from service-related causes, and of veterans needing prescription drugs, is simply not acceptable to me. I do not understand their priorities.

Finally, Mr. President, as I noted at the outset, this compromise was crafted behind closed doors. I was denied any opportunity to participate in the conference. I asked for a public meeting of the sub-conference on a number of occasions in order to give us the opportunity to discuss the differences between the House and Senate provisions in a public forum. The only response I received was an invitation to a private meeting in Senator SIMPSON's office after the final agreement had been reached. That's just not good enough. The American people deserve better. America's veterans deserve better. We should conduct our business in the open, not behind closed doors. This package was developed with no input whatsoever from Senate Democrats. That is not how our Committee has functioned in the past. I regret that we are now taking that approach.

Mr. President, this package is a bad deal for veterans. It cuts too deeply and in wrong areas. As the Ranking Democrat on the Veterans' Affairs Committee, I see my role as looking out for our Nation's veterans, as making certain that our promises made to those who gave of themselves in our common defense are kept. This package does not do that. That is why I must oppose it.

CUT TAXES: BALANCE THE BUDGET

Mr. PRESSLER. Mr. President, the American people want and deserve an end to shameless, wasteful spending programs. They want a reduction in taxes for working middle-class families and a balanced budget so we finally live within our means—as people in my home state of South Dakota do every day. I feel passionately that we must give the dream of America back to our children. That is why I support the Balanced Budget Act of 1995.

The working men and women in America are fed up with politics as usual in Washington. They have spoken loudly that they want us to cut wasteful spending, reduce taxes for working middle-class families, and finally balance the budget. The Republicans in Congress have heard this call for change. We, too, are tired of business as usual. That is why we have proposed tax relief for working, middle-class Americans so they can keep more of what they earn, rather than leave it in the hands of Washington bureaucrats.

Recently, an editorial in the Rapid City Journal praised the current Republican tax plan. This editorial is right on target. Mr. President, I ask unanimous consent to place this editorial in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. PRESSLER. Why do middle-class, working Americans want us to cut spending and provide tax relief? The reason is obvious. The Federal Government wastes billions of their tax dollars every year on more and more programs that do less and less to meet the needs of average Americans. Working Americans are paying more and more for less and less. Now we have the opportunity to cut taxes and in the process make government more efficient and effective, smaller and smarter. It is time to give the American people what they want—a balanced budget, an end to wasteful spending, and a reduction of taxes for wage-earning, middle-class working families.

EXHIBIT 1

WIDE APPEAL IN TAX BREAKS

THE TAX BREAKS INCLUDED IN CONGRESSIONAL BUDGET PROPOSALS WILL BENEFIT MIDDLE-INCOME AMERICANS MOST

In the great budget debate of 1995, congressional Democrats and President Clinton have continually argued that Republicans are targeting the poor and elderly with spending cuts to pay for tax breaks for the wealthy.

Hmmm. Tax breaks for the wealthy?

There are flaws in this argument.

For one thing, the $500-per-child tax credit under the expected budget compromise would go to families with incomes under about $100,000. That means the wealthiest Americans—those with taxable incomes over $100,000—wouldn't qualify for it. And it means most families that pay taxes would pay lower taxes.

A second tax break included in both the House and Senate budget bills would reduce the top capital gains tax rate from 28 percent to 19.8 percent. Although this tax break would result in wealthy taxpayers paying a lower rate, it could very well mean their total tax bills would be higher. The lower tax rate likely would motivate sales of investment assets that otherwise wouldn't be sold and thus wouldn't generate any tax revenue.

Plus, the increased economic activity that a lower capital gains tax rate would generate would result in increased capital for job-creating small businesses and a healthier economy that produces more tax revenue.

Besides, a cut in the capital gains tax rate doesn't apply only to wealthy individuals. It applies to everyone who increases their taxable income by selling a home or some other investment. In today's economy, that takes in a lot of people. One study showed that in 1990, when the top capital gains tax rate was lowered from 33 percent to its current 28 percent, 70 percent of the tax returns reporting capital gains were from people with taxable incomes below $75,000.

So, while it may be correct that House and Senate budget proposals include some benefit for the wealthy, it's the middle income taxpayers that benefit most.

On the other side of the budget's impact on taxpayers are proposed reductions in the Earned Income Tax Credit, a tax break for workers with low incomes. The House bill proposes decreasing planned EITC spending by $23 billion over the next seven years, while the Senate bill proposes $43 billion.

Some of this reduction is justified. EITC eligibility requirements need to be tightened so people with low taxable incomes but high nontaxable incomes, from sources such as tax-free annuities, don't qualify. And in a program with a high rate of fraud—the Internal Revenue Service estimates up to 40 percent of the tax returns claiming the EITC contain errors or fraudulent claims—the plan to double penalties for fraudulent EITC claims is justified.

But because the EITC program is, in effect, a reward for people who work rather than rely on welfare assistance, the budget proposals should be scaled back so as not to affect the people the EITC is intended to help.

Of course, these changes in tax credits and tax rates would increase the complexity of a federal tax code that is already too complicated. We should really be going in the opposite direction, toward a simpler tax code.

And on the other side of the budget proposals, the decreases in proposed spending, there is room to argue whether the decreases are targeted fairly.

But the tax breaks included in Republican budget proposals aren't as hideous as they've been made out to be.

A lot of hard-working, middle-income Americans would benefit.

THE 7-YEAR BALANCED BUDGET RECONCILIATION ACT OF 1995—CONFERENCE REPORT

The PRESIDING OFFICER. The Chair announces that the Senate has received the conference report from the House, and the clerk will now state the report.

The assisted legislative clerk read as follows:

The committee on conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2491) to provide for reconciliation pursuant to section 105 of the concurrent resolution on the budget for fiscal year 1996, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses this report, signed by a majority of the conferees.

Thereupon, the Senate proceeded to consider the conference report.

(The conference report is printed in the House proceedings of the RECORD of November 16, 1995.)

The PRESIDING OFFICER. The Senator from Nebraska.

POINT OF ORDER

Mr. EXON. Mr. President, I raise a point of order that the sections designated on the list that I now send to the desk violate the Byrd rule, sections 313(b)(1)(A) and (D) of the Congressional Budget Act.

The list follows:

EXTRANEOUS PROVISIONS IN H.R. 2491

Subtitle and section	Subject	Budget act violation	Explanation
Subtitle M Sec. 13301.	Exemption of physician office laboratories.	313(b)(1)(A)	No deficit impact
Sec. 1853(f) of the Social Security Act as added by Section 8001 of the bill.	Application of antitrust rule of reason to provider-sponsored organization.	313(b)(1)(A) .... 313(b)(1)(D)	No deficit impact Merely incidental

Mr. ABRAHAM. Mr. President, pursuant to section 904 of the Congressional Budget Act, I move to waive the point of order for consideration of the antitrust provisions that have been raised in this point of order.

The PRESIDING OFFICER. Under the Budget Act, there is now debate on the motion. Who yields time? The Senator from New Mexico.

Mr. DOMENICI. On behalf of the majority leader, I ask unanimous consent

that at 8:15, the Senate proceed to a vote on the motion to waive, without any further action or debate, and that the time be equally divided between now and 8:15 between the proponents of the point of order and the proponents of the waiver.

The PRESIDING OFFICER. Is there objection?

Mr. KYL. I object.

Mr. BRADLEY. Reserving the right to object.

The PRESIDING OFFICER. Objection has been heard. Who yields time?

Mr. KYL. If the Senator from New Jersey wishes to speak, I will reserve the right, but I intend to object until Senator HATCH arrives.

The PRESIDING OFFICER. There is an hour for debate. Who yields time?

Mr. EXON. Mr. President, was there an objection?

The PRESIDING OFFICER. The Chair heard an objection from the Senator from Arizona.

Mr. DOMENICI. Mr. President, I would like to assign, from the standpoint of the majority, the privilege of debating the opposition to the point of order to be led by Senator KYL, and he can direct the time to whomever he desires in reference to our time on this side. If he will reserve me a minute or two, I would like to join him in the argument.

Mr. BUMPERS. Parliamentary inquiry.

The PRESIDING OFFICER. Who yields time?

Mr. EXON. He has requested a parliamentary inquiry, which I do not think requires a yielding of time.

Mr. BUMPERS. Parliamentary inquiry. Is this a point of order? Are we going to be voting on a motion to waive the point of order and will that require 60 votes, Mr. President?

The PRESIDING OFFICER. The vote does require 60 votes. Who yields time?

Mr. EXON addressed the Chair.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. EXON. Mr. President, I yield myself 5 minutes off the time that I have under my control, and will the Chair advise me how much time the Senator from Nebraska controls?

The PRESIDING OFFICER. The Senator from Nebraska controls 30 minutes.

Mr. EXON. Mr. President, I have been fascinated and horrified by the press reports about the horse trading that went on to win the support for the Republican budget. I am not speaking about wooing recalcitrant Republicans who strayed from the party line. No, I am looking at some of the sweeteners that were loaded into this bill to keep the medical establishment at bay and to pay the American Medical Association for their support of the Republican budget.

This conference report is groaning with extraneous giveaways to the medical establishment. They do not only violate the Byrd rule, but they violate every sense of decency and fair play. The conference report exempts physicians' offices and laboratories from the Clinical Laboratory and Improvement Act of 1988.

It is clear that this is a violation of the Budget Act. It is extraneous, in addition to being bad policy. Antitrust regulations are turned on their heads in this conference report just to boost physicians' salaries. The conference report exempts certain groups of health care providers from the most basic antitrust violations against price fixing. This is also a violation of the Budget Act and is likely to impair competition and raise costs for non-Medicare health care purchasers.

It is appalling that when our seniors, our poor, our disabled, and our children are being asked to sacrifice basic health care, the Republicans are trying to enlarge special interest giveaways to the Nation's physicians.

The provisions do not belong in this fast-track reconciliation bill and are a violation of the Byrd rule. I urge my colleagues to vote against the motion to waive this well-founded point of order.

Madam President, at this time, I ask for the yeas and nays.

The PRESIDING OFFICER (Mrs. HUTCHISON). Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. EXON. Madam President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. EXON. Madam President, since there are no other Members seeking recognition at this time, I yield 5 minutes of my time to the Senator from Arkansas.

The PRESIDING OFFICER. The Senator from Arkansas is recognized for 5 minutes.

Mr. BUMPERS. Madam President, it is not unusual when I go home and visit with some of my wealthy friends—and I do have some wealthy friends—they say, ''The only objection I have to you Democrats is you are constantly engaging in class warfare. You are always talking about the wealthy.''

I repudiate that idea, but I would like for my colleagues to look at this chart for just a minute. This is a quote from David Gergen—one of Ronald Reagan's right-hand men when he was President—from an op-ed piece that he wrote in this week's U.S. News and World Report. Without straining your eyes, I will tell you what he said about this bill we are debating tonight. Eighty percent of the tax breaks in this bill go to the wealthiest 20 percent of Americans. Eighty percent of the spending cut burden goes to the poorest 20 percent. Now, you talk about class warfare. There is class warfare. It violates every principle I ever learned as a Methodist Sunday school boy. It violates every principle I have ever held dear, and the very reason I came to the U.S. Senate. Madam President, let me say something about the wealthy people of this country. They do not like this. Seventy percent of the people of this country say they do not want a tax cut until the budget is balanced. Why are we going against what 70 percent of the people say?

Last fall, when people were voting, Madam President, most did not have a clue what was in the Contract With America. And I can assure you they were not voting for this. They were not voting to penalize the poorest 20 percent of the people in America. They were not in favor of depriving a million children in this country of an education. They were not voting to put another million people in poverty, which this bill does. They were not voting to cut school lunches, which is the only decent meal an awful lot of children in this country get. They were not voting to savage Medicare and make the elderly people of this country pay it. They were not voting to savage Medicaid. In my State, Medicaid will be cut 33 percent, Madam President. We will not have a Medicaid program.

The people of America were not voting to slash the Earned Income Tax Credit for people who are trying to work and stay off welfare. What are we doing? We are cutting that $32 billion.

So I remind my colleagues on the other side of the aisle, when the American family gathers around the dinner table in the evening, what do they talk about? What do they say they love? Not the Mercedes in the driveway. Not that posh office downtown or that magnificent farm out back. They love their children. That is who they want us to protect. What are we doing? We are savaging the children of this country. For what? So that the biggest corporations in America get a break. I yield the floor.

Mr. HATCH. Madam President, we are trying to accommodate Members around here. And there is no use kidding, I am very upset about this point of order. This is not going to be the last time we mention it either. But I want to accommodate everybody around here. We ought to have at least a 2-hour debate on the thing because it is not easy to explain, but it is easy to understand. I have to tell you that I think even my colleagues on the other side might understand. But the fact of the matter is that this point of order is wrong. I personally feel very badly about it because what we are doing here is we are allowing the rule of reason in some areas and not allowing it in others. It is very unfair, it does not work right. We are happy to enhance bureaucracy but we are not happy to enhance individuality. I think we can clarify it for anybody in just a few minutes. But we want to accommodate those who want to get out of here and, frankly, I think we can put a lot of what we have to say into the RECORD.

Let me address this point of order against antitrust rules relating to provider-sponsored organizations—PSO's, if you will—and health care groups

that contract with them to provide Medicare services. These provisions would grant antitrust relief to these two different entities by subjecting their conduct to the rule of reason, rather than the per se illegal rule.

Let me be clear about what this language would do. This is not an antitrust exemption. Under the rule of reason, the conduct of the PSO's and their subcontracting health care groups will not be legal if it is designed to fix prices, divide markets, or exclude competitors. Instead, their conduct will be illegal if it is anticompetitive, but if it is competitive, leads to efficiency, and produces lower prices for health care, it will survive antitrust challenge, as it should.

This provision that we are about to strike out of here is one of the few that really saves an awful lot of money in health care and flies in the face of bureaucratizing the process, which I thought we defeated last year. We believe that this reform—which is necessary only because the Department of Justice and the Federal Trade Commission have overzealously enforced the antitrust laws—is central to the savings we anticipate in our Medicare reforms. Right now, because of these enforcement policies, groups of doctors cannot form, decide on a fee schedule, and negotiate with anyone over providing health care services, if this is knocked out. This knocks out of the market a potentially new class of competitors with low overhead and little or no bureaucracy, who can make these other groups bring prices down.

The Congressional Budget Office scored the savings to be generated by the House and Senate Medicare reform bills at between $34.2 billion and $50.4 billion over 7 years.

CBO did not break out how much of this savings was attributable to the creation of health care provider groups that could contract with PSO's, and the importance of the antitrust reform needed to encourage the groups to form. The CBO noted the creation of PSO's in these groups would have an impact on Medicare outlays and that is all that is needed to meet the express language of the Byrd rule.

Further, since this bill is creating two whole new classes of competitors in the Medicare market, and the antitrust provisions are critical to encouraging their formation, it is clear that these provisions are critical to producing the billions of dollars in savings we are counting on for innovation and competition. I do not think that anyone can seriously contend that these provisions have no budgetary impact.

The second argument that one might raise against these provisions is that they are somehow incidental to reconciliation. This aspect of the Byrd rule is designed to prevent the addition of provisions that have nothing to do with the budget. The antitrust provisions clearly satisfy the Byrd rule. The rule has nothing to do with the larger changes in all antitrust law.

In fact, it does not change antitrust law at all, only the administration's enforcement. More importantly, the antitrust provisions are expressly limited only to conduct that is necessary to provide health care services under Medicare contract or plan. It has no application outside of the Medicare context, and any attempt to use information gained in Medicare context beyond the limits of that program—what some people call a leakage or seepage problem—would be illegal. Any conduct occurring in the Medicare context that is just a sham for price fixing or boycotting would still be illegal under the rule of reason.

I suggest that those who would use the BYRD rule to stop these provisions are not concerned, Madam President, about budgetary impact or incidental provisions. Instead, they are interested in suppressing competition in the health care market and reducing Medicare costs.

We should be frank. The status quo helps large hospitals and insurance companies and HMO's. These antitrust provisions that are in this bill that they are trying to rule out of order may cut down on their profit margins by introducing whole new classes of health care providers into the marketplace. New market actors will spur competition efficiency and lower costs.

When we are fighting to find ways to reduce Government costs and the Government's tax burden, why turn away an attractive mechanism to make the markets work better and to reduce the budget?

The fact is per se illegal activity will still be illegal. These entities would have to live within the rule of reason. If they do not and they do not increase competition, increase efficiency, and reduce costs, then they are not going to be able to function, and they should not be.

The fact of the matter is that this point of order is wrong, and I hope that we will vote to waive the point of order.

Mr. EXON. Mr. President, I yield 3 minutes to the Senator from Florida.

Mr. GRAHAM. Thank you, Madam President.

As I read the front cover of the document which has just been presented to us, Balanced Budget Act of 1995, Part 1 of 2—Part 2 apparently has not yet arrived—the question arises, why will I vote against this proposition?

It is not, Madam President, because I am opposed to a balanced budget. I am, in fact, strongly supportive of a balanced budget, and every occasion I have had an opportunity to advance that cause I have done so.

I frankly commend the Republicans for having presented us an alternative which purports to achieve that goal of balanced budget because it will provide a significant point of debate and dialog as to how to achieve that goal.

However, Madam President, I do not feel that this legislation presented tonight will accomplish the objective of balanced budget for two primary reasons. One, just as in foreign policy, I do not believe this Nation can achieve an important long-term domestic policy goal unless that goal is broadly shared, unless there is bipartisan support.

The fact is, there is no bipartisan support for this provision. There has been no attempt to secure bipartisan support. No Democrats were sanctioned into the conferences which led to the production of this legislation. No Democratic ideas were solicited for inclusion.

Second, this will not achieve the goal of a balanced budget over the next 7 years because it is fundamentally unfair and will soon be seen to be unfair by the American people and rejected.

I am going to concentrate my comments on fairness on only one section of this multihundred-page bill, Part 1 of 2, goes to 966 pages. That is the sections that relate to Medicaid.

First, the statement is made that this legislation reduces Medicaid spending by $163 billion over the next 7 years. Madam President, that is not true. In fact, this legislation reduces Medicaid spending by almost $400 billion over the next 7 years.

What is the difference? The difference is because this legislation removes virtually all of the current requirements on States to make a significant contribution towards the health of their poor, their disabled and their frail elderly.

Second, this allows for future manipulation of the Medicaid Program. We worked hard in this Senate to eliminate the abuses that had become so rampant in the disproportionate share hospital program. This legislation allows all those abuses to return. This legislation, in fact, rewards those very States that have been the principal abusers of the disproportionate share program.

Madam President, for those and many other reasons that we will find in these 966 pages, this proposal fails to meet the duel test of bipartisanship and fairness necessary for its sustained achievement of the goal of the balanced budget.

Madam President, we are here debating a bill that nobody has received. Even for those who may have a copy, it would be impossible for them to have possibly read the legislation from cover to cover.

And yet, this is one of the most significant bills to come before the Congress. This is a bill that makes up to $1 trillion in reductions to our Nation's budget—including $256 billion in Medicare reductions and $163.5 billion in Medicaid reductions—over the next 7 years.

I rise today to speak to the best of my knowledge about some of the provisions in this bill. Of course, the ''best of my knowledge'' is limited by the amount of information we have managed to obtain, some of which our office has had to get from lobbyists who always seem to get such materials before the rest of the Congress.

Due to time limitations, I will focus on the massive reductions or $420 billion in Federal cuts that will be made in this bill to our Nation's Medicare and Medicaid programs which are integral parts of our Nation's health infrastructure.

MEDICAID CUTS EVEN HIGHER DUE TO STATE-FEDERAL COMBINATION

The first point that has been neglected about this budget deal are that the real Medicaid reductions are more in the neighborhood of $400 billion over the next 7 years. Part of this figure comes from the $163.5 billion in Federal reductions to Medicaid. However, an often overlooked but just as significant provision is the language in the bill that guts the matching rate requirements of States.

This reduction will have the effect of reducing another $200-plus billion in State funding over the next 7 years to the Medicaid program.

How does this work? At present, States such as New York have to match a Federal Medicaid dollar with a State Medicaid dollar. No longer. According to the revised State matching requirements, New York would be allowed to match a Federal Medicaid dollar with just 67 cents—a 33-percent reduction.

The effect of the change to the matching rates across the Nation will be a $200-plus billion reduction in State funding to Medicaid.

Moreover, the conference agreement eliminates two provisions in the Senate bill that were agreed to unanimously in the Senate Finance Committee. These amendments would have continued to prohibit the gaming of the Medicaid System through the use of provider taxes and prohibited States from supplanting current State health expenditures with Medicaid dollars.

The conference committee agreement encourages States to go back to the days of fictitious accounting and gaming that in the past effectively raided the Medicaid Program.

The effect of this policy under a block grant is not to raid the Federal treasury but to make the State matching rate illusory at best. In fact, the conference report effectively makes Medicaid a general revenue sharing program.

It is no wonder that some of our Nation's Governors are clamoring and cheerleading the destruction of the Medicaid Program. I have a warning for them, or more accurately, a proverb for them. The proverb goes as follows: ''Fish see the worm not the hook.''

The Governors who are anxious to gobble up these block grants and illusory matching rates will feel took in the future when their economies stumble, when an epidemic strikes, when a nature disaster hits, when inflation creeps up again, or when their populations grow.

NATION'S LOW-INCOME ELDERLY AT RISK

Another often misunderstood provision of this legislation is the impact that it will have on our Nation's low-income elderly.

Let me emphasize that the Republican bill repeals the current law guarantee of payment of the Medicare Part B premiums on behalf of elderly Americans with income below the poverty level—$622 per month for an individual.

Although the Speaker of the House claims the bill ''provides that senior citizens at the poverty level and below have all of their Part B premium paid for by the taxpayers—100 percent,'' the fact is that, no poor senior citizen has a guarantee to any coverage or assistance whatsoever.

States would be asked to set aside a certain percentage of their program spending each year to pay for Medicare premiums, deductibles, and coinsurance on behalf of low-income elderly. However, this set-aside will be sufficient to cover only about 44 percent of the costs of Part B premiums for those now eligible by the year 2002.

NURSING HOME—LIENS OF FAMILY HOMES

Another provision that was unanimously agreed to in the Senate Finance Committee was a provision that protected spouses having liens placed against their home or family farm. Incredibly, this provision was also dropped by the conference committee.

As a result, the conference agreement repeals current law protections against the use of liens and expressly authorizes States to impose liens on the home or family farm of a beneficiary, even when the spouse is still living in it.

UNFAIRNESS OF MEDICAID CUTS AND FORMULA

Finally, I want to raise some policy questions that the bill creates. First what is the policy justification for $163.5 billion in Medicaid reductions? This provides for just a 1.9 percent increase in Medicaid spending per person over the seven year period and is far less than the 7.1 percent the Congressional Budget Office projects private sector spending to increase.

Second, what is the policy justification for arriving at the Medicaid formula in the bill? Can anybody possibly explain how the fiscal year 1996 State-by-State allocations are arrived at? Dollar figures are stated in law. How were those numbers arrived at?

Clearly, one impact is to reward those States that have extremely high share of disproportionate share in the past. Some of those States abused the Medicaid Program and will be rewarded for that abuse in the new Medicaid formula.

At one point, the Senate Finance Committee staff had proposed that States with excessive disproportionate share payments would lose those excess payments. The Senate Finance Committee voted to cap those payments at 12 percent.

That provision was deleted, and instead, States are now rewarded for their excesses and—in some cases—their abuse.

These States will have those funds permanently cemented in their base allocation and allowed to increase them well into the future. What is the policy rationale for this?

Whatever the rationale, the effect is to apportion funding in a manner that is fundamentally unfair to those States that did not scam the Medicaid disproportionate share program, those States that are growing and those States that have been efficient in the past.

In Florida's case, we have a larger population than either Pennsylvania and Ohio and an elderly population that is 40.7 percent greater than Pennsylvania and 79.2 percent greater than Ohio, yet will receive less money over the next 7 years from Medicaid than either of those two States.

Florida has 5.4 percent of the Nation's population, 8 percent of the Nation's elderly population but will receive just 4.2 percent of the overall Federal Medicaid allocation between fiscal year 1996 and 2002.

If Florida were to just receive its population share of money, it would receive $42.7 billion instead of the $33.0 billion allowed in this bill, a $9.7 billion disparity or loss to Florida over the 7-year period.

OTHER PROBLEMS

For all these reasons and for numerous others—such as the conference committee's level of Medicare cuts on our Nation's elderly and the danger and exposure that Medicare beneficiaries will be subjected to due to watered down emergency care managed care standards, I cannot and will not support this legislation.

I would like to turn the Senate's attention from Medicaid and Medicare for a moment to another important issue before the Senate tonight.

Madam President, when the Senate votes on the reconciliation bill shortly, there will be one important issue which risks being lost in the enormity of the Medicare cutting, Medicaid gutting, tax cutting, and budget balancing package.

That issue is welfare reform.

The effrontery of burying such a monumentally important matter in the middle of a massive Medicare, Medicaid, Tax Code, and budget overhaul speaks for itself.

The welfare reform component of this reconciliation bill deserves strict scrutiny instead of token consideration.

My support for sweeping change in our Nation's welfare system is a matter of record, and as recently as September 19, 1995, I joined with 86 of my colleagues in supporting the Work Opportunity Act of 1995, Senate bill 1120.

I voted in support of this bill, even though I had serious reservations, in order to keep the welfare reform effort in this Congress alive.

Unfortunately, the conference agreement moves welfare reform in the opposite direction. The pending legislation is worse than what we had to consider 2 months ago.

Madam President, I support welfare reform. I want to see Congress pass a welfare reform measure, and I want to

see the President sign welfare reform legislation. But this bill deserves neither.

Welfare reform, when it is done well, works and works well.

Florida boasts of two very successful welfare pilot projects, the largest in America in instituting a ''time limited benefit.'' Florida, in fact, has been one of the pioneers in the ''two years and you are out'' approach that is mirrored in the pending legislation.

But, Madam President, these pilots are succeeding because there is a front-end investment in the lives of those affected by the program change.

Whether it is day care, job training, temporary transportation assistance, or health care, the welfare recipient is given a hand up instead of a hand out.

I visited the program in Pensacola, FL. Earlier this year President Clinton met some of the participants that I met, and he touted the program.

Madam President, the conference agreement before the Senate, as it pertains to welfare reform, is a mixture of good news and bad news.

The good news is that the conference agreement no longer treat education as welfare. We have Congressman CLAY SHAW and others to thank for that improvement.

Thankfully, the welfare reform legislation no longer kicks legal immigrants who pay taxes and are eligible for Federal student loans or grants, out of school.

This change assures 21,000 students in universities, colleges, and community colleges in Florida that they can continue to study and train in order to provide for their families and enhance our Nation's productivity.

Further, the conference agreement renounces the previous position of the Senate where deeming would occur past the date of citizenship. That provision appeared unconstitutional on its face, and fortunately, it was dropped.

But, Madam President, I am sorry to report that there is an overwhelming amount of bad news emerging from the conference on welfare reform.

First, the formula to allocate funds to the States continues welfare as we knew it. It treats poor children differently, depending upon which State they live in.

The conference formula says that if your State spent a lot in the old days, and thus built incentives to keep people on welfare, you will be given a leg up on every other State under block grants.

That is how it is possible, for example, that the State of Michigan would be given $217 million more, each year, than the State of Florida, which has a population that is 4.5 million greater than Michigan's population.

The conclusion is simple: the formula adopted by the conferees is flawed, if not rigged.

The conferees had an option: adopt a fair share allocation which treats children the same regardless of their ZIP codes. I offered such an amendment 2 months ago.

Instead, the conferees chose to reward the big spenders who got us in this mess in the first place.

If parents rewarded bad behavior of their children like this, we would be a nation of reform schools.

Madam President, another glaring disappointment in the conference agreement before the Senate is the retreat on a commitment to funding child care.

The Senate voted for a $3 billion increase over 5 years and now we see that the conference agreement proposes $3 billion over 7 years.

That may sound like an innocuous accounting change until you look at the impact on the States.

That change means for Florida less child care money next year, I repeat, less money next year, than it had this year.

Keep in mind that Florida is expected to more than double in one year its population of welfare recipients in the work force.

The conference agreement shortchanges Florida $18 million in child care funds from the amount that passed the Senate in September. That is movement backward, not forward.

When you take the faulty funding formula for the block grants, and combine them with the paltry child care allocations, you get the growing sense that Florida has been set up to fail.

Madam President, it did not have to be this way. If government were run like a business, you would have had by now a debate about a business plan.

In effect, you would have identified outcomes to be achieved, and then identified the means necessary to achieve those outcomes.

Just in the area of child care alone, in order to meet the job requirements of the conference agreement for the first 5 years after enactment, Florida would need approximately $800 million in child care funding. The conference agreement gives Florida $509 million.

That $291 million shortfall means that tens of thousands of children can not get child care, and therefore, their mothers or fathers can't go to work.

But the Congress wasn't interested in outcome and resource analysis. The Congress didn't want to do a business plan.

The Congress wanted to cut tens of billions of dollars out of welfare and shift those burdens to the States.

I will highlight a few more disappointments.

The Senate placed $878 million in a growth fund to assist States which experience caseload increases, and thus, cost increases. The conference agreement reduces that about 10 percent.

I mentioned earlier that there was good news in the conference agreement as it pertains to legal immigrants and access to Federal assistance to higher educational programs.

But even that good news has a new catch. The conferees have set up a new class system now in the Stafford loans program. Now legal immigrant applicants must have a sponsor or other citizen cosign the loans.

No debate on this change. No hearings. A brand new provision written in conference.

So I am left to believe that the conferees felt that only the better off of the legal immigrant communities are eligible for a Federal loan program, even though they all pay taxes like citizens pay taxes. So much for the American dream.

The city of Miami had more legal immigrants admitted last year than 20 States combined did. Thus the prohibitions and timetables on certain benefits will shift to Miami costs that once were shared or born by the Federal Government.

The State of Florida does not set immigration policy. The State of Florida did not negotiate a 20,000 legal immigrants per year agreement between Cuba and the United States.

But the State of Florida is now being told the following: first, we are going to cheat you on the block grant, and give States like New York more than four times what you get.

Second, we are going to cut child care for your State, and leave you $300 million below what you need to achieve the work participation rates that we intend to grade you on.

Finally, we are going to stick you with hundreds of millions of dollars in costs for legal and illegal immigration, even though you have no control over those policies.

How is that for fairness? How is that for reasonableness?

Madam President, I am disappointed with the direction the welfare reform measure went after it left the Senate. It has taken a turn for the worse. For the State of Florida, a State which did not have a high welfare benefit check and thus did not contribute as greatly to the welfare culture as those States who now reap windfalls for having created the problem, the conference agreement is not acceptable.

I urge the President to veto this bill and for both sides to begin to work together immediately toward reaching a consensus plan on balancing the Nation's budget. There is another way.

Mr. KYL. Madam President, let me get back to the issue before us, which is the objection to the point of order that has been made to certain provisions of this bill.

Madam President, we ought not to waive this provision. We should not have to waive the provision because there is nothing violative of the Byrd rule in the antitrust provisions of the Medicare part of the Balanced Budget Act of 1995.

Let me go back a little bit to set the stage here. The whole theory of our Medicare reform, how we are beginning to strengthen Medicare and save it from bankruptcy, is to create more choices in the marketplace so that competition will drive costs down while also ensuring quality of care.

Now, in order to create those choices, we allowed for the creation of a couple

of new products in this legislation. One of the products is the medical savings account whereby people would have an incentive not to spend all of the deductible amount that they did not have to spend, and we provided that tax free.

As a result of a Byrd problem on that provision, the inside buildup—that is to say, the part that you do not spend—is now going to be taxed.

One of the products is not going to be nearly as attractive as it was when we wrote our bill.

The other new product is the hospital and physician organization, a new type of entity, somewhat similar to an HMO, but not really the same because here instead of having an insurance company or some kind of administrative organization that runs the whole program you simply have physicians and hospitals in a community getting together to offer their services on a capitated basis for the people who would be eligible for Medicare benefits.

It is believed the creation of these organizations by cutting out the middleman and creating a new product would, in fact, create that kind of choice and therefore the competition in the marketplace would cause costs to be reduced.

The two products, together, along with existing Medicare and the HMO option that currently exists would therefore create lower costs, thus allowing us to save the $270 billion over the 7 years that is needed in order to prevent the bankruptcy of the system.

Madam President, as I said, the medical savings account part of this is now jeopardized because of the Byrd rule. If we also cripple the physician-hospital organizations because of the Byrd rule, we will have largely failed to create the two new products and therefore the competition, the choice, and the competition in this, and I fear, Madam President, that our entire Medicare reform will fail. And the commitment that we have made to our seniors, as a result of the Democrats raising the objection here, will cause our Medicare reform to fail.

Madam President, I will say this as clearly as I can. If and when that happens, the American people, and in particular the seniors of this country, ought to know precisely where the blame lies. Because we have an opportunity this evening to save the Medicare system. But if people do not vote down this point of order, it is in serious jeopardy of going bankrupt because our system will not have within it the two key products that would be created to create this competition and choice.

What exactly happens here? Why are we so concerned about this? For the doctors and the hospitals to get together to create this kind of organization, they have to talk to each other and they have to talk about prices and how they are going to treat patients. When that happens, lawyers are going to say, you are violating the antitrust laws. Under a per se rule, which means ''in and of itself,'' that would be true. The mere fact that you sit down and talk about it violates the law.

So we have said in here, let us substitute the rule of reason, a rule of antitrust law that says we will consider it under the circumstances. If what they did is really wrong and violative of the antitrust laws, then we are still going to prosecute them. But if, under the circumstances of creating this new product, and only for the purpose of contracting with Medicare, they get together and talk about these things, things such as prices, then it would be OK. But the Justice Department, FTC, still would look at this under a rule of reason, as Senator HATCH pointed out.

There are two main points, and this is what I will close on. The CBO allegedly has not scored this—excuse me, has said it would have no budgetary effect. That is not true. The CBO has never said that, so that basis for a parliamentary ruling would simply be in error. Quite the opposite is true with respect to the physician-hospital networks.

Second, the conclusion is that the antitrust provisions are merely incidental. In this regard, two contradictory arguments are made. One, that this is such a big deal that all kinds of doctors are going to get together and fix prices and it is going to affect the market far beyond the Medicare market. The other is that it is merely incidental.

Both cannot be true. The fact of the matter is, the antitrust provisions are critical to the creation of this product. It is going to be very hard for them to work without the antitrust exemption. So it is not merely incidental. It is there for the sole purpose of enabling these organizations to operate.

If they cannot operate, then the cost savings are not there because they cannot compete in the marketplace, and our system is destined to fail. It is only for Medicare contracts.

Madam President, I will conclude it this way. If this provision comes out, if these antitrust modifications, just to the rule of reason, come out of the bill, then I am going to predict that this could easily fail. If it does, the people who vote against this this evening are the ones who should be held responsible.

I hope that Democrats and Republicans alike will join us in defeating this objection and in sustaining the waiver to the budget point of order.

Ms. MIKULSKI. Mr. President, I rise to support Senator EXXON's Point of Order that the Clinical Laboratory Improvement Amendments [CLIA] repealed in this budget reconciliation bill violates the Byrd Rule.

The Senate Parliamentarian has ruled that repealing CLIA violates the Byrd Rule because it produces changes or outlays that are merely incidental to the nonbudgetary components of the provision. That is a violation of the Byrd Rule.

Let me explain briefly to my colleagues what CLIA is, and why it is so important to me and to millions of Americans.

CLIA '88 set for the first time uniform quality standards for all clinical labs. I am proud that this law, which I authored, was passed with broad bipartisan support.

CLIA was passed in 1988 and implemented in 1992 to address serious and life-threatening conditions in clinical labs.

To now even suggest we turn back the clock to pre-1988 will have devastating results. Do we really want to:

Turn back to a time when tests were misread and diseases misdiagnosed.

Turn back to the bad old days of misdiagnosis of the HIV/AIDS virus.

When doctors were using inferior methods of reading slides.

When people with the virus went undetected because the virus was mutating and was recognized by physicians.

Or turn back to a time when the lab technicians were overworked and undersupervised.

When slides were taken home.

When dirty labs were tolerated.

When lab technicians had little or no formal training, resulting in many diseases going undetected.

My colleagues, CLIA works, CLIA saves lives. Reconciliation is not the place to make such changes. I urge you to sustain this point of order.

Mr. BIDEN. Mr. President, we are being asked to vote on the antitrust provisions of this conference report. As I understand it, these provisions would allow doctors to form Medicare provider networks—similar to existing managed care networks that are run by insurance companies—without running afoul of the per se standards of antitrust law.

This provision violates the Byrd law. It is extraneous. It has no effect on the deficit, and therefore it does not belong in the budget reconciliation bill.

Furthermore, Madam President, this issue has just now been brought before the Senate. There was no similar provision in the Senate version of the reconciliation bill. There have not been hearings before the Judiciary Committee. And, we have not had a chance to examine the effects of this change in anti-trust law.

But, let me say that as ranking member of the Judiciary Committee, I would be happy to give this matter full consideration. We should find out whether the change proposed here would really create more competition in the health care sector of the economy—and we should examine whether this would be a benefit to rural areas of the country.

And, frankly, in this new health care climate, with the emphasis on big insurance companies running managed care plans like HMO's, doctors need some protection. I have told physicians in Delaware that I am willing to help find ways to ensure that doctors can be doctors. I think that if doctors ran the managed care networks, we might all be better off. If that means that we

must provide anti-trust relief, then I am willing to look closely at it.

But, I cannot support doing it here—doing it now—on a bill that is supposed to reduce the deficit. Therefore, I will support stripping this provision from the bill, and I will vote against the motion to waive the rules for physician anti-trust relief.

I hope, however, that we will look at this more closely, in a more rational way, on another day.

Mr. EXON. I yield 8 minutes to the Senator from Vermont.

Mr. LEAHY. Madam President, the argument we have heard, unfortunately, is somewhat like the trial in ''Alice in Wonderland.'' First you have the sentence and then you have the trial afterward. In this case—and this shows the very reason for the Byrd rule—we have special antitrust rules that are embedded in the reconciliation bill on behalf of the doctors' lobby. They are significant matters. They propose changes in antitrust law, in the policy that competition provides the best protection for consumers. I have said when you have the sentence first and you have the trial after: You would think that if you were going to make these major antitrust rules changes—I do not know, Madam President, if I am disturbing this conversation in front of me or not.

The PRESIDING OFFICER. The Senator is correct.

Mr. LEAHY. It is a fascinating conversation, and I will probably pause long enough to listen to it myself.

The PRESIDING OFFICER. If the Senators will come to order, so we can hear the Senator from Vermont.

Mr. LEAHY. As I was saying, we are being required to make these major antitrust changes without any proceedings, hearings or debate. We are being required to do it without any vote. All we hear from is, apparently, the back room somewhere. Here some highly-paid lobby comes in and says, ''Whisper, whisper, whisper,'' and what comes out of that? We end up with a special provision in a budget reconciliation bill. We have a reconciliation bill and tucked in there are major changes in the antitrust law.

Mr. KYL. Will the Senator yield a moment?

Mr. LEAHY. I tried not to interrupt the Senator from Arizona before. Let me finish, and then I will be happy to yield for a question.

Mr. KYL. Thank you.

Mr. LEAHY. The Senate budget reconciliation bill that the Senate passed contained no such provision of which I am aware. The House originally had two. Then they end up with one. An unnecessary and dangerous antitrust law change is in the conference report on budget reconciliation.

Again, I do not know where it came from. It did not come from hearings or debate, and it certainly did not come from any votes on the Senate floor. I am not aware that it came from any votes on the House floor.

Yet in proposed new subsection (f), of proposed new section 1853 to the Social Security Act, as contained in section 8001 of title 8 of the Budget Reconciliation Conference Report, in a special antitrust rule and change in our antitrust policy.

What it does is this: It exempts certain groups of doctors and other health care providers from the so-called per se rule against price fixing in our antitrust laws.

The conference report does omit the heading ''Special Antitrust Rule For Provider Service Networks''—originally the House-passed bill actually had a heading and flagged the change—they took the heading out, but they left a rewrite of the section in. Maybe because this reconciliation bill is so long and filled with so many special interest gimmicks and gimmies and give-aways, maybe they thought that if you take the headings off, people will not know they are there. But it is still there as a subsection.

It attempts to enact a special antitrust rule for groups of health care providers. It provides that the conduct of members of a group of health care providers, such as doctors, in ''negotiating, making, and performing a contract—including the establishment and modification of fee schedule—'' with a provider-sponsored organization for services under a MedicarePlus plan cannot be subject to the per se rule against price fixing.

Basically, it says, go ahead and agree on whatever you want because we will make it harder for anyone to prove that you are violating the antitrust laws. You are on your own.

Instead of the per se rule that is usually applied to stop price fixing, the only antitrust rule that can be applied is to consider and test the conduct based on its ''reasonableness, taking into account all relevant factors affecting competition, in properly defined markets''.

This is changing one of the most basic rules of antitrust law, changing it in a little special gimmie or give-away provision, tucked in the reconciliation bill for whatever special interest wrote it. It changes the rule from the one that applies to competitors throughout the rest of the economy and that works to protect competition and consumers.

The antitrust law treats a very limited category of conduct as per se unlawful. That is reserved for naked restraints, that is, those that are inherently harmful to competition without conferring offsetting benefits. The classic example, Madam President, I say to my colleagues, is an agreement among competitors to fix the price of the products or services they sell when the agreement is not reasonably necessary to the operation of an efficiency-enhancing joint venture.

In fact, seeing my friend from Arizona on the floor, I would refer to the Supreme Court decision *Arizona* v. *Maricopa County Medical Society,* 457 U.S. 332 (1982). In that case, the Supreme Court held that a group of competing doctors who agreed on the maximum price at which they would sell their services to insurers without substantially integrating, that is, without becoming partners or joint venturers that share financial risk, was engaged in per se illegal price fixing.

Madam President, I am advised the leadership would like to make an unanimous consent request, and I yield for that.

The PRESIDING OFFICER. The Senator from Arizona.

UNANIMOUS-CONSENT AGREEMENT

Mr. KYL. Madam President, I ask unanimous consent that Senator DOMENICI have 30 seconds to close, and the Senate then proceed to vote on the motion to waive without further action or debate.

The PRESIDING OFFICER. Is there objection?

Mr. LEAHY. Reserving the right to object, 30 seconds to close after I finish or right now?

Mr. KYL. Right now.

I am sorry——

Mr. DASCHLE. I understand Senator LEAHY was going to complete his speech and then that would take place.

Mr. KYL. At the conclusion of his remarks.

Mr. LEAHY. Instead of giving the full amount, I will take about another half minute, and then I have no objection. I enjoy hearing——

Mr. KYL. I amend the unanimous consent request.

The PRESIDING OFFICER. If the Senator from Arizona would finish his request?

Mr. KYL. The request is that at the conclusion of Senator LEAHY's remarks, Senator DOMENICI have 30 seconds to close and we then proceed without any further debate to a vote on the motion to waive.

Mr. GRAHAM. Madam President, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. LEAHY. Madam President, I understand Members may be trying to restate the question by the Senator from Arizona. I will assure the Senator from Arizona and the Democratic leader that when they are getting close to that I will yield immediately for them to make the request again.

Basically the point is a very serious point. I do not want to make motions on this or other reconciliation bills. I do so only reluctantly. But this is such a major change in the antitrust law to be tucked in here absent hearings, absent debate, and absent votes. I think is wrong.

For those Members of the Senate who are here, when we talked about the Byrd rule in the first place, it was specifically for this. We are talking about a reconciliation bill that goes past the normal debate rules of the Senate. I see the distinguished senior Senator from West Virginia on the floor. I think he would be the first to agree regarding this reconciliation.

The budget reconciliation conference report would cast aside the per se rule, and override the Maricopa decision for provider groups and provider-sponsored organizations or PSOs. Members of provider groups, such as doctors, would not be required to share financial risk in order to avoid per se treatment when they collectively set fees at which they provide services. Instead, these loose-knit groups would merely have to meet a checklist of criteria to qualify for the special treatment.

None of the group requirements is a substitute for the antitrust law's requirement of meaningful, shared risk. Under the language of the conference report the members need only be part of a group that ''is funded in part by capital contributions made by the members.'' This is no substitute for the shared risk required of a joint venture under antitrust law.

Nor would members of PSOs be required to share financial risk under currently governing law in order to avoid per se treatment under traditional analysis. Instead, they are provided their own special antitrust rule in subsection (e) by which ''affiliated'' providers need share, ''directly or indirectly,'' barely a majority financial interest in the PSO. So long as the providers, who would otherwise be competitors, meet the indirect affiliation provisions of the bill, they will be allowed to exchange information ''relating to costs, sales, profitability, marketing, prices, or fees for any health care product or service.''

These provisions each require the antitrust enforcement agencies to conduct a resource-intensive analysis of the ''properly defined market'' in order to challenge conduct that normally would be swiftly condemned as price fixing. Given limited enforcement resources, this change in law inevitably would mean that some anticompetitive activities will go unprosecuted. Could it be that this explains the doctors' lobby's insistence on inclusion of this provision in the conference report?

The provisions regarding the provider groups admittedly have to revenue or savings effect for deficit reduction purposes. The provisions regarding the PSOs did not have a score until, miraculously, just before this debate was about to being.

Neither set of special rules is integral to Medicare reform. Although defended as a means to encourage provider-sponsored health plans as an alternative to insurers, no such special antitrust treatment is needed to promote Medicare reform.

Provider networks already exist without any special antitrust rule. According to industry statistics, 20 percent of all PPOs and 15 percent of all HMOs are provider-owned. A survey by Modern Healthcare showed that in 1994, without a special antitrust rule, over 9 million people were enrolled in provider-owned PPOs. In addition, many other provider-sponsored managed care plans are being developed or planned without the enactment of a special antitrust rule. The Physician Payment Review Commission concluded in its 1995 Report to Congress that the available information did not indicate a significant problem of antitrust laws impeding the development of provider-sponsored managed care plans. The PPRC Report noted press accounts indicating that many physician-sponsored networks are in the process or formation and that ''three-fourths of state medical societies are either contemplating or are actually in the process of establishing physician-sponsored networks.''

Finally, in the past 2 years the Federal Trade Commission and the Department of Justice have issued literally dozens of staff advisory opinions approving the proposed development of provider-sponsored networks.

The Senate bill contains no such provisions. In debate on our bill, Senator FRIST expressly noted the absence of a Senate provision like proposed section 1853(f). Senator HATCH spoke to the ''creative tension'' in the health care delivery system involving providers and insurers, and noted Senate consideration of the '' antitrust requirements in current law.'' He concluded that the Senate bill, which had no such special antitrust rule, met the goals of providing real health care choices while making sure that there is accountability. Thus, no special antitrust rule was considered necessary when the Senate debated its Medicare reform package in its budget reconciliation bill a short time ago.

These provisions threaten significant injury to competition outside the Medicare program. By allowing competing providers to share information about ''costs, sales, profitability, marketing, prices, or fees'' and to agree on prices in the context of MedicarePlus, the exemption is likely to have the effect of dampening competition among those same providers for non-MedicarePlus business. For this reason among others, special antitrust rules of this type are opposed by the U.S. Chamber of Commerce, the National Business Coalition on Health, the National Manufacturers Association, the ERISA Industry Committee, the Business Roundtable, the APPWP—The Benefits Association, and the National Association of Attorneys General.

No language—and certainly not the fig leaf provided in proposed section 1853(f)(1)(B)(ii), which purports to limit the information exchanged among providers affiliated with a PSO to having not been used for any other purpose than to establish the PSO—can effectively prevent against this spillover effect.

Once putative competitors are authorized by statute to share information about ''costs, sales, profitability, marketing, prices'' and fees and to agree on prices for MedicarePlus, they cannot and will not be able to ignore that knowledge they already possess when it comes to setting their prices for others.

Providers who agree on prices to be demanded from PSOs or as PSOs may implicitly agree to adhere to similar prices with respect to other activities or moderate their competitive behavior based on the knowledge gained thereby. Once competing providers have met to negotiate their fees, the information they have exchanged and the understandings they have reached would likely spill over into their other dealings and into non-MedicarePlus areas in which health care services ought to be governed by competitive forces.

Thus, Gail R. Wilensky, Ph.D., the Chair of the Physician Payment Review Commission, recently testified on September 22, 1995, before the House Ways and Means Committee on Medicare Reform that ''even if a change (in the antitrust laws) applies only to the Medicare market, it may be difficult to keep potentially anticompetitive practices from spilling into other markets served by the networks.''

We do not need to enact such provisions and certainly should not do so as part of budget reconciliation. I object and trust my colleagues will not approve such changes in our antitrust laws without proper analysis, justification, study or debate.

Mr. DASCHLE. Madam President, will the Senator from Vermont yield?

Mr. LEAHY. Certainly.

Mr. DASCHLE. I apologize for the second time for interrupting the distinguished Senator from Vermont. We want to accommodate a number of schedules, and the clock is ticking. I am trying to see if we can accommodate all Senators and arrive at a unanimous consent agreement that will allow us to vote. The distinguished Senator from Florida had some questions.

If we could have the unanimous consent request again propounded with the understanding that, in addition to the 30 seconds for the Senator from New Mexico, the Senator from Florida could have 1 minute to ask some questions, and I would ask unanimous consent that be included, and pose the motion at this time.

The PRESIDING OFFICER. Is there objection? If not, the Chair understands that there will be 30 seconds for the Senator from New Mexico, and the Senator from Vermont would have 30 seconds.

Mr. LEAHY. No, the Senator from Vermont would complete his statement at which point I understand that the Senator from Florida would have a minute, the Senator from New Mexico would have 30 seconds, and then we would have the vote that was discussed before.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. KYL. Madam President, I further ask unanimous consent that, if the motion to waive is not agreed to and the point of order is sustained, that the

Senate proceed immediately to vote on the motion to concur with the Senate amendment to the House amendment with no further action or debate, other than 5 minutes for each leader or manager, and that the vote be limited to 10 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. DOMENICI. Reserving the right to object, I thought I was going to get 5 minutes also.

Mr. KYL. For each leader and manager, I will amend the request. I am sorry. I misread that—each leader and manager.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. LEAHY. Madam President, to accommodate those Senators who have schedules and other debates, I will wrap up with this.

The Byrd rule was put here by the distinguished senior Senator from West Virginia because this reconciliation process changes the normal procedures of the Senate. It changes the normal unlimited debate. It was done to handle these fiscal matters, and not to allow a whole lot of things to come in without the debate.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. LEAHY. No. Madam President. That was not the unanimous consent request, I say to the Chair. The unanimous consent request was that at the conclusion of my time we would have a minute for the Senator from Florida, and 30 seconds for the Senator from New Mexico.

The PRESIDING OFFICER. The time of the Senator from Vermont has expired. He had 8 minutes, and the time has expired.

Mr. LEAHY. The Chair is correct in that.

I ask unanimous consent that the material of the Chamber of Commerce, the National Business Coalition, Health, the National Association of Attorneys General and others, who objected to this provision be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FEDERAL TRADE COMMISSION,
DEPARTMENT OF JUSTICE,
Washington, DC, October 31, 1995.

Hon. PATRICK J. LEAHY,
U.S. Senate, Washington, DC.

DEAR SENATOR LEAHY: The Federal Trade Commission and the Department of Justice (the ''Agencies'') are writing in response to your letters of October 26, 1995, requesting the Agencies' comments on two antitrust provisions in H.R. 2425, the Medicare Preservation Act of 1995. The Administration supports the increased availability of provider networks to promote competition and expand competitive choices for consumers. Further, the Administration believes that legislative reforms, which include appropriate consumer protection safeguards, are necessary to achieve this goal. The Federal Trade Commission has taken no position on aspects of Medicare reform other than the comments in this letter on the two antitrust provisions of H.R. 2425.

However, the two antitrust provisions of H.R. 2425—one a broad exemption for medical self-regulatory entities and the other a relaxation of antitrust rules for provider service networks—are unnecessary and could seriously undermine the cost containment goals of Medicare reform efforts. Moreover, these provisions would deprive all consumers—not only Medicare beneficiaries—of the benefits of competition in health care markets. The Agencies urge that Congress not enact these provisions.

ANTITRUST EXEMPTION FOR MEDICAL SELF-REGULATORY ENTITIES

Section 15221 of H.R. 2425, ''Exemptions from Antitrust Laws for Certain Activities of Medical Self-Regulatory Entities,'' would create a special antitrust exemption for medical groups' setting or enforcing of ''standards'' that are ''designed to promote quality of health care services.'' If enacted, it would provide broad antitrust immunity for anticompetitive activities that purport to improve the quality of care, but in fact raise health care costs and deprive consumers of choices in the marketplace, by anticompetitively excluding other economic participants from health care markets.

Antitrust enforcement actions have stopped physicians, acting through medical societies and hospital medical staffs under the guise of quality concerns, from engaging in boycotts, price fixing, and other conduct harmful to consumers. These enforcement actions have been instrumental in enabling competitive alternatives to traditional fee-for-service medicine to enter health care markets in the face of provider opposition. For example, the Agencies enforcement actions have challenged: medical societies' standards that banned procompetitive alternatives to traditional fee-for-service medicine—including physicians' employment by HMOs and affiliation with non-physicians; hospital medical staff boycotts, coercion of hospitals, and abuse of the credentialling process, to block the development of innovative forms of health care delivery, such as health maintenance organizations; and medical societies' boycotts of insurers to force them to pay higher fees to the societies' members.

The unfortunate fact is that self-regulatory bodies sometimes act to obstruct competition, and when they do so their actions are often couched in quality-of-care terms. This kind of conduct is not a thing of the past. Continued antitrust enforcement against such anticompetitive activities is essential if competitive forces are to play a role in containing health care costs.

Encouraging industry self-regulation that is aimed at improving quality is a laudable goal, but legitimate self-regulatory activity is already permitted under current antitrust law. The Federal Trade Commission and the Department of Justice have not brought suits against such legitimate conduct. In fact, they have repeatedly spread the message that such conduct is lawful.

The Report of the House Committee on Ways and Means on H.R. 2425 indicates that the exemption for medical self-regulation is intended to address concerns about private lawsuits challenging peer review. The Report states that the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101, which eliminated private damage actions for good faith peer review that is undertaken with certain procedural safeguards, has been beneficial, but that antitrust suits have continued. Even if some unjustified suits continue to be brought, concerns about possible imperfections in that statute's limitations on private damage actions would not justify H.R. 2425's broad exemption from all antitrust enforcement, particularly including actions by the government.

The potential harm from the broadly worded exemption is not significantly limited by Section 15221(b)(2)'s exclusion from immunity where conduct is undertaken ''for purposes of financial gain.'' As noted above, quality of care is typically offered as a justification for anticompetitive conduct by health care providers, sometimes based on the sincere—but erroneous—belief that competition is inappropriate in the health care industry. Moreover, making the availability of immunity turn on defendants' intent, rather than on the objective market consequences of the challenged behavior, offers no real protection for consumers. The absence of a motive for personal financial gain does not lessen the injury to consumers that occurs when competitors engage in conduct that is unreasonably anticompetitive.

The Congressional Budget Office concluded that this provision would *increase* federal spending, rather than promote the cost containment goals of H.R. 2425. And the impact would not be limited to the Medicare program. Granting private medical organizations the power to adopt and enforce standards without the check against abuses that antitrust law provides is likely to stifle innovation, unnecessarily limit consumer choice, and frustrate health care cost containment efforts.

SPECIAL ANTITRUST TREATMENT FOR PROVIDER SERVICE NETWORKS

Section 15021 of Subtitle A of H.R. 2425, ''Special Antitrust Rule for Provider Service Networks,'' would exempt certain groups of health care providers from the per se rule against price-fixing that applies throughout the rest of the economy. This provision is not necessary for the development of the provider-sponsored entities that the Medicare reform bills seek to encourage. It could, however, both undercut H.R. 2425's reliance on competition to provide more cost-effective services to Medicare beneficiaries, and impair non-Medicare competition as well.

Like the Senate Medicare bill, H.R. 2425 would permit certain provider organizations to contract directly with the Medicare program to provide all covered services in return for a monthly capitation payment. These organizations are called ''provider service networks'' in the Senate bill and ''provider-sponsored organizations'' (PSOs) in H.R. 2425. ''Provider service networks'' (PSNs) under H.R. 2425 are groups of providers that may contract with a PSO—in essence as subcontractors—to provide services to Medicare beneficiaries.

Section 15021(a) provides that the conduct of a PSN or its members in fixing prices would be evaluated only under the ''rule of reason'' antitrust analysis, rather than under the ''per se'' rule usually applicable to price fixing by competitors. Legitimate provider joint ventures already receive ''rule of reason'' treatment, for example, where their members share substantial financial risk. This is because risk-sharing among members of such a group gives each member the incentive to assure that the group as a whole provides services in a cost-effective manner, achieving efficiencies and cost-savings that competition is intended to secure. Under Section 15021(a), however, members of a PSN who do not share any financial risk, and thus do not have those same incentives for cost-savings, would be able to set fees collectively for services provided through a PSO without regard to the usual ''per se'' rule against price fixing.

No special antitrust rule is necessary to allow providers to form groups or networks, develop fee schedules for participating providers, or set up providers panels, so long as the providers share financial risk. In fact,

risk-sharing among providers in a group appears integral to the purposes of the legislation: PSOs and other entities offering Medicare products are required to assume full financial risk for the provision of all covered services, in exchange for a predetermined capitation payment. Under existing antitrust law, such groups already receive rule of reason treatment, and any other provider group that similarly shares financial risks would receive the same antitrust treatment. H.R. 2425 would allow PSNs that do not involve risk-sharing to qualify for special antitrust treatment by meeting certain criteria. However, none of these criteria is a substitute for the incentives created by substantial financial risk-sharing.

The goal of promoting more cost-effective delivery of Medicare services would not be furthered by allowing groups of competing providers in a PSN to agree on the prices they would demand from the PSO for treating patients under a Medicare PSO contract, bargain collectively with the PSO, and threaten a boycott if the PSO did not accept the providers' terms. In such a case, even though the anticompetitive effect of the conduct is clear and no countervailing efficiencies are produced, the bill would require the antitrust agencies to conduct a resource-intensive analysis of the market under the rule of reason. Given the constraints on federal antitrust enforcement resources, this can only mean that some plainly anticompetitive activities will go unprosecuted.

The impact of the exemption could also extend beyond PSOs to all managed care organizations operating in a particular market. By allowing competing providers to agree on prices in the context of bargaining to provide services to a Medicare PSO, the exemption could have the unintended effect of dampening competition among those same providers for non-PSO business. Providers who agree on prices to be demanded of PSOs may implicitly agree to adhere to similar demands when dealing with other plans. Even absent bad intentions, once competing providers have met to negotiate their fees for PSO business, the information they have exchanged and the understandings they have reached would likely spill over into their dealings not only with other MedicarePlus organizations, but also with the various organizations that provide health care benefits to non-Medicare patients.

In sum, the antitrust provision in H.R. 2425 would harm consumers and would run counter to the cost-reduction goals of Medicare reform efforts.

The Department of Justice has be advised by the Office of Management and Budget that there is no objection to the submission of this letter from the standpoint of the Administration's program.

Sincerely,

ANNE K. BINGAMAN,
Assistant Attorney General.

By direction of the Commission.

ROBERT PITOFSKY,
Chairman.

September 26, 1995.

Hon. WILLIAM V. ROTH, Jr.,
Chairman, Committee on Finance
Washington, DC.

DEAR MR. CHAIRMAN: We are a coalition of physician group practices, non-physician providers, employers, managed care networks and insurers who are opposed to including special antitrust preferences for physicians as part of Medicare reform legislation.

Physicians are not alone in feeling the pressure of increased competition. All of us doing business in the health care market are facing increased competition. Yet, we do not believe that competitive pressures warrant special antitrust preferences for physicians or any other provider. Such preferences are unnecessary and harmful to competition and consumer choice in the marketplace. If the goal is to apply the successes of the private health care market to reforming the Medicare program, then weakening the antitrust laws for physicians is truly misguided. Senior citizens and all consumers should have health plan choices—but choices that are indeed competitive.

The attached Washington Post article underscores the need to maintain strong antitrust enforcement in order to ensure that consumers, not competitors, determine the range and prices of goods and services offered in the health care marketplace.

Unfortunately, the American Medical Association (AMA) is seeking special treatment under the antitrust laws. Under the AMA's proposal, physicians would be allowed to agree on the prices they will charge and collectively negotiate with lawyers while essentially remaining individual competitors. In other words, little substantial risk-sharing on the part of physicians would be required, effectively reducing incentives to compete on cost, quality and efficiency. In addition, physician networks would be subject to more lenient enforcement of the law than all other providers.

Advocates of changes to the law contend that current antitrust laws and enforcement must be relaxed to allow physicians to compete on a ''level playing field'' with other network organizers such as hospitals. HMOs and insurers. While this argument may appear reasonable at a glance, a closer examination of the issue reveals quite the opposite. The antitrust changes that the AMA seeks to include as part of Medicare reform are little more than well-disguised attempts to side-step the strong free market protections afforded by current law.

The following briefing paper tells the real story.

Sincerely,

American Group Practice Association, American Association of Nurse Anesthetists, Academy of Nurse Practitioners, American Nurses Association, AETNA, American Managed Care and Review Association, American College of Nurse Mid-wives, Association of Private Pension and Welfare Plans, American Speech-Language-Hearing Association, Blue Cross & Blue Shield Association, CIGNA, FHP Health Care, Group Health Association of America, Health Care Compare, Corp., Health Insurance Association of America, Kaiser Permanente, Kansas City Blue Cross & Blue Shield, Metrahealth, National Association of Manufacturers, National Capital PPO, Nat's Assoc. of Nurse Practitioners in Reproductive Health, Opticians Association of America, Sierra Health Services, The Erisa Industry Committee, The Principal Financial Group, The Prudential, U.S. Healthcare, Inc., Wausau Insurance Companies.

[From the Washington Post, Sept. 14, 1995]

DOCTORS, HOSPITALS SUED ON MONOPOLY CHARGES

The Justice Department yesterday charged doctors and hospitals in two states with using monopoly power to block lower-priced managed health care systems from competing—in one case for almost a decade.

It was the first time the agency's antitrust division filed price-fixing lawsuits accusing hospitals of scheming with doctors to ensure their own higher profits while health care costs rise.

Both groups—in Danbury, Conn., and St. Joseph, Mo—denied the charges. But both also agreed to consent decrees in which they promised to change the way they do business.

The complaint said that beginning in May 1994 and continuing through August, Danbury Hospital, the only acutecare facility in the area, forced patients to use its outpatient facilities, joined with ''virtually all of the doctors on its medical staff' to raise fees, and purposely limited the size and mix of its medical staff to reduce competition among local doctors.

In Missouri, the Justice Department said, the price-fixing conspiracy occurred from April 1986 through June 1995. The complaint said about 85 percent of the doctors in Buchanan County formed a group in 1986 ''to prevent or delay the development of managed care in the area.''

In 1990, the group then joined with the only local hospital, Heartland, to form Health Choice to further lock up the medical services and profits in the area, the lawsuit said.

SPECIAL ANTITRUST PREFERENCES FOR PHYSICIANS LIMIT COMPETITION, CHOICE AND INNOVATION IN THE HEALTH CARE MARKET

Current antitrust law does allow for the formation of physician-sponsored networks.

Physicians can join together and agree on price and other terms of business so long as they ''integrate'' by sharing financial risk. Risk-sharing can be achieved in a variety of ways and is critical to ensure that physicians do not come together to simply fix prices while remaining separate competitors. Numerous physician networks have successfully ''integrated'' and are now competing in virtually every market in the country. Some of the most notable examples are the Mayo Clinic in Minnesota and the Cleveland Clinic in Ohio. These multi-specialty physician group practices were formed under existing antitrust laws, without special preferences.

Alternatively physicians can also join together to form Preferred Provider Organizations (PPOs) and negotiate fees with HMOs and other third-party payers without integrating their practices. These more loosely organized groups can perform many of the same functions as their fully integrated counterparts, including quality assurance, utilization review, and administrative services. Guidelines issued by the Department of Justice (DOJ) and the Federal Trade Commission (FTC) make this clear.

Loosening integration requirements is harmful to consumers because it reduces the incentive for providers to compete. Current integration requirements are not barriers to the formation physician-sponsored plans. They are barriers to price-fixing, boycotts and other forms of anti-market activities. Ultimately, substantial financial integration is what drives competition on quality, efficiency and cost.

Physicians are not disadvantaged with respect to other providers under the antitrust laws.

The purpose of strong antitrust enforcement policies is to protect consumers, not competitors. The notion that physicians need special antitrust preferences because the antitrust laws are biased against physicians is inaccurate and misleading. Joint ventures arranged by like competitors in every other industry are subject to essentially the same level of scrutiny as physician-sponsored networks.

Similarly, insurers and other providers are not exempt from antitrust enforcement. If insurers either agreed among themselves on payment levels or tried to wield market power by driving prices down, they too would run afoul of the antitrust laws.

In its 1995 Report to Congress, the Physician Payment Review Commission (PPRC)

concluded that "the available evidence of problems is not sufficient to warrant creating safe harbors or other exemptions from the antitrust laws for physician-sponsored networks at this time. Amending the antitrust laws is a serious step that should be undertaken only in the face of compelling evidence that change is required. The limited available factual evidence, however, does not currently suggest the widespread existence of problems."

Consequently, what the AMA is really asking for is the ability to compete outside the free market principles that every other competitor must abide by.

Special antitrust treatment for physicians, such as loose integration requirements and substitution of the rule of reason for the per se rule would diminish consumer power in the marketplace.

A number of changes to the antitrust laws have been advocated by the AMA, ranging from outright exemptions to relaxing risk-sharing requirements and elimination of the per se rule. The per se rule has allowed the courts and enforcement agencies to efficiently call a halt to activities that are blatantly harmful to consumers. It reflects a determination that some conduct—such as price-fixing and group boycotts—is so likely to harm consumers that it should be found unlawful in all circumstances. It is a rule that applies to all providers and all industries.

The rule of reason, in contrast, requires a balancing of the competitive harm arising from particular conduct against the possible economic benefits it produces. However, it is also more difficult under this rule to challenge anticompetitive conduct because many more creative defenses and justifications can be raised. If antitrust enforcement agencies could only prosecute antitrust violations by provider physician-sponsored networks under the rule of reason, they would be forced to utilize greater resources and face a reduced likelihood of success. If rule of reason treatment was extended to provider-sponsored networks, but not to other types of health care networks, provider organizations would enjoy distinct advantages that would not be shared by other health plans. This would put those plans at a competitive disadvantage.

History is replete with examples of physician group boycotts and efforts to keep other physician group practices and non-physicians, such as nurse mid-wives and nurse anesthetists, from offering consumers choice. One of the best examples of this is the experience of the physician-owned Cleveland Clinic. In 1991, the Federal Trade Commission (FTC) put a halt to physician boycotts aimed at preventing Cleveland Clinic doctors from establishing a practice in Florida. This case was brought under the per se rule—the very rule from which AMA seeks an exemption. Similarly, prior to 1979, the AMA bound its members to rules that prevented physicians from contracting with HMOs. These rules effectively prevented price competition among doctors and hindered the development of new, innovative health care delivery systems, such as HMOs and PPOs. The Supreme Court agreed and forced the AMA to drop its anticompetitive rules.

The DOJ and FTC have provided substantial guidance to health care providers to address their concerns.

In response to concerns raised by providers, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) jointly issued the Statements of Antitrust Enforcement Policy in the Health Care Area. These statements, or guidelines, provide a detailed road map of the analysis that the federal enforcement agencies will apply to the most significant issues facing the health care industry. The guidelines include "safety zones" clarifying what types of mergers, joint ventures, and other activities would be considered lawful. The DOJ/FTC have made a special effort to address physician networks and rural health care markets.

For physicians and other providers who have questions about forming integrated networks, the agencies offer opportunities for more specific advice through their business review and advisory opinion letter process. The agencies' business review and advisory opinion procedures allow parties to obtain a statement of the agencies' enforcement intentions before the transaction is implemented. The agencies have committed to providing expedited 90-day reviews. The agencies have also committed to continued monitoring of evolving health care markets so they can respond to changes on an ongoing basis. To date, virtually every physician-sponsored network has been approved.

The health care industry has responded enthusiastically to these initiatives. According to a January 1995 Bureau of National Affairs (BNA) survey of counselors advising providers, the "almost blanket clearances by the Justice Department and FTC of proposals to create managed care networks is assuaging health care industry concerns about the impact of antitrust law . . ."

BUSINESS FOR MEDICARE REFORM: APPWP—THE BENEFITS ASSOCIATION; THE BUSINESS ROUNDTABLE; THE ERISA INDUSTRY COMMITTEE; NATIONAL ASSOCIATION OF MANUFACTURERS; NATIONAL BUSINESS COALITION ON HEALTH; U.S. CHAMBER OF COMMERCE,

October 17, 1995.

Hon. NEWT GINGRICH,
Hon. WILLIAM ARCHER,
Hon. MICHAEL BILIRAKIS,
Hon. THOMAS BLILEY,
Hon. DENNIS HASTERT,
Hon. GERALD SOLOMON,
Hon. WILLIAM THOMAS.

DEAR REPRESENTATIVES: We are writing as representatives of small and large businesses who have been supportive of your efforts to save Medicare by passing the Medicare Preservation Act. We have been gratified by the commitment you have made to fundamentally restructuring Medicare by drawing on the successful health care reform strategies pioneered by private employers. Moreover, employers have been willing to accept considerable costs in order to save Medicare.

Just a very few years ago, most health care policymakers and analysts believed that the private sector could not contain health care costs. Employers have proved this wrong, by using their purchasing power to create more competitive markets and demanding better care at lower cost. Based on our knowledge of what it took to get this job done, we have important reservations about a limited number of the Medicare Preservation Act's provisions. We are concerned that these provisions would undermine the very strategies that (a) employers have used to control costs and improve quality and (b) the Act uses as the foundation for a new and sustainable Medicare program. We urge you to reconsider these provisions.

Our most important concerns are as follows:

Antitrust Changes for Health Care Providers. We are extremely concerned by the antitrust law changes included in Sections 15021 and 15221 of the Act, which would affect employer-sponsored health plans as well as MedicarePlus plans. We ask that they be stricken.

Unfortunately, organized medicine has a long history of attempting to suppress alternative health care delivery systems. Antitrust enforcement has been an important tool in overcoming this opposition to innovative ways of delivering higher quality care at lower cost. Section 15221's changes to antitrust law would allow organized medicine to engage in a much higher level of anticompetitive activity, thereby increasing costs and reducing the quality of care. In contrast, employers have created the new, competitive health care market and better ways to measure and improve quality under current antitrust law, which also leaves broad leeway for health care providers to collaborate in legitimate self-regulatory activity.

Employers have been able to control costs and improve quality by using their purchasing power to create competitive health care markets. The antitrust law changes in Section 15021 would shift the balance between health care providers and purchasers in favor of providers, undermining employers' ability to be effective purchasers and jeopardizing their hard won victories over health care cost inflation and poor quality care. Putting purchasers at a disadvantage by changing antitrust law risks a return to health care hyperinflation and unaccountability for quality.

Medical Liability Reforms. Employers have long supported medical liability reform, including changes to the collateral source rule. However, the version of collateral source rule reform in the Act eliminates employers' right of subrogation. This shifts the cost of treating injuries caused by a negligent provider from the provider who caused the injury to employers. We urge that you revise the Act to provide for a different version of collateral source rule reform that appropriately prevents double recovery by plaintiffs without inappropriately shifting responsibility for injuries caused by negligent providers to employers.

Medicare Secondary Payer Expansions. The Act expands employers' Medicare secondary payer liability. This does nothing to improve health care efficiency or quality. Rather, it simply shifts costs to private sector payers. Small employers in particular are vulnerable to this kind of cost-shifting. We urge that the expansions of Medicare secondary payer liability be eliminated.

As you know, managed care plans able to efficiently deliver high quality care have played a key role in employers' market-based health reform strategy. No aspect of the Medicare Preservation Act is more important to employers than its treatment of managed care plans. We are gratified that the Act as introduced by Chairman Archer and Chairman Bliley did not include antimanaged care rules. Including antimanaged care rules in the Act would increase costs and reduce quality. Moreover, including antimanaged care rules would directly and adversely affect employer-sponsored health plans as well as MedicarePlus plans, since the same networks will serve Medicare beneficiaries and employer-sponsored plans.

It is our understanding that most of the antimanaged care rules adopted in committee as amendments to the Act have been stricken. (These amendments included restrictions on (1) the criteria health plans may use when selecting providers, (2) efforts to eliminate medically inappropriate emergency room treatment and (3) denial of care that is not medically necessary.) We applaud this result. We urge you to strike the remaining antimanaged care amendment (restricting permissible contractual relationships between health plans and providers) and to continue adhering to the policy of avoiding antimanaged care rules as the Medicare Preservation Act moves through the legislative process.

It also is our understanding that a technical error in the medical liability reforms that would have inadvertently expanded employers' liability by interfering with current grievance procedures provided for under the Employee Retirement Income Security Act has been resolved. We appreciate your efforts to resolve this matter, which is vitally important to employers who voluntarily sponsor health benefits for their employees.

Again, we strongly support your efforts to save Medicare. It is essential that they succeed. However, as representatives of the businesses that originated the strategies that the Medicare Preservation Act is built on, we urge adoption of a few technical changes that would greatly strengthen the Act's ability to achieve its goals. These changes also would eliminate our concerns about the Act's effects on businesses that voluntarily offer health benefits to their employees.

We would be pleased to further discuss these issues with you at your convenience.

U.S. CHAMBER OF COMMERCE,
BUSINESS FOR MEDICARE REFORM,
October 23, 1995.

Hon. WILLIAM V. ROTH, JR.,
Chairman, Finance Committee,
Washington, DC.

DEAR CHAIRMAN ROTH. We are writing as representatives of small and large businesses that are working hard to control health care costs and improve quality. We have been gratified by the Finance Committee's decision to fundamentally improve Medicare by drawing on the successful health reform strategies pioneered by private employers.

Just a few years ago, most health care policymakers believed that the private sector could not contain health care costs. Employers have proved this wrong, by using their purchasing power to create more competitive markets, demanding better care at lower costs, measuring outcomes and consumer satisfaction, and developing networks through selective contracting with the best providers. Based on our knowledge of what it took to get this job done, we are concerned that potential floor amendments to the Finance Committee bill would undermine the very strategies that (a) employers have used to control costs and improve quality and (b) the bill uses as the foundation for a new and sustainable Medicare program. These potential amendments include antitrust exemptions for health care providers and mandated point-of-service coverage by network-based plans. We strongly oppose these potential amendments to the Finance Committee bill.

The damage that would be caused by adding these amendments to Medicare reform legislation would not be limited to higher Medicare costs and lower quality. Because Medicare is such a large factors in health care markets and because Medicare and employer-sponsored health plans will use the same provider networks, antitrust exceptions for providers and antimanaged care rules would directly harm employer-sponsored plans. Working Americans and their families would face higher costs, reduced coverage and lower quality.

OPPOSITION TO ANTITRUST EXEMPTIONS

One potential amendment would grant an antitrust exemption to medical self-regulatory organizations. Unfortunately, organized medicine has a long history of attempting to suppress coordinated health care delivery systems. Antitrust enforcement has been an important tool in overcoming this opposition to innovative ways of delivering higher quality care at lower cost. An antitrust exemption for medical self-regulatory organizations would allow organized medicine to engage in a much higher level of anticompetitive activity, thereby increasing costs and reducing the quality of care. Notably, current antitrust law leaves broad leeway for health care providers to collaborate in legitimate self-regulatory activity.

Employer-led efforts to improve accountability and quality in the health care system by making data available to health care consumers has been a leading cause of the positive changes in the health care market. This data has become available—often in the face of provider resistance—only because private employees took the initiative to develop it and demand that providers supply it. Granting providers an antitrust exemption, thereby permitting them to monopolize the quality standard-setting process, will seriously erode accountability for quality and value.

Another potential antitrust amendment would grant an exemption to provider-sponsored organizations. Employers have been able to control costs and improve quality by using their purchasing power to create competitive health care markets. An antitrust exemption for provider-sponsored organizations would shift the balance between health care providers and purchasers in favor of providers, undermining employers' ability to be effective purchasers. Putting purchasers at a disadvantage by changing antitrust law risks a return to health care hyperinflation and unaccountability for quality.

OPPOSITION TO POINT-OF-SERVICE MANDATE

A recent Lewin-VHI study found that a point-of-service mandate would add even more to the nation's health care bill than an ''any willing provider'' mandate. Experience confirms a point-of-service mandate's high cost. A study of Florida employers' 1993 health crisis found that point-of-service plans cost over 20 percent more than HMOs. Prohibiting closed-panel plans from participating in Medicare would force even those Medicare beneficiaries who want to enroll in a closed-panel plan—such as the 3 million seniors who already have chosen such plans over the traditional Medicare system—to pay higher premiums.

A point-of-service mandate undermines the entire purpose of Medicare reform. Because the traditional Medicare program is unsustainable, the Finance Committee bill encourages beneficiaries to shift to private health plans. A point-of-service mandate would drive up private plans' costs, encouraging continued enrollment in the government-run system. As a result, Medicare reform would fail to produce a modernized, more efficient Medicare.

Both point-of-service plans and closed panel plans have earned an important place in the market—based on consumers' choices, not government mandates. In fact, employers have found that employee enrollment in closed panel HMOs increased at the same time that point-of-service plan availability and enrollment increased. Market forces rather than government microregulation should determine point-of-service plans' role in Medicare. Certainly, the federal government should not deny consumers the freedom to choose and the savings of private health plans that only contract with selected providers. Moreover, the Finance Committee bill requires all plans that only contract with selected providers, like every other private plan (but not the traditional government-run Medicare program), to meet quality standards.

The Finance Committee made the right choice by keeping antitrust exemptions for organized medicine and a point-of-service mandate out of its Medicare reform bill. We urge you to oppose any floor amendments that would add these provisions, or any other antimanaged care rules, to the Finance Committee's Medicare bill.

NATIONAL ASSOCIATION OF
ATTORNEYS GENERAL,
Washington, DC, October 26, 1995.

Hon. NEWT GINGRICH,
Speaker of the House, House of Representatives,
Washington, DC.

DEAR SPEAKER GINGRICH: As Chair and Vice-Chair of the Antitrust Committee and Chair and Vice-Chair of the Health Care Task Force of the National Association of Attorneys General (NAAG), we are writing to express our concern about two antitrust provisions included in H.R. 2425, the Medicare Preservation Act of 1995. These provisions, sections 15021 and 15221 of the Act, are unnecessary and could frustrate the cost-containment goals of the Medicare legislation. We urge that these provisions not be included in the final Medicare reform package.

The Attorneys General, as chief law officers of their states, are the primary enforcers of the states' antitrust law, and also represent their states and the citizens of their states in federal antitrust litigation. As chief legal officers, the Attorneys General have had and continue to have an important role in the development of national competition policy. We know first-hand that the antitrust laws benefit consumers by protecting competition and promoting efficiency, innovation, low prices, better management and greater consumer choice. Although the Attorneys General as a group have not had an opportunity to consider this legislation, past NAAG policy positions have consistently opposed both new antitrust exemptions and the weakening of antitrust enforcement standards for specific industries.

Section 15221 of the Act provides an exemption from both state and federal antitrust laws for activity relating to medical self-regulation. We believe that inclusion of this provision is inadvisable. Unfortunately, state Attorneys General have had experience with physicians and other health care providers who have engaged in anticompetitive activities, including physicians' attempts to eliminate competition from HMOs, PPOs and allied health care professionals. For this reason, in a 1993 Resolution, the Attorneys General stated their belief that exempting health care providers from the antitrust laws is undesirable. Nor is the exemption contained in section 15221 necessary. Current antitrust law permits collaborative activities, including standard-setting activities, that benefit the public and do not injure competition.

Section 15021 of the Act provides that certain actions of a provider service network or an individual member of that network shall not be deemed illegal *per se* under either federal or state antitrust law, but shall instead be judged under the ''rule of reason.'' We are concerned that this relaxation of antitrust standards could lead to higher prices and fewer choices for consumers. Under current law, *per se* treatment is reserved for the most anticompetitive conduct, including horizontal price-fixing. As stated in a 1986 NAAG Resolution, the Attorneys General oppose new industry-specific antitrust standards because present antitrust standards adequately protect the interests of businesses, as well as consumers, by preventing activities that have no pro-competitive justification. More specifically, in the health care area, the Attorneys General believe that competition promotes more affordable health care, development of innovative new delivery systems, and increased information for health care consumers.

Finally, we are concerned about the broad preemption of state antitrust enforcement, particularly in section 15221, which is not limited to protection of activities within the Medicare program. In a 1994 Resolution, the

Attorneys General opposed preemption of state antitrust enforcement in the health care area because such preemption crodes state sovereignty and threatens the system of federalism established by the Constitution. Health care is predominately a local industry that varies significantly from state to state. The Attorneys General, as chief law enforcement officers, should continue to be able to prevent anticompetitive behavior within each state.

If you have any questions about our views, please feel free to contact us or Emily Myers, NAAG Counsel for Antitrust and Health at (202) 434–8015.

Very truly yours,

J. JOSEPH CURRAN, JR.,
Attorney General of Maryland, Chair, NAAG Antitrust Committee.

TOM MILLER,
Attorney General of Iowa, Vice-Chair, NAAG Antitrust Committee.

PAMELA FANNING CARTER,
Attorney General of Indiana, Chair, NAAG Health Care Task Force.

JEFFREY L. AMESTOY,
Attorney General of Vermont, Vice-Chair, NAAG Health Care Task Force.

NOVEMBER 17, 1995.

DEAR SENATOR. It is our understanding that the reconciliation bill before the Senate includes a number of anti-consumer provisions which may violate the Byrd rule. Those provisions include antitrust exemptions for provider service networks, elimination of laboratory testing standards for most tests performed in physician offices, preemption of state authority to implement consumer protection standards for managed care plans and physician self-referral.

On behalf of the following organizations, we strongly ask that you support every effort to remove these harmful provisions from the reconciliation bill. Inclusion of the items listed above will drive up costs, threaten patient safety and reduce the quality of health care for all Americans.

Sincerely,

AIDS Action Council, American Public Health Association, Church Women United, Citizen Action, Consumer Federation of America, Consumers Union, National Association of Social Workers, National Farmers Union, National Council of Senior Citizens, Neighbor To Neighbor, Public Citizen's Congress Watch, Service Employees International Union.

The PRESIDING OFFICER. The Senator from Florida is recognized for a minute.

Mr. GRAHAM. Madam President, I would like to ask if the Senator from Arizona would please respond to a question. I hope they could be answered ''yes'' or ''no''.

Mr. KYL. If I can.

Mr. GRAHAM. Does this provision relate exclusively to the Federal, or does it apply to State antitrust law?

Mr. KYL. My understanding is that it applies to both Federal and State.

Mr. GRAHAM. Please refer to the bottom line, page 17, No. 2. Does this provision relate exclusively to Medicaid, or does it apply to other forms of health care?

Mr. KYL. It refers only to the Medicare contracts, and the organizations pursuant to obtaining the Medicare contract.

Mr. GRAHAM. I would ask the Senator to refer to 318, paragraph B.

Thank you, Madam President.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, the BYRD rule was put into effect—not that it would rule all the time but that it would be waived.

I submit that anybody in this body that wants the Medicare law to work in rural areas, if you talked to anybody in rural areas, they will tell you one of the most important things pending before us, to see that we get delivery in rural areas, is this provision which is being dropped, if we make it subject to the BYRD rule. Because, without it in rural areas there will be no ability for doctors and hospitals in the rural areas to get together and have new units to deliver health care. There will be no competition and no service except for monster HMOs in the rural areas.

We really ought to waive the Byrd rule in this instance.

I yield the floor.

The PRESIDING OFFICER. All time has expired. The question is on agreeing to the motion to waive the Congressional Budget Act with respect to the antitrust provision. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The yeas and nays resulted—yeas 54, nays 45, as follows:

[Rollcall Vote No. 583 Leg.]

YEAS—54

Abraham	Faircloth	Mack
Ashcroft	Frist	McCain
Baucus	Gorton	McConnell
Bennett	Gramm	Murkowski
Bond	Grams	Nickles
Breaux	Grassley	Nunn
Brown	Gregg	Pressler
Burns	Hatch	Roth
Campbell	Hatfield	Santorum
Coats	Helms	Shelby
Cochran	Hutchison	Simpson
Cohen	Inhofe	Smith
Coverdell	Jeffords	Snowe
Craig	Kassebaum	Stevens
D'Amato	Kempthorne	Thomas
DeWine	Kyl	Thompson
Dole	Lott	Thurmond
Domenici	Lugar	Warner

NAYS—45

Akaka	Feinstein	Levin
Biden	Ford	Lieberman
Bingaman	Glenn	Mikulski
Boxer	Graham	Moseley-Braun
Bradley	Harkin	Moynihan
Bryan	Heflin	Murray
Bumpers	Hollings	Pell
Byrd	Inouye	Pryor
Chafee	Johnston	Reid
Conrad	Kennedy	Robb
Daschle	Kerrey	Rockefeller
Dodd	Kerry	Sarbanes
Dorgan	Kohl	Simon
Exon	Lautenberg	Specter
Feingold	Leahy	Wellstone

The PRESIDING OFFICER. On this vote, the yeas are 54, the nays are 45. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is not agreed to.

The Chair is prepared to rule on the points of order made by the Senator from Nebraska.

The Chair sustains both points of order.

The question before the Senate is whether the Senate shall recede from its amendment to H.R. 2491 and concur therein with a further amendment. Pursuant to the Budget Act, that amendment is the text of the conference report (House Report 104–350) excluding the provisions stricken on the points of order.

According to the previous order, each leader and each manager have 5 minutes for debate.

Who seeks recognition? Who seeks recognition under the previous order? Under the previous order, each leader and each manager has 5 minutes.

The Senator from Nebraska is recognized for 5 minutes.

(Mr. GORTON assumed the chair.)

Mr. EXON. Mr. President, in a few minutes, the Senate will unfortunately adopt this conference report to the reconciliation bill.

Although I will not vote for the legislation, I certainly want to congratulate Chairman DOMENICI for his leadership and for the many months of yeoman labor that he put in on this piece of legislation. He made the hard choices, some good and, in my opinion, many bad, but he was a true leader of great merit, and I congratulate him.

Mr. President, my colleagues on the other side of the aisle will savor their victory, but I must also say to all Senators that it is time to move on. With victory short lived and the fate of this bill certain, it will soon take its place in veto history.

Mr. President, where do we go from here? In my 17 years in the Senate, I have never seen such a poisonous atmosphere as the one that hangs thick over the Nation's Capitol. The nervous truce that existed in January has collapsed. We are, in the words of President Lincoln, ''a house divided against itself.'' I still nurture the hope that we will find a way out of this morass and that our leaders—especially those in the other body—will set aside pettiness, vanity, and rigid ideology for the good of the Nation. There is no honor in the dishonor that has been brought about by the actions of the last few days and the last few hours.

I firmly believe, with every fiber in my body, that we should balance the budget. So do the American people. It is the stark route that the Republican majority took, however, that cleaves our ranks.

I tell my Republican friends that if we ever can come to an agreement on a balanced budget, we cannot adhere to the current formulas that exist in the conference report. It hobbles any hope that we can redeem our differences in a constructive alliance to balance the budget. But we must keep trying.

I yield my remaining time.

The PRESIDING OFFICER. Under the previous order, the Senator from New Mexico is recognized.

Mr. DOMENICI. Mr. President, fellow Senators, I have a lot of people to thank for this evening. While the Senators on that side do not think it is a very joyous or auspicious occasion, Senators on this side do, and I do. I have waited a long time, as a U.S. Senator, to see this evening arrive. It is truly a historic opportunity for politicians because, as I see it, this was the one chance we have to vote for the future. We have an opportunity every day to vote for something for today, a program for today, something to give to people today. But, essentially, what we are voting on this evening is a vote for the future of this country and for children not yet born and for those who are not yet receiving anything from the Federal Government, but who want an opportunity and have a dream.

We are saying the one thing that makes that more and more difficult is 25 years of fiscal policy that has the United States borrowing as if no one else needed any money, as if those that work, those that need investment did not need money, just the Federal Government needed it. And it was like we were a money tree, America was a money tree, and the money all went to Washington. And when we did not have enough, we borrowed it from foreigners—from Japan, from our banks, from our people. The question is: Who will pay the piper?

We have decided here tonight that the piper will not be our children and grandchildren, but rather in due course, the adults who live today will pay for what we give to our people today and provide a future for our children and grandchildren.

Now, I understand that the President is going to veto this bill, and I have a word for the President. Since he has told us in advance, I would like to tell him in advance. As he sits down with his veto pen, I hope he feels heavy, because on his shoulders is our future and our children's future. As he signs with that left hand of his, he better have something pretty good in mind for our children in the future, because he is throwing away a real legacy of opportunity, and he better be prepared to tell us and tell the American people and tell our senior citizens what he has in mind, because I have not seen anything yet that he has in mind that comes anywhere close to what we are giving to our children and grandchildren here tonight when we vote ''aye'' on this measure.

For those who have voted these many times—58 votes on the budget resolution, and I do not know how many different times—I say to each one of them, your vote was not in vain. And if those on the other side and in the White House think they will use this against us, just think what we are going to use against them if this President vetoes this and we end up with nothing.

For those who are against that, there is a real chance that we will get nothing, except $200 billion in deficits for as far as the eye can see. I also say to those who voted for it, and will vote for it again tonight, you have changed the course of fiscal policy and the way we spend our people's money forever, because no longer will a Budget Committee in the future have its hearings and hear ''there is no way we can cut spending, and we cannot do this and we cannot cut that.''

Well, we have shown that, in a very fair way, we can do what is necessary to get a balanced budget. So we have changed forever the profligacy of a great Nation, and we ought to be proud of it and thankful for it.

To all the chairmen who worked so hard, thank you. I want to close and say to our leader, Senator DOLE, thank you for all the confidence you placed in me. When I had to get things done, you told me ''do them.'' When I needed tough decisions and I could not get the votes, you said, ''Bring them in my office.'' And last, I thank the budgeteers. You have a tough job; you do not get to pass anything except this crazy resolution that cuts everything, but I thank you for your unity and your support. It has been a privilege being your chairman. Thank you very much.

The PRESIDING OFFICER. Under the previous order, the Democratic leader is recognized for a period of not to exceed 5 minutes.

Mr. DASCHLE. Mr. President, I yield 2 minutes to the Senator from New Jersey.

Mr. BRADLEY. Mr. President, this reconciliation bill, from top to bottom, is intoxicated with the fantasy that it is abandoning the welfare state. Mr. President, we do not have a welfare state, we have a safety net for a few poor people. This drives big holes in that safety net. Welfare reform—block grants replace welfare. What it does is take money from Federal pols and give it to State pols. The theory is, if you do not like Washington, you are going to love Lansing, or Trenton, or the State capital. Hardly. What this does is, in the Federal commitment to poor children, 1.2 million more children will be plunged into poverty because of this. The Medicaid block grant. Send it all back to the States. Do not say who is eligible, and do not say what the benefits will be, or how the providers will provide the benefits. Just send the money back.

The only thing we know is that when we pass this bill, 12 million Americans will be uninsured. Uninsured. I predict that, 5 years from now, there will be Medicaid scandals in States where Governors are putting in a health care program that will help their constituencies.

Why are State governments different? They are not. For what purpose? The purpose is that we are giving a gigantic break to wealthy Americans. On the other side, they say, ''Oh, no, only 35 percent of the cut goes to people above $75,000.'' Yes, but they only represent 13 percent of the people. And embedded in this bill for estates of $2.5 million is an $800,000 tax cut. At the same time, we are ripping holes in the safety net, we are giving estates of $2.5 million an $800,000 tax cut. We should say ''no.''

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. DASCHLE. Mr. President, I want to commend the distinguished ranking member for the excellent job he has done in representing our caucus and commend all of the Members who have played a role in on our side, as we have debated this bill.

I believe that this is the most dangerous document in America. I believe it is one of the most extreme documents that we have had before this Congress in the time that I have served here. When the lowest 20 percent of the people in this country lose more than all the other 80 percent combined, that is extreme. When the upper 20 percent gain more than all the other 80 percent combined, that is extreme.

When you see the biggest shift in income from the middle class to the top brackets in history—Mr. President, there is no other word to describe it but extreme. When it represents the biggest cut in health care benefits in history, Mr. President, this document belongs in the Guinness Book of World Records.

The American people did not vote to see the kind of change this document represents. No one in this country voted to gut Medicare $270 billion to provide tax breaks for those who do not need them. No one voted to cut Medicaid $163 billion to provide tax breaks for those who do not need them.

The distinguished Senator from New Mexico talked about protecting our children. How in Heaven's name do we protect our children when we cut the legs out from under them in education, in student loans, in nutrition programs, in housing, in virtually every single area of opportunity this country has provided them—how do we do that? How in the name of children can we stand up and support this document?

Mr. President, we can do better than this. The American people now by more than a 2 to 1 margin believe—demand—we do better than this. The President will veto it, and he has good reason to veto it.

We need to sit down together and take the extreme measures out of this document. We need to work to govern better. We need to send a better message to the American people.

We will not gut the investments in people that we have committed to for a long, long time. The most dangerous document in America needs to be vetoed and, indeed, it will be.

The PRESIDING OFFICER. Under the previous order the majority leader is recognized for 5 minutes.

Mr. DOLE. Mr. President, I think probably the most extreme thing that has happened in the last 2 or 3 years is

the $265 billion tax increase passed by this Congress without a single Republican vote. You talk about extremism—that is a good example, particularly when the initiator confesses that he raised taxes too much, the President of the United States.

I believe we have a good package here. We have had a lot of work, and I want to thank, first of all, Senator DOMENICI and the entire Budget Committee, but everyone else on this side of the aisle who have been working the past several weeks to bring us to this moment.

I really believe, and I am sitting here thinking I have cast a lot of votes in the U.S. Senate. I think this is probably the most important one that I will cast, knowing it is not bipartisan. I would like to have it bipartisan. But it is a very important vote. It is a fundamental change in America. It is a fundamental change in direction in this country. I think it is probably the most important vote I have cast in my years in the Senate.

I have never been so certain that we are doing something right—yes, right—for our children, as the Senator from New Mexico pointed out, for our grandchildren, and for everybody else.

It is right for States. Yes, we are giving some power back to the Governors. We are following the admonition of the 10th amendment of the Constitution, part of the Bill of Rights, 28 words in length, that says, in effect, if the power is not reserved to the Federal Government it belongs to the States and to the people. We believe when the people gave us a majority last November, they wanted us to give power back to the States and back to the people.

This bill is right for senior citizens. We will save, preserve, and strengthen Medicare. It will still grow at a rate of 6.4 percent. We believe that is a step in the right direction.

But looking at other beneficiaries, somebody who buys a home will save a lot of money because interest rates will come down. If you buy a car, if you are going to buy farm machinery, if you take out a loan to send your child to college, or if you are trapped in a failed welfare system—not anyone in this body would say we do not have a failed welfare system.

It seems to me that if we are going to promise to end business as usual, we have to start putting up or shutting up. We cannot do all of the things that my colleagues on the other side say—keep spending more money, spending more money, more taxes, more regulations, more government—and ever make a fundamental shift in America.

I hope, again, knowing the bill is going to be vetoed, but I hope the American people know that we are not going to mortgage their future with this bill; that we are going to cut taxes for families with children; we are going to encourage savings and investment and economic growth. We have kept our promise. We kept our promise to shift power out of Washington, DC, to the States, and we have kept our promise there.

I just conclude, because I know there are some of us going to another debate, and some are getting nervous, which is all right with me, but I simply ask the President of the United States to take another look at this product. This is a good product, Mr. President. You ought to sign it. You ought to make up for all the things you have done wrong in the past 3 years and sign this bill. Then you would be right on target again. You would be that new Democrat you wanted to be or thought you were or might have been.

Mr. President, we are doing the right thing. We are doing it because we stuck together, because we kept our promise, and because we love America.

Mr. President, soon after my election to the Kansas State House of Representatives, a reporter asked me whether I had a legislative agenda. And I replied that my agenda was simple—it was to stand up for what I thought was right.

And I have tried to follow that philosophy throughout my career.

In just a few minutes I will vote to approve the Balanced Budget Act of 1995.

I believe the vote is one of the most historic votes ever taken in this Chamber—and certainly the most important one I have cast in my years in the Senate.

And as I cast my vote to approve this landmark legislation, I can say that I have never been so certain that I am standing up for what's right.

I have never been so certain that the U.S. Senate is standing up for what is right.

Mr. President, the Balanced Budget Amendment Act of 1995 is right for America's future.

It is right for the American people.

It is right for our children and grandchildren.

It is right for our States, our cities, and our neighborhoods.

It is right for our senior citizens.

It is right for every American who is saving to buy a home.

It is right for every American who is buying a car.

It is right for every American who takes out a loan to send a child to college.

It is right for those trapped in our failed welfare system.

Mr. President, last fall, Republicans asked voters to give us a majority on Capitol Hill. And we left absolutely no doubt about what we would do if we got that majority.

We promised we would put an end to business as usual. Tonight, Americans know that we have kept our promise.

We promised to stop the mortgaging of our children's and grandchildren's future, and to put America on a path to a balanced budget. Tonight, Americans know that we have kept our promise.

We promised to replace our failed welfare system with one based on the principles of work, family, and personal responsibility. Tonight, Americans know that we have kept our promise.

We promised to cut taxes for America's families, and to encourage savings, investment, and economic growth. Tonight, Americans know that we have kept our promise.

We promised to shift power out of Washington, DC, and to return it to where it belongs—our States, our cities, and our people. And tonight Americans know that we have kept our promise.

A balanced budget. True welfare reform. Lower taxes. More freedom and power for our States, our cities, and our people. That's what Republicans are all about. And that's what this bill is all about.

President Clinton has said that he will veto this bill. He will, as is his habit, stand in the way of change. And I would simply say to the President to take another look at this bill.

We are told that the President's pollsters are advising him that the American people have concluded that his actions don't match his words. By signing this bill, President Clinton would prove that his actions do match his words on a number of issues.

President Clinton has told the American people many, many times that he is for a balanced budget.

He said on June 4, 1992 he would balance the budget in 5 years.

He said on May 20, 1995, he could balance the budget in less than 10 years.

He said on June 13, 1995, he would take 10 years.

And on October 19, 1995 he said he could balance it in either 7 years, 8 years, or 9 years.

Despite these claims, President Clinton did everything he could to defeat a balanced budget amendment, and the Congressional Budget Office— which the President has previously endorsed as an honest scorekeeper—has said that the budgets the President did propose left us with $200 million in deficits far into the next century.

President Clinton said in 1992 that he would end welfare as we know it. Yet, he admitted recently that the only welfare bill he proposed was a disappointment.

The President promised in 1992 that he would give middle-class Americans a tax cut. Yet, in 1993 he gave America the largest tax increase in history.

The President said that he wants to prevent Medicare from going bankrupt, as three of his Cabinet members have projected it will do within 7 years. Yet, he has refused to work in a bi-partisan manner with Republicans to save Medicare. Instead, according to a remarkable editorial in the Washington Post, the President has ''shamelessly used the Medicare issue * * * demagogued on it * * * and taken to the airwaves with a slick scare program.''

So, Americans have every reason to be confused. Just where does the President stand on balancing the budget? Where does he stand on reforming welfare? Where does he stand on cutting

taxes for America's families? Where does he stand on saving Medicare?

The President's decision on this bill will, once and for all, clear up all confusion. Because by signing this bill, the President will finally allow his actions to match his words. But by vetoing it, he will make very clear that he is against a balanced budget, and the benefits it will bring. He is against welfare reform. He is against tax reduction. He is against saving Medicare.

And by vetoing this bill, the President will be against many other provisions. He will be against a capital gains tax cut. He will be against putting an end to the marriage penalty tax. He will be against medical savings accounts. He will be against adoption tax credits. He will be against helping Americans who provide care to their parents.

Now, when President Clinton vetoes this bill, he will shake his head, and he will say what many of his liberal allies have said today. He will say that he would like to sign this bill, but it's just too harsh. He will say that we are cutting spending on programs for the less fortunate among us. He will say we are cutting Medicare. He will say our tax cuts favor the business community.

He will say all that again and again. And he will be wrong every time he says it.

He will be wrong because this bill does not cut overall Federal spending—it allows it to grow by 22 percent over the next 7 years.

He will be wrong because this bill does not cut Medicare. In fact, Medicare will continue to grow at a rate of 7.7 percent a year.

He will be wrong because this bill does not cut programs to the needy—it allows 34 percent growth over the next 7 years.

He will be wrong because total funding for student loans will be increased by nearly 50 percent over the next 7 years.

He will be wrong because 73 percent of the tax cuts in this bill will help families throughout their lives.

Those are the facts. The President will try his best to obscure these facts with emotional rhetoric. In fact, the Democrat National Committee already has a television commercial on the air trumpeting the President's so-called balanced budget proposal, and saying that the Republican plan will cut Medicare.

It's a nice commercial with catchy music, but not a word of it is true. As I have said, the President has never submitted a budget anywhere near balance. And the Republican plan increases Medicare spending.

Mr. President, I'm from a farm State, and I want to say to the farmers of Kansas and the farmers of America that this bill is also important to them.

Since the days of Franklin Roosevelt, the Government has been in the business of telling farmers how to farm. Under this bill, that will end, and beginning in 1996, farmers will be planting for the market place.

Under this bill, farmers will have full planting flexibility, elimination of set-asides, program simplicity, and a farm policy that transitions farmers into the next century without disrupting the farm economy or land values.

While I am concerned about farmers receiving payments in good years, I am pleased we were able to cap the entitlement spending of agriculture programs. We accomplish this goal through a declining transition payment which is guaranteed to the farmer. In exchange, farmers will be required to maintain their land conservation efforts in both good and bad years. And this bill also protects family farms by providing some much needed estate tax relief.

Mr. President, let me conclude by saying that I know that the American people have wondered about the events taking place in Washington this week. They have wondered why the Government was shut down. They have wondered why Congress and the White House aren't talking to each other.

Well, as I have said many times this week, I wonder why we haven't spent more time talking to each other. And I remain ready to talk with the President any time to put all Federal employees back to work.

But I also would tell Americans that if ever there was a debate you wanted your elected Representatives to have, this is it. This is it. Because we are debating your future. We are debating the future of your children and grandchildren. We are debating the future of America.

I speak for all Republicans in saying that, as we approach Thanksgiving, we are thankful to have the opportunity to stand for something.

We are thankful to have the opportunity to stand for fundamental change.

We are thankful to have the opportunity to stand for a better future for the next generation of Americans.

And let me close by saying—and I know I speak for all Members of the Senate—that we are thankful that we have the opportunity to serve with a Senator as courageous and committed as PETE DOMENICI, and I salute him for his many years of leadership in support of a balanced budget.

Mr. President, let's do the right thing for America's future. Let's pass the Balanced Budget Act of 1995.

The PRESIDING OFFICER. The majority leader is informed the yeas and nays have not been ordered.

Mr. DOLE. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the motion to recede from the Senate amendment to H.R. 2491 and concur thereto with an amendment.

The yeas and nays have been ordered.

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 52, nays 47, as follows:

[Rollcall Vote No. 584 Leg.]

YEAS—52

Abraham	Gorton	McConnell
Ashcroft	Gramm	Murkowski
Bennett	Grams	Nickles
Bond	Grassley	Pressler
Brown	Gregg	Roth
Burns	Hatch	Santorum
Campbell	Hatfield	Shelby
Chafee	Helms	Simpson
Coats	Hutchison	Smith
Cochran	Inhofe	Snowe
Coverdell	Jeffords	Specter
Craig	Kassebaum	Stevens
D'Amato	Kempthorne	Thomas
DeWine	Kyl	Thompson
Dole	Lott	Thurmond
Domenici	Lugar	Warner
Faircloth	Mack	
Frist	McCain	

NAYS—47

Akaka	Feingold	Levin
Baucus	Feinstein	Lieberman
Biden	Ford	Mikulski
Bingaman	Glenn	Moseley-Braun
Boxer	Graham	Moynihan
Bradley	Harkin	Murray
Breaux	Heflin	Nunn
Bryan	Hollings	Pell
Bumpers	Inouye	Pryor
Byrd	Johnston	Reid
Cohen	Kennedy	Robb
Conrad	Kerrey	Rockefeller
Daschle	Kerry	Sarbanes
Dodd	Kohl	Simon
Dorgan	Lautenberg	Wellstone
Exon	Leahy	

So the motion was agreed to.

Mr. COATS. Mr. President, I move to reconsider the vote.

Mr. KEMPTHORNE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mrs. BOXER addressed the Chair.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER Mr. President, I will make a unanimous-consent request to the Republican side. I anticipate, as they did last night, they will once more object.

I would ask that there be order in the Chamber?

The PRESIDING OFFICER. The Senate will be in order. The Senator from California was propounding a unanimous-consent request but no one could hear.

The Senator from California.

Mrs. BOXER. Mr. President, in about 3 minutes I will offer my unanimous-consent request. But I do appreciate your getting order in the Chamber so that I can make a comment very briefly for a minute on another matter, and then talk about my unanimous-consent request.

THE OKINAWA RAPE

Mrs. BOXER. Mr. President, I think many of us were shocked to read today that the commander of U.S. forces in the Pacific called the recent rape of a 12-year-old Okinawan girl ''absolutely