

assigned by Congress, which is the ultimate authority. The Constitution specifically directed the Congress to determine what kind of post office the Nation should have. That is what my bill is all about.

Interestingly, Mr. Speaker, the United States is not the only country experiencing this quandary of what business line its post office should and should not be permitted to enter. In Canada, the Canada Post Corporation is currently in the business of competing with the private sector. There is no constraint on Canada Post in this regard under Canadian law, and the Canada Post has jumped in with enthusiasm.

In 1993, Canada Post purchased the largest private, Canadian owned courier service, Purolator Courier, in order to compete with local and American delivery services. Further, it is in the mailing center business as well. Much as its American counterpart, it is competing head to head with local and franchised private centers such as MailBoxes, Etc.

Canada Post is aggressively promoting unaddressed admail in direct competition with private mailers and even going so far as to deny access to private apartment boxes to its private sector competition.

This is the future for the U.S. Postal Service if my bill is not passed and Congress does not act to set ground rules in this area of what the U.S. Postal Service can and cannot do.

The Situation in Canada has so deteriorated that the government appointed a one man commission to review these and other issues and to make recommendations to the Canadian Government.

That Commission held hearings and took testimony throughout Canada and thoroughly examined the issue of competition by Canada Post with private mailing centers. Its conclusion was straightforward:

"The Government should direct Canada Post Corporation to withdraw from all competition with the private sector in areas of activity outside its core public policy responsibilities for providing postal services." [Report of the Canada Post Mandate Review, p. 86]

"Specifically, that means exiting from the courier business, from unaddressed admail, from the operation of business support or mailing centers, from electronic products and services, and from retailing of non-postal merchandise." [Report of the Canada Post Mandate Review, p. 84]

Mr. Speaker, my bill does not take on all the issues that this comprehensive review did, but that review hit the issue on the head. The basic conclusion of the Commission was that no government agency, like Canada Post or the USPS, can serve and compete with its customers at the same time.

The Postal Service Core Business Act is sound and fair in identifying a workable solution for all parties. I urge my colleagues to join me in support, because it establishes the rules necessary for both the Postal Service and the private sector as to this area of postal related business. These small business owners are looking to us to ensure that they are afforded a fair chance to succeed, and as their Representatives we need to work to meet their needs.

LEGISLATION TO CORRECT
MEDICARE BENEFICIARY OVER-
CHARGES IN HOSPITAL
OUTPATIENT DEPARTMENTS

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. STARK. Mr. Speaker, today Representative WILLIAM COYNE and I introduced a bill to correct a glaring failure in the Medicare Program—the massive overcharging of beneficiaries in hospital outpatient departments [HOPDs]. This bill will save Medicare disabled and senior beneficiaries about \$35.7 billion between 1999 and 2003. It will stop the steady, upward climb in the percentage of HOPD costs that beneficiaries have to pay.

The problem is difficult to describe and the legislative solution is also complicated. But what is not complicated is understanding the impact on Medicare beneficiaries. I would like to include in the RECORD at this point an article from the June 30 New York Times and the AARP Bulletin of August, 1996 that does an excellent job of explaining why our bill is needed—ASAP.

I also include some prospective payment assessment commission analysis of data from the Health Care Financing Administration on how beneficiary copayments in HOPDs can far exceed a patient's 20 percent share at an ambulatory surgical center. Clearly, these HOPD payments are grossly excessive, and patient advocacy groups should help spread the word about cheaper sources of safe and effective medical care.

[From the New York Times, June 30, 1996]

QUIRK IN MEDICARE LAW YIELDS BIGGER BILLS FOR OUTPATIENT CARE; OFFICIALS SAY BURDEN ON THE ELDERLY IS INCREASING

(By Robert Pear)

WASHINGTON, June 30—Because of a quirk in the Federal Medicare law, elderly people are being required to pay more than their normal share of the bill for hospital outpatient services. It is far more than Congress originally intended and the burden is rising rapidly as such services account for a larger portion of all health care in the United States.

Beneficiaries are ordinarily responsible for 20 percent of the cost of services under Part B of the Medicare program. But because of the law, they are now responsible, on average, for 37 percent of the total payments to hospitals for outpatient services, one of the most important benefits under Part B, according to a recent report to Congress by a Federal advisory panel.

For many such services, the patients' share is even larger. Donna E. Shalala, the Secretary of Health and Human Services, said beneficiaries were paying more than 49 percent of the total Medicare payment to hospitals for outpatient surgery, radiology and other diagnostic services.

And Dr. Shalala said, "We expect that the beneficiary share of total hospital payments for these services will continue to increase rapidly," to 68 percent in 2000.

Since 1983, the Government has paid a flat amount for each Medicare patient admitted to a hospital, depending on the diagnosis. But there are no such limits on outpatient services. A hospital can often increase its Medicare revenue "by simply increasing its charges" for outpatient services, the Department of Health and Human Services told Congress. When the hospital increases its charges, the beneficiary pays more.

The Clinton Administration acknowledges that the costs are already causing hardship for many Medicare beneficiaries. But Administration officials say they lack the authority to limit what hospitals charge for outpatient services under Medicare, and they are fighting a lawsuit by Medicare patients who insist that the Government is supposed to set such limits.

The new Medicare handbook, sent to all beneficiaries in May, explains the situation this way: "When you use your Part B benefits, you are responsible for paying the first \$100 each year of the charges approved by Medicare. This is called the Part B annual deductible. After the deductible is met, Medicare pays 80 percent of the Medicare-approved amount for most services. You are responsible for the remaining 20 percent."

But, it states, there is one big exception: "If you receive outpatient services at a hospital, you are responsible for paying 20 percent of whatever the hospital charges, not 20 percent of a Medicare-approved amount."

In March, the Federal advisory panel, the Prospective Payment Assessment Commission, urged congress to correct this problem. "The growing financial burden for Medicare enrollees who receive services in hospital outpatient departments should be alleviated immediately," the panel said. "Beneficiary coinsurance for these services should be limited to 20 percent of the Medicare-allowed payment."

But neither Congress nor the Clinton Administration is pushing for a quick solution, partly because of the complexity of the problem and partly because of disagreement over who would foot the bill. If beneficiaries paid less, then the Federal Government would have to pay more or hospitals would have to accept less overall? Any solution would increase Federal Medicare costs, reduce hospital revenue or both.

For example, a 74-year-old woman named Marie Lohse had outpatient cataract surgery on one eye at a Los Angeles hospital. The hospital charged \$6,277. She was responsible for 20 percent of that amount, or \$1,255. But, she later learned, Medicare paid the hospital only \$1,280. So the hospital received a total of \$2,535, and Ms. Lohse paid 49.5 percent of the total reimbursement.

If she had paid 20 percent of the Medicare-approved amount, as required for many other Part B services, she would have paid only \$507.

Robert J. Myers, who was chief actuary of the Social Security Administration for 23 years, said of the current formula, "It's a raw deal, a gross injustice to beneficiaries that ought to be remedied."

Mr. Myers said it had always been "the general philosophy, the general principle of the Medicare program, that the beneficiary should be responsible for 20 percent of what Medicare recognizes as the reasonable and appropriate amount for a service."

And in most cases that is true. But hospital outpatient services are different: the patient is responsible for 20 percent of whatever the hospital charges. Originally, what hospitals charged and what Medicare recognized as reasonable were about the same. But in recent years, hospitals have charged far more than Medicare pays for outpatient services. So in paying 20 percent of the hospital charges, beneficiaries end up paying much more than 20 percent of what the hospitals ultimately receive for such services.

Earlier versions of the Medicare handbook, in 1991 and 1992, said inaccurately that beneficiaries were responsible for only 20 percent of the approved amount." The handbook now says "20 percent of whatever the hospital charges."

The financial burden on patients has been increasing because outpatient care accounts

for a rapidly growing share of all medical care.

New surgical technology and advances in anesthesia have reduced the need for overnight hospital stays. Common outpatient services include colonoscopy, breast biopsy and hernia repair. But complex procedures like hysterectomies and reconstructive knee surgery can also be done in hospital outpatient departments.

The demand for such services increases as the procedures become safer and easier to perform. In addition, said Dr. Richard B. Reiling, chairman of the ambulatory surgical committee of the American College of Surgeons, "Managed care and financial considerations have given us incentives to do more procedures on an outpatient basis."

Carol S. Jimenez, a lawyer at the Center for Health Care Rights in Los Angeles, said, "Medicare beneficiaries expecting to pay a 20 percent copayment should not be paying 49 percent or more of the amount paid to the hospital."

But in a legal brief recently filed with the United States Court of Appeals for the Ninth Circuit, in San Francisco, the Clinton Administration said such charges were "entirely permissible" under current law.

Congress has never instructed Medicare officials to "limit what hospitals could charge to beneficiaries for outpatient services," the Clinton Administration said.

And in a letter to a Medicare beneficiary in Florida, the Federal Government said that "there are no restrictions on the amount that a hospital charges" for outpatient services.

While expressing sympathy for Medicare beneficiaries "burdened by ever-rising medical costs," the appeals court has so far refused to step into the dispute.

Outpatient services can be a major source of revenue because hospital admissions have fallen over the last decade and Medicare has sharply restricted payments to hospitals for inpatient services.

Spending for outpatient hospital services, by Medicare and other insurers, has grown twice as fast as outlays for inpatient hospital care, rising 15.7 percent a year since 1980, to \$86.7 billion in 1994, while inpatient spending rose 7.8 percent a year, to \$212.4 billion.

Many elderly people have supplementary insurance, known as Medigap policies, to help pay costs not covered by Medicare, but as they pay more for outpatient services, their Medigap premiums tend to increase. In December, when the American Association of Retired Persons announced premium increases averaging more than 25 percent for 1996, it cited the increased use of outpatient services as a major reason.

Under instructions from Congress, the Department of Health and Human Services is developing a proposal to pay hospitals a fixed amount, set in advance, for each outpatient service. Medicare could then follow its general policy of requiring beneficiaries to pay 20 percent of the approved amounts. Such a system would be complex and would need approval from Congress.

[From the AARP Bulletin, August 1996]

MEDICARE OUTPATIENT DEBACLE—HOSPITALS ALLOWED TO CHARGE MORE FOR OUTPATIENT CARE

(By Don McLeod)

A federal court ruling has focused new attention on a growing problem for Medicare beneficiaries, first reported nearly four years ago in the Bulletin.

The problem is this: When beneficiaries receive medical treatment in hospital outpatient facilities, they often pay much more than their fair share of the bill.

Why? Because under federal law hospitals can charge Medicare beneficiaries whatever they wish for hospital outpatient care. (By contrast, federal law does limit how much hospitals can charge Medicare inpatients and how much doctors can charge Medicare beneficiaries.)

All of this is perfectly legal. And if the situation is to be fixed, the Ninth U.S. Circuit Court of Appeals said in essence this summer, it is up to Congress to fix it.

Congress has the authority to limit what hospitals charge Medicare outpatients, all experts agree, but thus far has declined to do so.

Since Congress hadn't exercised its authority in this area, some Medicare beneficiaries sued the Department of Health and Human Services (HHS), which runs Medicare, to force the agency to correct the situation.

But in its ruling the court agreed with HHS Secretary Donna Shalala that existing law does not require her to take action on the issue.

All of which means hospitals can continue to charge Medicare outpatients any amount they want.

The high charges beneficiaries pay for hospital outpatient service are "terribly unfair," says Brandeis University economist Stuart Altman. And, he adds, the problem "is getting worse and worse."

The situation comes about because of a longstanding loophole in the law. Under current law, Medicare pays for hospital outpatient treatment under Medicare's Part B, which also covers physician costs.

In the case of doctors, Medicare pays them 80 percent of what it considers a "reasonable and customary" amount, based largely on costs, and beneficiaries pay the remaining 20 percent of what Medicare considers reasonable.

When it comes to hospital outpatient services, Medicare pays 80 percent of what it considers reasonable, based on a complex formula that includes the hospital's costs.

But beneficiaries, by contrast, are required to pay 20 percent of the amount that hospitals decide to charge them, rather than 20 percent of what Medicare considers reasonable.

And that hospital charge can be sizable. As a result, beneficiaries often find themselves paying almost as much as the government does for hospital outpatient treatment.

In a report to Congress last year, HHS's Shalala estimated that Medicare outpatients on average pay 49 percent of the total payment made to hospitals for several common treatments.

In part, this is extra income for hospitals. If beneficiary copayments for these treatments were cut to the 20 percent Medicare believes reasonable, she said, the amount paid by enrollees "would be reduced by over \$4 billion in 1997 and by \$15.7 billion in 2001."

Nor is that all. Given the way hospital charges are rising, beneficiaries could be paying as much as 68 percent by the year 2000, Shalala warned.

"This is a windfall for hospitals," says AARP legislative representative Kirsten Sloan. "There's no question about it."

Not surprisingly, hospitals see the situation differently. Under Medicare, hospitals "are already being paid less than their costs," says Carmela Coyle, the American Hospital Association's vice president for policy.

Paradoxically, the anomaly in hospital outpatient payments stems from an attempt in 1986 to bring outpatient payments closer to the billing system for inpatients.

But what Congress actually did in 1986 was create a temporary payment structure for determining what Medicare can pay hospitals for outpatient fees. At the same time,

it left unaddressed the question of whether there should be limits on what beneficiaries themselves must pay. This structure is still being used and has created the inequity that exists today.

Since then, reimbursement for outpatient care has been treated differently. Beneficiaries have been required to pay 20 percent of the charges that hospitals bill them. That didn't seem significant in 1986, says Brandeis' Altman, because relatively few treatments were done on an outpatient basis and hospital charges were close to their costs.

Times have changed. Between 1985 and 1989 the number of outpatient surgeries performed by hospitals on Medicare beneficiaries increased by 50 percent and has risen since.

Other forces are helping drive up the amounts hospitals charge, some associated with actual hospital costs, some not, critics say.

Whatever the reasons, "20 percent of charges has turned out to be a lot more than 20 percent of costs," says Altman, meaning that beneficiaries are paying a good deal more than what critics believe is "reasonable."

Beneficiaries are feeling the pinch. "With more people using hospital outpatient services," says AARP's Sloan, "the problem of the amount that beneficiaries pay out of pocket is becoming much more severe."

The recent court decision, all sides agree, tosses this growing problem into the lap of Congress. "So the question becomes," says Altman, "why don't they change the law?"

Thus far, Congress has shown little interest in revamping the law. The major reason: money. Either Medicare—its future spending already under attack in Congress—would have to make up the costs, or hospitals would lose their windfall and have to absorb the costs.

Or the two would have to share the fiscal pain. For instance, the American Hospital Association's Coyle, insisting that Medicare has underestimated hospitals' actual outpatient costs, suggests that hospitals and beneficiaries join forces to compel "Medicare to pay [its] fair share of costs." That idea hasn't caught on.

Until Congress decides what to do, beneficiaries should help themselves by being informed consumers, analysts say. "Before they go in for hospital outpatient surgery, they should ask about the likely cost to them," advises AARP legislative representative Patricia Smith.

But that's only a stopgap solution. With concern in Congress growing, a move to produce change could occur next year or shortly thereafter, analysts say. It won't be easy: Congress will have to change the law in a way that hospitals, as well as Medicare and the taxpayers who finance it, will support.

The ball is squarely in Congress' court now, says Altman. The Ninth Circuit Court of Appeals has essentially ruled, he adds, that "the law is the law, and it remains for Congress to change it. And that's what needs to be done."

BENEFICIARY COINSURANCE PAYMENTS ACROSS SETTINGS, 1995

Procedure	Median hospital OPD coinsurance	20 percent of the national ASC rate	20 percent of the national physician fee schedule
Cataract removal w/lens insertion	\$558	\$176	\$195
Diagnostic colonoscopy	164	79	65
Upper GI endoscopy w/biopsy	172	79	51
Diagnostic upper GI endoscopy	150	59	45
Diagnostic sigmoidoscopy	75	18
Initial inguinal hernia repair	519	112	92

ANNUAL HOSPITAL OPD COINSURANCE PAYMENTS FOR BENEFICIARIES WHO RECEIVED HOSPITAL OPD SERVICES, 1995

Deciles (percent)	Annual beneficiary co-insurance
Top 10	\$802
Top 20	505
Top 30	335
Top 40	227
Median	154
Bottom 40	103
Bottom 30	67
Bottom 10	20

MEDIAN BENEFICIARY COINSURANCE PAYMENTS FOR CATARACT SURGERY FOR HOSPITALS IN THE SAME MSA, 1995

Provider	Percent of total volume	Median charges	Median coinsurance payment
Hospital A	39	\$2,751	\$550
Hospital B	52	1,218	244
Others (2)	10
Total	100	2,002	400

HONORING EUGENE AND DORIS HERDMAN ON THEIR GOLDEN ANNIVERSARY

HON. PAUL E. GILLMOR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. GILLMOR. Mr. Speaker, I am pleased to extend best wishes to Eugene and Doris Herdman on the occasion of their golden wedding anniversary, February 9, 1997.

Eugene and Doris Herdman have shared a partnership of love and commitment which has been an inspiration to all who have known them. Enriched by all of life's experiences, their union has endured and grown stronger over time.

Marriage is the principal foundation on which civilization has been built. The loyalty and love that Eugene and Doris Herdman have demonstrated through the past 50 years strengthens the institution of marriage and increases our faith in the idea of trust between human beings.

As Eugene and Doris Herdman celebrate this special occasion, I wish them, their two children, Nancy and Jim, and their two grandchildren, Jon and Alison, many years of happiness and fulfillment.

TRIBUTE TO ELDER WILLIAM ALONZO GIVENS

HON. JULIAN C. DIXON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. DIXON. Mr. Speaker, I rise to celebrate the life of Elder William Alonzo Givens, who passed away on Christmas Day, December 25, 1996.

Elder Givens was born in Austin, TX, on April 20, 1916, to Arthur Givens and Lizzy Burton. He received his ministry license at the age of 17. In 1929, the Givens family relocated to Midland, TX, where they continued to serve God faithfully, ministering to the needs of many others in the community.

On August 3, 1939, Elder Givens married the former Louise Estelle Thomas. Their blessed union produced seven children, two of whom preceded Elder Givens in death. In December 1942 Elder Givens moved his family to Los Angeles, CA. In 1943, he embarked on a career as a longshoreman, a career that would span nearly 30 years.

In 1976, Elder Givens was assigned by Bishop S. M. Crouch to serve as assistant pastor to the late Walter Sanders at All Nation Church of God in Christ, located in San Pedro, CA.

During his lifetime, Elder Givens traveled throughout California pastoring to the needs of the sick and the shut-in. He not only preached the Gospel, he worked to counsel troubled youths, and those who were in need of spiritual nourishment and fellowship. At his home-going celebration, person after person rose to speak of their love and selfless devotion for this gentle, kind, and always God-fearing man, who loved unconditionally and cherished his family and his God.

Those who knew best of his love for humankind—his family—spoke lovingly of a man who was not only a husband and a father, but of a man who was their friend, counselor, spiritual guide, provider, and protector.

Mr. Speaker, Elder Givens was a man of tremendous character and integrity. His success was measured not in material terms, but in the honorable manner in which he lived his life. His devotion to God was unwavering, and his commitment to the sacrament of marriage and the responsibilities of parenthood, stand as the true measure of this humble servant of our God.

I, therefore, ask you to join me in celebrating the extraordinary contributions of this extraordinary man. In honoring his memory, we extend our condolences to his beloved wife, Louise; his children: Nettie, Linda, Gwendolyn, Jerry, and Robert; and his 19 grandchildren and 9 great-grandchildren, and numerous friends who mourn his loss.

SALUTE TO COYA KNUTSON

HON. MARTIN OLAV SABO

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. SABO. Mr. Speaker, today I would like to pay tribute to Coya Knutson, the only Minnesota woman ever elected to the U.S. House of Representatives, who died in October at the age of 84.

Congresswoman Coya Knutson received considerable attention in 1958 when her husband ignited a nationwide debate over the role of women in politics by sending his now-famous "Coya, Come Home" letters to Minnesota newspapers. The letters—which unfairly implied that her public career in Washington was forcing her to neglect her private duties as a wife and mother in Minnesota—are probably responsible for her close electoral defeat in 1958 after two terms.

Before the letters made national news, Knutson seemed a shoo-in for a third term. Her opponent that year—who ran on the slogan "A Big Man for a Man-Sized Job"—helped put her husband up to the letters. It also didn't help that she broke with leaders of the State Democratic Party—including Hubert

Humphrey—by supporting Estes Kefauver over Adlai Stevenson in the 1956 Minnesota Presidential primary. Many of her Democratic friends did not forgive her for that break, and may even have supported the "Coya Come Home" campaign.

But the story of Coya Knutson is far deeper than the "Coya Come Home" letters that gained her national notoriety and ended her congressional career.

In an era when many women in Congress were widows serving out their late husbands' terms, Coya Knutson represented much more. Former Vice President, and Minnesota Senator, Walter Mondale likened her to Hubert Humphrey. "She was full of life," he said. "She was electric and people liked her. She was kind of like Humphrey. She could go into a room and get the dead to wake up."

When she arrived in Washington, Knutson's first choice for a committee assignment was the Agriculture Committee, where she could champion the cause of the family farmers who populated her district. But the committee's chairman "had no interest in women serving with him." Most women of the time would have backed off. Knutson, however, went to Speaker Sam Rayburn and convinced him that she should be on Agriculture. So it was there she served, and it was there that her grasp of issues—and her hard work—eventually earned her the respect of the chairman.

Many of Coya Knutson's legislative priorities still have resonance today. The Washington Post cataloged her congressional work in a story published a short time after her death.

In her four years in Washington, Coya Knutson pushed for the first Federal appropriations for cystic fibrosis research. She introduced the first bill to include an income tax checkoff for Presidential campaign financing. She created the legislation that would eventually establish a Federal student loan program. She supported the equal rights amendment when labor and many liberals still opposed it on the grounds that it could bring an end to legislation enacted to protect women in the workplace.

Unlike most of the women serving at the time, she felt no need to make the big men like her. It was that trait, combined with a real dedication to the job, that tells the real story of Coya Knutson.

During her 4 years in Washington, she did much to pave the way for women who would later serve in Congress. She overcame obstacles and pushed down barriers that women today no longer encounter. She served with grace and accepted defeats without bitterness. Coya Knutson showed the Nation that a woman's place is not only in the home, but also in the House. For that, Mr. Speaker, the Nation owes Minnesota Congresswoman Coya Knutson a tremendous debt of gratitude.

RELEASE MONEY TO SAVE WOMEN'S LIVES

HON. ELIZABETH FURSE

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Ms. FURSE. Mr. Speaker, a very important vote on family planning will occur by the end of February.

The fiscal year 1997 Foreign Operations appropriations bill directs the President to submit