the financial burden to beneficiaries, and increase the quality of care—all without the confusing maze that privatized Medicare has become today. There is enough money that America spends in health insurance and health care today to cover everybody. Every year, \$2.2 trillion is spent, and only about 69 cents out of every dollar actually goes to providing health care services. We are all paying for universal health coverage, we just aren't getting it.

Congress will be required to hold hearings on and propose changes to Medicare due to the financial situation of the program which privatization has created. I intend to use this opportunity to emphasize the best, most comprehensive, and most cost efficient way to strengthen benefits for those enrolled in Medicare—H.R. 676.

What's happening in Washington.—Many of you know an early version of a bill to provide health insurance to millions of children through a program called SCHIP, also called for cuts to one of Medicare Advantage slush funds I mentioned earlier. I supported that bill but the insurance industry mounted an expensive and aggressive lobbying campaign that ensured their slush fund stayed in place. Now there is talk of using that slush fund money to pay for maintaining Medicare payments to doctors as opposed to allowing scheduled cuts of about 10 percent to take place.

H.R. 676 now has 85 cosponsors and is the only national health care reform bill that has an entire national movement behind it. There are two national non-profit organizations and several regional organizations devoted to its passage. And it has the official backing of 93 Central Labor Councils, including several Cleveland and Ohio unions as well as cities and states across the nation.

There is the possibility of implementing an interim measure of providing a prescription drug benefit that gets rid of the insurance companies and lets the benefit be administered by Medicare. Doing so would clearly lower costs, increase access and increase quality. But I would like to hear what you think of that idea. Would people be willing to give up their privatized plans for more plans that give greater security and coverage?

And while I'm asking for your input, I'd like to ask you about another related issue that has recently come up. As I understand

it, Ohio Public Employees Retirement System (OPERS) has announced that it will shift from offering two traditional Medicare plans to offering one traditional Medicare plan and one Medicare Advantage plan. I am concerned about this choice and would like to hear from you about it.

I know you all have been waiting for the opportunity to ask questions and share your comments, so let's transition to that right now.

IN MEMORY OF EARL PATY, JR.

HON. MIKE ROSS

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 23, 2007

Mr. ROSS. Madam Speaker, I rise today to honor the memory of my dear friend Earl Paty, Jr., of Sheridan, Arkansas, who passed away October 17, 2007, at the age of 76.

Earl Paty, Jr., was a lifelong resident of Grant County where he built a solid foundation of community service that impacted countless lives and will forever be remembered by all who knew him. Whether serving others during his 40-year career at International Paper Co., or through his involvement with numerous local and state organizations, he devoted his lifetime to selflessly giving back to the citizens of Grant County and the State of Arkansas to make the world a better place.

Earl Paty, Jr., was a devout man of faith and a member of Moore's Chapel United Methodist Church. He took great pride in serving the church and congregation on the Administrative Board, as a Sunday School teacher and as a delegate to the Arkansas Annual Conference. He even rose to the level of becoming a certified lay speaker within the United Methodist Church. In addition, he was actively involved with numerous local organizations where he devoted his time and heartfelt energies to others. These included the Grant County Fair Board, the Grant County 4-H Club, the Southeast Arkansas District Development Cooperative and the Sheridan Masonic Lodge.

Perhaps my fondest memories of Earl Paty, Jr., are the many discussions we had over the years about politics, as he well understood how a career in public service could positively affect the lives of thousands. I always admired his fervor for politics which took him up the ladder from chairman of the Grant County Democratic Party to the Executive Director of the Senior Democrats of Arkansas. His contributions to the Democratic Party were recognized in 2003 when he was honored with the distinguished Harold Jinks Democratic Memorial Award. In fact, it was Earl Paty, Jr., who inspired me, through his passion and love of politics and public service, to seek elected office and run for the seat I now hold as U.S. Representative of Arkansas's Fourth Congressional District. For that, I am forever grateful. He was a man I truly looked up to and admired and I am blessed to have been able to call Earl a dear friend.

I send my deepest condolences to his wife of 53 years, Betty Sue Autrey Paty; his children Patricia Knighten, David Paty, and Leslie Tannahill; his two sisters Sue Walker and Faye Welch; and his nine grandchildren, two great grandchildren and numerous nieces and nephews. Earl Paty, Jr., will be greatly missed

in Sheridan, Grant County and throughout the state of Arkansas, and I am truly saddened by this loss.

FEDERAL RAILROAD SAFETY
IMPROVEMENT ACT OF 2007

SPEECH OF

HON. SILVESTRE REYES

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 17, 2007

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 2095) to amend title 49, United States Code, to prevent railroad fatalities, injuries, and hazardous materials releases, to authorize the Federal Railroad Safety Administration, and for other purposes:

Mr. REYES. Mr. Chairman, I rise today in strong support of H.R. 2095 the Federal Railroad Safety Improvement Act of 2007. This bill, introduced by my colleague Chairman JAMES L. OBERSTAR, provides a long-overdue reauthorization and reorganization of the Federal Railroad Administration. I am proud to count myself as a cosponsor of this legislation.

My district of El Paso has a rich history with the railroad industry. Following the arrival of the railroads in 1881, El Paso experienced enormous economic growth due in part to the railroad connections in the area. Today, my city's connections to the industry persist, and hundreds of my constituents go to work in the rail yards and along the tracks every day. Rail workers and the Americans who live near rail operations deserve the highest level of safety, and the Federal Railroad Safety Improvement Act provides just that.

Roughly 40 percent of all train accidents are the result of human factors, and, of this startling number, one in four results from fatigue. This bill will set new hours-of-service for our railroad workers and will help ensure they follow proper rest and shift periods. Under the proposed measures, personnel would receive at least 10 hours of rest per 24-hour period and would ultimately be limited to no more than 12 consecutive hours of shift work. The bill would also nearly double the number of rail safety inspection and enforcement staff. These changes would hopefully reduce the number of accidents caused by human error and fatigue and would help ensure safer working conditions for the approximately 1,100 rail workers of El Paso and across the United States.

In addition, H.R. 2095 would reorganize the Federal Railroad Administration (FRA) and rename it the Federal Railroad Safety Administration (FRSA). Over the 4-year period from 2007 to 2011, the FRSA would authorize \$1.1 billion for general expenses and grant programs. This legislation has taken into account many of the safety investigations and recommendations of the Department of Transportation, especially regarding human fatigue, defective tracks, and railroad crossings. With the reauthorization of this funding, I am confident that great strides will be made to improve the safety of the railroad industry in the United States.

Mr. Chairman, I ask that my colleagues join me in supporting this important legislation so that substantial improvements in Federal railroad safety can be made nationwide.

IN REMEMBRANCE OF J. ROY
GABRIEL

HON. JIM COSTA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 23, 2007

Mr. COSTA. Madam Speaker, I rise today to honor the life and dedication of Mr. J. Roy Gabriel, director of labor affairs for the California Farm Bureau Federation and chief operating officer of the Farm Employers Labor Service. Roy passed away suddenly this month in our Nation's Capital while representing the agricultural community on the issues he found most near and dear to his heart. His service and commitment to California agriculture and his passion and joy for life will be sorely missed.

A native of southern California, Roy attended California Polytechnic University, San Luis Obispo where he earned a degree in Agricultural Business Management and a technical certificate in crops production. Armed with this knowledge and a love for farming, Roy became active in local politics, honing his negotiating skills. In 1973, he joined the California Farm Bureau as a legislative assistant and began his life long commitment to the betterment of agriculture in California. Recognizing Roy's breadth of experience and political prowess, Gov. Pete Wilson appointed Gabriel in 1998 to serve as chief deputy director of the California Department of Industrial Relations.

Roy's involvement with California farming has spanned 30 years. Throughout his lifetime, he has been a tireless voice in support of the valley's immigrant population. In the eighties, Roy helped more than 50,000 workers apply for legal immigration status under the Federal Immigration Reform and Control Act of 1986. Like me, Roy believed the current agriculture labor shortage to be a crisis and fought to bring attention to the issue and enact reform legislation like AgJobs. The agricultural labor reform movement has lost a great champion in his passing.

We also shared a passion for rail transportation. He was not only an avid historian of nineteenth and twentieth century rail development, but he was respected for his knowledge and opinions on the subject matter. Roy was also an active supporter of today's national high speed and inner-city passenger rail efforts. For all these reasons, we will miss him dearly.

Mr. Gabriel's leadership and dedication will continue to inspire Californians for many years to come. A man of great principle and integrity, his passion and enthusiasm has touched many lives, including my own. It is with fond sadness that I remember and honor the life of my colleague and friend, Mr. J. Roy Gabriel.

PERSONAL EXPLANATION

HON. TIMOTHY V. JOHNSON

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 23, 2007

Mr. JOHNSON of Illinois. Madam Speaker, unfortunately yesterday, October 22, 2007, I was unable to cast my votes on H.R. 189, H.R. 523, and H. Res. 76.

Had I been present for rollcall No. 983 on suspending the rules and passing H.R. 189,