

York, Republican Committee is hereby directed to forward this resolution to the above named State and Federal Officials.

JOHN SCHEMMELE, GERMAN-AMERICAN OF THE YEAR

HON. DAVID E. BONIOR

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mr. BONIOR. Mr. Speaker, I rise today to pay tribute to my good friend, John Schemmel. John was honored by the members of the German-American Cultural Center this past Sunday during the 45th anniversary banquet. He was named German American of the Year at the Carpathia Hall in Sterling Heights, MI.

John is a first generation German-American. His parents immigrated from Siebenbuergen before he was born in 1920. From an early age John developed an appreciation of his heritage. He attended St. Thomas German Lutheran School as an elementary student. His German roots were rapidly becoming intertwined with America by the time he became a teenager. He was first baseman in the Transylvania Saxons Junior Association fast pitch softball league and, as team manager, he and his teammates won the championship in 1939.

In 1942, John found himself in the U.S. Army as an infantryman. He served in the Aleutian Islands and eventually in France and Germany. After returning to the States, John worked for Chrysler Corp., the Detroit Police Department, and he attended the Michigan Technical School for electrical study. He eventually joined the engineering staff at General Motors where he worked for 33 years. John also became one of the first trustees of UAW Local 160 at the General Motors Technical Center.

Long before John began engineering world class quality cars, he was active in organizations that celebrate and commemorate his German heritage. He has been a member of the Alliance of Transylvanian Saxons since 1937 and has served in every office of the Siebenbuenger Sachsen Verein. He sang tenor with the GBU-Saxonia Gemischterchor. The members of the German American Cultural Center are well aware of John's efforts to preserve the rich German heritage that exists in the metropolitan Detroit area. He served as the center's president for 4 years and is currently the group's first vice president.

In addition to his involvement with cultural organizations, John is a member of the Fraternal Order of Police, the Veterans of Foreign Wars, the Fraternal Order of Eagles, the United Automobile Workers Local 160, and the Roseville Democratic Committee.

John's pride in his German heritage is only equaled by his pride in being American. He has devoted time and energy to his colleagues, his community, our Nation, and his family and friends in numerous capacities. I applaud the German American Cultural Center for recognizing John. He has provided outstanding leadership to the group and I know he is proud to be honored by the members.

On behalf of the German-American community, I urge my colleagues to join me in saluting John Schemmel, German-American of the year.

FAIR WINDS AND FOLLOWING SEAS FOR VICE ADM. DONALD F. HAGEN, MC, USN

HON. OWEN B. PICKETT

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mr. PICKETT. Mr. Speaker, I rise today to recognize and honor a truly outstanding naval officer and physician, Vice Adm. Donald F. Hagen, for his devoted and distinguished service as the Surgeon General of the Navy. It is a privilege for me to recognize his many outstanding achievements and commend him for the superb service he has provided to the Department of the Navy and to our great Nation as a whole.

During his 30 year Navy career, Vice Admiral Hagen has served our Nation in a variety of roles, ranging from combat surgeon to the chief executive of a unique, worldwide health care system dedicated to providing health care and related medical services to Navy and Marine Corps members, retirees, and their families.

Upon commissioning as a lieutenant in the U.S. Navy Medical Corps in 1964, Vice Admiral Hagen assumed his first assignment as a battalion surgeon with the Marines in Chu Lai, Republic of Vietnam. He returned to Vietnam twice more, serving aboard the hospital ship *U.S.S. Repose* and then as staff surgeon with the Riverine Assault Forces in the Mekong Delta.

Vice Admiral Hagen's experiences as a primary care physician under combat conditions led him to seek a career in surgery. His surgical training took him to Naval Hospital, St. Albans, NY, and Naval Hospital, Portsmouth, VA. He then served as staff surgeon at Naval Aerospace and Regional Medical Center, Pensacola, FL; Naval Hospital Yokosuka, Japan; and Naval Regional Medical Center, Jacksonville, FL. During these years, Vice Admiral Hagen gained not only clinical expertise, but became proficient in all aspects of hospital medical staff leadership.

Due to his extensive combat experience aboard hospital ships and service with the Marine Corps, Vice Admiral Hagen was selected to head the Contingency Planning Division at the Bureau of Medicine and Surgery where he served from 1981-1984. Returning his energies to peacetime clinical medicine in 1984, he assumed command of Naval Hospital, Camp Pendleton, CA. During this tour, Vice Admiral Hagen's broadly based record of excellence was recognized by his selection to flag rank. As a rear admiral, Dr. Hagen returned to Washington, DC, as Director, Health Care Operations, Navy Medical Command and Chief of the Medical Corps. In December 1988, he assumed command of the National Naval Medical Center, Bethesda, MD. On June 28, 1991, Dr. Hagen took command of all aspects of Navy Medicine with the rank of vice admiral as the 31st Surgeon General of the Navy.

Vice Adm. Donald F. Hagen will complete his tour as the Surgeon General of the Navy in July 1995, concluding more than 30 years of Federal service. Vice Admiral Hagen has provided the broad vision, innovation, and dedicated leadership which have resulted in the Navy's current high state of medical excellence. A man of Vice Admiral Hagen's talent and integrity is rare indeed and while his hon-

orable service will be genuinely missed, it gives me great pleasure to call upon my colleagues from both sides of the aisle to wish him and his family every success as well as fair winds and following seas.

TRIBUTE TO THE CHURCH OF ST. MARGARET MARY ON ITS 75TH ANNIVERSARY

HON. CHARLES E. SCHUMER

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mr. SCHUMER. Mr. Speaker, June 4 will mark the 75th anniversary of the Roman Catholic parish of St. Margaret Mary in Manhattan Beach. Though small in membership, the church of St. Margaret Mary remains one of the largest parishes in the Dioceses of New York. This church has provided strong leadership to the community of Manhattan Beach, while serving as a role model to other small Catholic churches within the dioceses. Since 1928, the families of Manhattan Beach have maintained an active membership to St. Margaret Mary's Church. In honor of this anniversary celebration, I rise to salute the generations of parishioners who have made St. Margaret Mary's Church a valuable addition to New York's spiritual community.

The history of St. Margaret Mary's Church is characterized by courage, strength, and a will to survive during difficult times. For over 75 years, parishioners have overcome severe financial obstacles, often threatening the very existence of the church. Yet, the church and its members fought hard to keep it functioning. By maintaining a strong sense of unity throughout the years, the parishioners of St. Margaret Mary's Church have successfully preserved the character and vitality of the Manhattan Beach community.

On this most joyous anniversary celebration, the Church of St. Margaret Mary remains a beacon of strength and hope for every Catholic church in New York. May the families and future parishioners of St. Margaret Mary's be blessed with the good fortune of celebrating many more anniversary celebrations well into the future.

TRIBUTE TO LOW-INCOME HOUSING PARTNERSHIP

HON. WILLIAM (BILL) CLAY

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mr. CLAY. Mr. Speaker, I would like to recognize the collaborative efforts of two institutions in my district, whose achievements are helping to rebuild and restore hope in south St. Louis. DeSales Community Housing Association and Equality Savings and Loan Association have been recognized by the Social Compact in the 1995 Outstanding Community Investment Awards for their partnership achievement: the creation of an innovative housing program that allows residents to participate fully in the decisions that are shaping their community.

The Social Compact is a national coalition of leaders from the financial services industry

and the nonprofit sector, dedicated to increasing private investment in low-income communities, both rural and urban. To achieve this mission, they lead by example, recognizing successful and innovative partnerships between financial services institutions and neighborhood nonprofit organizations that are working together to reclaim vulnerable neighborhoods. As a result of the Outstanding Community Investment Awards, DeSales Community Housing and Equality Savings were chosen out of 160 applicants as a model partnership.

DeSales and Equality are being recognized for the creation of the DeSales Mutual Housing Association. This kind of development represents the first step toward home ownership for life-long renters. Mutual housing associations encourage community-based ownership of affordable rental properties. Neighborhood residents and project tenants actively participate in ownership and management decisions of their buildings, including site selection, design, construction, and organizational structure.

DeSales began working with residents on the mutual housing association model in the early 1990's. Today, thanks to the dedication of 30 neighborhood residents, the Iowa Avenue Townhouses and the California Townhouses have taken the place of nine vacant buildings in south St. Louis as models of affordable, resident-controlled housing.

Equality Savings and Loan Association assumed a critical leadership role in making this project happen. The small thrift took charge of convincing the financial community, businesses, foundations, and the major's office of the credibility of the project. Equality also helped enlist additional investors to provide permanent financing and, equally important, they convinced St. Louis residents and others that this innovative approach could work.

Thanks to the first mutual housing association model ever enacted in Missouri, neighborhood residents are taking on leadership responsibilities in their community. Small-scale rehabilitation is happening elsewhere, and the community's church and elementary school are crediting the townhomes for stabilizing their surroundings.

I applaud DeSales Community Housing Corporation and Equality Savings and Loan Association as a replicable example of a public private partnership that empowers residents to reclaim their neighborhoods.

**MEDICAL SAVINGS ACCOUNTS—
DISABLED COMMUNITY EX-
PLAINS WHY THEY ARE A PRO-
FOUNDLY BAD IDEA**

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mr. STARK. Mr. Speaker, medical savings accounts are a brilliant scheme to skim the healthiest people out of the insurance pool—and leave the rest of us to face sky-rocketing insurance rates. MSA's are a bad idea that has spread like wildfire.

Following is a portion of the testimony of the Consortium for Citizens With Disabilities before the Ways and Means Subcommittee on Health on May 25. I hope the CCD's insights will help stop this lemming-like pursuit of MSA legislation.

MEDICAL SAVINGS ACCOUNTS

Many Members of Congress believe that Medical Savings Accounts (MSAs) have the potential to reduce health care costs and increase the number of Americans with insurance. There have been suggestions that MSAs be implemented not only in the private sector but in the Medicare program as well.

The Consortium for Citizens with Disabilities Health Task Force has major concerns with the emphasis presently being placed on Medical Savings Accounts as a solution to our health system's problems of access and affordability. The use of MSAs is not only untested, but also has the very strong potential for making comprehensive health insurance less affordable for persons with disabilities and serious chronic illnesses. Because of our many concerns, which are discussed below, and in the absence of other reforms, the CCD Health Task Force does not support the establishment of MSAs as either an incremental reform or as a solution to the health care problems facing millions of uninsured and underinsured individuals in the U.S.

Supporters of MSAs state that:

MSAs will allow the marketplace, not the government to address the cost and access issue. By giving responsibility for paying for health care to consumers, it is assumed that MSAs will reduce unnecessary health care expenditures because individuals who are spending their own money will be more prudent purchasers. It is also assumed that the lower cost of catastrophic health insurance will lead more employers to offer the health insurance.

MSAs will lead to lower administrative costs because insurance companies will only be involved with claims higher than the deductible amount.

However, MSAs are untested, and it is not clear that they will either lower costs or improve access to services.

What are MSAs and How do they Work?

Medical Savings Accounts are tax-exempt savings accounts modeled on Individual Retirement Accounts that employed individuals can use to pay for health-related expenditures. State MSA laws generally create incentives for people to set up these accounts by exempting from state taxes the money contributed to these accounts. MSAs work like this:

Employers can purchase a standard health insurance plan with a low deductible (\$250-\$500 annually per person) or a catastrophic health insurance plan with a high deductible (\$3000-\$5000 annually per person). Because most people will not have health care costs higher than several thousand dollars, the premiums for high deductible catastrophic health insurance plans are much lower than for plans with low deductibles.

An employer sets up a MSA for employees who want to participate in this type of plan and deposits, in pre-tax dollars, an amount equal to the difference between the cost of a standard low deductible plan and a catastrophic high deductible plan. The self-employed can also set up a MSA.

Employees can use the money in their individual account for health care expenses. When the high deductible is met, the insurance company then pays the bills. If money is left in the account at the end of the year, it can be withdrawn and used for other purposes or carried over with accrued interest into the next year.

The CCD has several major concerns about MSAs:

The catastrophic health plans that are purchased in conjunction with MSAs can impose pre-existing condition limitations and can refuse to cover persons with certain health conditions or disabilities.

Catastrophic health plans with high deductibles often do not provide the comprehensive coverage needed by persons with serious illnesses or conditions. Some of these plans have lifetime or per condition limits of only \$100,000.

The American Academy of Actuaries has estimated that persons with high health expenses will experience major increases in out-of-pocket costs with MSAs. MSAs may also increase out-of-pocket costs if the amount employers contribute to the MSA is not sufficient to cover the annual catastrophic deductible. Additionally, the combined cost to the employer of an MSA contribution and the catastrophic health plan premium may not be less than the cost of a standard health plan.

If large numbers of individuals choose MSAs plus catastrophic health plans, the health insurance market will be further segmented, reducing the size of the population pool needed to spread risk adequately.

MSA will likely lead to adverse selection because they will be utilized primarily by younger, healthier people who do not anticipate a need for health care. Persons who anticipate health care expenditures, those who need comprehensive coverage, and those who are older and at higher risk for needing health care are likely to remain in standard low deductible health insurance plans. Individuals with MSAs could also change to a low-deductible plan when they become sick or anticipate medical bills (e.g., childbirth expenses), thus exacerbating the problem of adverse selection.

Adverse selection will lead to higher premiums for persons in standard, low deductible health insurance plans. It has been estimated that if MSAs are widely adopted, the cost of a standard, low deductible health insurance policy would rise by as much as 26%. Increases of this magnitude will make comprehensive, low deductible insurance unaffordable both for employers and individuals who want to purchase these policies.

There is no evidence that MSAs will make consumers more cost conscious when they are seriously ill. Physicians—not consumers—determine what treatment is needed. If surgery is recommended, consumers don't look for the cheapest surgeon, they look for the best surgeon.

Some individuals may forgo preventive and early intervention services if they are allowed to use money left in their MSAs at the end of the year for personal expenses other than health care. This concern also raises the question of whether it is appropriate to allow pre-tax dollars to be used for non-health expenses.

It is likely that catastrophic health plans will restrict the type of health care expenditures that will count towards the deductible. For example, if an individual spends \$3000 on mental health services, there is no guarantee that all of these expenses will be counted towards the deductible, particularly if the insurance has limited coverage for these services.

A majority of Americans are enrolled in some form of managed health care plan. It is unclear whether MSAs can be coordinated with these plans. Those opposed to managed care view MSAs as a means to maintain the market for indemnity insurance and fee-for-service health care delivery.

Experience with MSAs is very limited. It is not clear whether they will result in savings. Some analysts predict that any potential system cost savings will be eliminated by the additional costs required to administer MSAs.

Most importantly, the CCD Health Task Force believes that allowing employers and the self-employed the option of establishing tax deductible MSAs in conjunction with