of-pocket if they had the same procedure done in an in-patient hospital. I do not believe that was Congress' intent when the beneficiary copay limitation was first enacted last year.

There is no reason seniors in my district should check into a hospital overnight for a procedure because of the exorbitant copay they would face if it were done on an outpatient basis. HCFA should revise its interpretation accordingly to include all the services provided to a beneficiary in the course of an outpatient visit as envisioned by this year's Medicare ''giveback'' legislation.

CARDIAC ARREST SURVIVAL ACT OF 2000

SPEECH OF

HON. TOM BLILEY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 26, 2000

Mr. BLILEY. Mr. Speaker, I strongly support H.R. 2498, the Public Health Improvement Act of 2000. This package, referred to by many as the ''minibus,'' is composed of a number of different, but all very worthy, proposals designed to improve our public health infrastructure.

The first title of the bill, the Public Health Threats and Emergencies Act, strengthens the nation's capacity to detect and respond to serious public health threats, including bioterrorist attacks and disease-causing microbes that are resistant to antibiotics. Few things are more important than the ability to quickly and effectively respond to outbreaks of infectious diseases and bioterrorism.

Also in the bill, thanks to the good work of the Chairman of the Health Subcommittee, Mr. BILILRAKIS, is the Twenty-First Century Research Laboratories Act. This bill responds to the fact that while our nation possesses the best research institutions in the world, the infrastructure of many of these facilities is outdated and inadequate. The bill authorizes the NIH to make grants to build, expand, remodel and renovate our nation's research facilities.

The bill contains a number of other meritorious provisions. We reform the certification process for organ procurement organizations, providing them with due process and better performance-based measures; we provide better support for our nation's clinical researchers, so that we continue to attract and retain leaders in patient-oriented research; and we require the NIH to enhance research efforts for Lupus, Alzheimer's Disease, and Sexually Transmitted Diseases.

I'd be remiss if I didn't acknowledge the hard work of my colleague, the gentleman from Florida, Mr. STEARNS, on the Cardiac Arrest Survival Act, which is critical life-saving legislation. Sudden cardiac arrest kills more than 250,000 Americans every year. Many of these lives could be saved by immediate defibrillation. In our Committee investigations, we found that counties with defibrillation programs were able to save up to 57% of cardiac arrest victims. The legislation by Mr. STEARNS would protect good Samaritans who use defibrillators to help save the lives of our fellow Americans. It also encourages widespread use of defibrillators by removing the threat of unlimited and abusive lawsuits, and by establishing guidelines for the placement of defibrillators in Federal buildings.

In conclusion, I must note the hard work that went into this bill on both sides of the aisle, and in both bodies. This bill could not have been finalized without the dedication and efforts of Senator BILL FRIST and my colleague MIKE BILIRAKIS, and they are to be saluted, as is the minority. This is a good bill, and I urge my colleagues to support it.

MOTION TO INSTRUCT CONFEREES ON H.R. 4577, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2001

SPEECH OF

HON. BENJAMIN A. GILMAN

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Sunday, October 29, 2000

Mr. GILMAN. Mr. Speaker, I support the motion to instruct on Medicare+Choice being offered by the gentleman from New Jersey.

This motion will allow Medicare+Choice organizations to offer Medicare+Choice plans under Part C of Title XVIII for a minimum contract period of three years and to maintain the benefits specified under the contract for the three years.

At the time the Medicare+Choice Program was being developed, it seemed like a revolutionary concept that would greatly expand services available under Medicare, while keeping overall costs down. Regrettably, for far too many seniors, Medicare+Choice has become a false choice and a cruel joke.

In theory, Medicare+Choice sounded like a good program. Private health maintenance organizations (HMOs) would enter into contracts with the Health Care Financing Administration to provide services to seniors who signed up for membership. These services were included in various benefit plans, the content of which varied with the premium price. The higher the premium, the more services it offered. It bears noting however, that many of the benefits packages initially came with little or no premium cost to the individual senior. Moreover, many of these plans offered extensive benefits for such little cost, including prescription drug coverage. It sounded too good to be true. As history would show, this was precisely the case.

Within the first year, many of the HMOs recognized that providing health coverage for seniors, especially prescription drug benefits, was a highly expensive matter. Once the books were balanced, it became apparent that the cost of providing these services was not being offset by the per patient reimbursement being offered by HCFA. Being creatures of profit, the various HMOs began to take one of two courses of action. They either received permission to drastically raise their premium rates, as much as 1,500 percent in some cases, or they conveyed their intent to HCFA to withdraw their services from areas which they deemed to be unprofitable, usually surburban and rural counties.

My region, the 20th Congressional District of southeastern New York has been devastated by this process. When the Medicare+Choice Program was started, there were approximately six HMOs for seniors in my district to choose from. Today, none remain in Sullivan County, two small plans exist in Orange County and the remaining plans in Rockland and Westchester Counties have sharply raised their premiums.

This is inexcusable. Our seniors deserve to be able to sign up for a plan with the knowledge and comfort that it will not be ripped out from under them after a year's time. The current system simply presents seniors with false hopes.

The fault for this situation lies with: HCFA, for not offering reasonable floor reimbursement rates, the HMOs, for seeking unreasonably high profits above patient care, and with the Congress, for failing to attach any punitive measures to HMOs that pull out of certain counties when they arbitrarily decide they will not meet their projected profit margin.

Mr. PALLONE's motion is a good first step toward solving this problem even though it represents the bare minimum of what the Congress should do to address this crisis. Last year, the Congress sent $1.4 billion in additional funds to HMOs so that they would remain in the Medicare+Choice Program. Yet no accountability provisions were attached. The result was further pullouts this year. The House did the same thing last week with the Balanced Budget Act (BBA) giveback legislation that was incorporated into the tax bill; additional funds for HMOs with no strings attached. I predict this latest action will meet with the same results.

For the sake of those seniors who have been left out in the cold by their Medicare+Choice providers, I urge my colleagues to vote for this motion, and restore some common sense and basic accountability to this broken program.

IN HONOR OF DR. HERBERT B. ANDERSON, PASTOR OF THE BRICK PRESBYTERIAN CHURCH, ON HIS RETIREMENT

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 31, 2000

Mrs. MALONEY of New York. Mr. Speaker, I rise today to pay tribute to Dr. Herbert B. Anderson, the Pastor of the Brick Presbyterian Church in Manhattan, New York, on his retirement after twenty-two years of service to the church. Dr. Anderson will be honored for his many years at the church at a Festival Service of Worship this upcoming November.

Dr. Anderson, recently confirmed to become Pastor Emeritus after his retirement, has dedicated his life to the Presbyterian Church. After graduating from Chicago's McCormick Theological Seminary in 1954, Dr. Anderson began his career as a young pastor at the First Presbyterian Church in Harrison, Arkansas. After five years in this position, he moved onto the Southminister Presbyterian Church in Tulsa, Oklahoma, where he served as pastor for eight years. He then began preaching at the First Presbyterian Church in Lake Forest, Illinois, where he remained from 1967–1978 until he moved to the Brick Presbyterian Church, where he has remained.

Throughout his many years as a pastor, Dr. Anderson has served as a member and leader of numerous religious organizations. Since 1993, Dr. Anderson has been the Chairman of