the Federation of Protestant Welfare Agencies, Inc. He has also worked to promote interfaith dialogue and understanding. In the early 1980s, Dr. Anderson served on the delegations of the Appeal of Conscience Foundation to China, Argentina, and Hungary. In 1975 he traveled to Nairobi, Kenya as the Delegate to the Fifth Assembly, World Council of Churches. Throughout the years, Dr. Anderson's extensive involvement in Presbyterian and interfaith organizations has served as a contribution to the already superior reputation of the Brick Presbyterian Church.

Mr. Speaker, as a member of his congregation, I am confident that the work of Dr. Anderson will have a lasting effect on the Brick Presbyterian Church's congregation, whether it is through our recollection of a particularly memorable sermon by Dr. Anderson, or through the many wedding and baptism ceremonies that Dr. Anderson has presided over. Although Dr. Anderson is retiring, his many contributions to the Brick Presbyterian Church will continue to be appreciated for many years to come.

I congratulate Dr. Anderson on his inspiring career and I wish him an enjoyable retirement.

OMNIBUS INDIAN ADVANCEMENT ACT

SPEECH OF

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 26, 2000

Mr. YOUNG of Alaska. Mr. Speaker, as chairman of the Resources Committee and author of title XV of H.R. 5528 as passed by the House, I wish to make a statement to provide factual background and clarify congressional intent as to the meaning and implementation of that title.

The Secretary of Interior has created allocation pools for acreage entitlements of regional corporations under sections 14(h)(1) and 14(h)(8) of the Alaska Native Claims Settlement Act (ANCSA) and conveyances to one regional corporation under section 14(h)(1) may have the effect of reducing the entitlements of all other regional corporations under section 14(h)(8). Chugach Alaska Corporation (Chugach) currently has significant entitlement remaining under its section 14(h)(1) allocation and the Secretary believes Chugach is overconveyed under its current section 14(h)(8) but allocations under section 14(h)(8) have not been finalized. In the event that any acreage ultimately conveyed to Chugach as a result of title XV would have the effect of reducing the section 14(h)(8) allocations of other regional corporations under current regulations, section 1506(a) provides that such reduction shall be charged solely against Chugach's final section 14(h)(8) allocation, notwithstanding such current regulations, or other applicable law.

SUPPORT FOR H.R. 5543

HON. HEATHER WILSON

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 31, 2000

Mrs. WILSON. Mr. Speaker, the House recently passed a bill to increase the minimum wage, increase the amount Americans can save each year through an IRA, and to improve add funds to Medicare and Medicaid programs. An important part of that Medicare package improves the reimbursement rates for Medicare+Choice. This program offers more choices for seniors to decide what kind of health care plan they prefer. The Medicare+Choice managed care plans usually offer better services and benefits than traditional Medicare—most importantly—they can provide prescription drug coverage to seniors who cannot afford a Medigap policy. In my district, nearly 60 percent of seniors who earn less than $20,000 per year who chose a Medicare+Choice plan. But in my state, Medicare reimbursement for this program is half of what places in New York or Florida receive. And New Mexico's rate is too low for the plans to continue to offer the same quality service. H.R. 5543 will correct that disparity.

This measure is strongly supported by New Mexicans, and I wish to bring your attention to the attached article written by Bob Bada, that clearly illustrates the current situation and need for this legislation and the need for a long term reform of Medicare.

THE DUAL EDGED SWORD OF MEDICARE REIMBURSEMENT—THE MEDICARE PROVIDER AND HEALTH MAINTENANCE ORGANIZATION PERSPECTIVE

(By Bob Badal)

While the nation's booming economy and concomitant boosts in Federal tax revenues over the past six to seven years has extended the solvency of the current Medicare program to 2023, the baby-boom generation soon will begin to enter the program. Paying for the extended range of benefits for this increase in senior citizens will exact a large financial toll. In 2025, 69.3 million elderly and disabled persons are expected to be eligible for Medicare, up from 39 million today. The share of our nation's gross domestic product spent on Medicare is projected to almost double from 2.7 percent in 1998 to 5.3 percent in 2025. Congress passed the Balanced Budget Act of 1997 (''BBA'') to secure the financial stability of the Medicare program by providing an estimated $115 billion in cuts, over five years, in spending to physicians, hospitals, nursing homes, and home health agencies. In addition, the BBA sought to provide alternative network and product choice to beneficiaries via Medicare+Choice plans. Medicare patients, as intended by the BBA, would be able to elect coverage from Preferred Provider Organizations or private insurers, or they could establish a medical savings account, financed by the Health Care Finance Administration (''HCFA''), and purchase a high-deductible insurance policy. With the benefit of hindsight, it is apparent that the BBA, and subsequent amendments, have negatively affected not only the financial stability of Medicare providers, but also the level of choice for the beneficiaries it is mandated to protect. On this point, Senator Pete Domenici R–N.M., Chairman of the Senate Budget Committee stated: ''Seniors in many communities are treated like second-class seniors because their choice and access to care is practically nonexistent. We have created a system of healthcare defined by the 'haves' and 'have nots' ''.

MEDICARE REIMBURSEMENT TO PROVIDERS

The BBA has created a surplus in funds for the Medicare Program over the past 2 years. This surplus is a pyrrhic victory, however. The BBA has reached a surplus by effectively transferring a growing share of the risk to the provider. The Medicare spending cuts called for by the BBA far exceeded the $115 billion Congressional Budget Office (CBO) estimate, and, in fact, will reach more than $212 billion over the five-year life of the BBA. The subsequent Balanced Budget Refinement Act of 1999 served only to restore a modest $15 to $18 billion in payments back to providers. Many providers have been forced into bankruptcy by these draconian cuts, while others have been forced to close their doors.

Cardiac surgeons saw over a 10 percent drop in their reimbursement and anesthesiologists experienced an 8 percent decline. In heavily penetrated Medicare and Managed Care markets, such declining reimbursement can have a serious financial impact on many providers. John DuMoulin, director of managed care and regulatory affairs for The American College of Primary Care Physicians—American Society of Internal Medicine, voiced his concern about the declining Medicare reimbursement schedule by stating that the model was flawed, and called it a ''mixed bag'' of tricks.

In communities like Albuquerque, New Mexico, which has experienced a 15-physician-per-month exodus due, in part, to poor levels of physician-based Medicare reimbursement, access to quality healthcare is becoming a serious concern (New Mexico Hospital Association, January 2000). In addition, as reported in July, 2000, by the American Hospital Association, 10 percent of the nation's nursing homes have filed for bankruptcy protection, and 35 percent of the nation's hospitals are losing money on inpatient services (Healthcare Financial Management, July 2000). Faced with escalating costs of as much as 8–10 percent due in part, to scientific/technological advances, higher drug costs, and increases in union labor nursing costs, hospitals are faced with a dilemma. They are scheduled to receive increases in Medicare reimbursement of 1.1 percent, less than the market-basket rate of inflation in fiscal 2001 and 2002.

Public and provider confidence in HCFA's understanding of the relevancy and possible drastic consequences of their continued pressure on provider reimbursement is not high. To understand the reason why, one need only examine the misguided approach that HCFA has used to determine the initial solvency estimates of Medicare: In 1998, following the passage of the BBA, the General Accounting Officer (GAO) generated new estimates that said that Medicare could remain solvent until 2008. In April 1999, the Bipartisan Commission on the Future of Medicare entered the fray when it issued its report to the nation: Medicare would live until 2015, said the commission. Then in early 2000, the Medicare trustee issued yet another revised estimate for the solvent life of Medicare—2023. That estimate lasted only a few weeks before the trustees admitted they had made a few calculation errors. Medicare would be alive and kicking until 2025. (Healthcare Financial Management, ''Never Underguesstimate the Financial Future of Medicare,'' Jeanne Scott, June 2000).

The formula used by HCFA to calculate physician payment creates extreme oscillations in the reimbursement scale. The swings are due in large part to HCFA's use of a variety of time periods—the current fiscal year, the calendar year and other time frames—to make calculations about physician payment. Part of the problem exists within the new ''sustainable growth rate system'' enacted by the BBA to help control expenditures for physician services under fee-for-service Medicare. The growth rate system calculates the updates to the Medicare fee schedule conversion factor, which is used to set standardized reimbursement for specific service categories. The problem, however, is that HCFA is using projected data on utilization