

Ferndale will welcome visitors with an old-fashioned birthday party in celebration of this historic anniversary on August 23rd and 24th, 2002. The art galleries, parks and beautiful houses that grace the city make Ferndale a delightful place to live and to visit.

Mr. Speaker, it is appropriate at this time that we recognize the City of Ferndale, California on the occasion of its 150th anniversary.

MEDICARE BENEFICIARY ASSISTANCE IMPROVEMENT ACT OF 2002

HON. JOHN D. DINGELL

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, July 26, 2002

Mr. DINGELL. Mr. Speaker, today my colleagues and I are introducing a bill that will make significant and long-overdue improvements in the programs that provide assistance to low-income Medicare beneficiaries. Medicare provides coverage to all 40 million elderly and disabled beneficiaries, regardless of income, but the cost of uncovered services, premiums, and cost-sharing is a serious burden on those with the lowest incomes.

More than 40 percent of Medicare beneficiaries have incomes below 200 percent of poverty (a little more than \$17,000 a year). These low-income beneficiaries are nearly twice as likely as higher-income beneficiaries to report their health status as fair or poor, but are less likely to have private supplemental insurance to cover the cost of uncovered services or Medicare cost-sharing. Poor beneficiaries also bear a disproportionate burden in out-of-pocket health care costs, spending more than a third of their incomes on health care compared to only 10 percent for higher-income beneficiaries.

Medicaid, through what is known as the "Medicare Savings Programs," fills in Medicare's gaps for low-income beneficiaries, providing supplemental coverage to 17 percent of all Medicare beneficiaries. Millions of beneficiaries, however, who are eligible for assistance under the Medicare Savings Programs are not enrolled. For example, only half of the beneficiaries below poverty who are eligible for assistance are actually enrolled. Lack of outreach, complex and burdensome enrollment procedures, and restrictive asset requirements keep millions of seniors from receiving the assistance they desperately need.

The Medicare Beneficiary Improvement Act of 2002 takes a number of steps to address these problems. First, the legislation improves eligibility requirements for these programs. It raises the income level for eligibility for Medicare Part B premium assistance from 120 percent to 135 percent of poverty. This expansion was originally enacted in 1997 but it expires this year; it is simple common sense to make this provision permanent. The bill also ensures that all seniors who meet supplemental security income (SSI) criteria are automatically eligible for assistance. Currently, automatic eligibility is only required in certain states, meaning that beneficiaries in other states may miss out on critical assistance unless they know enough to apply. The bill also eliminates the restrictive asset test that requires seniors to become completely destitute in order to qualify for assistance. Most low-income Medicare

beneficiaries have limited assets to begin with—85 percent of beneficiaries with incomes below the poverty level have fewer than \$12,000 in assets—but the asset restrictions are so severe, a beneficiary could not keep a fund of more than \$1,500 for burial expenses without being disqualified from assistance.

Second, the legislation eliminates barriers to enrollment. The legislation allows Medicare beneficiaries to apply for assistance at local social security offices, encourages states to station eligibility workers at these offices (as well as at other sites frequented by senior citizens and individuals with disabilities), and ensures that beneficiaries can apply for the program using a simplified application form. In addition, this bill will ensure that once an individual is found eligible for assistance, the individual remains continuously eligible and does not need to re-apply annually.

Third, the legislation improves assistance with beneficiary out-of-pocket costs. It provides three months of retroactive eligibility for "qualified Medicare beneficiaries" (QMBs). All other groups of beneficiaries have this protection currently. In addition, it prohibits estate recovery for QMBs for the cost of their cost-sharing or benefits provided through this program. The fear that Medicaid will recoup such costs from a surviving spouse is often a deterrent for many seniors to apply for such assistance.

Finally, the legislation funds a demonstration project to improve information and coordination between federal, state, and local entities to increase enrollment of eligible Medicare beneficiaries. This demonstration would help agencies identify individuals who are potentially eligible for assistance by coordinating various data and sharing it with states for the purposes of locating and enrolling these individuals. In addition, the legislation provides grant money for additional innovative outreach and enrollment projects for the Medicare Savings Programs.

All told, this legislation should go a long way in making sure that the Medicare Savings Programs are working as they should to provide assistance with health care cost-sharing and premiums for vulnerable low-income seniors. As Congress addresses Medicare issues this year, we must ensure that in addition to addressing provider payments, we also address these important beneficiary protection issues as well. I look forward to working with my colleagues to pass this legislation.

H.R. 5250—VETERANS HEALTH CARE FUNDING GUARANTEE ACT OF 2002

HON. LANE EVANS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 26, 2002

Mr. EVANS. Mr. Speaker, today, I want to end my support as an original cosponsor of the "Veterans Health Care Funding Guarantee Act of 2002" being introduced by the Chairman of our Committee, CHRIS SMITH. The bill, supported by all of the major veterans' service organizations, would create a mandatory spending stream for veterans' health care and medical construction in the Department of Veterans Affairs.

VA medical care is one of the biggest domestic discretionary accounts in the federal

budget. While Congress has historically improved upon inadequate Administration budget requests, VA has still suffered from ebbs and flows in its funding streams that often have little to do with the number of veterans served or the cost of the services they receive. We, in Congress often must work within artificially constrained budget limitations that do not allow the growth in funding VA needs or our veterans deserve.

This has been particularly difficult in recent years in which the growth in veterans seeking care in the system, often for the first time, has been unprecedented and unpredictable. A mandatory funding stream, such as that which the Chairman of our Committee proposes, will bring increased stability and predictability in funding the health care system designed to meet the needs of our nation's veterans.

The Chairman's bill would use medical inflation and growth in the VA's enrollment to ensure that these uncontrollable factors are appropriately addressed. The bill would also require a one-time "bump" of twenty percent in the appropriation to adjust VA's baseline, deemed by our major veterans' service organizations to be significantly under-funded for the last several years.

Our veterans' health care system is struggling to accommodate significant growth in use by veterans. Finding that VA is a source of inexpensive prescription drugs, aging middle-class veterans have recently enrolled in record numbers. About five years ago, lower priority veterans (those who are not service connected or medically indigent) constituted about 2–3 percent of the veterans' patient population; they now constitute about 30 percent of the 6 million veterans enrolled in the system.

Appropriations have simply not kept pace with veterans' increased demand for VA health care. As a result VA has unmanageable waiting times and is neglecting its core population—the veterans with service-connected conditions, with certain exposures or service or the veterans who are considered medically indigent. I recently received data from the Secretary of Veterans Affairs that indicates that there are more than 300,000 veterans either waiting for their first VA appointment or who have waited longer than six months for care. I believe that all veterans deserve access to their health care system, but we cannot pretend that they have this access simply because we allow it. The system must be funded to ensure that it is able to meet the demand veterans produce.

I believe the Chairman's bill will address the problems Congress has chronically been unable to redress. I applaud his innovation and look forward to working with him on this bill.

PERSONAL EXPLANATION

HON. LUIS V. GUTIERREZ

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, July 26, 2002

Mr. GUTIERREZ. Mr. Speaker, I was unavoidably delayed on June 26th and was absent for a journal vote. I would like the record to reflect that had I been present, I would have voted "yea" on rollcall vote 261.

I was also unavoidably absent from this chamber on July 12, 2002. I would like the