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 Centers, 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 injectible 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