

Chairman and Chairman of the Energy and Commerce Subcommittee on Health; STEVE BUYER, our Chairman of the Subcommittee on Oversight and Investigations; and CLIFF STEARNS, our former Chairman of the Subcommittee on Health and Chairman of the Energy and Commerce Subcommittee on Commerce, Trade and Consumer Protection.

As we watch with deep concern the unfolding events and investigations regarding anthrax in Florida and New York, in my own Congressional district in Trenton, New Jersey, and now here in Congress, in the Brentwood Post Office and a number of other locations, I believe that it is imperative that Congress ensure our Nation better prepare itself for incidents of terrorism. We need timely, effective, and comprehensive responses to protect the health of the American people, and that is why my colleagues and I are introducing this bill. The new centers would be under the general umbrella of the Department of Veterans Affairs, but would have special—even unique—missions that encompass a much larger role in protecting Americans.

The bill calls for the establishment of at least four geographically dispersed locations. Each center would independently study and work toward solutions to problems emanating from exposure to dangerous chemical, biological and nuclear weapons. Although the VA would oversee these new centers, their work products should provide for the general welfare of the people. Mr. Speaker, we have learned a great deal in the last month about our health system's ability to recognize and respond to a biological attack. It is clear to me and the cosponsors of this legislation that there needs to be a significant investment in teaching health professionals about the effects of chemical, biological and nuclear agents. While health care specialists in the Armed Forces have developed a substantial body of information, their mission does not extend to teaching and assisting community health care providers throughout the United States. Further, we have seen the limitations of the Centers for Disease Control and Prevention in responding to outbreaks and attacks. The VA health care system is an important piece to addressing the problems we currently face.

Perhaps what is most important about the VA's capability is that it already exists in the 54 states and territories. The VA consists of 171 hospitals, 800 outpatient clinics and other facilities with their 182,000 employees including 14,000 physicians, and 60,000 nursing personnel of whom 37,000 are registered nurses. This represents a federally-appropriated resource with centralized command and control leadership that is the largest fully integrated health care system in the United States. In past disasters, the VA hospital has sometimes been the only operational medical facility in affected localities. This widely dispersed but integrated healthcare infrastructure makes the VA an essential national asset in responding to potential biological, chemical, or radiological attacks. VA's existing medical capability could be quickly expanded and enhanced with only modest investments.

The mission of these centers would be to conduct research and develop methods of detection, diagnosis, vaccination, protection and treatment for chemical, biological, and radio-

logical threats to public safety, such as anthrax, smallpox, bubonic plague, radiation poison and other hazards to human health that we may not be able to fathom today. My bill would authorize these centers to engage in direct research, coordinate ongoing and new research and educational activity in other public and private agencies, including research universities, schools of medicine, and schools of public health. The centers would act as clearinghouses for new discoveries and serve to disseminate the latest and most comprehensive information to public and private hospitals in order to improve the quality of care for patients who are exposed to these deadly elements. The skills and knowledge they produce would also help to protect health care workers, emergency personnel, active duty military personnel, police officers, and hopefully, all our citizens.

Through its extensive medical and prosthetic research and clinical care programs, VA already has expertise in diagnosing and treating viral and bacterial illnesses associated with previous serious health problems, such as the hepatitis C epidemic, the HIV pandemic, and in earlier generations, the tuberculosis crisis. In the early part of this century, a number of VA hospitals were created specifically to combat tuberculosis, which had a high incidence in the veteran population. VA currently operates two War-Related Illness Centers tasked with developing specialized treatments for those illnesses and injuries that result from veterans' combat and wartime exposures. VA has successfully launched new centers with expertise in geriatrics and gerontology, mental illness and Parkinson's disease. These centers are superb examples of what experts can do when provided appropriate resources dedicated to specific goals. They show VA's ability to organize and develop programs and provide treatment for vexing health problems. In essence, these new National Medical Preparedness Centers would study those illnesses and injuries likely to come from terrorist attacks with weapons of mass destruction, or from another national environmental or biological emergency with similar risks.

As we have seen since the anthrax incidents occurred, in many instances we possess no real protection, few treatments and only rudimentary methods of detection or diagnosis—this situation is simply unacceptable, Mr. Speaker. We need to make a major effort, and provide funding to accomplish it, such as we have done in many other cases. Whether in putting a man on the moon 32 years ago, or in combating polio closer to home, it is incumbent upon this Congress to encourage and fund solutions—in this case, to prepare the Nation to prevent or respond to the new and very real threats from terrorist use of chemical, biological and radiological poisons.

Mr. Speaker, this is a time for all of us to think hard about what has happened to us, and what we need to do about it. The President has taken the right action by deploying our military forces in search of justice overseas. We need to help him with the right solutions here at home. These centers that our legislation would authorize are the right way to proceed in this important work. Please join with us in supporting our initiative to authorize four new National Medical Preparedness Cen-

ters, working within the Department of Veterans Affairs, but working for us all.

TRIBUTE TO RILEY'S

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 8, 2001

Mr. SKELTON. Mr. Speaker, let me take this means to congratulate Riley's Irish Pub, of Lexington, Missouri, for being recognized in a recent issue of American Profile. Riley's has played an instrumental role in revitalizing the heritage of my hometown, keeping downtown alive with activity seven days a week.

Mr. Speaker, Riley's Irish Pub is a fine restaurant and an asset to Lexington. My friends, Shirley Childs and Katherine VanAmburg, the owners of Riley's, are doing a terrific job. I know that Members of the House will join me in wishing them all the best in the days ahead.

INTRODUCTION OF THE MEDICARE+CHOICE CONSUMER PROTECTION ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 8, 2001

Mr. STARK. Mr. Speaker, I rise with a group of colleagues to introduce the Medicare+Choice Consumer Protection Act of 2001. Congress should enact this bill immediately to ensure overdue protections for Medicare+Choice enrollees who are seeing increasing costs, decreasing benefits, and fewer options to obtain affordable supplemental coverage for Medicare.

The Medicare+Choice program is an option that many seniors appreciate and it is an option that should remain viable in Medicare. Unfortunately, the problem of plan pullouts, benefit reductions, and cost increases, will never be solved by continuing to pour more money into HMOs. Even if their demands for ever higher payments are met, they will change yearly—just as our benefits do in the Federal Employee Health Benefits Program. This is because—unlike the rest of Medicare—these plans are private companies that make annual changes to their benefit offerings based on costs and other business decisions. The bottom line is that they are in business to make money. That's understandable, but it undermines program stability, and confuses beneficiaries.

The bill I am introducing today, along with a group of colleagues including Reps. GEPHARDT, RANGEL, DINGELL, WAXMAN, BROWN, KLECZKA, CARDIN, THURMAN and TIERNEY, will help senior citizens and other beneficiaries deal with the everchanging world of Medicare+Choice.

It doesn't heap any new money on the HMO industry.

Instead, it extends important consumer protection standards to Medicare beneficiaries who find themselves in a plan that no longer meets their needs. There are three major components to the bill:

(1) Eliminate the Medicare+Choice lock-in scheduled to begin going into effect in January 2002.

(2) Extend the existing Medigap protections that apply to people whose Medicare+Choice plan withdraws from the program to anyone whose Medicare+Choice plan changes benefits or whose doctor or hospital leaves the plan.

(3) Prohibit Medicare+Choice plans from charging higher cost-sharing for a service than Medicare charges in the fee-for-service program. This provision is crafted to continue to allow reasonable flat-dollar copayments.

The bill is endorsed by a host of senior and consumer advocacy organizations including: the National Committee to Preserve Social Security and Medicare, Alliance for Retired Americans, National Council on the Aging, Families USA, The Medicare Rights Center, California Congress of Seniors, and California Health Advocates. They've endorsed it because the three components are each important consumer protection improvements for beneficiaries in Medicare+Choice plans.

Eliminating the lock-in means that no one will be forced to stay in a health plan that doesn't meet their needs. When seniors get marketing material from an HMO and choose to join, they don't know what illnesses will befall them or what injuries may occur. If they picked a plan that suddenly doesn't meet their specific needs, they need to be able to get out. The lock-in prohibits that flexibility. Especially with the volatility of the Medicare+Choice marketplace over the past several years, it is important that seniors know that if they test an HMO and don't like it, they'll be able to leave and choose a Medicare option that better suits them. This is a provision that is agreed upon and strongly supported by both consumer advocates and the managed care industry.

Under current law, if your Medicare+Choice plan leaves your community or withdraws from Medicare all together, you can move into a select category of Medigap plans (A, B, C and F) without any individual health underwriting. This protection is obviously important because it makes more affordable Medigap options available to people who through no fault of their own can no longer remain members of the Medicare+Choice plan in which they had been enrolled.

Unfortunately, these protections do not extend to seniors whose plans make drastic changes, but stop short of completely withdrawing from the program. Many Medicare beneficiaries are getting letters from their HMOs describing changes to their plan for next year that are so dramatic that the plan no longer meets their financial needs, health needs—or both.

In my district, PacifiCare is pulling out of some parts of the county, but remaining in others. In the areas where they remain, they have instituted a new \$400 hospital deductible for each covered admission (up from \$100 last year), a new \$50 copayment for dialysis where there had been none, and increased Medicare-covered inpatient injectable medication cost-sharing from \$30 to \$250 or the full cost of the drug, whichever is less. By any standard, these are dramatic increases. HealthNet, which also serves my district, will now have a hospital deductible of \$750, and they have

dropped all coverage of prescription drugs, while more than doubling their premium from \$30 to \$85 a month.

These changes may well affect the ability of current enrollees to afford to continue in the plan—and certainly could impact their ability to get needed care. It is very likely that a Medigap supplemental policy might make better sense for these beneficiaries. Therefore, it is critical to extend the current Medigap protections for when a plan terminates Medicare participation to participants of plans that have made changes to their benefits like those described above.

Those same protections need to apply if a patient's doctor or hospital discontinues participation in the Medicare+Choice plan as well. There have never been any lock-in provisions for providers that require that they continue with a Medicare+Choice plan for the full contract year. Again, it is beyond a patient's control if their doctor or hospital withdraws from their HMO. They need to have the option to follow that doctor—and that likely means being able to join a Medigap supplemental plan and return to traditional fee-for-service Medicare.

The third provision of the bill may be the most important. I am truly shocked by the level of gamesmanship going on with the cost-sharing proposals being put forth by many HMOs in their Medicare+Choice plan outlines this year. I believe that the Secretary has the latitude in current law to prohibit many of these schemes from being put in place—and I encourage him to make ample use of that power. But, I think we need a change in law that makes it perfectly clear that Medicare+Choice plans cannot charge patients more for a service than the patient would face under the Medicare fee-for-service program.

Medicare+Choice guarantees beneficiaries the same benefits they get from Medicare—plus more. If a Medicare HMO is charging \$50 for dialysis services that a patient needs to stay alive and those same costs would be approximately \$23 in fee-for-service Medicare, that is not meeting Medicare's level of benefit coverage. I can't understand why we would want to allow that. If Medicare covers home health care with no cost-sharing, why should we allow Medicare+Choice plans to diminish the value of that benefit by charging cost-sharing? The same is true with durable medical equipment, and the list goes on and on.

On top of being unfair, the ability to charge higher cost-sharing for services like DME, home health, and dialysis perpetuates the cherry picking and risk avoidance that is well-documented in the Medicare HMO program. It has the obvious unfair consequence of allowing Medicare+Choice plans to avoid patients that know they will need those services. Patients with specific health needs read the benefit package carefully to see what is covered before they enroll. They won't even apply for the plan if their needed services are too costly or not covered at all. That keeps the Medicare+Choice plans from enrolling costly patients. They've already won at delaying risk adjustment which would help solve that problem. We shouldn't let them begin to use cost-sharing as another mechanism to avoid risk.

These are common sense protections that would help beneficiaries feel more confident

about their choices. Proponents of the Medicare+Choice program should support enactment of this legislation because it will reduce the uncertainty and fear factor that makes beneficiaries understandably skeptical about the Medicare+Choice program in the first place.

The bottom line is that the Medicare+Choice Consumer Protection Act is a simple, incremental bill that will help protect Medicare beneficiaries who choose to enroll in a Medicare+Choice option. We've made this option available to seniors, and I think it is our responsibility to assure that they don't lose other options in Medicare because they've taken us up on the offer. I urge all of my colleagues to join us in enacting this small, but important bill this year.

THE INJUSTICE THAT BEFELL THE
UKRAINIAN PEOPLE

HON. MICHAEL R. McNULTY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 8, 2001

Mr. McNULTY. Mr. Speaker, I condemn the horrible injustice that befell the Ukrainian people 68 years ago. Approximately seven million Ukrainians fell victim to the famine inflicted by the Soviet government to extinguish the Ukrainian struggle for freedom. The 1932–1933 famine was a premeditated effort to exterminate the national consciousness of the Ukrainian peasantry in order to stop their continuous resistance to Leninist/Stalinist ideals.

The causes of the famine had nothing to do with the harvest. Production of grain during those years remained at the usual levels. The government confiscated the grain in order to export it to gain money for industrialization in the former Soviet Union. Such was Stalin's undeclared war against the Ukrainians' right to independence and freedom. Many Ukrainians died heroically to preserve their right to live in a free and independent state. But their deaths were not in vain—the fight for Ukrainian freedom continued on and on August 24, 1991 Ukraine finally declared its independence from the Soviet Union.

The Ukrainian people have been fighting for their independence since the 16th century. With the arrival of the Marxist/Leninist ideas at the end of World War 1, their struggle continued and intensified because of the farm collectivization efforts. Stalin's government could not frighten or punish Ukrainians enough to make them give up their land and desert their ideal of freedom and nation-statehood. Instead, his government made a decision to exterminate the sense of nation among the Ukrainian people and as a result, Stalin's government murdered a large portion of the population. Almost a quarter of all Ukrainians died in those dreadful years.

These abhorrent events were hidden from the public for the duration of the Soviet rule. Now it is our duty to bring them to the attention of the world in order to remind us all of the benefits of democracy and horrors that an oppressive government can perpetrate on its people. At this time of war, when the United States and the world battle terrorism, we once