for domestic onshore oil and gas exploration in the United States. The opponents of opening the coastal plain argue that the amount of oil at stake is not significant, that it is only a 200-day supply. However, a single field large enough to supply this country with all of the oil it consumes for 200 days represents a huge reservoir of oil. Eighty percent of all onshore oil fields discovered in the lower 48 States over the last 100 years have contained less than 1 day's supply.

According to the BLM, the mean estimate of oil thought to be economically recoverable from the coastal plain of the ANWR is 3.2 billion barrels. The range of estimated economically recoverable reserves runs from 400 million barrels to over 9 billion barrels. The probability of discovering economically recoverable oil has been estimated by that agency at 46 percent. The oil industry routinely considers probabilities of discovery in the range of 10 percent worth the payment of substantial bonuses for the right to explore for oil.

As many of my colleagues know, the USGS has recently completed its 1995 assessment of onshore oil and gas resources for the United States. In general, the assessment shows an increase in the amount of natural gas thought to be present in northern Alaska and a decrease in the amount of oil thought to be present in that area. The USGS has prepared a preliminary analysis of the oil potential of the coastal plain and has concluded in a draft memorandum that the mean estimate for oil in the 1002 area is slightly less than a billion barrels, with a 1 in 20 chance that some 4 billion barrels are present. The agency is currently in the process of gathering more information from the 1002 area to refine its very preliminary estimate. The BLM, it should be noted, continues to have confidence in its earlier mean estimate of 3.2 billion barrels for the 1002 area.

Since 1980, when we began to debate the issue of opening the coastal plain of ANWR, there have been numerous studies and estimates of the amount of oil likely to be found if the area is opened to leasing. These estimates have been made by the BLM, USGS, the Energy Information Administration, the GAO, the State of Alaska, the American Association of Petroleum Geologists, and others. These estimates vary considerably due to different methodologies employed, different interpretations of geologic data, and differing geologic engineering and economic assumptions that are made relative to the methodology.

As a result, it is very difficult to directly compare these estimates. However, two important conclusions can be drawn from these estimates.

First, they all reflect a wide range of uncertainty, which is expected for an area that has not been drilled. Until we have reliable well data from the 1002 area, we simply have no way of knowing how great the potential of the area is. Second, all these estimates show a very large potential for oil and gas, with even the lowest estimates that have been made having an upside potential of at least 4 billion barrels.

In addition to the benefits to the country provided by the oil itself, the Federal Treasury will also benefit. Under the ANWR provisions contained in the bill currently before the Senate, the CBO estimates that two lease sales in the coastal plain will occur between now and the year 2000 which will result in bonus bids totalling $2.6 billion. The legislation requires a 50–50 revenue split with the State of Alaska—the same as other western States—which will mean that the Federal Treasury will receive $1.3 billion in new revenue during the next 7 years if the coastal plain is leased. Should oil be discovered and produced from ANWR in significant amounts, a steady stream of royalty income will also accrue to the Federal Treasury for many years to come.

In addition to the direct budget plus for the Treasury, this measure provides that the Federal share—50%—of bonus bid revenues in excess of $2.6 billion will be made directly available for maintenance, repair and rehabilitation projects at our Nation's national parks and refuges. This provision will provide a significant funding source for our parks that so desperately need more money.

Mr. President, oil and gas development on the coastal plain is a step that must not be postponed any longer. Most experts agree that it will take up to 10 or 15 years before commercial production could begin if the area is leased this year. Sometime between 2008 and 2014, the DOE estimates that production from Prudhoe Bay and adjacent fields, which currently account for nearly 25 percent of our domestic oil production, is projected to decline to approximately 300,000 barrels per day, the minimum level needed to operate the Trans-Alaska Pipeline System [TAPS]. If we continue to delay exploring for oil on the coastal plain and developing what we find there, the TAPS could be forced to shut down, and we will have lost our ability to transport billions of barrels of Alaskan oil to waiting consumers.

When Congress enacted the Alaska National Interest Lands Conservation Act in 1980, we declined to designate this portion of ANWR as wilderness and specifically reserved for ourselves the decision on whether that area should be made available for oil and gas leasing. We directed the Secretary of the Interior to study the area and to make recommendations on whether to allow oil and gas development. In 1987, the Secretary recommended that oil and gas development be allowed to take place. Since that report was issued, the Senate Energy and Natural Resources Committee alone has conducted 11 hearings and built a solid and thorough record on this issue. Our committee has voted on three separate occasions, on a bipartisan basis, to proceed with oil and gas leasing.

It is now time for the Senate to exercise its responsibility and make a decision with respect to oil and gas development on the coastal plain. Our Nation can have the benefit of the oil from ANWR, the revenues leasing will generate, and still preserve the beauty and the vastness of the Refuge.

THE BUDGET RECONCILIATION BILL—A MISSED OPPORTUNITY TO MAKE SMART CHOICES

Mr. DORGAN. Mr. President, during the past few days, we have had extensive debate on the Senate floor about what this budget reconciliation package will mean for the Medicare and Medicaid programs. Now, as we reach the conclusion of this debate, I want to explain some of the reasons why I must oppose it.

I want to say right off that I am deeply committed to ensuring that the Medicare and Medicaid programs will be here for the millions of older Americans, children, and individuals with disabilities who have come to rely on the services they provide. Thanks to Medicare, 99 percent of senior citizens, who have paid into the program during their working years, now have affordable, guaranteed health care coverage. Likewise, Medicaid provides a much-needed safety net for 36 million low-income elderly nursing home patients, the disabled, and pregnant women and children.

WHAT IS THIS DEBATE ABOUT

The debate on Medicare and Medicaid has centered not so much around whether projected spending for these programs should be reduced, because Members of both parties agree that this should be done. Instead the focus has been on how much spending should be cut. I believe we should limit the rate of growth of both of these programs to a more sustainable level so that they will continue to be here for the beneficiaries who depend on them.

However, I am convinced that the bill before us—which will cut projected Medicare spending by $270 billion and Medicaid spending by $182 billion—goes far beyond what should be done to achieve this goal, and instead will jeopardize the very programs the reductions are intended to protect. This drastic level of cuts would require that Medicare spending per beneficiary be held to a growth rate of 4.9 percent, while private health insurance will continue to grow at a rate of 7.6 percent per person. It is just not reasonable to expect Medicare to grow by such a small amount, especially when you consider that 200,000 Americans become eligible for the program each month. Just within the 7 years covered by this budget reconciliation bill, Medicare will insure 3.7 million more people than it does today.

We have been told repeatedly by the majority that these $450 billion in cuts are necessary, particularly to save the Medicare program from insolvency.

But according to Medicare actuaries, only $89 billion is needed to extend the Medicare trust fund for 10 years.

So why does this bill cut Medicare by $181 billion more than the experts say is necessary—and cut Medicaid by $182 billion? Because this budget reconciliation bill also contains $245 billion in new tax breaks, which will largely benefit the wealthiest in our country.

It is wrong to be making an unprecedented level of cuts to Medicare, Medicaid, and other critical programs while granting tax relief to people making over $100,000 per year and to large corporations taking advantage of tax loopholes.

THE IMPACT OF THIS BILL ON SENIORS

Under this bill, older Americans will be asked to pay more for their health care but can expect to get less for their money. The premiums that seniors pay out of their Social Security checks for their physician services will double and could exceed $100 per month in the year 2002. On top of that, their deductible would also increase from $100 to $220.

I fear that these premium and deductible increases could make Medicare coverage out of reach for some seniors. Most older Americans have very modest incomes. Seventy-five percent of seniors on Medicare live on less than $25,000 a year. And in North Dakota, older Americans get by on even less: 70 percent of our state's seniors have incomes of under $15,000.

Already, seniors spend 21 percent of their income for health care. In 1994, the average older American spent $2,500 for medical care, prescription drugs, and other health care expenses not covered by Medicare—and this figure does not even include the cost of long-term nursing home care, which averages nearly $40,000 a year.

In addition to costing more, the quality of health care older Americans receive could very well decline. That is because the portion of the cuts that do not fall directly on beneficiaries will be borne by doctors, hospitals, and other health care providers, who even now are reimbursed at only 68 percent of the amount they get from private payors. As a result, these cuts could create a second-class health care system for the elderly.

This budget bill, with its $182 billion cut in projected Medicaid spending, could force hundreds of thousands of middle-income seniors and their families to shoulder the substantial burden of nursing home costs also. It turns the Medicaid program over to the states in the form of a block grant and repeals the Federal guarantee for nursing home care for the 60 percent of nursing home patients who qualify for Medicaid—many of whom have already used up their life savings in paying for their care.

CONSEQUENCES OF MEDICAID ''BLOCK GRANT'' FOR THE NEEDY

Our Nation's seniors are not the only ones who are being asked to pay the bill for tax breaks for wealthy individuals and corporations. Children will also lose under this plan to turn Medicaid over to the States as a block grant. One in five children currently receive their health care through Medicaid. Their care is not expensive—they represent 50 percent of all Medicaid beneficiaries but receive only 15 percent of the benefits—but it is important. The immunizations and preventive care that these kids receive help them to grow up to be healthy, productive adults. I think it is also worthwhile to note that fully half of the kids now covered by Medicaid are members of working families.

Under the block-grant plan, North Dakota will receive 22 percent less Medicaid funding over the next 7 years than our State is projected to need. Cutting provider reimbursement rates and enrolling more beneficiaries in managed care simply will not generate enough savings to offset the loss in Federal funding, so States will have no choice but to terminate coverage for some current recipients or to reduce the benefits offered.

IMPACT ON THE HEALTH CARE SYSTEM

I believe cuts of the magnitude called for under this bill will also devastate the health care system, particularly in rural areas. The majority of the savings achieved in Medicare will come through reducing payments to hospitals, home health care providers, and other health care professionals.

One-quarter of all rural hospitals are already operating at a loss and are in danger of being shut down if their payments are reduced further. Rural hospitals are dependent largely on Medicare and Medicaid patients for their livelihood. Between 1983 and 1993, the number of rural hospitals dropped by 17 percent, compared to a 2 percent drop in urban hospitals. Rural residents already suffer from a lack of access to medical care, and additional hospital closings in rural areas will further exacerbate this problem.

Cuts of this magnitude cannot be absorbed within the Medicare system alone, so health care providers may have no choice but to shift the burden for their uncompensated costs onto their other patients in the form of higher fees. I do not think it makes much sense to force higher costs for medical bills and health insurance onto the rest of the population, thereby pricing health care out of reach for even more Americans.

A RESPONSIBLE MEDICARE ALTERNATIVE

I believe it is possible to balance the budget and protect Medicare at the same time, and I supported Senator ROCKEFELLER's amendment that would have accomplished this goal. Under Senator ROCKEFELLER's amendment, Medicare's projected spending would have been reduced by $89 billion, ensuring the solvency of the Medicare trust fund through 2006. This $89 billion is a far more reasonable reduction and could have been achieved without new increases in costs for people who simply cannot afford to pay more for health care and without damaging our world-class health care system.

Senator ROCKEFELLER's amendment would have been paid for by scaling back the tax breaks provided in this bill for wealthy Americans. I thought that was the responsible course of action, but unfortunately, a majority of my colleagues did not agree, and the Rockefeller amendment was rejected by a 53–46 vote.

A BETTER CHOICE FOR MEDICAID

As with Medicare, I agree that we must control Medicaid's rate of growth, but I cannot support the block grant approach provided for in this bill. As an alternative, I voted for Senator BOB GRAHAM of Florida's amendment to reduce Medicaid's projected spending by a more reasonable $62 billion over seven years. This amendment would have maintained the guaranteed safety net that Medicaid provides for more than 36 million needy older Americans, the disabled, and pregnant women and children. At the same time, the Graham amendment would have restrained the rate of growth of the Medicaid program by placing a cap on federal funding based on per person spending, rather than by a flat block grant. But, as with the Rockefeller amendment for Medicare, Senator GRAHAM's amendment was defeated by a narrow 51–48 margin.

I am very disappointed that a majority of my colleagues have let these opportunities for responsibly controlling Medicare and Medicaid spending pass them by, and I simply cannot support the more drastic, and unnecessary, cuts to spending still called for in this bill.

President Clinton has indicated that he will veto this bill unless these severe cuts are moderated before it reaches his desk. It is my sincere hope that, after this bill is vetoed, Congress and the President will be able to work together to achieve a reasonable compromise that will provide the fiscal discipline the American people want from the Federal Government without sacrificing the health security they deserve.

Mr. ROCKEFELLER. Mr. President, in my view, every United States Senator will be making a statement about their fundamental priorities as they cast their vote on this reconciliation package. While each and every vote cast on this floor is key, today's vote on the reconciliation bill is a pivotal one about the future of our country, and the role that our Federal Government can and should play in the lives and well-being of American families.

While most of our debates have focused on budget numbers, I have tried to talk about the families and the real people who depend on Medicare, Medicaid, student loans and all the other major programs affected by this legislation in many serious ways. The provisions of this bill will have enormous impact on children, families, and seniors in West Virginia and every State

in this Nation. We should be mindful of them as we cast our votes.

I want to be clear. I believe we can and should balance the Federal budget and eliminate the Federal deficit. This is a vital goal, but it is equally important to ensure that the burdens of achieving a balanced budget are responsibly and fairly shared among all Americans. I strongly feel that we should not balance the budget on the backs of seniors, poor children, and working families.

The programs that would be drastically cut and changed by this reconciliation bill often are the difference between security and insecurity, health and illness, and sometimes life or death for seniors and American families who depend on Federal programs for their health care security.

I was proud to take the lead in offering the first major amendment to this budget, designed to save Medicare, a historic program that has provided seniors with health care security since 1965, giving them peace of mind and a higher quality of life. While some may cast aspersions on Medicare, I believe it is one of America's proudest achievements.

Our amendment was not to retain the status quo. We know we must make changes in the system to restore the solvency of the Medicare trust fund. But the solvency of the trust fund does not require cutting Medicare by $270 billion. Such extreme cuts will threaten health care for 30 million seniors—330,000 of them living in West Virginia—and further erode our health care system.

For seniors, the reconciliation package means that their Medicare deductibles will double and their premiums will skyrocket. When the average income of seniors citizens is $17,750, and they pay 21 percent of their income on health care, they are incredulous and petrified to hear that their Medicare is being used to pay for tax breaks and tax give-aways to far, far wealthier Americans and every imaginable kind of corporation.

I cannot go back to West Virginia and hold town meetings in senior centers as I often do, and justify a vote to slash Medicare by $270 billion in order to finance tax breaks for the wealthy. West Virginians believe in fairness and common sense, and this attack on Medicare flunks that test.

Seniors will not be the only ones hurt by the budget's Medicare cuts. West Virginia hospitals are threatened with the possibility of losing $25 million in 1996 and more than $681 million over the next 7 years, and I fear that some of our hospitals may not survive such cuts.

For real people in West Virginia who depend on Medicare for their health care coverage, the Republican rhetoric about Medicare reform rings hollow.

And Medicare is not the only health care program slated for harsh cuts under this Republican plan. This reconciliation package also seeks to cut Medicaid funding by a whopping $187 billion over 7 years.

People need to understand what such harsh cuts mean. Medicaid covers poor children, pregnant women, the disabled, and low-income seniors who need nursing home care. What happens to these people and their families when we slash Medicaid funding?

Coming from West Virginia, when I think of a family, I think about children, parents and grandparents. What happens to parents struggling to balance raising children and caring for aging parents?

If a working family gets a new child tax credit but loses Medicaid nursing home coverage for an aging parent, what is the overall effect on that family? The child tax credit is $500 a year for ''some'' families lucky enough to qualify, but the loss of Medicaid nursing home coverage will cost those same families $16,000 to $30,000 a year.

For example, Julie Sayres of Charleston, WV cared for her mother who suffers with Alzheimer's Disease as long as she could at home. But as her mother's illness got worse, she had to move to a local nursing home where Julie can visit her daily. Julie may get a partial child tax credit of $500 under this package, but if she cannot get Medicaid coverage for her mother in the nursing home when her mother's meager savings are exhausted, Julie and her family with be much, much worse off. That child tax credit will not cover even a month of nursing home care for her mother.

This is real story about a family hurt, not helped by drastic health care cuts in this package. In my State of West Virginia, over 21 percent of our residents rely on Medicaid so their are countless more stories and fears about what will happen to aging parents.

And it will not just be individual families hurt by the Medicaid cuts. The health care system in my State is fragile, rural hospitals are already closing, and West Virginia cannot absorb more than $4 billion in cuts without cutting necessary health care services, including basic issues like infant mortality. A recent newspaper article made this point, clearly with a headline: ''[Medicaid] Cuts may affect infant mortality.'' The article reports that my State, thanks to Medicaid-funded programs, has reduced its infant mortality death rate from 18.4 deaths per 1,000 in 1975 to 6.2 deaths per 1,000 in 1994 which is even better than the national rate of 8.0 deaths per 1,000 births. As Governor, I helped start the effort to reduce infant mortality, and I must protest any action that turns back the clock.

We should not tolerate backwards steps on basic health care objectives like reducing infant mortality.

I understand that Medicaid needs reform and Democrats offered an amendment that suggested reducing the growth in Medicaid spending in a responsible way with a per capita cap. I truly want meaningful reform of health care, but I do not believe that creating a Medicaid block grant is serious reform, it is merely passing the buck—or actually passes far fewer dollars and far greater problems onto States. This is not fair to states or to the Americans who desperately need health care from Federal programs.

The assault on families in this budget package is not limited to the attacks on federal health care programs. Republican rhetoric claims that this legislation will help families, because of its $500 child tax credit.

As chairman of the National Commission on Children, I am clearly on record in support of a child tax credit, but it must be a refundable credit so that children in all families can benefit. Unfortunately, the child tax credit in this legislation is not refundable, and every amendment offered to make it even partially refundable was rejected. Consequently, over 20 million children are excluded from this child tax credit, and I do not think this is fair. These children are in families earning less that $30,000 a year and their parents clearly need and deserve a tax break.

To add insult to injury, not only do Republicans deny the credit to such hard working, low-wage families, Republicans are paying for the credit by imposing a tax increase on working families by cutting $43 billion from the earned income tax credit (EITC).

There has been much debate about the EITC, and I want to clearly state that EITC is tax relief only available to working families, and it is designed to offset payroll taxes, which often are a greater tax burden for low wage families than personal income taxes.

The Republican leadership dismisses these arguments, saying that their tax package helps middle class American families. And this sounds good, but I want to know how they define the middle class?

In my State of West Virginia, we believe that parents who go to work every day and struggle to raise their children are middle class, admirable and deserving of support and encouragement. More than 65 percent of our taxpayers are working hard but earn less—less than $30,000. For many of these families, they will worse off, not better, under this bill.

Just 2 years ago, these working families were promised tax relief. Now Republicans are reneging on that deal and raising taxes on families earning less than $30,000. For families with two or more children, their taxes will go up an average of $483. For families with one child, taxes will keep an average of $410. This will hit more than 77,000 families with children in my state of West Virginia alone.

But such numbers can be numbing. We need to get beyond the rhetoric and look at real families.

A real family, like the Helmick family of New Milton, WV, will be worse off, not better. The Helmick family has 6 children, ranging in age from 15 to four. Mr. Helmick works full-time as a

truck driver for a local construction company, and Mrs. Helmick is a full-time homemaker. In the past, they have used their EITC for baby furniture and to buy a used truck so Mr. Helmick has reliable transportation to get to work. Mr. Helmick will not get to claim the full tax credit for his children, and he will lose EITC benefits under the Republican plan.

This is a real working family that will be hurt, not helped.

Families like the Helmicks cannot claim all of the child tax credit, and they will be hurt by the cuts in EITC; and I doubt that they will be claiming capital gains tax breaks either. For them, this package does little more than renew their cynicism since it reneges on promises made just two years ago when we told families to play by the rules, go to work instead of on welfare, and we will offset your payroll taxes so that you do not have to raise your children in poverty.

Mr. President, I am not against the idea of tax cuts. In fact, I would support a limited tax cut for the most needy families and some relief from burdensome taxes for companies that need it. But when you look at this bill, while it was artfully crafted to appear to have something for everyone, it is really a farce. It is full of tax pork for the wealthy and goodies for those who do not really need it.

On the surface, how can anyone oppose tax relief for families? The Republican rhetoric is, as always, good—tax relief for families, and help for companies to create jobs. It sounds so tempting to give hundreds of billions of dollars away, but when you look at what Republicans are reality doing, and how they are doing it, you say ''wait a minute.'' Their rhetoric is one thing, but reality is another.

They say they are balancing the budget, but they will add nearly a trillion dollars to our national debt in the next seven years. They say the tax cut is ''paid-for'' by an economic dividend of balancing the budget; but the truth is, they are adding $224 billion to our accumulated debt over the next 7 years. In fact, if you add interest, the total is more like $268 billion. Republicans are borrowing money from the middle class they claim to be championing in order to give money away to their fat-cat friends.

Think of it as a new credit card with a credit line of $1,000. Every month you take home $1,500 after taxes and spend $1,600. You can do that because you have the credit card. You are charging $100 every month to your credit line. Well, after 5 months, you owe the $500 you borrowed on your credit card, plus interest. Then you decide, you don't like spending more than you are making, so you force yourself to spend less. For the next 7 months, you bring your spending down from $1,600 a month to $1,585 a month, then $1,570 a month, then $1,570 a month, and so on until at the end of the year, you are spending $1,500 a month. You have a Balanced Budget. You are making $1,500 a month and spending $1,500 a month. Then you look at your balance you owe on your credit card, and guess what—you owe $800, plus interest. How did that happen? You went on a path to balance in June when you owed $500 plus interest, but in December you owe more than $800. It is because every month on the way to balance, you borrowed more to cover your over spending. You borrowed $85 dollars one month, $70 the next, $55 the month after that, and so on.

That is what this bill does. Sure, it gets us to balance by 2002, but along the way, we are going to overspend what we take in by nearly $1 trillion. Every year between now and 2002 we spend more than we take in. We borrow more to pay for this tax cut. That is $1 trillion added to our accumulated debt. And of that $1 trillion added to the debt, $224 billion is this tax cut ($268 billion, if you add the interest). If we got rid of this tax cut, or reduced the tax cut down to size of the real economic dividend, our deficit every year would be less, and the accumulated debt, the amount the American people owe, would be less.

This debate is about priorities. Do we want to run up the bill on all of us in order to give money to the wealthy to buy goodies? We are running up our national credit card so the richest Americans—those who earn more than $350,000 a year—get a tax cut of $5,600. Do we want to spend $40 billion on capital gains tax cuts for the richest Americans and recklessly slash health care for the most needy and the elderly? Do we want to cut taxes by more than $1.7 million on estates worth over $5 million by raising taxes on the working poor?

Again, West Virginians have a basic sense of fairness. How can I tell them that families are helped, when the result of this whole bill will mean that poorest fifth of Americans would shoulder fully half of the program cuts with an average loss of nearly $2,500 per family in 2002.

At the same time, the Treasury estimates that almost two thirds of the proposed tax breaks would go to the wealthiest fifth of the population, who would gain almost $1,400 per family.

In fact, the top one percent of families—those with incomes greater than $350,000 per year, would get an average tax break of $5,600. The capital gains tax break will benefit taxpayers with incomes between $20,000 and $30,000 by about $5 on average. Those making more than $200,000 will receive an average cut of nearly $1,500. How is that fair?

How can the authors of this bill look at themselves in the mirror, let alone look into the faces of the most needy in America, and say they are doing the right thing? I cannot go to town meetings in my state and tell West Virginians that I supported such an unbalanced, unfair deal.

I could support tax cuts that were honestly paid for. I could support tax cuts that are fair. But I am not going to support tax cuts paid for by raising the money from those least able to pay. I even think we should consider giving some limited tax relief to American companies that need it. In fact, I am proud to be the author of a bill that helps capital intensive industries such as steel, chemicals and wood-paper compete in the international market place. That bill fixes something called the Alternative Minimum Tax (AMT) by changing the way companies calculate the value of their property. Unfortunately, even in this bill of tax goodies, and big corporate give-aways, the Republicans could not do it right, they only did a half measure.

The problem these companies have is that under the AMT, the tax code does not recognize in any real-world way, how to depreciate their assets. Steel, chemicals, wood-paper, any capital intensive industry, where the costs are high and the margins are low, these companies need to change the length of time they have to depreciate their assets. This is known as lives. Under the current tax law, after 5 years, a US steel maker under AMT recovers only 37 percent on its investment in new plant and equipment, versus 58 percent in Japan, 81 percent in Germany, 90 percent in Korea, and 100 percent in Brazil. This is largely a result of the AMT. It is my strong hope that conferees will look at this with an understanding eye. I am hopeful that they will. When you look at how the AMT puts our companies in such a competitive disadvantage, I think the need for corrective action is clear.

Another disturbing provision tucked into this package is the proposal to eliminate the 50 percent interest exclusion on loans to purchase employees stock ownership plans (ESOPs). As Governor of West Virginia, I worked closely with the workers of Weirton Steel to establish an ESOP that kept the mill open, and the community alive. Weirton officials question if they could have secured the financing necessary in the early 1980's to create this ESOP without this tax incentive. Weirton Steel is the largest private employer in West Virginia in my State. Despite the rocky roads that the American steel industry has faced, Weirton Steel has not only survived, it has invested almost half a billion dollars in modernization so that it will be internationally competitive into the next century—and it remains an ESOP with involved employee owners. There are other successful ESOPs in West Virginia, and I hope there will be more in future. We should not slam the door shut on such future ESOPs by eliminating the incentives for start-up loans, in my view.

Mr. President, this legislation is nearly 2000 pages long—I shudder to think about other provisions tucked quietly into this bill. It was presented to the Senate on October 23, 1995, and

we are expected to vote on the legislation with only four days of review. There has not been time to carefully analyze this massive legislation or to learn what is on each and every page—much less understand the complicated interactions of the policies and programs.

I do know that on page 1851 there is a proposal that I cannot support. It is a secret deal in the Republican budget that fundamentally breaks the promise of lifetime health benefits to retired coal miners and their widows—nearly 30,000 of whom live in the State of West Virginia. More than 60,000 more older miners and their widows are living in almost every other State in this union.

I am obligated to expose the secret and to call it what it is—a pay-off for a set of greedy corporate interests that will not stop until they have bled the miners' health trust fund of every last dollar needed to protect miners benefits. Republicans say they will restore the miners' trust fund—the miners' only real guarantee that their health care will be there for them when they need it. I am not willing to gamble with the health security of 92,000 miners and their widows.

I cannot abide such a tawdry provision in this or any reconciliation package. I appeal to whatever sense of justice my Republican colleagues have. I ask them to give up this corporate pay-off before any more damage is done.

This cruel little provision might have escaped the notice of many. In a package that gives away billions, this provision only deals with tens of million of dollars. But these millions mean security to the older miners and their widows. This small trust fund is all they have, and it stands between their health security and a peace of mind, and financial ruin and destitution when illness strikes these aging miners.

This is a complicated issue with a long history, and I could go into excruciating detail. But the bottom line is that Republicans want to hand over the money that is keeping the retired miners' health trust fund solvent to a group of special interests represented by high priced lobbyists.

As I have said earlier, I want my colleagues to think about the real families that could be truly hurt by this package.

The day after the Finance Committee reported out their handiwork that demolishes the health security of more than 92,000 miners and their widows for the sake of a few of the biggest and most profitable companies in this country, I went back home to West Virginia. I went back to tell miners and their wives what happened.

The miners I met with were reserved, as many miners are, especially older ones who have seen it all, strikes and cave-ins, shut-downs and lay-offs. They have learned to accept a lot in life. They have seen their coworkers killed, or mangled, or dismembered. They have suffered the loss of their own lungs and limbs. They do not have a lot to pass onto their families in temporal terms, but they have good hearts and an incomparable work ethic. They have the values they hold dear—their emphasis is on community and family and caring. And until the Senate Finance Committee action, they had their UMW health card to get their health benefits and knew that it would protect their wives when they died too hard and too soon.

One miner who worked for decades in the mines told me starkly, ''We're worried to death.'' He said, ''Now it seems like the company is the one running the whole show. They want to do away with us when we were the ones that worked and built everything else.''

His question was this, ''What's going to happen to me if I lose my benefits?'' And he answered his own question with, ''They'll probably put me in my grave before my time.''

Another miner, characteristically, worried about his wife who is a diabetic. ''Gosh, if I had to buy her medicine, I do not know what would happen.'' Today retired miners' health benefits pay for prescription drug medication after they meet a modest deductible.

Under this reconciliation package, on page 1851, we are taking away the health care security of these miners, and we are reneging on a promise made more than 40 years ago by President Truman and reaffirmed just 2 years ago and signed into law by an act of Congress.

If this Senate and this society renege on this promise to a group of old frail miners, their wives and their widows, what are we worth?

Does a promise have no meaning? Does a contract not matter? Can a law be repealed when it becomes inconvenient for a profitable, influential businesses?

Promises do have meaning for me.

When I was elected by the people of West Virginia, I made promises to West Virginians. I vowed to fight for their priorities and do my best to serve them and respond to their concerns.

This reconciliation bill simply does not respond to the real needs of West Virginia families, or even West Virginia businesses.

The Republican rhetoric is good, but the reality is that this bill will undermine health care for seniors, raise taxes on working families, and jeopardizes the health care for retired coal miners and their families.

This is a harsh package that hurts real people, and I strongly oppose it. With this legislation, we are walking away from basic commitments to some of the most needy individuals in our society, and the debate over this package has saddened me greatly. We can, and we should, do better as public servants. I will vote no, and continue to fight against such unfair legislation.

Mr. FRIST. Mr. President, before we vote on final passage of S. 1327, a historic piece of legislation, I wanted to submit for the RECORD materials presented to me by the United States Chamber of Commerce. The Chamber of Commerce is an ardent supporter of S. 1327 and believes that the time is now to balance the Federal budget, streamline Government programs and, importantly, save the Medicare Program. Included in these materials is a study prepared by the Chamber of Commerce regarding the economic impacts of Medicare. I commend this study to my colleagues and thank the chair.

I ask unanimous consent that the material be printed in the RECORD.

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

[From the U.S. Chamber of Commerce, Economic Policy Division]

THE MEDICARE CRISIS: THE TAX SOLUTION IS NO SOLUTION

The only solution detailed by the Medicare Board of Trustees for achieving financial balance in Medicare Part A is to raise taxes. Unfortunately, this is no solution at all. Higher taxes will rob working individuals of their hard-won dollars, significantly increase costs on small and large businesses alike and bring the economy to the brink of recession.

The Trustees calculate that balancing the Medicare trust fund for the next 75 years requires us to immediately hike the Medicare payroll tax from 2.90% to 6.42%. While the tax increase may seem to amount to only a few percentage points, it amounts to hundreds of dollars to the typical worker, thousands of dollars to the small business, and billions of dollars for the economy. Analysis by the Economic Policy Division of the U.S. Chamber of Commerce suggests the following impacts on individuals, businesses and the economy:

For a worker making $30,000 a year, total Medicare payroll taxes paid would jump to $1,926 from the current $870.

A small business employing 25 such workers would be liable for an additional $13,200 tax payment per year.

When aggregated across the entire economy, the effect would be to lower real GDP by $179.4 billion within two years and hold GDP about $95 billion lower 10 years later. This amount to a 3.1% decline in GDP in the short run. With economic growth projected to average less than 3% over the next five years, this decline could easily result in a recession.

These results are even more startling when you consider that they represent an optimistic evaluation, not a worst-case scenario.

OVERVIEW OF MEDICARE: WHY REFORM IS NECESSARY

Medicare is a nationwide health insurance program for older Americans and certain disabled persons. It is composed of two parts: Part A, the hospital insurance (HI) program, and Part B, the supplementary medical insurance (SMI) program.

Part A covers expenses for the first sixty days of inpatient care less a deductible ($716 in 1995) for those age 65 and older and for the long-term disabled. It also covers skilled nursing care, home health care and hospice care. The HI program is financed primarily by payroll taxes. Employees and employers each pay 1.45% of taxable earnings, while self-employed persons pay 2.90%. In 1994, the HI earnings caps were eliminated, meaning that the HI tax applies to all payroll earnings.

Part B is a voluntary program which pays for physicians' services, outpatient hospital services, and other medical expenses for persons aged 65 and over and for the long-term

disabled. It generally pays 80% of the approved amount for covered services in excess of an annual deductible ($100). About a quarter of the funding comes from monthly premiums ($46.10 in 1995); the remainder comes from general tax revenues and interest.

Medicare is not a means-tested program. That is, income is not a factor in determining an individual's eligibility or, for Part B, premium levels. Age is the primary eligibility criteria, with the program also extending to qualified disabled individuals younger than 65.

Over the years, tax revenues for Medicare Part A have exceeded disbursements, and so the remaining revenues have been credited to the Medicare HI Trust Fund. At the end of 1994, the trust fund held $132.8 billion.

CONCLUSION OF THE TRUSTEES

Each year, trustees of Medicare's Hospital Insurance Trust Fund analyze the current status and the long-term outlook for the trust fund, and their findings are published in an annual report. The 1995 edition, issued in April, demonstrated that the Medicare system is in serious financial trouble. The program's six trustees—four of whom are Clinton appointees (cabinet secretaries Robert Rubin, Robert Reich and Donna Shalala, and commissioner of Social Security, Shirley Chater)—reported the following conclusions:

Based on the financial projections developed for this report, the Trustees apply an explicit test of short-range financial adequacy. The HI trust fund fails this test by a wide margin. In particular, the trust fund is projected to become insolvent within the next 6 to 11 years. . . (HI Annual Report, pg. 2)

Under the Trustees intermediate assumptions, the present financing schedule for the HI program is sufficient to ensure the payment of benefits only over the next 7 years. (pg. 3)

The program is severely out of financial balance and substantial measures will be required to increase revenues and/or reduce expenditures. (pg. 18)

. . . the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program. (pg. 28)

The Trustees believe that prompt, effective and decisive action is necessary. (pg. 28)

The same set of Trustees also oversees the Medicare Part B program. In their 1995 Annual Report, they wrote: ''Although the SMI program (Medicare Part B) is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. . . Growth rates have been so rapid that outlays of the program have increased 53% in the aggregate and 40% per enrollee in the last 5 years.'' (SMI Annual Report, pg. 3).

''The Trustees believe that prompt, effective and decisive action is necessary.'' (pg. 3)

Obviously, the Trustees believe that the Medicare program deserves our careful, immediate attention. The following pages present the figures that led the Trustees to their conclusions.

WHERE MEDICARE STANDS TODAY

Medicare is a huge federal program. In 1994: Medicare expenditures reached $160 billion, just over half the size of Social Security; Expenditures grew 11.4% from 1993; Eleven cents of every dollar spent by the federal government went to Medicare; Medicare represented one-fifth of total entitlement spending.

Between 1990 and 1994, Medicare grew at a 10.4% average annual rate, almost three times the 3.6% average inflation rate over the same period and twice the 5.1% average annual growth of the economy as a whole.

MEDICARE AND THE FEDERAL BUDGET

Medicare spending must be addressed as part of the solution to balancing the federal budget. That's because spending on federal entitlements—such as Medicare, Medicaid and Social Security—soared 8.4% annually on average between 1990 and 1994. Spending on discretionary, annually appropriated programs—such as defense, education and infrastructure—increased 2.2%, which is less than the rate of inflation. Coming decades will see even more pressure for entitlement growth, as the leading edge of the Baby Boom generation reaches 65 in 2011.

Entitlements are not only the fastest growing portion of the federal budget, they're already its largest component, as shown in the accompanying chart. Just over half of all federal expenditures is spent on entitlements; only a third go to discretionary programs. If we are going to balance the federal budget—and keep it in balance over the long term—entitlement reform must be part of the solution.

WHERE MEDICARE IS HEADED IF WE DO NOTHING

Under current law, Medicare is projected by the Congressional Budget Office to grow at a 10.4% average annual rate over the next seven years. In 2002, the CBO projects Medicare spending will reach $344 billion, claiming almost 16 cents of every dollar spent by the federal government.

Moreover, beginning next year, Medicare HI expenditures will exceed the program's revenues. The HI Trust fund, which at year-end 1994 held $132.8 billion, will have to be tapped to cover the projected $867 million difference.

However, according to the Trustees' Annual Report, this shortfall isn't temporary. Instead, it will balloon to be about seven times larger in 1997, which is just the following year, and more than twenty times larger by 1999. Under assumptions reflecting the most likely demographic and economic trends. 1996 will be the first year of hemorrhage that will deplete the entire trust fund by 2002—just seven years away. The optimistic set of assumptions buys us only a little time, with trust fund depletion projected in 2006. Under the pessimistic scenario, the fund is exhausted as early as 2001. In other words, within the next 6 to 11 years, it's virtually certain that Medicare will be insolvent—unless we take action.

The danger of inaction was made clear last winter when the President's Bipartisan Commission on Entitlement and Tax Reform, chaired by Sen. Bob Kerrey and then-Sen. John Danforth, issued its final report. The focus of the report was to look not years ahead, but decades ahead to assess the impact of federal budget trends. The report is sobering: Under current trends, virtually all federal government revenues are absorbed by entitlement spending and net interest by 2010, as shown in Chart 2. Deficit-financing will be required to cover almost all of the discretionary programs, including defense, health research, the FBI, support for education, and the federal judicial system.

Ten years later, the situation is worse. Growth in entitlements is so explosive that not only would the government have to borrow to pay for discretionary expenses, it would have to borrow funds to pay the lion's share of interest payments on the national debt.

MEDICARE'S IMPACT ON THE PAY STUB

In addition to detailing the projected dissipation of Trust Fund under current law, the Trustees' Report also describes the measures that would be necessary to shore up the trust fund over the next 25, 50 and 75 years. If the expenditure formulas are not altered, then preserving the trust fund can only be done through increases in the payroll tax or additional subsidies from general revenues. Table 1 illustrates the payroll tax increases that would be necessary to balance the trust fund.

CURRENT LAW

Currently, the combined (employee and employer) Medicare tax rate is 2.90%, applied to all payroll earnings. A worker earning $30,000 a year in salary or wages, for instance, is directly taxed 1.45%, or $435 annually, for Medicare Part A, the hospital insurance program. Employers then match that payment with another $435, resulting in $870 of tax revenue earmarked for the Medicare HI trust fund generated by having that worker on the payroll.

The Medicare contributions from both the worker and firm don't stop there, however. Because two-thirds of Medicare Part B (SMI) is financed through general revenues (the other third coming from Medicare premiums and interest), a portion of the worker's and the firm's general income taxes are also financing Medicare. The Trustees reported that $36.2 billion of general funds were used to pay Medicare Part B claims in 1994.

TABLE 1.—MEDICARE HOSPITAL INSURANCE PAYROLL TAXES

	Current law employee plus employer	To balance the HI trust fund over the next—					
		25 yrs.		50 yrs.		75 yrs.	
		Additional tax	Total HI tax	Additional tax	Total HI tax	Additional tax	Total HI tax
Tax rates (pct.)	2.90	1.33	4.23	2.68	5.58	3.52	6.42
Pct. increase over current law	.....	.....	45.9	.....	92.4	.....	121.4
Payroll earnings:							
$10,000	$290	$133	$423	$268	$558	$352	$642
20,000	580	266	846	536	1,116	704	1,284
30,000	870	399	1,269	804	1,674	1,056	1,926
40,000	1,160	532	1,692	1,072	2,232	1,408	2,568
50,000	1,450	665	2,115	1,340	2,790	1,760	3,210
60,000	1,740	798	2,538	1,608	3,348	2,112	3,852
70,000	2,030	931	2,961	1,876	3,906	2,464	4,494
80,000	2,320	1,064	3,384	2,144	4,464	2,816	5,136
90,000	2,610	1,197	3,807	2,412	5,022	3,168	5,778
100,000	2,900	1,330	4,230	2,680	5,580	3,520	6,420

Source (for all tables): 1995 Annual Report of the Board of Trustees. Medicare Hospital Insurance Trust Fund. Table 1.D3, page 22, Calculations and macroeconomics simulations by the U.S. Chamber of Commerce.

To Balance the Medicare HI Trust Fund for the Next 25 Years (through 2019): According to the Trustees' analysis, the hospital insurance payroll tax would have to rise from 2.90% to 4.23% (a 46% increase) to keep the HI trust fund in balance for the next 25 years. Further, the increase would have to be made immediately and maintained through the entire 25-year period.

For our $30,000/year worker for whom $870 is currently provided to Medicare HI, this increase means an additional tax of $399, bringing total annual hospital insurance payroll taxes to $1,269. And that's before any other federal and state payroll taxes (such as unemployment insurance and Social Security) or federal and state income taxes.

However, even this increase in payroll taxes still leaves the trust fund exhausted in 2019, with the oldest of the baby boomers just shy of reaching their life expectancy. Because of this demographic bulge, balancing the HI trust fund over a longer period would require even higher payroll taxes.

To Balance the Medicare Trust Fund for the Next 50 Years (through 2044): Balancing the trust fund over the next fifty years—a span long enough to see most of the Baby Boomers through their lifetimes—would require virtually doubling the hospital insurance payroll tax from 2.90% to 5.58%. The increase would have to be made immediately and remain permanent through the entire 50-year period. Again, for the worker earning $30,000 a year, the total HI payroll tax rises from $870 to $1,674, an increase of 92.4%.

To Balance the Medicare Trust Fund for the Next 75 Years (through 2069): Balancing the trust fund over the next seventy-five years—roughly through the life expectancy of an individual born this year, and the usual period for long-term fiscal solvency—would require an immediate boost in the Medicare tax rate of 121.4%, from 2.90% to 6.42%. Total HI payroll taxes for a worker earning $30,000 a year would rise from $870 to $1,926.

MEDICARE'S IMPACT ON BUSINESS

Because it's levied on employment levels, not income, the payroll tax due remains the same through both good and bad economic times. This feature accentuates the pain of a downturn on employers, who need to pay the tax regardless of profitability. Consequently, relative to the income tax, a payroll tax can be particularly punishing to start-up firms or companies trying to weather a drop in business.

Table 2 shows the liability for Medicare HI payroll taxes that would be faced by firms of various sizes. Total liability is shown under current law and under the three tax rates computed by the Trustees to bring the HI trust fund in balance over periods of 25, 50 and 75 years.

For instance, a 25-person firm where the average worker earns $20,000 per year is currently liable for a $7,250 tax payment for the Medicare HI program (for their contribution, the workers themselves would be taxed an identical amount). To balance the trust fund over the next 25 years, the combined employee and employer tax rate would have to rise from the current 2.90% to 4.23%. Assuming that the liability continues to be evenly split between the employee and employer, the firm will face an HI payroll tax of about 2.11% per worker. For our 25-person firm, the total HI payroll tax would rise from $7,250 to $10,575 per year.

TABLE 2.—MEDICARE HOSPITAL INSURANCE PAYROLL TAX ANNUAL EMPLOYER TAX LIABILITY

[In dollars]

	Number of employees—						
	5	10	25	50	100	500	1,000
Average salary: $20,000:							
Current law	1,450	2,900	7,250	14,500	29,000	145,000	290,000
To balance Medicare HI over the next:							
25 yrs	2,115	4,230	10,575	21,150	42,300	211,500	423,000
50 yrs	2,790	5,580	13,950	27,900	55,800	279,000	558,000
75 yrs	3,210	6,420	16,050	32,100	64,200	321,000	642,000
Average salary: $30,000:							
Current law	2,175	4,350	10,875	21,750	43,500	217,500	435,000
To balance Medicare HI over the next:							
25 yrs	3,173	6,345	15,862	31,725	63,450	317,250	634,500
50 yrs	4,185	8,370	20,925	41,850	83,700	418,500	837,000
75 yrs	4,815	9,630	24,075	48,150	96,300	481,500	963,000

MEDICARE'S IMPACT ON THE ECONOMY

Raising payroll taxes to keep the Medicare Hospital Insurance trust fund afloat imposes substantial burdens on both workers and firms. To measure what that means for the economy as a whole, we conducted several policy simulations using the highly respected Washington University Macro Model from Laurence H. Meyer & Associates of St. Louis, MO.

The results are striking: The economy would suffer through sharply slower economic growth and higher unemployment in the near term. Over a longer period, the economy is saddled with a permanent loss of production and employment. As shown in Tables 3 and 4, the degree of severity for GDP and employment depends upon the increase in Medicare taxes enacted.

The tables compare each of three alternative tax simulations specified in the Trustees' Annual Report to LHM&A's June 1995 baseline forecast. To demonstrate the policy change working its way through the economy, we display the results for three of the ten years of our simulation: 1997, 2000 and 2004. This gives us snapshots of the short-term, intermediate-term and long-term impacts on economic output and employment. In each case, the imposition of the Medicare payroll tax increase takes place in the fourth quarter of 1995.

TABLE 3.—IMPACT ON GROSS DOMESTIC PRODUCT

[Balancing the HI Trust Fund Through Raising Payroll Tax Rates]

Years to balance HI trust fund	Required Medicare tax rate (pct.)	Difference from baseline in given year, billions of 1987 dollars			Percent difference from baseline in given year		
		1997	2000	2004	1997	2000	2004
25 Years	4.23	−68.4	−30.1	−36.1	−1.2	−0.5	−0.5
50 Years	5.58	−137.1	−60.5	−72.1	−2.4	−1.0	−1.1
75 Years	6.42	−179.4	−79.4	−95.6	−3.1	−1.3	−1.4

As shown in Table 3, if the government imposed the most modest payroll tax increase—enough to keep the Medicare trust fund in balance for the next 25 years—production in the economy would be 1.2%, or almost $70 billion, lower in 1997 than it would have been otherwise. By 2000, the percentage-point gap between the alternative closes to within 0.5% of the baseline level of production, but that distance is maintained even ten years after the tax increase took effect.

The short-term loss in output translates into 1.2 million fewer jobs relative to what we would have had otherwise, as shown in Table 4. While this decline, amounting to about 1% of the economy's jobs, moderates over time, the economy appears to have lost over 0.5% of its jobs permanently.

Of course, all of this economic turbulence puts the Medicare HI trust fund in actuarial balance for only the next 25 years. To generate long-term actuarial balance for the full 75-year period, the Medicare payroll tax rate would have to jump from 2.90% to 6.42%, triggering even stronger economic impacts than those described above. Production in the economy would be about 3% lower in 1997 than it would have been otherwise, with the long-term loss in output projected at 1.5%. Over 3 million jobs would be eliminated in 1997 relative to the baseline, with a projected permanent loss of about 1.5% of total employment over the long term.

TABLE 4.—IMPACT ON EMPLOYMENT

[Balancing the HI Trust Fund Through Raising Payroll Tax Rates]

Years to balance HI trust fund	Required Medicare tax rate (pct.)	Difference from baseline in given year, millions of jobs			Percent difference from baseline in given year (pct.)		
		1997	2000	2004	1997	2000	2004
25 Yrs	4.23	−1.2	−0.6	−0.8	−0.9	−0.4	−0.6

TABLE 4.—IMPACT ON EMPLOYMENT—Continued

[Balancing the HI Trust Fund Through Raising Payroll Tax Rates]

Years to balance HI trust fund	Required Medicare tax rate (pct.)	Difference from baseline in given year, millions of jobs			Percent difference from baseline in given year (pct.)		
		1997	2000	2004	1997	2000	2004
50 Yrs	5.58	−2.4	−1.2	−1.6	−1.9	−0.9	−1.2
75 Yrs	6.42	−3.2	−1.5	−2.2	−2.5	−1.2	−1.5

As dramatic as these figures are, there's good reason to believe that they are optimistic estimates. Because the macro model used in these simulations treats the Medicare payroll tax like the Social Security payroll tax, the increases in the tax rates apply only to the first $61,200 earned (in 1995, and rising afterwards). That is, the model is not picking up the economic impact of applying the higher tax rates to incomes over the taxable base. Thus, these results should be considered a minimum measure of the economic impact of raising Medicare payroll taxes. Attempts to account for this problem yield significantly greater job loss and lower GDP. These results are available from the Economic Policy Division of the U.S. Chamber of Commerce.

It is important to note that, even with the set of numbers presented here with its inherent bias toward underestimating the economic impact, we can see that using payroll taxes to balance the Medicare trust fund imposes severe costs on the U.S. economy. These results clearly indicate that the Medicare problem must be solved by fundamental program reform, not tax increases.

U.S. CHAMBER OF COMMERCE—MEDICARE FAX POLL RESULTS

On October 11, 1995, the U.S. Chamber surveyed 9,700 business, chamber and association members on their attitudes concerning Medicare reform and specific reform elements. Responses to the Chamber survey (nearly 10 percent responded, 68.9% of which employ fewer than 50 workers) indicated strong support for market-oriented Medicare reform comparable to the House and Senate Majority plans for Medicare reform. The complete survey and results are provided below.

Medicare is ''severely out of financial balance and the Trustees believe that . . . prompt, effective and decisive action is necessary.''

Medicare reform has become a focal point of the budget debate. Medicare—the national health insurance program for seniors—will run out of money in seven years, according to the system's trustees. Spending on Medicare and other entitlements threatens to crowd out all other budget priorities and increase the budget deficit.

Previous approaches to Medicare reform have failed to slow Medicare's growth. Worse, these approaches have increased the burden on businesses and their employees through higher payroll taxes and higher insurance premiums.

Since 1970, Congress has raised payroll taxes over 20 times and the Trustee's Report pointed out that payroll taxes would have to be raised by another 1.3 to 3.5 percentage points to bring the system into balance. When you consider that many small and medium size businesses already pay more in payroll taxes than income taxes and that payroll taxes must be paid regardless of economic conditions, it becomes clear why Medicare requires solutions other than tax increases.

We need your help. Please review the following questions on Medicare reform and FAX back your answers by close of business October 16.

1. Medicare should be modernized by adopting the market-based strategies private employers and health plans are using successfully to improve health care quality and control costs. These strategies include improving the quality of care provided to enrollees, increasing enrollee choice by expanding health plan options, and reducing the rate of growth of Medicare spending.

Agree, 98.9 percent; Disagree, 0.6 percent.

2. Two competing approaches to Medicare reform have emerged in Congress. One more limited approach addresses the Medicare Part A trust fund, delaying insolvency for an additional two years through $89 billion in Medicare savings, primarily from reducing the rate of growth in Medicare payments to providers. A second approach is more comprehensive in nature, addressing both Medicare part A (hospital bills) and Part B (doctors bills). Medicare Part A would be protected at least an additional 10 years through $270 billion in Medicare savings achieved through increased competition and reducing the rate of growth in Medicare payments to providers. Which approach would you favor?

Limited, 4.3 percent; Comprehensive, 94.6 percent.

3. Do you favor or oppose the following elements of Medicare reform?

a. Provide seniors choices between competing health plans including existing fee-for-service benefits.

Favor, 97.4 percent; Oppose, 1.6 percent.

b. Contain Medicare spending by increasing competition and reducing the rate of growth in Medicare payments.

Favor, 97.4 percent; Oppose 2.0 percent.

c. Increase managed care options for seniors.

Favor, 93.8 percent; Oppose, 4.3 percent.

d. Provide seniors a medical savings account option.

Favor, 88.2 percent; Oppose, 7.3 percent.

e. Allow provider groups (i.e., doctors and hospitals) to offer health coverage (similar to managed care networks) directly to seniors—a new proposal known as provider sponsored networks or PSNs.

Favor, 91.9 percent; Oppose, 5.7 percent.

f. Require managed care plans to provide out-of-network benefits at a higher cost to the beneficiary.

Favor, 72.4 percent; Oppose, 18.2 percent.

4. For purposes of tabulation: Type of Organization: Business, 93.2 percent; Chamber, 4.3 percent; Other, 2.0 percent. Approximate Number of Employees: under 10, 29.4 percent; 10–49, 39.5 percent; 50–99, 12.5 percent; 100–249, 8.6 percent; 250–499, 3.7 percent; 500–4,999, 3.7 percent; 5,000 +, 1.4 percent.

U.S. CHAMBER OF COMMERCE

MEDICARE REFORM—THE RIGHT SOLUTION

Medicare reform is at the crux of the balanced budget battle. Medicare—the national health insurance program for seniors—will run out of money in seven years, according to The Board of Trustees. Spending on Medicare and other entitlements threatens to crowd out all other budget priorities and increase the budget deficit.

Previous approaches to Medicare reform have failed to slow Medicare's growth. Worse, these approaches have increased the burden on businesses and their employees through higher payroll taxes and higher insurance premiums.

Since 1970, Congress has raised payroll taxes over 20 times and the Medicare Trustees 1995 Report pointed out that payroll taxes would have to be raised by another 1.3 to 3.5 percentage points to bring the system into balance. When you consider that many small and medium-sized businesses already pay more in payroll taxes than income taxes and that payroll taxes must be paid regardless of economic conditions, it becomes clear why Medicare requires solutions other than tax increases.

The House and Senate Majority has proposed market-oriented alternatives to traditional Medicare reform, an approach that modernizes the 30-year old Medicare program by increasing competition while restraining the growth in spending. Key elements include:

New choices for Medicare beneficiaries.—Beneficiaries will have the right to choose traditional Medicare, as well as the right to choose from a range of private health plan options including managed care and medical savings accounts. These options will provide beneficiaries access to expanded benefits—such as prescription drugs, preventative care, vision and hearing care.

Restrained growth in Medicare spending.—Increases in Medicare spending are inevitable, given the growing Medicare population and the advance of medical technology. However, controlling the rate at which Medicare spending increases is as important to our nation's future financial health as Medicare itself is to seniors' health care. Introducing competition to Medicare through beneficiary choice of health plans will help control costs and allocate resources more fairly and efficiently than Washington bureaucrats.

Accountability.—The Republican plan allows seniors to take responsibility for making their own health care decisions. Instead of relying on a bureaucratic, one-size-fits-all approach, seniors will decide which health plans are best for them. Doctors and hospitals are also held accountable. The bill rewards beneficiaries who report incidences of waste, fraud and abuse, and strengthens penalties for anyone who defrauds Medicare.

By passing this legislation Congress will have taken timely, critical action that will avert the program's bankruptcy and preserve and protect it for current recipients and future generations.

MEDICARE REFORM

MYTHS VS. FACTS

Myth. The House and Senate Republican Medicare reform plans will cut $270 billion from Medicare in order to finance a tax cut for the wealthy.

Fact. The Medicare Trustees' 1995 Annual Report urged Congress to take ''prompt and decisive action'' to address the solvency of the Medicare Part A (hospital insurance) Trust Fund and the continued growth of Medicare Part B (supplemental medical insurance).

The House and Senate Majority has proposed market-oriented alternatives to traditional Medicare reform, an approach that modernizes the 30-year-old Medicare program by increasing competition while restraining the growth in spending. Under the Republican plan, spending per beneficiary will still *increase* 40% by 2002 ($4,800 to $6,700).

Tax cuts provided for in the budget resolution were considered and passed independent

of Medicare. Whether or not taxes are cut, Medicare will still go broke in 2002.

Myth. It's not fair for Congress to take away benefits from seniors who have faithfully paid into the system.

Fact. The average Medicare beneficiaries receive far more than they put in. The average two-earner couple receives $117,200 more in benefits than it contributes to the program. The average single-earner couple receives $126,700 more.

By encouraging competition among private health plans based on quality and innovation, the Republican plan may lead to increase benefits.

Myth. The business community is a latecomer to the Medicare debate.

Fact. Medicare's influence is felt throughout the business community—from payroll taxes paid to finance the system to insurance premiums inflated by consistent shortfalls in Medicare reimbursements to providers who in turn shift the cost to private health plans.

Myth. Medicare is in trouble because doctors and hospitals charge too much. The Republican plan fails to address this problem.

Fact. Solving the Medicare crisis will require the participation of all—doctors, hospitals, seniors and other taxpayers—particularly the business community. Just as no one factor led to the Medicare crisis, a single-minded focus on providers won't get us out. Further, cost controls have failed miserably whenever they have been tried—particularly in the context of health care.

ECONOMIC ACTIVITY AND JOB CREATION IN PUERTO RICO

Mr. DOLE. Mr. President, as the Congress moves toward final action non budget reconciliation legislation for this year, I want to call special attention to an initiative by Gov. Pedro Rossello of Puerto Rico which seeks to establish a wage credit-based economic program as an alternative to the current law section 936 tax credit.

Neither the House nor Senate was able to give the Governor's proposal an extensive examination before either body adopted revisions to the section 936 credit. Together with my colleague from New York, Senator D'AMATO, I was pleased to ensure that the Senate version more appropriately recognizes the positive impact that many U.S. companies have on the Puerto Rican economy and the jobs they provide.

I commend Governor Rossello's efforts to enhance economic opportunity in Puerto Rico through the creation of new jobs, and I would hope that the Congress will continue to give serious consideration to the Rossello program as an alternative to programs such as under section 936. It is important to ensure that any program focused on Puerto Rico will create new jobs and encourage self-reliance and economic growth.

ANWR

Mr. LIEBERMAN. Mr. President, the Arctic National Wildlife Refuge has been managed as one of the great wilderness systems on this continent since the Eisenhower administration. It is on par with other great places in our natural history, including the Grand Canyon, Yellowstone, Jackson Hole, the Badlands, Glacier Bay, Denali, and others. Opening the Arctic Refuge to oil and gas development violates our stewardship commitment to future generations, fails to use common sense about balancing the budget, and destroys a highly threatened piece of our American heritage. This is a unique and treasured land that must serve our entire Nation for the next century, not just a few for the next few years.

Unnecessary development of significant Federal lands like the Arctic Refuge is not the way to balance the budget. The amount of oil that can potentially be recovered from the Arctic Refuge is simply too small to affect our energy security, and too destructive to the environment, to be worth it. The U.S. Geological Service estimates a 95-percent chance of only 148 million barrels of oil in the refuge. The Congressional Budget Office assumed 3.2 billion barrels in its budget scoring of oil and gas leases, more than 20 times this recent USGS estimate. Worse yet, CBO assumed oil prices of $38.60 in 2000, compared to Energy information administration estimates of only $19.13—less than half.

And, it is possible that 90 percent of the lease revenues could go to Alaska instead of balancing the Federal budget. Under the most favorable scenario, only 50 percent of the revenues go to balancing the budget.

Clearly, the $1.3 billion we have been promised by CBO in return for developing this pristine area is a massive fiction, like so many other bogus asset sales in this budget. The OMB has estimated oil and gas revenues more realistically to be between $750 million and $850 million, assuming Alaska does not sue for a 90-percent split. If the State does, these revenues fall another 40 percent.

We all hope for another strike like Prudhoe Bay. But the simple reality, based on the very best geological science and economics available today, is that the next Prudhoe Bay is expansion of Prudhoe Bay itself, and the continued implementation of national energy conservation programs. The next major source of energy is not a long-shot wildcat strike in an undeveloped Alaskan wilderness area, and it is incorrect to suggest otherwise. And it is ironic that we would consider opening this refuge to oil drilling now that the oil export ban will be lifted, as the House and Senate have voted to do. If the ban is lifted, a substantial percentage of the oil that is recovered, if any, would be exported to Asia, according to the Cato Institute, the Congressional Research Service, and others. The Arctic Refuge oil supplies would do almost nothing to help our energy security.

Make no mistake, environmental impacts to the refuge would be severe and irreversible. The Arctic National Wildlife Refuge includes the calving grounds for one of the largest caribou herds in North America, the porcupine herd of 152,000. It supports several thousand native Americans whose hunter-gatherer culture depends directly on it today as it has for 20,000 years. Over 200 species of plants and animals thrive in the refuge, including Muskoxen, Snow Geese, Arctic Foxes, Arctic Grayling and Arctic Char. It is the only natural area in the United States with all three species of North American bears—the black bear, the grizzly bear, and the polar bear. It is one of the most pristine areas in our Nation, untouched by development, and the last of its kind. Environmental studies repeatedly show that oil development is not compatible with the protection of these resources. Biologists from Federal and State agencies and universities conclude that oil development will harm the calving success of the caribou herd, and reduce its long term numbers very significantly.

The remaining 90 percent of the Alaskan North Slope is already open to oil and gas leasing. Is it too much to protect what little we have left? Let us honor our history of conservation, and the future of generations to come, by protecting this last Arctic Refuge.

I ask unanimous consent that a letter from the President on this subject be printed in the RECORD.

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

THE WHITE HOUSE,
Washington, October 26, 1995.

The Hon. JOSEPH I. LIEBERMAN,
U.S. Senate, Washington, DC.

DEAR JOE: Thank you for your letter today seeking my views on striking the provision in the reconciliation bill that would open the coastal plain of the Arctic National Wildlife Refuge [ANWR] to oil and gas drilling.

Because you stated that the Senate is expected to vote on that motion in the near future, let me be clear: I will veto any reconciliation bill that opens ANWR to drilling. Consequently, I strongly support your and your colleagues' efforts to remove this provision from the bill. In my view, this is one of the most significant environmental votes facing Congress, posing a clear choice between protecting a unique, biologically-rich wilderness and pursuing a misquided energy policy.

I appreciate and support your efforts to preserve ANWR.

Sincerely,

BILL.

Mr. LEVIN. Mr. President, I voted against the combined Harkin and Dorgan amendments. The constraints imposed by the rules under which the budget reconciliation bill is being considered create an absurd situation in which important, complex, and difficult amendments are decided without debate. In addition, because a long stack of votes are occurring at 7½ minute intervals, there is little time to properly consider each provision. This is exacerbated when amendments are quickly patched together with little warning on the floor.

In this case, I oppose the capital gains portion of the Dorgan-Harkin combined amendment. While I do favor capital gains reform, focused on long-term capital gains investment, in my view, the provision goes too far by imposing a lifetime limit of $250,000 on capital gains deductions. The Tax Code

is complex enough without adding a restrictive difficult to administer, lifetime provision such as this.

I do support the Harkin portion of the amendment which attempts to further restrict the so-called Benedict Arnold loophole.

Because the two amendments were joined together on the Senate floor, I could not vote on one and against the other. Therefore, I voted no on the amendment.

Mr. FRIST. Mr. President, I would like to speak briefly in support of the antitrust reform provisions of section 15021 of the House Medicare bill. While these provisions are not in the Senate Medicare bill, they are important, because they permit doctors to form Provider Service Networks without having to go through an institutional intermediary such as another HMO or an insurance company. I urge my colleagues to support the provisions when this bill goes into conference, as they are modest antitrust law reforms that will improve the quality and lower the cost of our health care system.

I would first like to discuss how the House Medicare bill defines a Provider Service Network (or, as it is more commonly known, a ''PSN''). In the House Medicare bill, a PSN is one of the new organizations that provides Medicare beneficiaries with an option called MedicarePlus. That option allows a beneficiary to select a health plan called a MedicarePlus Product that would be offered by a MedicarePlus Organization. A MedicarePlus Organization is a private sector organization, such as an HMO, that offers a health plan that meets Federal Medicare standards. A Provider Sponsored Organization is a type of MedicarePlus Organization which is owned and operated by affiliated providers, such as hospitals and physicians. A PSN is an organization owned and operated by providers that contract with a Provider Sponsored Organization to provide services to Medicare beneficiaries.

Current antitrust law effectively makes it automatically illegal for a group of physicians to set up a PSN or Provider Sponsored Organization, yet permits insurance companies, HMO's and other nonphysicians to do so. This does not make sense.

Why do we want to reform the antitrust restriction so that physicians can form PSN's and directly compete with insurers and HMO's for Medicare beneficiaries? Because permitting physicians to do so will bring physicians to the table and will encourage increased competition that will provide Americans with better quality health care at a lower price. By permitting physicians—rather than just accountants—to oversee the treatment systems, Medicare beneficiaries will receive better quality care. By removing an insurance company's significant administrative costs from the picture, Medicare beneficiaries will likely see more of their health care premium dollars go to patient care and less to overhead.

It should be made clear that section 15021 of the House bill does not exempt physician networks from antitrust law. I, for one, would oppose it if it did. I too believe that physicians must be held accountable under the antitrust laws if they in any way engage in anticompetitive price fixing.

Under the House Medicare bill, physician networks would remain subject to all of the antitrust statutes that currently exist. The only limitation on antitrust enforcement is that physician created networks which meet the standards for PSN's (as set forth in section 15021(b)(6) of the House bill) would not be considered automatically unlawful. If the formation or operation of these networks can be shown to harm competition, then the DOJ, FTC, or a private party could challenge them. This is precisely the same rule which applies to the formation and operation of joint ventures in other industries in America. This provision does not exempt physician networks from the law. It holds them accountable for their actions, while giving them the opportunity to compete.

I again urge all of my colleagues to support the antitrust provisions of section 15021 of the House Medicare bill.

Mr. HATCH. Mr. President, while we are considering the manager's amendment to S. 1357, the Balanced Budget Reconciliation Act, I want to take this opportunity to comment on the health provisions contained within the bill and on some of the changes made therein.

First of all, I know there is a great deal of consternation about the impact of the reductions in spending growth for Medicare and Medicaid contained within this bill.

Medicare and Medicaid have been tremendously successful programs by anyone's measure, providing life-saving and life-sustaining services to literally millions of persons over the last three decades. These programs need to be continued.

What we cannot continue, though, is the high rate of growth in these entitlement programs. This growth, quite simply, is contributing significantly to the deficit situation which is bankrupting our country.

Mr. President, there is no disagreement on either of these points.

As I see it, the question before us today is not whether to act but, rather, how to act.

The question is not ''Why?,'' as some assert, but rather the more critical ''Who, what where, when, and how?'' we bring these programs under fiscal control while preserving vital services for the people who need them.

It is clear that we are poised to act on a bill with very far-reaching ramifications. This is not a responsibility I take lightly.

Indeed, the prospect of reforming programs which have become such an integral part of America's health care delivery infrastructure over the past 30 years is a daunting one. The implications are enormous—enormous for all participants in the health care system, be it patients or those who provide services to patients.

Consider how intertwined the Medicare and Medicaid programs have become with our health care delivery system.

A whole generation of facilities has been built based on funding from the Federal Government. A whole generation of health care professionals has been trained with funding from the Federal Government, with many academic health institutions continuing to rely heavily upon Medicare graduate medical education funds for their viability. Facilities providing care to the underserved in both rural and urban areas count on Medicare revenues to keep from closing their doors. And, coverage policy in many private health care plans and our military health care system have been designed around Medicare policy.

Viewed from another perspective, more than a generation of Americans has come to rely on the vital services provided under Medicare and Medicaid. This is true for our seniors and disabled who are eligible for Medicare, and for the pregnant women and children, the aged, the blind, and the disabled who receive services under Medicaid.

The prospect of the reforming this system can be threatening to all I have mentioned, because it represents a change, a change from the norm we have all come to accept.

But I ask you to consider how different the America of 1995 is from the America of 1965. The health care of today is very different from that of 30 years ago. We have come a long way. Life expectancy has improved dramatically thanks to the fruits of medical research and technology. Fee-for-service medicine is no longer the only option for delivery of services.

But we have paid a heavy price for those improvements. Continued increases in health care costs run rampant have fueled the deficit, and have priced health care out of the reach of many, with a concomitant impact on the Medicaid roles and the States' ability to provide services.

I implore my colleagues to see the changes in this bill today as an opportunity to make the system better and more responsive to our national needs, needs which extend beyond health care services to, indeed, the health of our country as a whole.

The deficit situation cannot be ignored any longer. It is unfair to our children, and to their parents and grandparents.

The alternative to change is foreboding. The costs of these entitlement programs is running out of sight, endangering the future viability of the programs as well as the Federal and State budgets. By all recognition, Medicare's hospitalization trust fund could go bankrupt, starting as early as next year. The work of the Medicare

Trustees, reinforced by testimony the Finance Committee heard from the former Chief Actuary of Medicare, Guy King, indicates that we will need at least $165 billion for the hospitalization fund alone to stave off bankruptcy by 2002. Payment for physician services under Medicare, funded 68.5 percent from tax revenues, is rising in double digits.

Medicaid spending also remains troublesome.

The Congressional Budget Office has estimated that the Federal share of Medicare will grow over 10 percent a year between now and 2002, about three times the projected rate of inflation.

The changes made in S. 1357 are a good start to resolve these problems.

For Medicare, the bill provides greater opportunity for seniors and the disabled to participate in innovative coordinated care programs, many offering the possibility of benefits beyond the traditional Medicare package such as preventive services, eyeglasses, and prescription drugs.

It is clear that the health care marketplace has been undergoing dramatic changes over the last several years and that further changes will occur.

As new types of provider organizations and reimbursement practices have evolved over recent years, many observers note that the traditional doctor-patient relationship is being redefined.

There are complex and novel issues presented by the introduction of many new nonphysician decisionmakers in the care of patients.

Tensions often are apparent between the twin goals of providing high quality care and providing this care at reasonable costs. That became evident in our consideration of S. 1357, as we struggled to make certain that the bill afforded Medicare beneficiaries the opportunity to participate more in the medical marketplace, while still maintaining a marketplace which allows doctors, nurses and other health care professionals to continue to practice traditional medicine.

There is no doubt that coordinated care offers abundant opportunities for our citizens, including those who participate in the Medicare and Medicaid programs, to receive quality health care services in the most cost-effective setting.

On the other hand, as we enter this new era in which managed care becomes the norm, it is imperative that the overriding goal be to save lives, not dollars.

What I am saying is that managed care is an important option in the health care delivery continuum, but so is traditional medicine.

Fee-for-service medicine must be maintained as an option for patients who are more comfortable with that kind of care, as well as for providers who do not wish to join the managed care environment.

One of the major innovations in this reconciliation bill is that it will encourage the further participation of Medicare enrollees in managed care plans. A key feature of the legislation is that it allows individuals to choose the type of health care delivery system which best meets their needs. This bill allows American citizens, not the Federal Government, the freedom to make this choice.

I think it critical that Medicare beneficiaries be allowed to choose the provider of their choice, if this is important to them. In fact, the bill contains a provision I authored which will make certain that beneficiaries are provided with the information they need to gauge whether the Choice plan they contemplate joining allows them this freedom.

At the same time, I do not think it is fair for the Congress to require that all plans mandate this option, since participants in Medicare do have flexibility under the current bill.

I also want to note, in turn, that health care providers will face individual choices with respect to which type of health care delivery system best meets their career plans. Some will prefer a managed care environment, while others will not. They, too, must have the freedom to make that choice.

And that freedom must not be in name only.

For some time, I have been concerned that we are destroying the incentives providers have to practice good medicine in America. Liability concerns, cost constraints, regulations which impede technology development, change in medical education reimbursement—all these can have a stifling effect on the ability of health care professionals to be satisfied with the work environment.

That is one reason I was so pleased about the House inclusion of a medical liability reform proposal. Medical liability reform is something I have been fighting for for some time, and I am pleased at the House action.

We had a good deal of debate about this ''creative tension'' in the health care delivery system during development of the physician service network (PSN) provision contained in this bill. Doctors and hospitals were rightly concerned that because of time-consuming state certification requirements, they would not have the ability to form networks to compete as providers under the new choice plans.

On the other hand, insurers were equally concerned that we not create a system which put them on an uneven footing, by allowing certain organizations to escape the solvency requirements and antitrust requirements in current law.

The challenge we face is to find the right balance between two competing interests—our intention to provide seniors with real health care choices, especially in rural areas, and our interest in making sure that those who provide that care have the incentives to do so, but to do so with accountability. I am satisfied that the bill before us meets these goals, but I will be monitoring its implementation carefully to see that it continues to measure up.

The bill before us today also provides beneficiaries with the option of establishing medical savings accounts, something I have long favored.

Under the proposed legislation, Medicare recipients would have new options, including the choice to remain in the traditional Medicare program, enroll in a health maintenance organization or select a high-deductible health insurance plan with a Medical Savings Account [MSA].

I support the MSA provisions in the pending bill and hope they will remain in the final measure as signed into law.

MSA's are personal, individual accounts used to pay for routine and preventive health care and are combined with high-deductible, catastrophic health insurance that pays for major expenses. Beneficiaries pay all medical bills up to the deductible with the MSA and out-of-pocket funds. Catastrophic insurance pays all expenses above the deductible.

Among the benefits of MSA's for seniors will be that they will have first-dollar coverage for such services as primary and preventive care, in contrast to Medicare, which has deductibles and copayments. Seniors could use their MSA's for items not covered by Medicare, such as eyeglasses and prescription drugs. In addition, patients would have incentives to make prudent choices because they would have a larger voice in deciding how their health care dollars were spent.

Medical Savings Accounts incorporate sound economics while encouraging individual responsibility and choice.

Mr. President, I want to point out that, contrary to many reports, the Balanced Budget Reconciliation Act does not cut Medicare spending. It does not reduce benefits. It does not breech our contract on Medicare.

And contrary to the assertions of many, Medicare spending will increase each year under this budget. It will rise from $181 billion this year, to $277 billion on fiscal year 2002, a $96 billion or 53 percent increase. Expressed differently, Medicare benefits will increase from an average of $4,800 per person this year, to $6,700 in fiscal year 2002, hardly a cut.

For Medicaid, S. 1357 allows a 5 percent rate of growth over the next 7 years, with the program rising from $157 billion this year to about $220 billion in 2002. I don't believe this increase of 40 percent can be termed a ''cut'', either.

Many of my constituents have visited with me, offering both praise and criticism about the provisions in this bill.

On a positive note, I have received much positive feedback about the provisions in this bill which inject a greater measure of private market competition in Medicare. I have received warm endorsement of the provisions in the bill which allow the States to tailor

their Medicaid programs to their own individual needs. In particular, many in my home state are pleased about the opportunity to work cooperatively together with our Governor to craft a Medicaid program which meets the needs of Utahns, not the needs of those in states across the Nation.

I have been troubled for some time about the inflexibility of the Medicaid program, and the innumerable, burdensome requirements placed on the programs at the Federal level. This has served to drive up costs, as well as to hamstring innovators such as our Governor, Mike Leavitt, who have some wonderfully creative ideas on how to deliver services in a cost-efficient manner.

I recall the story Governor Leavitt related to me about the Medicaid waiver he was trying to submit to the Health Care Financing Administration. Utah had determined that it could provide services to more citizens if it restricted the dental benefit to children and adult emergencies. HCFA turned him down cold.

Later, at a briefing with my staff, HCFA said they had not turned any states down on coverage requests such as this. When queried, they admitted that they had told the state not even to submit the request, because it would be turned down.

This bureaucratic gamesmanship is a prime example of why Utah should not have to seek approval from Washington of its State Medicaid plan. The changes made in this bill, which will allow Utah to design its own coverage program without a federal waiver—with continued coverage for the aged, disabled, and pregnant women and children—are in important step and a needed step.

That being said, I want to acknowledge openly and frankly my understanding of the tremendous unease the prospects of major change cast upon our citizenry.

This is a natural reaction to change.

I make the pledge that if we receive evidence that these reforms are not working, I will do everything I can to seek an immediate legislative solution in this Chamber.

I want to make that perfectly clear.

I, too, am not completely satisfied with each and every provision, as I will discuss in a moment. I am hopeful that in the conference we can improve these provisions.

But first of all, I want to discuss how the changes in this bill affect Native Americans. This is a subject in which I have a great interest.

NATIVE AMERICANS

Mr. President, I am especially pleased that the pending legislation contains needed provisions, which I sponsored in the Finance Committee, relating to the impact of Medicare and Medicaid reform on Native Americans.

As we debate this important legislation, I want to be sure that we do not lose sight of how these reforms will affect Indian Country.

And, I would point out to my colleagues that Congress has recognized the severely depressed health conditions existing among Native Americans. But there is a need to do more.

The current health status of Native Americans and Alaska Natives remains disproportionately low compared to the rest of the population. The Native American (IHS Service Area) age-adjusted mortality rates remain considerably higher than for the rest of the U.S. population.

Between 1989 and 1991 the mortality rates for Native Americans were 440 percent greater for tuberculosis; 430 percent greater for alcoholism; 165 percent greater for accidents; 154 percent greater for diabetes mellitus; and 46 percent greater for pneumonia and influenza.

These rates are simply unacceptable. The bottom line is this: per capita spending for Indian health care is approximately one-half that of the national average. In 1992, the U.S. National Health Expenditures per capita was $3,155 compared with an IHS Health Expenditures per capita of $1,489.

The Native American provisions contained in this bill serve to reaffirm our Nation's commitment with respect to Medicare and Medicaid reimbursement for Indian Health Service programs.

In effect, these provisions will help ensure that Indian health care continues to improve even as the Medicare and Medicaid programs undergo reform. Given the limited budget within which the Indian Health Service (IHS) and tribes must operate their health care programs, third-party income such as Medicare and Medicaid collections allow the IHS to supplement their already limited Federal appropriation.

The IHS estimates that it will collect $54,250,000 in Medicare and $120,750,000 in Medicaid reimbursements in fiscal year 1995. These collections allow the IHS and tribal programs to improve the conditions of their facilities and free-up financial resources to provide critical health care services which they could not otherwise provide.

In fiscal year 1995, Medicaid funds were used to pay the salaries and benefits for 1,379 FTEs. These staff positions include physicians, nurses, pharmacists, lab technicians, and support staff. The loss of Medicaid funds would mean that these health care providers would have to be laid off due to a lack of money to pay salaries and benefits.

The impact of the loss of this money would be tremendous because these funds supplement direct clinical care to Native Americans and Alaska Natives. It would result in the closure of critical inpatient services in some of the most remote parts of the country. The outcome would be truly devastating to the already poor health status of Native Americans.

Under existing law, IHS facilities like other health care providers are eligible to receive Medicaid and Medicare payments for services provided to eligible Indians. The provisions I sponsored will ensure that these arrangements remain in place in the new world of reformed Medicaid.

In addition, my language expands coverage to tribally owned and operated health care facilities as well as urban Indian organizations that serve Medicaid eligible Indian patients.

Approximately 1.4 million Native Americans receive health care services from the IHS and from Indian owned and operated health care facilities.

In an effort to address the poor health conditions of Native Americans and because of the fact that Indian health programs are almost entirely dependent upon Federal appropriations, Congress made two exceptions to allow the IHS and tribal health facilities to participate in the Medicare program and use their reimbursements to improve facility conditions.

First, Congress made an exception to the general ban against payments to Federal providers of services for IHS and tribal health providers pursuant to Section 401 of the Indian Health Care Improvement Act and Section 1880 of the Social Security Act.

Second, Congress made an exception to the requirement that the IHS and tribal health facilities meet all of the conditions and requirements for participation in the Medicare program, as long as those facilities provided the Secretary with a plan for achieving compliance.

Pursuant to Section 1880 of the Social Security Act, hospitals and skilled nursing facilities owned by the IHS may receive reimbursement from Medicare for services provided to eligible Indians.

Pursuant to Section 1861(aa)(4)(D) of the Social Security Act outpatient facilities that are owned by the IHS are eligible to be Federally Qualified Health Centers and participate in the Medicare program but only if those facilities are operated by tribes or tribal organizations under the Indian Self-Determination and Education Assistance Act, or by urban Indian organizations.

Tribally-owned health care facilities are able to participate in the Medicare program subject to the same conditions and requirements as any other provider in the State in which those facilities are located.

As this bill moves through the legislative process, I hope these provisions can be maintained, because I believe we should do all we can to enhance the level of health care provided to Native Americans through the Medicare and Medicaid programs. I thank my colleagues on the Finance Committee and the Committee on Indian Affairs for their support and assistance in developing these important provisions.

Another issue in which I have a great interest is the Federal effort to prevent health care fraud.

FRAUD AND ABUSE

The problem of health care fraud and abuse is certainly one of the most troubling aspects in our Nation's health care delivery system. By most estimates, the costs of health care in the

United States approach $1 trillion annually. By the turn of the century, the figure will exceed $1.5 trillion annually, consuming up to 16 percent of the Nation's gross domestic product.

Even by most conservative estimates, billions of dollars are lost to waste, fraud and abuse. Health insurance experts, the FBI and other agencies agree that fraud and abuse account for as mush as 5 to 10 percent of total health care expenditures. As much as $27 billion taxpayer dollars are lost to fraud and abuse in the Medicare and Medicaid programs. These losses are clearly not insignificant.

Clearly, the Federal Government must take steps to put a halt to the deliberate and unscrupulous act of defrauding individuals, health care providers, and State and Federal Governments in the provision of health care.

The anti-fraud and abuse provisions contained in this legislation essentially represent the provisions contained in S. 1088, which was developed by our colleague from Maine, Senator COHEN.

I am extremely pleased that the final compromise addressed my concerns about provisions in S. 1088 which would have authorized the use of health care fraud related fines and penalties to finance investigative and enforcement efforts of the HHS IG's Office and efforts at the Justice Department.

I have long opposed this so-called bounty hunter provision, as I strongly feel it would create an incentive for Federal investigators to forgo prosecution or exclusion where warranted in favor of large civil penalties that would provide additional funding for investigators.

Under the new language as contained in the bill, all penalties, fines and damages collected will be deposited into the Medicare trust fund. Under this arrangement, the original purpose to strengthen the financial solvency of the Medicare program is further achieved. I strongly believe this approach serves to address my concerns as well as ensuring the integrity of the anti-fraud and abuse provisions.

I do have remaining concerns, which I will work to address in conference.

First, I would note that the bill does not uniformly punish those who would attempt to defraud a health care plan or provider or those who would conspire with others to do so. Nor does it appear to criminalize attempts or conspiracies to embezzle.

I think it is vitally important that those who conspire with others to cheat our health care plans should be punished to the full extent of the law. Otherwise, a conspiracy to defraud or embezzle will be uncovered before the crime is actually completed. Those situations should be addressed by this statute.

Second, while we provide for the forfeiture of property, real or personal of persons convicted of health care fraud, it is unclear whether the bill would also permit the forfeiture of the fraudulently obtained proceeds. While it is certainly important to obtain fraudulently obtained property, it is even more vital to divest criminals of their unlawfully obtained proceeds. We must be careful to craft legislation that will destroy the financial incentive for criminals to abuse our health care system.

In the same vein, the bill only permits forfeiture of property from persons actually convicted of a crime. Thus, if someone perpetuates a fraud against a health care plan or provider, and then flees outside the jurisdiction of the United States, it may be difficult to obtain their ill-gotten gains remaining in this country unless we permit the government to bring a civil forfeiture action.

Civil forfeiture must be available even if a conviction cannot be obtained. This is an important, complex issue. Indeed, I am currently working on legislation that would affect forfeiture law, and want to be able to craft responsible language.

I also have several technical concerns with the fraud and abuse provisions. For example, section 7141 punishes those who commit health care fraud with a maximum 10-year penalty. If serious bodily injury results, the criminal can be punished for any term of years.

Unfortunately, the statute does not appear to address a crime leading to someone's death. Serious bodily injury is not defined to include death, so the possibility of a death occurring as a result of the crime must be taken into account.

Finally, we need to ensure that this bill does not improperly extend Federal criminal jurisdiction and that it conforms to accepted investigative demand procedures. In light of the Lopez decision issued by the Supreme Court last term, we must be careful to draft legislation that contains the proper legislative nexus to the Constitution's commerce clause. We must put an end to the days of federalizing crime without giving any thought to the legitimate prosecutorial interests of the States.

We must also guarantee that appropriate, established, investigative demand procedures are followed. The administrative subpoena is a powerful tool that should not be used unless accepted procedures are followed.

In addition, I have continuing concerns about the provisions relating to the anti-kickback statute. I have been concerned about the discount exception to the statute as currently interpreted, and the discount safe harbor regulation which is, in effect, impeding the implementation of commercially reasonable and non-abusive marketing practices.

One such practice is the combining for discount purposes of various products and/or services supplied by a company to a provider. Another example involves the provision of discounts based upon the volume purchased during a fixed time period.

Hospitals and health plans purchase medical devices, pharmaceutical products and other health care products and services from one manufacturer, and thereby receive a percentage price discount on the total products purchased. The discount is allocated on a flat across-the-board basis for all products. Similarly, hospitals and health plans routinely purchase all products used for treatment of a particular disease from a supplier, at a fixed rate for all products.

In addition, manufacturers want to be certain that they can lawfully bundle products into a single procedure kit which contains all items needed to perform a specific procedure or treatment, and to offer the kit for purchase at a discount. Without the discount exceptions, such arrangements can be construed as a sale of one product tied to another and, therefore, a kickback under Medicare law, even when practiced lawfully in the treatment of patients.

These arrangements are appropriate and create no potential for abuse so long as there is adequate disclosure of the financial parameters of these arrangements so that the Medicare and State health care programs are able to ascertain cost data for purposes of revising payment rates and are able to evaluate the impact of these arrangements.

While these arrangements may differ from pure time-of-sale price discounts on a single item or service, they are appropriate in the current health care environment.

Discount arrangements are, in fact, commonplace in the private sector and have resulted in substantial savings to hospitals, managed care companies and, most importantly, consumers.

Unfortunately, current Medicare law is vague in this area and implies potential illegality of certain innovative purchasing practices common in the private sector. These types of purchasing arrangements enable hospitals and managed care companies to purchase medical supplies and drugs at a discount when they are sold as a package or in volume.

The success of Medicare reform relies heavily on the ability of health plans to replicate successful private sector practices—including innovative arrangements between providers and drug and device manufacturers that result in savings to beneficiaries and ultimately to the Medicare trust fund.

Accordingly, it is my desire to clarify that these innovative purchasing arrangements are allowable under the existing Medicare antikickback rules. Although we have made some progress in this respect in the bill as reported by the Finance Committee, it is my desire to pursue clarifications in all these areas as the bill moves forward.

CHIROPRACTIC SERVICES

During consideration of the reconciliation bill an the Finance Committee, I offered an amendment to allow chiropractors to practice their profession

under Medicare to the full extent of the scope of practice permitted under State law. The Committee agreed to accept this amendment subject to working out the financing provisions with the Congressional Budget Office. However, due to the press of business, it has not yet been possible to complete the task of fine tuning a mechanism that would achieve this goal without significantly increasing the cost to the Medicare program.

This is unfortunate because I believe that the time is ripe to discard the antiquated restrictions on chiropractors that permeate current law. Today, chiropractic is recognized by the medical profession, and, indeed, a recent government report concluded that chiropractic treatment is among the most effective for the treatment of certain type of ailments. Many of us in this Chamber did not need a government study to tell us what we already know.

I am committed to work with my colleagues on the Finance Committee to effectuate a change in the limitations on chiropractors. I believe—and I am confident that a majority of my colleagues both on the Finance Committee and in this chamber agree with me—that chiropractors should be allowed to be reimbursed under Medicare as long as the service they provided is an existing covered service, and that they are operating within the scope of their license as defined by State law.

ORTHOTIC AND PROSTHETIC SERVICES

I wanted to take this opportunity to mention another amendment I authored in Finance Committee, which was approved but later dropped because we could not find a suitable offset. That amendment would have allowed a 1 percent update in the reimbursement rate for orthotics and prosthetics providers, in particular for artificial limbs and braces.

Orthotics and prosthetics providers design, fit and fabricate custom orthopedic braces and artificial limbs for a wide variety of persons with physical disabilities.

I understand that the O&P fee schedule has been frozen for a number of years, resulting in only a 1 percent update factor per year since 1985. The bill freezes the update.

I am sympathetic to concerns which have been raised about the growth in reimbursement for this industry, and I would only note that this is a highly specialized segment of the health care industry; where utilization controls should not be an issue. In addition, while the Congressional Budget Office cites large growth in O&P since 1990, part of this growth is due to parenteral and enteral nutrition [PEN], urological supplies and other non-custom devices which would have not been covered by my amendment.

I am hopeful that the final bill can include the one percent update.

ABSTINENCE EDUCATION

Providing education to young adults about the value of abstinence is extremely important and I applaud the effort that this bill makes in this area. Many of us share the belief that abstinence is the best and healthiest method for our young people to avoid the risks associated with early sexual activity—dangers that have both physical and psychological manifestations.

I am concerned, however, that the language defining abstinence education in section 7445 of S. 1357 may be interpreted by some as being so restrictive that some excellent abstinence-based programs, including some programs operating in my state, would not be eligible for funding. This issue turns on the interpretation of the term exclusive purpose in section 7445(c)(5)(A) and whether this will be read as encompassing programs, such as operated by the Community of Caring in Utah, for which abstinence is a primary goal. This program exists in 50 schools in Utah and has been successful in achieving abstinence by teaching and reinforcing it within the values of caring, respect, responsibility, trust and family. I would hope that a family values-based program this effective would not be excluded from funding.

PRESCRIPTION DRUG REBATES

Many of us opposed the Medicaid drug rebate program when it was first enacted in 1990, although I recognize that it has provided a valuable source of revenue for financially strapped State Medicaid programs. The theory behind this program is that it would constrain the costs of pharmaceuticals by guaranteeing State Medicaid programs the best price.

Because of the growing move toward Medicaid managed care, with its inherent cost containment strategies, the importance of the rebate program is now overstated.

I have been concerned that rebates are anticompetitive and constrain the ability of hospitals, HMOs, and other private sector purchasers of prescription drugs to negotiate discounts from pharmaceutical manufacturers. In addition, overly high rebates can act as a disincentive to provider participation in Medicaid, as well as to the pharmaceutical research and development necessary to foster breakthrough drug products.

Under the current Medicaid program, states receive a manufacturer's best price for a drug, plus an additional rebate reflecting any differences between price increases and inflation—as measured by the Consumer Price Index. Under the original Finance bill, the Federal rebate program would have been retained for 3 years, after which the States could choose whether to implement programs on their own. An amendment adopted in committee removed that sunset.

I believe it is important to clarify what was intended by an amendment that I offered at the Senate Finance Committee on the topic of prescription drug rebates.

Currently, several States require rebates from prescription drug manufacturers over and above what is required under the Federal Medicaid program. The bill that we will ultimately send to the President will also be likely to retain the authority for States to continue to collect rebates. My personal belief, and I think that most of my colleagues on Finance would concur, is that this authority should be along the lines of the original Finance Committee bill which included a transition period of 3 years allotted to States to integrate drug rebate programs into their overall health care programs.

At the Finance Committee there was discussion as to whether the language adopted would preclude States that choose to opt out of the Medigrant Program from collecting supplemental or additional rebates on top of the rebate amount authorized under the program. The Senate Finance Committee voted that States would be precluded from collecting unlimited rebates. At the committee level the point was made that the pharmaceutical industry is expected to spend about $15 billion on research and development in 1995 alone. States may choose to opt out of the drug rebate program but will be prohibited from collecting unlimited rebates from this research and development-intensive industry.

FDA EXPORT

I was pleased to learn this morning that the House adopted as part of its reconciliation bill legislation I authored with Representative FRED UPTON and Senator JUDD GREGG (H.R. 1300/S. 597) a bill which would dramatically expand export opportunities abroad for American manufacturers of pharmaceuticals and medical devices. That bill, the FDA Export Reform and Enhancement Act of 1995, will both create jobs in the United States, as well as provide incentives for us to enhance our technological capacity to develop new medical products.

I intend to work concertedly to ensure that this provision becomes law, and I commend my colleagues in the House, especially Representative UPTON, for their work in this area.

REIMBURSEMENT FOR EXPERIMENTAL MEDICAL DEVICES

On June 22, 1995, Senators GREGG, FRIST, KENNEDY, KASSEBAUM, GRAMS, WELLSTONE, CHAFEE, HUTCHISON, D'AMATO and I introduced the Medical Devices Access Assurance Act of 1995. A companion measure, H.R. 1744, was introduced in the House by Chairman BILL THOMAS, the first in Congress to step forward in this area.

This legislation addresses two serious threats to our health care system: restricted access for our senior citizens to the most advanced experimental medical technologies and our country's loss of clinical research activities to overseas facilities. This bill helps harmonize our reimbursement policies for experimental medical devices with those governing payment for experimental drugs. This is good policy that is fair and advances the public health.

Because of ''Byrd rule'' considerations we are not able to pursue this matter in the bill today, even though the measure is included in the House-passed bill. It is my intention to pursue this legislation vigorously throughout the remainder of this congressional term, either as part of the reconciliation bill, or on the Medicare/Medicaid technicals bill which I understand the Chairman intends to consider later this year.

OXYGEN THERAPY

As part of the Medicare reform legislation, the Finance Committee reported a 40 percent reduction of the home oxygen benefit payment. In contrast, the House Ways and Means Committee reported a 20 percent reduction.

While I recognize that these provisions, to a certain extent, mirror Health Care Financing Administration efforts under an inherent reasonableness proceedings, nevertheless I am concerned about the impact of such a significant reduction on patients in Utah who require a higher level of service, particularly those patients in rural or remote areas of the State.

In addition, I have met with numerous small home oxygen providers who believe that with their slim profit margins they cannot possibly sustain a 40 percent payment reduction. And for many patients, the small provider may be the only nearby source of home oxygen therapy.

As the legislative process moves forward, I hope that we can reexamine this proposal.

HOSPICE CARE

I would also like to mention my deep interest in making sure that Federal support for hospice care remains as strong as possible.

Hospice care provides palliative care for terminally ill individuals with a life expectancy of 6 months or less if the terminal illness runs its normal course. Specifically, hospice care provides relief of pain and uncomfortable symptoms through a specially qualified interdisciplinary group of medical, psychosocial and spiritual professionals. Besides being certified as terminally ill, an individual must be entitled to part A of Medicare in order to be eligible to elect hospice care under Medicare. Under the Medicare hospice benefits, a terminally ill individual can receive comprehensive high-quality care at a lower cost.

While I recognize the need to hold back the growth in spending for all components of the Medicare program, I am concerned that the effective and efficient service of hospice care currently available to Medicare beneficiaries may be compromised by the proposed 2.5 percent budget reduction.

Hospice care is in effect comprehensive managed care for a specialized population, the terminally ill, since the current Medicare hospice benefit is reimbursed on a fixed, all-inclusive per diem basis.

As a recent Lewin-VHI study indicated, ''efforts to control Medicare expenditures [that] discourage hospice providers from offering their services to Medicare beneficiaries, Medicare expenditures would likely increase.'' We must monitor this situation closely to assure that the benefits of hospice care are not undermined by this proposal.

In addition, I also think we need to clarify how the hospice benefit will interact with the managed care opportunities provided in both the House and Senate bills. The House language is explicit in stating that Medicare contractors will assume full financial liability for services other than hospice care. The Senate language is silent on this point and I am hopeful this can be addressed in conference.

HOME HEALTH CARE

I am also concerned about the impact of this legislation on the provision of home health care.

As my colleagues are aware, home health has long been a personal priority of mine. I have seen time after time how gratified Utah families are to be able to care for their loved ones in the home. This compassionate, caring alternative to institutionalization can make all the difference in the lives of those who are ill.

At the same time, I recognize that the rapid growth of these services in recent years attests to the fact that patients prefer home health care over traditional institutional care.

I have had the opportunity to talk to patients and their families who receive these services. Almost without exception the family setting enhances the patients morale and serves as a positive influence in speeding recovery or sustaining the critical nature of an illness.

Accordingly, as we reform Medicare we should be careful not to limit access artificially.

The legislation before us today proposes significant changes to the home health care industry. One provision will require that home health care services be paid on a prospective pay system. This is something I have favored for a long time; I think this provision will serve to address concerns regarding costs as well as to promote cost efficiency and effectiveness among providers without compromising the quality of care.

While I support the enactment of a PPS for home health, I do have concerns about some of the provisions contained in the Senate and House proposals which could have unintended consequences of erecting barriers to care for several categories of the elderly.

For instance, the greatest deficiency in the respective House and Senate plans, and one which will cause the greatest financial hardship to agencies as well as impact on patients, is the treatment of extended care/outlier cases; that is, patients who require more than 120 days of care.

According to some industry sources who have contacted me, as much as 30 percent of the national caseload falls into this category. The discrepancy between the per episode cap—based on the average regional cost of providing 120 days of care—and the per agency limit based on 165 days of care—must be addressed and eliminated.

If the episode cap is limited to 120 days, then additional payments, where warranted and approved by the fiscal intermediary, should begin on day 121. Or, alternatively, the per episode cap should be based on the regional average costs of providing 165 days of care.

The financial impact on providers of the discrepancy is obvious. The impact on patients is no less obvious. In the first place, the plan effectively—albeit certainly unintentionally—discriminates against patients with certain medical needs and conditions. While Medicare will pay providers the full cost of furnishing care to some patients whose needs fall within the arbitrarily day limits, it will pay for only part of the care for patients who are either more acutely ill or have chronic conditions.

Additionally, it is reasonable to assume that agencies with large caseloads of patients needing care beyond 120 days—but less than 165—cannot long operate under this system. The logical result will be limited access to care in some areas as agencies close.

With respect to the home health market basket updates, payment rates should be based on actual reasonable costs. The provision which would adjust payments by the home health market basket minus 2 percent is clearly unreasonable. Per visit payment directly affects per episode limits, so the limitation has a compounded effect.

Also punitive, particularly in light of the 45-day window of vulnerability/discrepancy, is the limitation of the savings share to 5 percent of an agency's aggregate Medicare patients. I think this is something we may need to examine, especially since the limitation serves as a disincentive to bring overall costs to a level that will yield savings greater than 5 percent.

The limitation could ultimately hurt the Medicare program, whose level of savings would increase if real incentives were in place for home health agencies to work to produce saving beyond the 5 percent limit.

Another issue regards the break in care between a particular illness or episode. Any required break in the delivery of home health services before a new episode can begin would, by definition, be arbitrary. A 60-day break seems to be unnecessarily long, given the nature of the Medicare home health care population. I think that 45 days might be more reasonable.

Another question I have about our proposal is that it leaves open the question of what responsibility, if any, a home health agency would carry for a patient who is discharged—for example at 120 days—and then who needs services for another condition 50 days later. This issue needs to be clarified. If patients cannot receive the care they

need through home health, it is reasonable to assume they will obtain it in a more costly institutional setting.

Finally, I note that the House bill extends the waiver provision until the implementation of the PPS system on October 1, 1996. I hope this is something we can reexamine.

CHILDREN'S HEALTH

Nothing can be more important to our future than the health of our children. Too often that fact is left out of our debate on entitlement programs.

This debate has underscored that there is obvious disagreement over whether Medicaid should remain an entitlement, but I am certain there is no disagreement that children should be a primary focus no matter how we reform Medicaid.

In particular, children with special health care needs—those with serious chronic conditions or disabilities such as those with cerebral palsy, cystic fibrosis, cancer or heart conditions—are fortunately very small in number. In fact, they represent only 2 percent of all children. But, it will take special attention to make sure their needs are being met.

For example, managed care can offer these children and their families better access to care and better coordination of services, but—as the managed care industry's own National Committee on Quality Assurance has recognized—managed care has little experience with children with special needs.

The bill we have before us today contains an amendment which would have States outline in their plans how they will serve children, and in particular, how they will serve children with special health care needs. While I am certain the Governors will devote appropriate attention to children with special needs, I think that outlining how this will be accomplished in the State plans will give us all the peace of mind that these very vulnerable children will not fall through the cracks.

In addition, the bill contains a provision I coauthored with Sen. GRAHAM to clarify that States are required within their Medigrant plans to describe the methodology to be used to continue disproportionate share payments to hospitals. An explicit methodology is important for hospitals such as Primary Children's in Salt Lake City, which receives 7 percent of its Medicaid revenues from disproportionate share payments.

NURSING HOMES

One of the reasons I have introduced S. 1177, the Quality Care for Life Act, is that I firmly believe we need to adopt a national policy for long-term care. That policy need not be a Federal-only solution. Indeed, any plan to provide comprehensive long-term care services for Americans citizens must embrace a mix of private and public solutions, including incentives for long-term care insurance development.

There are 17,000 nursing homes in this country, who serve 1.7 million residents. The care of two-thirds of these residents, some 1.13 million, is paid by Medicaid, and the care of 100,000 is paid by Medicare.

The impact of this bill on the provision of long-term care services is immeasurable, since we are reforming the Medicaid system which provides a good deal of the long-term care services in this country, as well as making substantial changes to Medicare reimbursement for skilled nursing facilities [SNF's].

There is no doubt that savings from SNF reimbursement should be included in a reconciliation bill; I think that all involved —providers, patients, and policymakers—recognize that fact. However, I have had some concerns about the way the provisions were crafted in the proposal that we considered in Finance Committee.

I have very much appreciated the willingness of Chairman ROTH, and his most capable staff, to work with me to address my concerns.

Two weeks ago, I received a letter from 28 organizations, representing a broad spectrum of companies and health professionals providing care to 1 million Medicare beneficiaries. These organizations, which include nursing homes, subacute facilities, ancillary service providers and health care professionals serving nursing home patients, were opposed to the committee proposal which would have established a flat, per-stay reimbursement rate for all ancillary services based on a blend of a facility-specific and a national average rate.

The basis of concern was that the move toward a national average could cause wide shifts in reimbursement, which could jeopardize patient care especially for those with severe illnesses. In addition, the funding mechanism could jeopardize the trend toward using subacute care as a cost effective alternative to hospital care.

I also think that, despite the Health Care Financing Administration's lack of priority in developing a prospective payment system for SNF's, there is consensus that future payment must be made on a prospective basis. The only practical solution to the funding problem for nursing homes under the fee-for-service sector of the Medicare Program is to implement a prospective payment system that contains the necessary cost containment incentives. This will take some time to develop. Under the most rosy scenario, such a PPS system could not be implemented before October 1, 1997.

To me, the goals in developing a SNF reimbursement proposal should be twofold. We must make certain that any proposal we approve maintains appropriate incentives for high quality services. At the same time, it must also provide reimbursement in the most equitable way, especially during the transition period as we move to a PPS system.

The key to designing a new system is to get a handle, not only on the price the Medicare Program is paying for the nursing home service package, but also on the amount of services provided in the coverage package. Control over the latter can only be accomplished by paying SNF's prospectively on a per episode, per case, or per spell of illness basis—as opposed to the per diem or per day approach that has been traditionally employed in the nursing home industry.

Faced with prospective per episode payments, skilled nursing facilities will be able to economize on the amount of services provided during each Medicare covered stay by adjusting the intensity of services provided during each day of the patient's stay in the facility and by making sure that the Medicare covered stay is no longer than necessary. Of course, other mechanisms outside of the payment system must be relied upon to control the number of Medicare covered admissions, but I expect we will be addressing these concerns through controls on coverage decisions, shifts to managed care, and modifications in eligibility rules.

These prospective episodic payments should cover all of the reasonable costs that skilled nursing facilities incur when providing Medicare covered services, including both operating costs (both routine and non-routine) and property costs. The prospective episodic payments under this system are intended to cover the entire cost of services provided during the period of Medicare part A coverage. This means that the payments are to cover both part A and part B services that are provided to the patients during their Medicare part A covered stays.

Additionally, the prospective episodic payments need not be the same for all patients in all facilities. For example, the prospective payments should be case-mix sensitive so that patients with varying service needs are associated with varying levels of payments. Skilled nursing facilities operating in different labor markets also should have their prospective payment schedules adjusted to account for these market differences. Finally, special consideration should be given to the prospective payments for patients in skilled nursing facilities with very low volumes of Medicare activity so as to preserve the access to SNF services that these providers afford. This can be done either by preserving the current low volume prospective per diem Medicare SNF payment system or by adjusting the prospective episodic payment levels for these facilities to recognize their higher costs of operation. No payment adjustments should be authorized other than those just described.

With this kind of approach to prospective Medicare SNF payment, we can expect to finally get a handle on one of the most rapidly expanding sectors of the Medicare Program.

I am extremely appreciative of the efforts that Senator ROTH and his staff have made to work with me to address

concerns I have had about the SNF provisions in the bill.

There is one other SNF issue I wish to address. The Finance Committee amendment we considered today differed somewhat from an earlier draft I reviewed with respect to section 7037. In the previous draft, the language made it clear that the Secretary of HHS should establish salary equivalency limits based on ''recent and accurate data relevant to the specific types of therapists and providers, subject to the salary guidelines.'' This language also specified that the existing guidelines for physical therapy and respiratory therapy would be updated to conform to that guidance. As my colleagues may be aware, the current guidelines for physical therapy and respiratory therapy are based on 1981 data and they are outdated.

This language was not included in the draft of this morning. I am hopeful that we can work to clarify this section during conference to make certain that the Secretary shall use accurate, timely, and relevant data in developing occupational therapy and speech language pathology guidelines and to assure that the Secretary will rebase the existing guidelines for physical therapy and respiratory therapy based upon timely, accurate, and relevant data.

CLINICAL LABORATORIES

Another provision about which I have some concern is the provision on reimbursement of clinical labs contained within this bill. I have no objection to reducing the level of spending under this category, and I am very appreciative of the fact that the bill does not contain the unwise proposal from 1993 to impose a copayment on lab services.

In committee, I had suggested a provision similar to the Ways and Means bill which would only freeze updates for lab payments and include much-needed administrative simplifications which could provide efficiency and cost-effectiveness in the delivery of lab services, a key regulatory reform goal of this Congress.

We were not able to work out the scoring on this proposal, but I am hopeful the issue of lab reimbursement, and especially administrative simplification, can be reexamined in conference.

FEDERALLY QUALIFIED HEALTH CENTERS

During Finance consideration of this bill, the committee adopted without objection a provision I authored with Senators CHAFEE and GRASSLEY which would allocate one percent of Federal Medicaid spending for the preservation of what I believe is really the Nation's primary care infrastructure—community health centers and rural health clinics. Since the bill rewrites title IX of the Social Security Act, Medicaid, it eliminates the cost-based reimbursement they would have received under Medicaid as Federally-Qualified Health Centers (FQHCs).

Let me make perfectly clear that I am extremely sensitive to the concerns that our Nation's Governors' have raised about using a Medicaid set-aside as a funding source for this amendment; I want to work to address these concerns as the process moves forward.

Under our amendment, one half of the amount allocated would be used for payments to community health centers, and the other half for rural health clinics. The Secretary of HHS would determine the methodology for determining payments to these centers and would make payments directly to the centers. Payments made to centers by the Secretary would be in addition to any other revenues the centers receive from Medicaid, either directly from States or from managed care plans.

Mr. President, over 1000 community health centers and 2500 rural health clinics play a unique role in the health care system. In inner-city areas, community health centers are often the only providers of care to Medicaid patients and the uninsured. In rural areas, community health centers and rural health clinics are often the only providers for the residents of the area, whether they are on Medicaid or Medicare, have private insurance, or are uninsured.

Community health centers and rural health clinics serve over 16 percent of Medicaid patients nationwide. My colleagues might be surprised to know that 36 percent of community health center patients are on Medicaid; 44 percent are uninsured; 8 percent are on Medicare; and 12 percent have private insurance.

For rural health clinics, 27.7 percent of the patients are on Medicaid; 29.4 percent are on Medicare; 14.4 percent are uninsured; and 28.5 percent have private insurance.

The current Medicaid Program recognizes the unique role of these centers, and provides them with cost-based reimbursement, in order to assure that the payments are sufficient to meet the health care needs of Medicaid patients they serve.

Unlike providers with large numbers of privately insured patients, these centers do not have reserves or available capital, and do not have the ability to cost-shift losses from insufficient payments under public programs.

Under many current Medicaid managed care programs, these centers have not received sufficient payments from managed care plans to meet their costs of caring from Medicaid patients.

Some of my colleagues may ask why these centers need special consideration. A major reason is that many will be forced to close their doors or reduce services if their reimbursement is not maintained.

Centers are committed to serve all in their communities. Without a sufficient flow of funds to meet the needs of their Medicaid patients, centers will be forced to substantially reduce their patient loads, and many will go out of business. Other providers will not enter these underserved communities because the economic base will not support them, and the community will be left with no remaining health care infrastructure.

Another reason is that Medicaid patients (particularly those seen by centers) often are more difficult to treat than the privately insured patient enrolled in a managed care plan because Medicaid health center patients have more serious health conditions and poorer overall indicators of health status.

In addition to traditional medical services, centers provide other services (such as outreach, transportation, health education, and translation) which enable Medicaid patients to better utilize care and comply with medical direction. These services are not generally included in a capitated payment which a health center receives from a health plan.

There are many benefits which would result from this legislation.

Since these centers must be located by law in underserved areas, access to cost-effective preventive and primary care services will be assured.

These centers deliver health care which is one of the best bargains anywhere. For example, the total annual cost of community health center comprehensive primary and preventive care is, on average, less than $300 per patient.

I would also like to reassure my colleagues that this provision could result in substantial savings for State Medicaid Programs. Several recent studies have found that Medicaid patients who regularly use health centers have lower total annual health care costs than Medicaid patients who use other primary care providers, such as HMOs, hospital outpatient units, or private physicians. These studies show that health center patients were 22 percent to 33 percent less expensive overall and had between 27 percent to 44 percent lower inpatient costs and days.

Other providers could also benefit from this provision. These centers serve disproportionate numbers of high-risk patients, and adequately compensating the health centers for their care can make risk levels more reasonable for other providers in communities with more than one provider.

As we prepare to vote on this landmark legislation, I want to express my deep personal appreciation to the Finance Committee health staff, who have labored long and hard under the most difficult circumstances to bring us a solid piece of legislation. In particular I want to cite the hard work of Julie James, Roy Ramthun, Alec Vachon, Susan Nestor, and Donna Norton. I would be remiss if I did not also mention the monumental efforts of Lindy Paull, Rick Grafmeyer, and last, but not least, Gioia Bonmartini.

In conclusion, Mr. President, unfortunately, there is no easy nor painless way to effect reductions in the growth of Medicare and Medicaid. But it has to be done.

My message is simple. I wish we lived in a world in which we had unlimited

resources so that all—aged, disabled, poor—could have the services they desire. But such a world does not exist.

We must be fair to our Nation's disabled, to our seniors, and to the low-income. But we must also be fair to our children, and their children. In short, we just have to do the best we can and this bill is a good start.

BALANCED BUDGET RECONCILIATION ACT

Mr. PRESSLER. Mr. President, I am pleased to be voting today for the Balanced Budget Reconciliation Act. For the first time in a generation, the United States Senate will be voting to end fiscal irresponsibility. Today, we have the opportunity to leave the next generation not mountains of debt, but the prospect of a stronger economy and a better standard of living.

Many of us have fought this battle to end runaway deficit spending for decades. I have done what I can. I have kept my votes within a balanced budget. I have cosponsored constitutional amendments to balance the budget, and measures to grant the President line item veto authority. When I assumed the chairmanship of the Committee on Commerce, Science and Transportation, I voluntarily reduced my staff budget by 15 percent. Those of us who believe in common sense budgeting fought tenaciously to reverse years of liberal excess and largess that has left the United States a debtor nation. For years, the only things I have had to show for my efforts to balance the budget are awards from grassroots, fiscal watchdog organizations. Today, with passage of this legislation, I have my eyes on the ultimate prize: a balanced federal budget. It is about time.

Of course, the people who deserve most of the credit are the American people. As they have done in so many instances throughout our nation's history, the American people made the difference. Last November they said enough is enough. They sent home many liberal caretakers of a run-down, bloated federal government, and sent to Washington a new corps of members that share my common sense approach to government. American families, working hard to provide for their children's future, knew that the federal debt stood as an ominous threat to their efforts and their way of life.

The people of South Dakota long ago made clear they do not tolerate wasteful deficit spending. South Dakotans believe that the federal government should live within its means—just like every family, every farm, and every business large and small. They are absolutely right.

No single act this Congress can take could have a more positive impact on more Americans than a vote to balance the federal budget. The facts are clear. A balanced federal budget and a lower debt free up investment dollars that have gone toward financing the debt or making interest payments on the debt. In practical terms, a balanced budget would mean three key things: First, it would mean lower interest rates by up to two percent, making loans for new businesses, a new home or car, or a college education more affordable; second, it would mean at least 6.1 million new jobs; and third, it would mean a higher standard of living. In fact, a balanced budget would result in per-family incomes rising on average by $1,000 a year.

With all the clear benefits, it is no wonder that the American people strongly favor a balanced budget. Americans recognize that fiscal irresponsibility has been a stifling barrier to progress—a barrier that gets larger, more onerous and more oppressive unless we act. Today, we are acting. A balanced budget is not just a restoration of common sense government. It is nothing less than economic liberation for every American family and business.

The balanced budget bill we pass today maintains our commitment to vital programs, such as student loans and national security. It also preserves and improves outdated, costly social programs that threaten to spiral our country into bankruptcy. Chief among them is Medicare.

Medicare reform is critical. I support Medicare. It provides essential hospital and health care services to 37 million Americans, including 113,000 South Dakotans. My mother depends on Medicare for basic health care.

As all of us know, earlier this year, we received troubling news from the trustees in charge of Medicare. They said that Medicare would be bankrupt in seven years. Without action by the year 2002, there would be no money to pay senior citizens' hospital bills. Seniors would be stuck for the entire bill because Medicare would not be around to help. That must not happen. If we enact the Medicare reforms contained in S. 1357, that will not happen.

This bill would save Medicare by making a number of key reforms. First, the bill would slow the rate at which Medicare is spending our tax dollars. At present, Medicare is growing at an annual rate of 10.4 percent. That is too fast. It is like forcing a person to run a marathon at a sprinter's pace. If allowed to grow at this pace, Medicare will burn out and run out of money in seven years. Like the marathon runner, we need to slow the pace of Medicare growth so it can run longer. That is just what this bill would do. It would slow Medicare growth to a more manageable 6.4 percent—still twice the rate of inflation, but at a pace that would enable Medicare to stay solvent for years to come.

In terms of dollars and cents, total Medicare spending would increase from $178 billion this year to $274 billion by the year 2002—that is a total of $1.6 trillion invested in Medicare and an increase of 54 percent over seven years. This growth rate is faster than any other major government program. Spending per South Dakota Medicare beneficiary would increase as well, from $4,816 this year to $6,734 in the year 2002—an increase of $1,918.

This bill would improve Medicare as well. The Republican Medicare reform plan rests on three basic principles: First, every senior would be able to choose the same fee-for-service Medicare plan they have now, with all of Medicare's benefits. Second, senior citizens would continue to be able to choose their own doctor. Third, seniors would have a new option—the option to choose from a variety of health plans, as do younger Americans and Members of Congress. Seniors could stay on Medicare, or opt for a health plan offered by a Health Maintenance Organization (HMO), a Provider Sponsored Network (PSN), or even a health plan sponsored by a pool of physicians.

For the first time, seniors would be given a greater choice over health care options. They would have leverage as health care consumers in a newly competitive health care market. This option of choice would offer senior citizens more benefits, such as eyeglasses, prescription drugs and hearing aids, at a lower cost.

In short, Republicans intend to improve Medicare by preserving its best elements, and empowering senior citizens, not the government, to choose the health plan that suits them best.

This legislation also contains much-needed reforms in the Medicaid program. Like Medicare, the Medicaid program is growing at an excessive rate that threatens funding levels for other vital social programs. The core element of Medicaid reform is to slow the rate of growth in the program, from 10.5 percent to just under 5 percent We further reform Medicaid by giving the States greater authority to administer the program, while maintaining our traditional commitments to cover pregnant women and children, as well as the disabled.

The balanced budget legislation also maintains our commitment to young Americans who need financial assistance for college. Much misinformation has been circulated by the liberals, but the reality is student financial aid enjoys wide bipartisan support. This was made evident just yesterday, when the Senate overwhelming approved an amendment I cosponsored to provide an additional $5 billion for student financial aid. This amendment would preserve the in-school interest subsidy for both undergraduate and graduate students. It also would prevent any increases in the interest rate on PLUS loans for parents and it eliminated a misguided .85 percent fee on student loan volume on colleges and universities.

I am very pleased the Senate adopted this amendment. During the Senate Labor Committee's consideration of its provisions in the balanced budget legislation, I contacted Chairman KASSEBAUM to express my opposition to any