

passed, the motion to reconsider by laid upon the table, and any statements regarding this matter appear in the RECORD at this point.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The bill (S. 2231) was read the third time and passed, as follows:

S. 2231

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Welfare Reform Extension Act of 2004".

SEC. 2. EXTENSION OF THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES BLOCK GRANT PROGRAM THROUGH JUNE 30, 2004.

(a) IN GENERAL.—Activities authorized by part A of title IV of the Social Security Act, and by sections 510, 1108(b), and 1925 of such Act, shall continue through June 30, 2004, in the manner authorized for fiscal year 2002, notwithstanding section 1902(e)(1)(A) of such Act, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through the third quarter of fiscal year 2004 at the level provided for such activities through the third quarter of fiscal year 2002.

(b) CONFORMING AMENDMENT.—Section 403(a)(3)(H)(ii) of the Social Security Act (42 U.S.C. 603(a)(3)(H)(ii)) is amended by striking "March 31" and inserting "June 30".

SEC. 3. EXTENSION OF THE NATIONAL RANDOM SAMPLE STUDY OF CHILD WELFARE AND CHILD WELFARE WAIVER AUTHORITY THROUGH JUNE 30, 2004.

Activities authorized by sections 429A and 1130(a) of the Social Security Act shall continue through June 30, 2004, in the manner authorized for fiscal year 2002, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through the third quarter of fiscal year 2004 at the level provided for such activities through the third quarter of fiscal year 2002.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

THE MARINES

Mr. THOMAS. Mr. President, I will make some comments in morning business. First of all, I had the privilege this morning of attending a meeting of Marines, which we have periodically, and I was very pleased to listen to a report from the commandant about the current situation in Iraq and Afghanistan. Certainly, he is very pleased with what is happening there with regard to our military, what they are able to do and accomplish there. We do not hear much about the good stuff that is going on. We hear, of course, the news on bad things. It was an excellent report. Certainly we are very proud of our Marines and all of our service personnel there.

HEALTH INSURANCE COSTS

Mr. THOMAS. Mr. President, I take a few minutes today to talk about an

issue I am sure we are all concerned about and interested in. As I go about Wyoming and talk to people, particularly in town meetings, the issue that arises most often and with the most passion is the high cost of health insurance. The cost of health insurance is directly related to the cost of health care. What we hear the most about is from people who are in private business, farmers and ranchers, who provide all of their own health care costs, which have become increasingly prohibitive. It seems to me we are going to have to focus properly on Medicare, Medicaid, veterans, those government programs for which we are responsible. I suggest we need to focus now and begin to take a look at the broader picture of health care. We have a system that has available certainly some of the best health care in the world, but the key is to have access. If the cost limits access, we have a problem.

We have some unique features in Wyoming. Because of a small population, we cannot have all the various professional services in every small town. There has to be a system. We have worked at that. There are several hospitals with the different kinds of specialties that help serve communities. We have had more and more critical access facilities which make it easier for small communities to work.

I visited Dubois, WY, this week, a new clinic to a small town. I also met with a group of physicians and hospital operators in Cheyenne. We talked about some of these issues. Before it was over, these professionals, these providers, indicated they agree this system is broken and there needs to be some kind of change made in the future. I don't know the answer. I don't know that anyone yet knows the answer. I suggest to my fellow Members of the Senate and the House, we need to begin to take a look.

If I can start out by saying I am not one who favors a Federal socialized medicine program, we need to find some ways to do something with what we have now.

National health expenditures grew \$1.6 trillion in 2002, a 9.3-percent increase over the previous year. The costs of health care generally have gone up 15 percent a year for several years.

It is hard to sustain 15-percent growth, particularly when, increasingly, health care for families is a relatively large portion of expenditures.

Health care as a share of GDP in 2002 was 14.9 percent, up from 14.1 percent in 2001. So we are seeing substantial increases. And over the years those increases have continued.

So one has to ask, if the costs are going up 15 percent a year, how long can you sustain that? What do we need to do? Folks are seeing double-digit premium increases each year, including Federal employees. So it is quite obvious to me that we cannot continue to grow rates at that level.

I indicated I had talked to some folks who certainly agree we need to deal

with that. We face more challenges in the health care system than just reforming the public programs or addressing the nearly 42 million people—15 percent—who do not have health insurance.

There are some things, of course, we need to consider. We need to improve the underlying health care infrastructure. Its rising costs affect all of us. I think we have to take some of the responsibility for fixing that system.

We have a health care system today where, for instance, hospital charges do not reflect the actual costs because of public and private insurance reimbursements. I recently met with a hospital CEO in my hometown. At that hospital they had some very interesting topics they talked about. Their gross charges, for example, were \$202 million; \$80 million was written off; \$120.7 million reflects actual costs; \$1.4 million was income from insurance, and they had \$3.3 million in other income. This is not a large profit margin.

What does that mean? No. 1, Medicare does not pay to the level of actual costs. Now, you may say, well, we need to keep the cost of Medicare down. That is true. On the other hand, if their payment is not equal to the cost, then someone else has to bear the cost; Medicaid even more so.

Medicaid pays even a smaller percentage of the actual cost than does Medicare. This is a combination, of course, of State and Federal programs. So we find that situation.

Charity, for those who are uninsured, for those who come in and are not able to pay, we still take them, of course. Trauma care, sometimes, is reimbursed by the county or the State. But if someone has an accident and arrives at the hospital, they are given care, of course, whether they have the ability to pay, whether they have insurance. And guess who pays the principal cost of that. Those who have insurance.

People who are insured represent about 35 percent of the people in a hospital, but they pay 98 percent of the cost. So what we are doing basically is taking the costs that are there, and those who have commercial insurance are paying a very large percentage of that cost. Therefore, we are shifting costs from the broad user base to a relatively small group who buy insurance, which causes the private insurance to be higher.

So there are some weaknesses there. Certainly, we have to do something about it. Health providers must shift this cost to private insurance or they do not make it up.

Emergency room costs, of course, are extremely expensive. They are used a great deal, particularly with Medicaid where there is no first-dollar payment by anyone. When anything goes wrong for someone who is under Medicaid, they can go to the emergency room because it does not cost anything.

Of course, we pay the highest prices for prescription drugs and shoulder the research and development costs for