

Blue Cross would like to convert all of its business, acknowledge that as much as 1/3 of the premium dollar goes to "administration" rather than patient care.

Faced with a diminishing piece of the premium dollar pie, physicians and hospitals dependent upon managed care dollars for survival are constrained to deny care to those in need. Primary care physicians are compensated by "capitation," meaning that they receive only a fixed monthly fee for caring for each patient. This fact has resulted in California in a lot more medicine being practiced by telephone. In addition, in many plans, a significant percentage of the primary care physician's capitation payment is withheld, with all or a portion of the sum returned to the physician at year's end, depending upon the "loss experience" of the group. And what "loss experience" means is simply that the more patients referred for tests, consultations, surgery, etc., the greater the loss experience. So there are powerful financial incentives built into the system for primary care physicians who act as "gatekeepers" for referrals, to deny care. In addition, managed care bureaucracies keep track of each primary care physician's financial track record, and have the right to terminate a physician whose loss experience is not to their liking. Managed care organizations are under no legal obligation to inform consumers of these facts when giving them a sales pitch to join an HMO. And if you look at the situation here in California, insurance companies have been aggressively advertising Medicare HMO products with offers that seem too good to be true. But in the end, in practice, what for-profit managed care organizations really do is to siphon money away from medical care, and redirect those dollars into multimillion dollar CEO compensation packages and huge bureaucracies. Do Medicare HMO's save the Federal Government any money over the existing system? Look for any proof of that; there isn't any.

When I look at the Republican proposals for Medicare reform, what I see first is that the deductible will be made so large as to make the overwhelming majority of Medicare recipients join for-profit HMO's who promise them a "no-deductible" plan. The business of other options such as medical savings accounts, etc. will never amount to anything in reality. I cannot understand why my buddies in the AMA cannot see that. If the California experience with HMO's is any indicator, there will be a merger and acquisition frenzy as larger HMO's swallow up smaller ones. More and more dollars will be spent on these mergers rather than patient care (When, for example, Health Net and Qual-Med merged, certain members of their respective boards of directors shared \$110,000,000 in stock and cash "compensation"). What will result is an oligopoly of three or four huge insurance companies controlling all medical care. And the primary factor determining success or failure in any competition in this marketplace will not be quality of care, but simply the profit picture of the company, which is inversely related to expenditures on patient care.

It is for these among other reasons that I am highly wary of the Republican plan. I strongly suspect that the Republicans are primarily doing the bidding of a few huge insurance companies who plan to be the major players in the Medicare marketplace once it is "privatized."

From this perspective, I am also highly suspicious of the provision in the proposed legislation to limit noneconomic malpractice litigation awards. This may surprise you, coming as it does from a physician. But according to my malpractice insurer, in California the largest growth area in medical malpractice suits is in litigation against the

formerly-low-risk-specialty of primary care for failure to timely diagnose and refer to specialists. Does this mean that managed care in changing practice patterns in primary care as regards the timeliness in which patients are referred for specialty care? I don't think that it takes a brain surgeon to figure that one out! Lawsuits filed against physicians are inevitably filed against the HMO's as well, and particularly after the 75+ million dollar judgment against Health Net in the marrow transplant denial malpractice case, the HMO's are quite aware that they have become the "deep pockets." From this perspective, I view such malpractice reform as contained in the Republican proposals primarily as a license for HMO's to be negligent, confident in the notion that a maximum \$250,000 liability in almost all cases represents a relatively small cost of doing business. As more and more doctors become virtual employees of for-profit HMO's, they will realize that malpractice reform was primarily meant to benefit their employers!

Right now Medicare works well, returning a high percentage of dollars spent in actual benefits to recipients. The increased spending on Medicare is primarily a function of the aging of the population and the fact that advances in medicine have made possible the successful treatment of many conditions not amenable to such treatment in 1964. While I would agree that the system requires reform, I would caution you that the Republican plan is simply a scheme for diverting billions of Federal dollars earmarked for Medicare recipients into the hands of a few at the expense of many. If you are unsure of this, just try to introduce some elements into the legislation that would insure that a certain percentage of Medicare dollars are to be spent on patient care, and not diverted by profiteering insurance giants. You will find that your Republican colleagues will be spouting all kinds of pure garbage in defense of their true benefactors, who would love to be an unregulated industry!

Sincerely,

MARC A. LEVINA, M.D.

Mr. Speaker, I now yield to the gentlewoman from Florida [Ms. BROWN].

Ms. BROWN of Florida. During the August recess I conducted 14 town meetings where I talked to over 3,000 of my constituents, and we in Florida understand that the \$270 billion that the Republicans are cutting out of the Medicare budget to save it, we understand just what kind of savings that is, and in fact the 10 years I served in the Florida House we had a saying for it: That dog don't hunt.

Now I have a contract that I signed yesterday in Orlando, and I signed it with the people of the Third Congressional District, but let me be clear. I signed it with the people of Florida and the seniors of the United States, and my commitment is to them. We do not like that reverse Robin Hood that has been going on since the 104th have taken over. You know what I mean, robbing from the poor and working people to give a tax break to the rich, and I know that you all do not like that word "cut." Well, I have got a better word for you. Try "gut." You are gutting the program.

Ms. PELOSI. Mr. Speaker, I thank the gentlewoman for her remarks, and I ask our colleagues to vote "yes" for Medicare and "no" for tax cuts.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida [Mr. SCARBOROUGH] is recognized for 5 minutes.

[Mr. SCARBOROUGH addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

THE FACTS OF THE REPUBLICAN MEDICARE PROPOSAL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Pennsylvania [Mr. FOX] is recognized for 5 minutes.

Mr. FOX of Pennsylvania. Mr. Speaker, the fact of the matter is, Mr. Speaker, despite the comments you may have heard tonight from others on the House floor, Republicans do care, care so much for seniors, that we, in fact, passed on the House floor earlier this year rescinding of the 1993 tax on Social Security. We now have legislation we have adopted here in the House which will allow seniors under 70 to make more funds than the \$11,280 they have been capped at without having deductions from their Social Security.

Now let us look at perspective when it comes to Medicare discussion about how we got to this point. It was the President's trustees working with others who came out with a report in April which said that Medicare, if nothing happens with the program, will go bankrupt by the year 2002. You may say, well, how did we get to this point with health care going up 4 percent a year and Medicare going up about 10 or 11 percent a year? How did we get to that point? Well, the facts are we got to this point because we have \$30 billion a year in fraud, abuse, and waste. We also have 12 percent of the costs of Medicare just going to paperwork.

So you say to yourselves, What's the solution? The solution is we cannot do nothing. We have to make sure the system is solvent and we have access to quality health care for our seniors. So what we have to consider is a program which would give seniors choice, continue their fee for services, if that is what they would like; the managed-care option, if they would like to have that, which would include such items as pharmaceuticals or dentures, eyeglasses, hearing aids. Also we have the possibility of the Medisave account whereby each subscriber now would get \$4,800 toward their health care costs. If they do not use it all, keep the funds they do not use or roll it over until the following year.

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One of the biggest problems has been the fraud, abuse, and waste. Under legislation which has been introduced by the gentleman from New Mexico [Mr. SCHIFF] and the gentleman from Connecticut [Mr. SHAYS], the penalties for fraud, abuse, and waste will be increased.