

MONUMENT FOR POLISH ARMY
OFFICERS MASSACRED IN 1940

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 10, 2000

Mr. CARDIN. Mr. Speaker, on Nov. 19, 2000 the National Katyn Memorial Committee will dedicate a monument in Baltimore, Maryland to the memory of more than 15,000 Polish Army officers who were massacred by Soviet soldiers in the spring of 1940.

In September, I was honored to accept an award on behalf of Congress presented by Father Zdislaw J. Peszkowski, a survivor of the massacre. The medal was presented on behalf of the Katyn families in recognition of U.S. congressional hearings conducted in 1951 and 1952 that focused world attention on this World War II massacre that occurred in the Katyn Forest.

While this massacre occurred more than 50 years ago, it is important that we remember what happened. In 1939, Nazi Germany invaded Poland from the west and the Soviet Union invaded from the east. In 1940, more than 15,000 Polish Army officers were placed in detention, then taken in small groups, told they would be freed and then were gunned down in the Soviet Union's Katyn Forest. In 1943, the Germany Army discovered the mass graves, which the Russians tried to blame on the Germans. It was long suspected that the massacre was the work of the Soviets. Final proof came in 1989, after the fall of the Soviet Union, when President Gorbachev released documents that clearly proved the Soviets, with the full knowledge of Stalin, had carried out the massacre.

For more than a decade, the Polish-American community has raised funds to construct a fitting memorial to honor the victims of the massacre. The 44-foot statue has been permanently installed near Baltimore's Inner Harbor at President and Aliceanna Streets. I want to commend the Polish-American community and Alfred Wisniewski, Chairman of the National Katyn Memorial Committee, and the entire committee, for their tireless efforts in making this memorial to the victims of this atrocity a reality.

I urge my colleagues to join me in paying tribute to the memory of these murdered Polish Army officers. The Katyn Memorial in Baltimore will be a lasting reminder to all of us that we must never tolerate evil and tyranny and that we must continue to speak out for justice and tolerance.

MEDICARE MENTAL ILLNESS NON-
DISCRIMINATION ACT

HON. MARGE ROUKEMA

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 10, 2000

Mrs. ROUKEMA. Mr. Speaker, I am today introducing the Medicare Mental Illness Non-Discrimination Act, legislation to end the historic discrimination against Medicare beneficiaries seeking outpatient treatment for mental illness. Under the current Medicare statute, patients are required to pay a 20 percent copayment for Part B services. However, the 20

percent copayment is not the standard for outpatient psychotherapy services. For these services, Section 1833(c) of the Social Security Act requires patients to pay an effective discriminatory copayment of 50 percent.

Let me say this again: If a Medicare patient has an office visit to an endocrinologist for treatment for diabetes, or an oncologist for cancer treatment, or a cardiologist for heart disease, or an internist for the flu, the copayment is 20 percent. But if a Medicare patient has an office visit to a psychiatrist or other physician for treatment for major depression, bipolar disorder, schizophrenia, or any other illness diagnosed as a mental illness, the copayment for the outpatient visit for treatment of the mental illness is 50 percent. The same discriminatory copayment is applied to qualified services by a clinical psychologist or clinical social worker. This is quite simply discrimination. It is time for Congress to say "enough."

Last year, U.S. Surgeon General David Satcher, M.D., Ph.D. released a landmark study on mental illness in this country. The Surgeon General's report is an extraordinary document that details the depth and breadth of mental illness in this country. According to Dr. Satcher, "mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer." The burden of mental illness on patients and their families is considerable. The World Health Organization report that mental illness including suicide ranks second only to heart disease in the burden of disease measured by "disability adjusted life year."

The impact of mental illness on older adults is considerable. Prevalence in this population of mental disorders of all types is substantial. 8 to 20 percent of older adults in the community and up to 37 percent in primary care settings experience symptoms of depression, while as many as one in two new residents of nursing facilities are at risk of depression. Older people have the highest rate of suicide in the country, and the risk of suicide increases with age. Americans age 85 years and up have a suicide rate of 65 per 100,000. Older white males, for example, are six times more likely to commit suicide than the rest of the population. There is a clear correlation of major depression and suicide: 60 to 75 percent of suicides of patients 75 and older have diagnosable depression. Put another way, untreated depression among the elderly substantially increases the risk of death by suicide.

Mental disorders of the aging are not, of course, limited to major depression with risk of suicide. The elderly suffer from a wide range of disorders including declines in cognitive functioning, Alzheimer's disease (affecting 8 to 15 percent of those over 65) and other dementias, anxiety disorders (affecting 11.4 percent of adults over 55), schizophrenia, bipolar disorder, and alcohol and substance use disorders. Some 3 to 9 percent of older adults can be characterized as heavy drinkers (12 to 21 drinks per week). While illicit drug use among this population is relatively low, there is substantial increased risk of improper use of prescription medication and side effects of polypharmacy.

While we tend to think of Medicare as a "senior citizen's health insurance program," there are substantial numbers of disabled individuals who qualify for Medicare by virtue of

their long-term disability. Of those, the National Alliance for the Mentally Ill reports that some 400,000 non-elderly disabled Medicare beneficiaries become eligible by virtue of mental disorders. These are typically individuals with the severe and persistent mental illnesses, such as schizophrenia.

Regardless of the age of the patient and the specific mental disorder diagnosed, it is absolutely clear that mental illness in the Medicare population causes substantial hardships, both economically and in terms of the consequences of the illness itself. As Dr. Satcher puts it, "mental illnesses exact a staggering toll on millions of individuals, as well as on their families and communities and our Nation as a whole."

Yet there is abundant good news in our ability to effectively and accurately diagnose and treat mental illnesses. The majority of people with mental illness can return to productive lives if their mental illness is treated. That is the good news: Mental illness treatment works. Unfortunately, today, a majority of those who need treatment for mental illness do not seek it. Much of this is due to stigma, rooted in fear and ignorance, and an outmoded view that mental illnesses are character flaws, or a sign of individual weakness, or the result of indulgent parenting. This is most emphatically not true. Left untreated, mental illnesses are as real and as substantial in their impact as any other illnesses we can now identify and treat.

Mr. Speaker, Medicare's elderly and disabled mentally ill population faces a double burden. Not only must they overcome stigma against their illness, but once they seek treatment the Federal Government via the Medicare program forces them to pay half the cost of their care out of their own pockets. Congress would be outraged and rightly so if we compelled a Medicare cancer patient to pay half the cost of his or her outpatient treatment, or a diabetic 50 cents of every dollar charged by his or her endocrinologist. So why is it reasonable to tell the 75-year-old that she must pay half the cost of treatment for major depression? Why should the chronic schizophrenic incur a 20 percent copayment for visiting his internist, but be forced to pay a 50 percent copayment for visiting a psychiatrist for the treatment of his schizophrenia?

It is most emphatically not reasonable. It is blatant discrimination, plain and simple, and we should not tolerate it any longer. That is why I am introducing the Medicare Mental Illness Non-Discrimination Act. It is time we acknowledged what Dr. Satcher and millions of patients and physicians and health professionals and researchers have been telling us: Mental illnesses are real, they can be accurately diagnosed, and they can be as effectively treated as any other illnesses affecting the Medicare population. We can best do that by eliminating the statutory 50 percent copayment discrimination against Medicare beneficiaries who, through no fault of their own, suffer from mental illness.

My legislation is extremely simple. It repeals Section 1833(c) of the Social Security Act, thereby eliminating the discriminatory 50 percent copayment requirement. Once enacted, patients seeking outpatient treatment for mental illness would pay the same 20 percent copayment we require of Medicare patients seeking treatment for any other illnesses. My bill is a straightforward solution to this last