SENATE—*Wednesday, August 17, 1994*

(Legislative day of Thursday, August 11, 1994)

The Senate met at 9:30 a.m., on the expiration of the recess, and was called to order by the President pro tempore [Mr. BYRD].

The PRESIDENT pro tempore. Prayer will be led in by the Senate Chaplain, the Reverend Dr. Richard C. Halverson.

Dr. Halverson, please.

PRAYER

The Chaplain, the Reverend Richard C. Halverson, D.D., offered the following prayer.

Let us pray:

In a moment of silence, let us remember in prayer the family of David Farley, 27-year-old Capitol Police officer who took his life last weekend. We pray for his family, his wife, Kimberly, their 4-year-old daughter, Megan Elizabeth, as well as his parents, Gene and Diana Farley.

Let us also remember a member of the Senate staff whose father-in-law recently took his life.

"If my people, which are called by my name, shall humble themselves, and pray, and seek my face, and turn from their wicked ways; then will I hear from heaven, and will forgive their sin, and will heal their land."—II Chronicles 7:14.

Almighty God, Ruler of history and the nations, the words of President Franklin Delano Roosevelt are relevant to our present situation. In a radio address to the Nation, he said, "No greater thing could come to our land today than a revival of the spirit of religion—a revival that would sweep through the homes of the Nation and stir the hearts of men and women of all faiths to a reassertion of their belief in God and their dedication to His will for themselves and for their world. I doubt if there is any problem—social, political, or economic—that would not melt away before the fire of such a spiritual awakening."—Brotherhood Day, February 23, 1936.

God of truth, justice, and love, every problem the world faces—economic, social, educational, crime, moral, and ethical—derives from a secular, materialistic, godless rejection of spirituality. In the words of G.K. Chesterton, "If we do not believe in God, the danger is not that we will believe in nothing, but that we will believe anything."

Lord, help us in our unbelief. Amen.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

MORNING BUSINESS

The PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 10 o'clock a.m., with Senators permitted to speak therein for not to exceed 5 minutes each.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

THE SCHEDULE

Mr. MITCHELL. Mr. President, Members of Senate, as the distinguished presiding officer has just noted, there will now be a period for morning business in which Senators may address the Senate on any subject for up to 5 minutes each. That period for morning business will conclude at 10 a.m., at which time the Senate will resume consideration of the health care reform legislation.

I am pleased that the Senate was able finally to begin voting on amendments last evening, pleased at the adoption of the Dodd amendment. We will now proceed to receive an amendment to be offered by Republican colleagues today. We have not yet had an opportunity to see or review that amendment. I hope we get the chance to do so shortly. And then we will debate that amendment during the day.

Without knowing what the amendment will be, it is not possible to estimate when we will be able to proceed to vote on it, but Senators should be prepared for debate and the possibility of voting during the day, depending on the nature of the amendment and the length of debate.

Mr. President, I note the presence of the distinguished Senator from Utah on the floor who is, I believe, here to be recognized in morning business, and I yield the floor.

The PRESIDENT pro tempore. The Senator from Utah [Mr. BENNETT] is recognized for not to exceed 5 minutes.

Mr. BENNETT. Mr. President, I ask unanimous consent I be able to proceed for up 10 minutes if my statement requires that much time.

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

GOLD

Mr. BENNETT. Mr. President, in this morning's Washington Post the lead story on the front page had to do with the action of the Federal Reserve Board, raising the interest rate yet again. This is a deserving spot for such news because it is very important to our economy.

During the debate on health care, we had a great deal of conversation about the entitlement commission and the fear that sometime in the next century the Federal Government will run out of money. This is tied to the size of the deficit. In my view, this morning's news and concerns about the deficit are tied together. Because as the interest rate goes up, the cost of financing the national debt goes up. When interest rates are low, we save a tremendous amount at the Federal level in terms of debt service payments. For every 1 percent on $4.5 trillion—if I get my decimal right—that is $45 billion in annual savings. So if the cost of servicing the debt can be brought down by holding interest rates down, it has implications for everything we are talking about here with respect to the budget deficit and health care costs and everything else.

In that context then, I would like to call the Senate's attention to an exchange I had in the Banking Committee with the distinguished Chairman of the Federal Reserve Board, Mr. Alan Greenspan. Some portions of that exchange were outlined in an editorial piece that appeared in the Wall Street Journal last week by Jude Wanniski.

I ask unanimous consent that article be printed in the RECORD at the conclusion of my statement.

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

(See exhibit 1.)

Mr. BENNETT. The subject I discussed with Chairman Greenspan was the question of tying the dollar to gold, that is the price of the dollar to the price of gold. Chairman Greenspan said, in response to my questioning, that the price of gold was, in his view, a very valuable indicator of forthcoming inflation. When the price of gold starts to rise, that is an indication that there is inflation on the horizon. When the price of gold remains stable, that is an indication that inflationary pressures are under control.

Why is this? This is a question I tried to explore with the Chairman. In the format of the committee we did not have an opportunity to get into it as deeply as I would have liked.

It seems to me the reason is that gold is the closest thing we have in this world to a universal currency. If I were

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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to leave the United States and go to some far-flung place and try to buy a suit with dollars, they might refuse my dollars, saying "That currency is not good in this society." I might reply, "All right, I will bring you something of intrinsic value, then. I will bring you food." In the terms of the Commodity Exchange, "I will bring you a pork belly." And it may well be they would say, in that part of the world, "We don't eat pork. We are not interested in your pork belly." But almost everywhere in the world, if I say, "I will give you this small bar of gold," they would say, "We will sell you a suit for a bar of gold."

All the way back to biblical times and the mythical King Midas, gold has caught the imagination of the human race as the one commodity that seems to have intrinsic value, regardless of what else changes. Let us stop and think about, then, the implications of tying the dollar to gold. It would mean, if we were on some kind of a system where the price of gold did not change in dollars, that you could predict the economic future with far greater certainty than you can today.

For example, if we were still in a circumstance where a dollar would buy one thirty-fifth of an ounce of gold—as we were through the vast majority of our historic years—that would mean that if you lent me $1,000 for a period of 10 years, you would know that at the end of the 10 years when you got your $1,000 back, every one of those dollars would still buy one thirty-fifth of an ounce of gold.

No matter what had happened to the prices of any other commodities, you knew you would get your $1,000 back in terms of gold without any erosion of the purchasing power of that $1,000.

What would this mean to interest rates? This would mean that you could depend upon getting your purchasing power back; therefore, the interest rate would not have to be so high as to compensate you, Mr. President, for the loss of purchasing power that would occur during that 10-year period.

If you assume that the $1,000 you lend me is only going to be worth $500 in purchasing power at the end of 10 years, you understand that the interest I pay you must not only compensate you for the use of the money, but that the interest I pay you must also allow you to recoup the $500 loss of purchasing power.

So instead of a 2- or 3-percent interest rate on the $1,000, you have to have a 6- or 7-percent interest rate so that you recover both principal and interest at the end of 10 years.

I have been in business. I understand the value of being able to project into the future the value of dollars. If we had a circumstance that gave us constant dollars, it would have a tremendous impact on the ability of businesses to plan for the future, as well as governments.

There are lots of arguments that I have heard from people saying we must return to a gold standard and, frankly, almost all of them strike me as being mystical and occasionally nonsensical. But the idea that I was exploring with Chairman Greenspan is neither of those if, indeed, it has merit. If, indeed, we could get to the point where there was no erosion in the purchasing power of the dollar and finance the Federal debt with that understanding, we could save up to $200 billion a year.

Mr. President, stop and think of all of the efforts we go through on this floor to try to cut the budget up to $200 billion a year. If, in fact, we could cut the debt service costs up to $200 billion a year, it would be more significant than all of the debates we have had on all of the other budgetary issues that we discuss here.

So I think it is appropriate on a day when the Federal Reserve is raising the interest rates and thereby raising the deficit because of the cost of financing our debt, that we, once again, spend some time thinking about the possibility of getting some kind of standard, some kind of stability in the unit of account, the money with which we pay our bills. I know of no historic standard that has the stability over centuries that gold has had.

So I hope, Mr. President, that as a result of this brief statement, economists around the country, people in the Federal Reserve System, people on the staff of the various committees that deal with these issues in the Congress will, once again, begin to explore the possibility that we could return to a historic stance with respect to our currency and tie it to some kind of stable commodity that will say borrowers can know with a certainty that when they are paid back, their dollars, at least in terms of this commodity, will still have the same purchasing power at the end of the transaction that it had at the first.

Chairman Greenspan said to me in the exchange we had in the Banking Committee, that a nation who had the most stable currency in the world would be the nation that had the lowest interest rates in the world, and that statement intrigues me tremendously.

That is my only purpose here this morning, Mr. President. Not to offer any specific solutions but simply to raise the issue in what I hope is a sober and thoughtful way so that we, as a people, can begin to address this question and find that commodity that will give us that kind of stability.

As I say, historically, the only commodity that has approached that kind of an impact on economies has been gold. And I think as we search for that kind of stability, gold is the place where we should begin. I thank the Chair.

EXHIBIT 1

HELP GREENSPAN, COMMIT TO GOLD

(By Jude Wanniski)

In hearings before Congress in July, Federal Reserve Chairman Alan Greenspan reaffirmed that he valued gold as an indicator of inflation expectations. He also readily agreed with the reasoning of Sen. Robert Bennett (R., Utah) that if the dollar was again fixed to gold, the U.S. probably would have the lowest interest rates in the world.

The Fed chairman's words were important. the lowest interest rates in the world would mean that America would boast rates lower than Japan—currently on the order of 3%. If the U.S. could refinance its $4.5 trillion national debt at 3%, as it matures, the annual savings in debt service would amount to perhaps $120 billion a year. This is a painless way to eliminate more than half the federal budget deficit.

Why does this important information get so little attention? It is because Mr. Greenspan's views on gold are held in disdain by the great majority of this fellow economists. Over the past 30 years, Mr. Greenspan has consistently made the case for a monetary role for gold—especially as a means of economizing on government finance of its debt. In the last two years, he has repeatedly dismissed the importance of money-supply statistics as reliable signals of future inflation. Yet he as often insisted that it is the gold price that has always been best at anticipating inflation.

Look at our own era. It was only after President Nixon on Aug. 15, 1971 severed the dollar's link to gold that inflation raced out of control, interest rates soared and the federal budget deficit and the national debt spiraled. The price of gold, at $380 an ounce, is almost 11 times higher than its official price of $35 in 1971. The general price level is roughly 10 times what it was back then. The national debt of $4.5 trillion is 11 times higher. The cost of debt service, at $210 billion, is 12 times the $17 billion of 1971.

The reason gold has this special utility as a standard of value is that for at least 3,000 years, until 1971, it has served as civilization's primary money. Throughout history, gold has been the benchmark used in almost every marketplace of the world, against which the people measured the official money of governments.

The truth is that, in a certain sense, we never went off the gold standard. The people of the world did not stop using gold as this benchmark simply because the U.S. led all the world's currencies away from gold in 1971. Since 1971, governments whose currencies have performed worst against the gold benchmark have been those most punished by their creditors—for the most part their own citizens. The price of gold in Japanese yen has risen only threefold, the best performance of any government in the world in that time. Hence the low interest rates enjoyed by the Japanese government.

Since 1987, when Mr. Greenspan was named chairman of the Fed, the fluctuations in the gold price (between $320 and $420) have been in a much narrower range than they were under his predecessor, Paul Volcker (between $240 and $850). This is no coincidence. Mr. Greenspan has kept an eye on gold from the day he arrived, as a reality check on his performance.

Indeed, the creditors of the U.S. rewarded the Greenspan Fed with steadily declining interest rates, especially insofar as he seemed able to keep the gold price in the range of $350—10 times the Bretton Woods target. It has only been since last September, when gold began another climb from

that level, that the bond markets have turned cold.

Mr. Greenspan undoubtedly had hoped the tightening the Fed began on Feb. 4 would chase gold into retreat. This would assure the owners of the nation's $4.5 trillion national debt that the value of their holdings would not suffer the 10% devaluation implied by the higher gold price. That's a $450 billion loss—big money indeed. Again and again, Mr. Greenspan has raised the overnight interest rate—the only rate over which the Fed has direct control. Still, gold has not dropped much below $380.

Academic economists hostile to gold dominate the entire Federal Reserve system. The chairman has only one of 12 votes on the Federal Open Market Committee. Absent a political consensus, it is therefore very difficult for Mr. Greenspan to simply aim his mighty monetary weapon at gold without legislation to back him up. If the Fed could fix the gold price at $350, it would simply do so by adding or subtracting dollars from the banking system, adding when it falls below that level, subtracting when it rises above it.

Gold would quickly sink to $350 and interest rates on government debt would resume their fall toward the 3% range. The value of all financial assets, stocks as well as bonds, would quickly rise, anticipating robust, noninflationary growth ahead.

Yet, to keep the academics happy, the Fed must target overnight interest rates, hoping the higher rates will cause bank reserves to fall to a certain level, in a way that eventually causes the gold price to fall and bond prices to rise. This is the equivalent of trying to kill a mouse by shooting a dog, so it will fall on a cat, which eventually will fall on the mouse. Maybe.

Politicians like Jack Kemp have lately recommended targeting gold, rather than simply hiking rates again. It's time to legislate instructions to the Fed to commit to gold. Academic economists argue that this is "price fixing," and that only the market should establish the price of gold. They fail to appreciate that it is the value of its debt that the government is fixing, not the value of gold.

In World War II, after 150 years of keeping the dollar defined as a specific weight of gold, the U.S. financed the largest deficits in its history, bigger than any since, with 2% bonds. When it is as good as gold, the dollar will once again be as good as it can get.

Mr. CAMPBELL addressed the Chair.

The ACTING PRESIDENT pro tempore. The Senator from Colorado is recognized for not to exceed 5 minutes.

NATIONAL PHYSICAL FITNESS AND SPORTS FOUNDATION ACT

Mr. CAMPBELL. Mr. President, yesterday, I introduced S. 2394 to establish a National Physical and Sports Foundation. This proposal is designed to support the President's Council on Physical Fitness.

The President's Council on Physical Fitness currently operates on a shoestring budget of $1.4 million. The establishment of a nonprofit foundation would permit the Council to have an independent source of funding to expand its scope and activities. This proposal will not conflict with existing efforts to provide funding for the U.S. Olympic Committee as moneys that would flow through the corporation to the Council would not be public funds.

Once established, the National Physical Fitness and Sports Foundation would be a charitable, nonprofit organization designed to "encourage and promote" the solicitation of private funds for the President's Council on Physical Fitness. After the deduction of administrative expenses, the foundation would annually transfer the balance of the contributions to the U.S. Public Health Service Gift Fund.

The foundation would have the following specific powers:

It could accept, receive, solicit, administer and use any gift, devise or bequest, absolutely or in trust.

It could acquire by purchase or exchange any real or personal property or interest;

It could enter into contracts or other arrangements with public agencies and private organizations and persons and to make such payments as may be necessary to carry out its functions.

A nine-member Board of Directors would govern the foundation. Three Board members must have experience directly related to physical fitness, sports, or the relationship between health status and physical exercise. The remaining six Board members would be leaders in the private sector with a strong interest in physical fitness. Ex officio members of the Board would include the Assistant Secretary of Health, the Executive Director of the President's Council on Physical Fitness the Director of the National Center for Chronic Disease Prevention and Health Promotion, the Director of the National Heart, Lung and Blood Institute, and the Director of the Centers for Disease Control.

Board members would serve for 6 years. Three Board members would be appointed by the Secretary of Health and Human Services; two by the majority leader of the Senate; one by the minority leader of the Senate; two by the Speaker of the House; and one by the minority leader of the House of Representatives. The Chairman would be elected by the Board members to a 2-year term. No individual could serve more than two consecutive terms as a Director.

Board members would serve without pay, but would be reimbursed for traveling and subsistence expenses. The Board would be empowered to appoint officers and employees, once the foundation had sufficient funding to pay for their services; and adopt a constitution and bylaws. Officers and employees of the foundation could not receive pay in excess of the annual rate of basic pay in effect for executive level V in the Federal service.

I think that this bill will help further an important national goal—encouraging and fostering physical fitness and well-being—and I urge my colleagues to support it.

Mr. President, yesterday when I introduced this bill, I did not have a copy of Griffin Joyner and Tom McMillen, who serve as co-chairs of the President's Council and support this legislation. I ask unanimous consent that the letter be printed in the RECORD.

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

THE PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS,
Washington, DC, August 12, 1994.

Hon. BEN NIGHTHORSE CAMPBELL,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR CAMPBELL: Thank you for the opportunity to share our excitement about the important work of the President's Council on Physical Fitness and Sports (PCPFS).

The leadership of the PCPFS would appreciate your support of proposed legislation to form a national foundation that would assist with the programmatic activities of our Council. Its formation would require no federal dollars. The PCPFS feels that Congressional backing of this important legislation is essential.

As all of us are currently discussing issues that involve protecting and improving the health of every American, the PCPFS continues to play a key role in this important dialogue. We are the only federal office that is solely devoted to programs involving physical activity, fitness and sports. The support of every member of Congress will send a powerful message indicating an understanding of how significant the role fitness and sports play in the daily lives of our youth, seniors, minorities and disabled. This is a bipartisan message about lifestyle and personal responsibility. Clearly with a budget of $1.4 million, the Council needs assistance in touching and motivating our country's most valuable asset: its citizens.

The foundation, established in collaboration with the Department of Health and Human Services (DHHS), would be a nonprofit, private corporation. It would encourage the participation by, and support of, private organizations in the activities of the Council.

Congressional support would add to the prestige of our mission and the significance of our goals. As you may know, Congress has also provided legislative authorization for the Secretary of DHHS to create two foundations—one in support of the National Institutes of Health and the other in support of the Centers for Disease Control and Prevention.

We would appreciate your help with this important piece of business.

FLORENCE GRIFFITH JOYNER.
TOM MCMILLEN.

Mr. CAMPBELL. I yield the floor.

Mr. DOLE addressed the Chair.

The PRESIDENT pro tempore. The minority leader is recognized.

CRIME

Mr. DOLE. Mr. President, I was encouraged by last night's White House meeting involving Republican whip NEWT GINGRICH and a delegation of House Republicans. Perhaps this is a signal that President Clinton now finally understands that last Thursday's

vote was not a procedural trick or a politically inspired attempt to hurt his Presidency, but rather a vote to improve the crime bill to make it stronger, tougher, better.

This is not rocket science. If the President is serious about passing a tough, no-nonsense crimefighting plan for America, here are some of the improvements he should support:

First, increase prison funding to the House level of $13.5 billion; tighten the language so that prison funds will definitely be used to build new prison cells, rather than half-way houses and other prison alternatives; and require truth-in-sentencing for first-time violent offenders.

Second, cut at least half of the spending on social programs, including the Local Partnership Act, the Model Cities Intensive Grant Program, and the so-called Yes Grant Program. When the crime bill left the Senate last November, it had a price tag of $22 billion. But, now, 9 months later, the conference report authorizes a staggering $33 billion, a 50-percent increase. Obviously, somewhere along the way, the crime bill was hijacked by the big-dollar social spenders.

Third, plug the so-called safety valve provision, which could result in the early release of 10,000 convicted drug offenders—a get-out-of-jail-free card brought to you by the U.S. Congress.

Fourth, no cuts for the FBI or the Drug Enforcement Agency. No crime bill should cut staffing at our Nation's top law enforcement agencies.

Fifth, restore some of the tough provisions adopted last April by the House, including Congresswoman MOLINARI's proposal on similar-offense evidence in sexual assault cases, and the Megan Kanka law, requiring State law enforcement agencies to notify the public when violent sexual predators are living in their communities.

Sixth, restore some of the tough provisions adopted by the Senate, including mandatory minimums for those who use a gun in the commission of a crime; mandatory restitution for crime victims; and Senator SIMPSON's provision requiring the swift deportation of criminal aliens.

And finally, Mr. President, give the States and localities more flexibility over how to use the funding for more cops. I have heard from many police chiefs, including Chief Fred Thomas of Washington, DC, who have indicated that what is needed most is not more police officers but better technology. We should provide that flexibility.

The ball is now in President Clinton's court. He can adopt a one-party strategy, trying to muscle his way up to 218 votes. Or he can continue to do what he started last night.

The President is wise to reach out to Republicans, but political lipservice will not do it alone. The President must publicly support real, meaningful, tough-on-crime improvements to the conference report, so that we can pass a bipartisan bill not with 218 votes but with 435 votes, if necessary, in the House and all the votes in the Senate.

If, however, the President wants to tinker around the edges, making small adjustments here and there to win over 8 or 9 or 10 votes, then he will be making a big mistake. In the end, that may be a successful strategy for the House, but you can bet it will not be a winner here in the Senate.

I think many in the Senate are going to wonder how it ballooned from $22 to $33 billion and what happened to a lot of the tough enforcement provisions that had broad bipartisan support. Keep in mind, this bill passed the Senate by a vote of 95 to 4 or 94 to 5. We had a lot of tough provisions in it, and suddenly they have all disappeared, or many disappeared. I think the American people will support a good crime bill. But keep in mind, also, that this only applies to Federal crimes. Many people see crime bill, they immediately believe it is going to have a big impact on their States and localities. I do not believe that is the case.

HEALTH CARE REFORM

Mr. DOLE. Mr. President, I would just add one thing in response to the majority leader's statement on health care. We are going to do all the business we can on health care. We are going to try to explain it to the American people, try to explain all the plans that are out there—the Gephardt plan, the Clinton plan, the Mitchell plan, the Dole plan, the mainstream plan, the Nunn-Domenici plan.

There are a lot of plans and some have similarities. Many of us think we ought to take all the common parts of these plans, put them together and pass that bill. Many of us are wondering, and certainly the Presiding Officer may have wondered, too, how are we going to—if we are going to spend $1.5 trillion over the next 10 years, what effect is it going to have on other appropriations, and how are we going to be able to find that money, and what will happen in the process.

So I would say to the majority leader, we are prepared to move ahead. We are not going to be rushed, but we are prepared to move ahead. This is the most important issue that will be around this year or maybe for many years, and we certainly welcome the debate.

CRIME BILL CONFERENCE REPORT

Mr. HATCH. Mr. President, today I wish to thank the minority leader for his comments about crime and also about health care as well. He is right on in those comments.

Today, Republicans renew their call for a bipartisan crime bill. Simply employing a bare knuckles strategy to turn a few votes in the House will not produce a tough bill, nor will it win passage of this bill. If President Clinton wants to pass a true crime bill, then Republicans will deliver the necessary votes, provided our suggested improvements are incorporated. And they have just been outlined by the distinguished Republican leader.

Ramming the crime bill through the House with a coalition of social liberals and big spenders will surely threaten the bill's passage in this body. The Senate will not accept the crime bill in its pork-feeding frenzy. Comprehensive changes must be made.

The Republican leadership has produced a list of changes for the President's consideration. I must concede that every change I would prefer is not on this list. There are literally dozens of Senate tough-on-crime provisions that were dropped or substantially weakened by the conference committee. However, we want to undertake a serious effort to reach a bipartisan compromise on the crime bill, and this list of changes is our bottom line.

Should the administration refuse to work in a bipartisan manner but still manage through arm twisting and obfuscation to squeeze the crime bill conference report through the House, we then will take up our concerns on the floor of the Senate. We will then offer a budget point of order because of the wasteful spending in the bill, and I believe that we will prevail with bipartisan support. Then we will offer a tough compromise package, a balanced proposal which adequately funds prison construction and restores the Senate's tough-on-crime provisions.

I hope we do not have to reach that point. I hope we can work together.

Incidentally, some of our colleagues on the other side, including our chairman of the Judiciary Committee, have suggested that our criticism of this wasteful spending in this bill is relatively recent. This is certainly not the case. I took the floor on May 19 of this year to criticize the wasteful spending in the House-passed crime bill. That was only a few weeks after the House passed the measure.

So I ask unanimous consent that a copy of my remarks on May 19 be printed in the RECORD immediately following my remarks.

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

(See exhibit 1.)

Mr. HATCH. In those remarks, I criticized virtually every one of these big spending, pork barrel, boondoggling aspects which have been adopted in that conference report, plucked right out of the pork barrel filled House crime bill.

We simply have to face the fact that the fight against crime does not permit the hiding of billions of dollars in pork barrel spending boondoggles under the

guise that they are trying to do something about crime.

Mr. President, this is an important issue. I would like to see a bipartisan issue. I would like to see us march together and do what we should do. Frankly, the Senate-passed crime bill passed 94 to 4, and that included the antigun provisions, which shows that that is not the sole, or even the most significant reason, why the fight over the crime bill right now. The significant reasons involve the pork barrel, boondoggle spending of the social liberals in both bodies who literally want to continue their spending practices and bring the rejected financial stimulus package back into law hidden in the crime bill, as though they are doing something against crime.

So, Mr. President, I appreciate the distinguished Republican leader's comments today, and I back him 100 percent, and the leader over in the House, NEWT GINGRICH. I appreciate his meetings at the White House yesterday and his offer to the President to have Republicans help resolve these problems. If we do not have a bipartisan bill, I do not think we are going to accomplish very much against crime in the ensuing number of months and years.

I thank the Chair. I yield back whatever time I have.

EXHIBIT 1

Mr. HATCH. Mr. President, what drives the emotion of the distinguished Senator from Florida and his counterpart on the Democrat side of the floor is that people out there are tired of the average sentence time served in the States being 40 percent. And they are specifically tired of it when it comes to violent criminals. When a murderer gets a sentence of 15 years on the average, and serves less than 7, the average murderer in this country, it does not take many brains to realize that there has to be something done to keep these people off the street.

When the average rapist gets sentenced to 8 years in prison and serves less than 2, a rapist—our daughters are at risk—it is not hard to understand why some of us would like to see those sentences, at least 85 percent, carried out. That is what the truth in sentencing is. Whether it should be triggered by the regional prison concept or some other concept, it is almost irrelevant to me. But we want to get the violent criminals, and lock them up and throw away the key for at least 85 percent of that time that they are sentenced. If they use a gun, then they ought to get it doubled.

That is the way to stop the unwise, the unlawful, and the dirty, rotten use of guns in this society, not some ridiculous, idiotic, 5-day waiting period that has caused almost everybody to go out and buy their guns now—the typical liberal solution to things. "Let us have a 5-day waiting period. That is going to solve all of our problems." All that has done is increased gun sales like 300 percent across this country because people could not wait to go out and get their guns now that they are going to have to wait 5 days.

These liberal solutions have never worked. Of course, now they have Brady II. Brady I was supposed to do everything for us. It has not done a doggone thing. In fact, it is going to undermine law enforcement in this country.

Now they want an assault weapon ban. They are going to ban 19 weapons. But they have defined them in such a way that over 100 will be banned, but they are going to exclude, exempt, 650 that have basically the same firing mechanism as these so-called 19—to take away the rights of American citizens, as defined in the second amendment to keep and bear arms, which is certainly more than a militia right as defined by some today. That is the national guard right. That is not what the Founding Fathers meant. That is not what they meant when they wrote that amendment. The militia was every American citizen who felt inclined to support our country.

So we can moan and groan about truth in sentencing all we want. But that is what the American people want. They want the violent criminals put away.

I happen to agree with the distinguished Senator from North Dakota that we should not be spending all of our expensive jail time for those who are not violent people. I happen to agree with the Senator from Delaware that boot camps may be a solution for people like that. We should not make prison a very nice time for people. Unfortunately, our do-gooders on the liberal side of the equation want to make sure that everybody is treated beautifully in prison. Frankly, I think it is time to get tough on these people.

I have another part of this I would like to spend a few minutes on.

Mr. President, the two Houses of Congress are soon going to go to a conference on the crime bill. I regret to report that the crime bill passed by the other body contains several billion dollars in ill-defined social programs—I might say ill-defined 1960's Great-Society-style social spending programs in the guise of anticrime legislation.

As such, these wasteful social spending boondoggles will rob the people of Utah and every other State of scarce resources which would be aimed at fighting crime, building prisons, hiring local, State, and Federal law enforcement officials and officers, and similar law enforcement measures.

Take, for example, the Local Partnership Act contained in the House bill. This program will give local governments $2 billion for fiscal years 1995 and 1996 to use for four purposes: education to prevent crime, substance abuse treatment to prevent crime, coordination of Federal crime prevention programs and, job programs to prevent crime. There are no other standards in the House bill. That is it—those four broad-based standards. We just have these four general purposes.

In plain English, this is just Federal money for local government social programs with the crime label put on them for cosmetic purposes. By slapping the phrase "to prevent crime" on these purpose clauses, this provides the cover to hijack $2 billion of precious crime fighting resources for anything at all that localities will label "education to prevent crime," or for drug treatment, or for more Government jobs programs.

The $2 billion would be much better spent in really fighting crime by spending it on prisons, law enforcement officers, and equipment.

Let me take another example of wasteful social spending in the House bill, the Model Intensive Grant Program. This program allows the Attorney General virtually total discretion to spend $1.5 billion over 5 years in grants for up to 15 chronic high-intensive crime areas to develop comprehensive crime prevention programs. This money apparently can be spent on anything that can arguably be said to attribute to reducing chronic violent crime.

The House bill says this includes but is not limited to youth programs, "deterioration or lack of public facilities, inadequate public services such as public transportation," substance abuse treatment facilities, employment services offices, and police services, equipment, or facilities.

I believe in spending wisely on crime prevention, although most of that funding should not come from the crime bill, where we should focus very heavily on enforcement.

But this open-ended Model Intensive Grant Program allows spending on just about anything that can be remotely described as crime prevention, however tenuously, including public transportation. We are supposed to be sending the President an anticrime bill. Let the Department of Transportation offer some of its existing funds for transportation services for preventive crime. Let us not take it out of our crime bill.

Mr. President, you can bet that conferees from the other side of the aisle will propose inadequate funding for new prisons in the crime bill. We will undoubtedly need to spend more on prisons. We need to spend more on prisons for two interrelated reasons. We can talk about ensuring that children do not go astray, and we should be concerned about that. But we have many vicious criminals right now who are not serving enough of their sentences. And speaking of crime prevention, one of the best things we can do to prevent crime right now is to take violent criminals off the streets for long periods of time so that they cannot commit anymore crimes.

Another social spending program in the House bill is $525 million for a Youth Employment and Skills Crime Prevention Program which funnels cash to State and local governments for job training and make-work programs.

This is a duplication of the programs I have just mentioned, except this one is run by the Department of Labor. Despite the fact that there are already over 150 Federal job training programs at a cost of over $20 billion a year, the Attorney General announced this week that the administration supports this program and has asked that Congress increase the program to $1 billion.

Frankly, the best crime prevention program is one that ensures swift apprehension and certain and lengthy incarceration for violent criminals. The more than $4 billion in these three boondoggle programs in the bill the other body sent belong in prison construction and other measures.

These social spending programs are neither tough nor smart on the fight against crime. We can and must spend our moneys more wisely, and in the process we have to move to truth in sentencing.

I want to point out a little bit about just how these programs work. This lists seven Federal departments who sponsor 266 programs which serve delinquent and at-risk youth—266. These are already existing programs. This is Federal departments on this side and the number of programs each department has.

The Department of Education has 31 programs already in existence without the crime bill. The Department of Health and Human Services has 92 programs already in existence. We are doing a lot in this area without the crime bill. The Department of Housing and Urban Development has 3 programs; Department of Interior, 9 programs;

Department of Justice, 117 programs; Department of Labor has 8; Department of Transportation, 6, for a total of 266 Federal programs for at-risk youth.

Yet, we would add $4 billion more. In other words, every time you try to do something about crime, those on the liberal side of the equation load the bill up with more social spending programs that are not working anyway, rather than do the things that have to be done against violent crime in our society.

So I repeat this. The GAO recently reported to Senator DODD, who heads our Family and Children Subcommittee on the Labor Committee, that there are 7 Federal departments fostering 266 prevention programs which currently serve delinquent or at-risk youth. Like I say, of these 266 programs, 31 are run by the Department of Education, 92 by HHS, and 117 by the Justice Department.

GAO found that there already exists a massive Federal effort on behalf of troubled youth," which spends over $3 billion a year. GAO went on to report that:

Taken together, the scope and number of multiagency programs show that the Government is responsive to the needs of these young people * * *. It is apparent from the Federal activities and response that the needs of delinquent youth are being taken quite seriously.

That is in the GAO report, Federal Agency Juvenile Delinquency Development Statements, August 1992.

Despite the findings of the GAO, the House crime bill throws even more money at State and local government under the prevention label, while failing to acknowledge our ongoing efforts. Listening to the House bill supporters, one would assume the Federal Government has done nothing in the area of crime prevention.

They load up the House bill with almost $10 billion of prevention. I believe there are some legitimate areas where we can do something about prevention, but I have to tell you right now that we are doing plenty without loading up this crime bill with more than we need. We need the prisons; we need the police; we need to get tough on crime; we need the mandatory minimum sentences; we need the beefing up of Quantico, of our DEA, of our FBI, of our Justice Department prosecutors, rather than cutting back on them. We need tough antirural crime initiatives, antigang initiatives, violence-against-women initiatives, the scams on the senior citizens, against telemarketing fraud. All of that in this bill would make a difference against crime in our society.

Mr. President, I have to say that we have a lot of problems in going to conference on this crime bill, not the least of which is the gun ban and, of course, not the least of which is this racial justice act, which would virtually outlaw all implementations of all death penalties in our society today, and would cost the American taxpayers billions, if not trillions of unnecessary dollars, as the whole capital punishment system would come to a screeching halt and be embroiled in all kinds of litigation, all kinds of statistical analysis, all kinds of social welfare work, to the point that people will throw their hands up in the air and say we really cannot get tough on criminals, especially those who commit willful, violent, heinous murders against the public.

Mr. President, I wanted to make a couple of these points during this debate today, because I have to go back to the truth-in-sentencing provisions. If we do not get tough on the violent criminals, we are not going to make headway in this society. All of the prevention programs in the world are not going to help us.

With that, I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDENT pro tempore. The time for morning business will shortly expire.

Mr. KENNEDY. I ask that this Senator be able to proceed for 5 minutes as if in morning business.

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

CRIME BILL CONFERENCE REPORT

Mr. KENNEDY. Mr. President, I was here on the floor prepared to move ahead, as were Senator MOYNIHAN and others, on the issue of health care. Then I heard our good friend, the minority leader, talk about the crime bill conference report. Listening to him, I did not recognize the bill he was describing.

Just yesterday, my Governor, a Republican, indicated that he was prepared to ensure matching funds for all the communities of Massachusetts to make sure that we would achieve the goal of adding 100,000 more police officers nationwide. He identified many different points of the crime bill that were worthwhile and valuable, and seemed eager for those measures to be supported here in the Senate. In frankness, he did not express a specific view on passage of the overall bill. He said he had not studied the issue well enough to be able to make a judgment in terms of its overall features, but he indicated that crime was an area of great priority and he wanted us to move forward, and the people of Massachusetts certainly do as well.

Second, the people of my State want action on the banning of assault weapons that have no purpose whatsoever for hunting, and only for killing individuals.

It is interesting that, with the exception of the 10 members of the Black Caucus, who have a longstanding history of voting against the death penalty, most of the members who voted against the rule also supported eliminating the assault weapon ban when that separate vote occurred in the House. That is basically what was going on over in the House of Representatives.

We listened to these protestations that have been made here earlier today, but these issues of public policy were resolved during earlier debates. We heard on the floor of the U.S. Senate when we were debating the funding of various prison cells—the issue was, are we going to have truth in sentencing? As the author of the Sentencing Reform Act, I believe in truth in sentencing.

But are we going to require truth in sentencing for the States before they will get the funding?

The Senator from Delaware spoke very eloquently about this issue. If we make it a very strict standard, many States will be unable to compete for the money. Many of those on the other side of the aisle wanted it stronger and stronger, even though most correctional and law enforcement officials say that will not work. So the conference report had a more balanced position.

I did not hear any complaints from our Republican conferees when we added additional money for border control and other law enforcement programs involving illegal aliens. I did not hear any of the conferees on that side of the aisle complain about adding more than $1 billion in the conference report to try to assist States that are incarcerating illegal aliens. I did not hear those complaints as a member of that conference committee. I did not hear complaints when we increased funding for police officers.

Mr. President, the Senate minority leader also spoke about 10,000 individuals who are going to be released from jails. His numbers are wrong and he has misstated the safety valve provision, but I would point out that this proposal was supported by Congressmen HENRY HYDE and BILL MCCOLLUM, leading Republicans. They know that the proposal will affect only a small number of nonviolent, low level drug offenders. And we need those prison cells for the violent rapists and murderers and those that are committing other crimes of violence. This was supported by Republicans on the conference. Now we hear other Republicans say they do not want that now.

I would say finally, Mr. President, we should listen to the majority leader who read into the RECORD some of the various proposals which have been advocated by our Republican friends under the concept of prevention. Many of their programs were included in the conference report. It is amazing that Republicans were willing to add them to the proposal here in the U.S. Senate, and now these measures are being railed against here on the floor by other Republicans.

I am hopeful we will get a good crime bill. I remember very well that we spent close to 2 days on the floor before the Senate adopted the Brady bill, and there was great uncertainty on that side of the aisle whether they were going to continue a filibuster or not filibuster. I think the President is going the extra mile to get a good bill. I know the leadership is trying to get a good measure. I thought that the explanations by the Senator from Delaware responded fully to these questions and I commend those remarks to my colleagues.

TRIBUTE TO MAJ. GEN. JOHN G. SMITH, JR.

Mr. DECONCINI. Mr. President, I rise today to enter into the CONGRESSIONAL RECORD a eulogy for an Arizona citizen, outstanding soldier, and American patriot.

Maj. Gen. John G. Smith, Jr., served his country, his State, and his God with unswerving devotion and dedication. As the adjutant general for the State of Arizona, his record was one of excellence and commitment to the public welfare. His untimely death is a loss for Arizona and the Phoenix community.

I ask unanimous consent that a eulogy given at General Smith's funeral by Gen. Curtis A. Jennings be included in the RECORD at this point.

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

GEN. JOHN GRADY SMITH, JR.—EULOGY PRESENTED BY CURTIS A. JENNINGS AT HIS FUNERAL ON JULY 11, 1994

We are here today to honor the memory of our colleague and friend LTG John Grady Smith, Jr. It is impossible to render a proper eulogy to Gen. Smith in a few words and capture the full and rich tapestry of his life and a complete catalogue of his accomplishments. He was an extraordinary individual who had a lasting impact upon the Arizona National Guard, the community and State and his friends and acquaintances. His passing leaves a void in the lives of all those who knew him. On behalf of the officers and enlisted persons of the Army and Air National Guard, both active and retired, Gen. Smith's friends and acquaintances, I convey deepest sympathy and profound condolences to Mrs. Jane Smith, their three children and their families.

John Smith was born on November 19, 1919, in Statesboro, Georgia, where he grew to manhood. He attended Georgia Southern College in Statesboro where he met, in 1940, his future wife Norma Jane Simpson, affectionately known to all of us as "Jane."

His military career began in April of 1938 when he enlisted in the Georgia National Guard. In November 1940, his Guard unit was called into Federal Service due to the winds of war which were sweeping over Europe and the concern that the United States would soon be involved. He was in a coast artillery unit and received training at and was assigned to Camp Fisher, Fort Stewart and Fort Bragg before being commissioned as a 2nd Lieutenant Infantry in August 1942 through the Officer Candidate Program at the Infantry School, Ft. Benning, Georgia. He was assigned to the 104th Infantry Division nicknamed the "Timberwolf" Division which had been activated and was in training as a combat division at Camp Adair near Corvallis, Washington.

After a period of courting as only a southern gentleman can court, he won the hand of Jane, and they were married on April 4, 1943. Jane says he kept asking her by letter, telephone and in person so she finally said "yes." Clearly they must have both meant the vows they exchanged since they celebrated their 51st wedding anniversary last April. He enjoyed telling the story that after he and Jane were married and were traveling across the country as a very young couple, they would stop at a motel or hotel and he would tell the clerk to register him as John Smith. The clerk would look at Jane and say, "and I suppose you are Jane Smith," and she would answer, "that's right," much to the hotel clerk's amusement. Jane is an outstanding ideal of an officer's lady. She followed her soldier from camp to camp until his unit was deployed overseas, and then waited to join him when he returned.

In the fall of 1943 the 104th Infantry Division moved from Camp Adair, Oregon, with its wet and rainy climate, to the dry desert of Camp Hyder, Arizona. The division's encampment was known as Camp Horn, and the location was described as in the Arizona Desert on the Southern Pacific Railroad somewhere between Phoenix and Yuma, Arizona. Then Lt. Smith and his lady Jane found a rooming house in Phoenix where they rented quarters from a couple who became lifelong friends, Guy and Esther Gaston. Here they spent weekends when Lt. Smith was not in the field on maneuvers. Having bought their first car, Jane learned to drive on the dusty unpaved streets and roads of west Phoenix, Gila Bend and Hyder. This was their first experience in Arizona, and they must have liked it since they returned after the war.

From Arizona, the Division went to Camp Carson, Colorado, and then to Camp Kilmer, New Jersey, for overseas deployment. In late summer 1944, the Division landed in Cherbourg, France and was transported soon thereafter to the Belgium/Holland area where it was committed to combat attached to the First British Corps of the First Canadian Army. Its mission was to assist in clearing the approaches to the Port of Antwerp. Jane, of course, stayed in the United States, where she bore their first daughter, Norma. John did not see his daughter until he returned from Europe in the summer of 1945 after V.E. Day.

The 104th Infantry Division had an outstanding combat record in Europe, serving continuously in combat for 195 consecutive days. It served under British and Canadian command, as well as under the First and Ninth United States Armies. It inflicted over 18,000 casualties and captured 2,000 towns and communities, including the great cities of Cologne, Eshweiler and Halle. It took 52,000 prisoners in the great sweep across Germany to the Elbe and Mulde Rivers where it met the Russian forces on April 26, 1945. It also liberated two Nazi concentration camps where, in addition to the stark reality of combat, Gen. Smith saw and experienced some of the worst examples of man's inhumanity to his fellow man.

During these campaigns, Gen. Smith was awarded the Combat Infantry Badge, the Bronze Star with Oak Leaf Cluster, and the French Croix de Guerre with Palms. MG Terry de la Mesa Allen, Commanding General of the 104th Infantry Division specifically commended him and other officers for the fine performance in the European Theatre of operations. As most combat veterans, he spoke little of his wartime experiences.

In June 1945, after V.E. Day, the Division moved to Camp Lucky Strike near Dieppe and La Havre, France, and then sailed to New York for redeployment to the Pacific Theatre of operations. After leave, the men of the Division reassembled at Camp San Luis Obispo, California, on August 1, 1945, for combat refresher training and deployment in the Pacific. Through the use of its nuclear power, the U.S. compelled the surrender of Japan on August 15, 1945, and the Division, no longer needed in the Pacific, was thereafter deactivated.

Gen. Smith was separated from active duty as a Major in November 1945, and he, Jane and Norma journeyed from Camp San Luis Obispo, California, to Statesboro, Georgia. After seeing family and friends, he went "job looking," as he put it, and found that Georgia was not a good place to find a job. He contacted his friend Guy Gaston in Phoenix, Arizona, and through contacts with the American Legion, he became a contact officer for the Veterans Administration and settled his family permanently in Phoenix where his second daughter Sharon and son Guy were born.

He was in the organized reserve following his separation from active duty until May of 1949 when he joined the Arizona Army National Guard. He remained employed with the Veterans Administration until 1952, when he became Executive Officer of the National Guard serving under Adjutants General Frank Frazier and later J. Clyde Wilson. I first met Gen. Smith on one of his trips to Washington with Gen. Wilson in 1957 when they came to see Senator Carl Hayden from whom I was working at the time.

In June of 1960, Gen. Smith became the U.S. Property and Fiscal Officer for Arizona, and served in that position for the next 15 years, with Adjutants General J. Clyde Wilson, Joe Ahee, Jackson Bogle and Charles Fernald.

In July 1975 he was appointed Adjutant General of Arizona by Governor Raul Castro and promoted to Major General. He was reappointed twice by Governor Bruce Babbitt and retired in November 1983, at which time he was given his third star and promoted to Lieutenant General.

He was an enthusiastic and cheerful individual with a "can do" attitude. During his tenure as the U.S. Property and Fiscal Officer, it operated smoothly and efficiently, providing the troops with all logistical needs. As Adjutant General, he presided over a major expansion of the Arizona Army National Guard that almost doubled its troop strength and placed new units in a number of Arizona's rural communities. A number of new armories and facilities were started during his tenure. He also supported major expansion and new missions for the Air National Guard. While Adjutant General, he convinced the Pentagon to put the Arizona National Guard in command of the Navajo Army Depot near Flagstaff and to operate the munitions storage facility with Guard troops. This was the first time an active Army installation came under control of a state National Guard.

General Smith had outstanding characteristics of leadership. Unlike so many of his contemporaries who chose Patton as their model, Gen. Smith chose to emulate General Omar Bradley. He was a soldier's General—a diplomat, courteous and compassionate in even the most difficult situations. He was honest and sincere. He never played a part; he was always himself. He made ordinary people feel good and that they were important. He always had time for anyone who wanted to talk to him. As Adjutant General, he established an "open door" policy that was followed throughout the command. He got along well with private soldiers, generals, senators and cabinet members.

When he was Adjutant General and I served as his Troop Commander, I would go to see him on some difficult policy or personnel matter, and when we were through, he would always thank me for coming to see him. This always surprised me. Jane tells me that it was his habit to thank her and the children for the smallest thing, like passing him a glass of water. This character of southern gentleness—one might say almost chivalrous

conduct—made him stand out as if he were from an earlier and more noble time. This manner earned him the loyalty and respect of his peers and subordinates alike. He was well respected and highly regarded by his fellow Adjutants General and the officers with whom he worked in the National Guard Bureau. Every Arizona Governor with whom he worked had the highest regard for him, including Governors Pyle, McFarland, Williams, Fannin, Goddard, Castro Bolin, Babbitt and Mofford. The Arizona Congressional Delegation always looked to him for advice on military issues and reserve and national guard matters. Even with his abilities, he could not have succeeded without the help of others. In this regard, I know he would have wanted special mention made of three ladies who took care of him as his assistants and secretaries during his service in the Guard and of whom he thought so highly. These ladies are: Helen Glenn, Marilyn Pomerenke and Anna Kroger. Another friend of long standing whose acquaintance with General Smith goes back to their days with the 104th Division in Germany is now retired Sgt. "Pinky" Martinez. Mention should also be made of individuals who have gone before him and on whom be counted during those busy years. Special mention should be made of General Bob Pettycrew, Sam Krevitsky, Norman Erb and Dr. Mark Westervelt.

During his years as Adjutant General when a crisis would arise, General Smith would assemble a small staff to advise him, which he would call his "crisis staff." Although others might be involved, depending upon the issues, always there was Gen. Jay Brashear, this eulogist and Bob Pettycrew, in whom Gen. Smith had such confidence and on whom he always relied.

Even though he had a busy career, he always had time for his family. He was a loving husband and father. His children recall his playing ball and other athletic events with them. They recall picnics and his love of a backyard barbecue and cookout. Although they mention that sometimes the meat was cooked a little too well, he would tell them that was the southern way. He took his family on trips and taught them the history and heritage of our state and nation. He was a firm believer in the biblical commandment to honor thy father and mother. We have all heard him speak of his family in Georgia, especially his mother whom he worshipped. He was faithful in his pilgrimage to Georgia every year or so to see her until her passing a few years ago.

General Smith also found time for civic activities. He was Chairman of the Arizona State Fair Commission, a member of the Phoenix Urban League, Federal Executives Association, Arizona Emergency Services Association, and Military Affairs Committee of the Phoenix Chamber of Commerce. He was also a lifetime member of the Timberwolf Association, the Association of the United States Army, American Legion and National Guard Associations of Arizona and the United States. He enjoyed life. When I last saw him just before he went into the hospital, he told me "I have had a good life. I have enjoyed all of it."

General Smith did have a fine and successful personal and military career. In addition to his combat decorations previously mentioned, he was awarded the Distinguished Service Medal, the Legion of Merit, Army Commendation Medal, the Arizona Distinguished Service Medal, and many other medals and decorations. He was inducted into the Infantry Hall of Fame at the Infantry School at Fort Benning, Georgia.

General John G. Smith passed away on July 6, 1994. In describing him and his career, I think of the words duty, honor, loyalty and integrity. He will be sorely missed. Although he has answered that final bugle call, he will not be forgotten. As the poet Angelo Patri said:

"In one sense there is no death. The life of a soul on earth last beyond his departure. * * * He lives on in your life and in the lives of all others that knew him."

And so it will be with General John Smith. This kind and gentle man left the world a better place than he found it. He touched all of our lives and we are all richer for having known him.—Curtis A. Jennings, Brigadier General (ret.) Arizona Army National Guard.

THE 100TH ANNIVERSARY OF ROGERS DEPARTMENT STORE

Mr. HEFLIN. Mr. President, September 4, 1894, marked the beginning of a legacy for Maj. Benjamin Armstead Rogers, for the small town of Florence, AL, and indeed for the entire northwestern region of the State. On that date, nearly 100 years ago, Major Rogers and his two sons, Thomas McLemore and Benjamin Armstead, Jr., opened the Surprise Store at the corner of Court and Mobile Streets in Florence. As recorded in the Florence Gazette, the opening was accompanied by Ben Rogers, Jr., leaving for New York to buy stock.

The Rogers family had arrived in Florence confident of the town's and area's future, and they wanted to play a part in its development. The family's ideas and vision about retail merchandising varied significantly from those of the average tradesmen of the day. They marked each and every item with its exact price and their policy of "One price-plain figures" led to their success. The store that still stands at the corner of Court and Mobile Street today is a living testament to the Rogers' success over the last century.

Five generations of the Rogers family have now worked at this location. A large part of the vitality of downtown Florence today is a direct result of the Rogers' commitment to maintaining the life of the central business district. Like most major department stores in recent decades, they have had opportunities to relocate to modern, state-of-the-art suburban shopping malls, but have chosen to remain as one of the anchors of downtown business. There are now Rogers stores in Decatur and Muscle Shoals, AL, as well.

Rogers family members have also taken a leading role in community service and have played pivotal roles in the progress and development of north Alabama. They have served as members of the chamber of commerce, the Rotary Club, United Way, Boy Scouts of America, the YMCA, and the Alabama State Legislature. Corinne Rogers Zaccagnini, a great-great granddaughter of the founders, presently works for Senator DECONCINI on the Security and Cooperation in Europe Commission.

I salute the Rogers family and congratulate them on the 100th anniversary of Rogers Department Store. It has become a legendary institution in this part of Alabama, and is poised for an even brighter future.

IS CONGRESS IRRESPONSIBLE? YOU BE THE JUDGE ABOUT THAT

Mr. HELMS. Mr. President, as of the close of business on Tuesday, August 16, the Federal debt stood at $4,667,394,077,182.19, meaning that on a per capita basis, every man, woman, and child in America owes $17,902.56 as his or her share of that debt.

IN MEMORIAM—MANFRED WOERNER

Mr. BIDEN. Mr. President, I rise today in praise of Manfred Woerner, Secretary General of the North Atlantic Treaty Organization and a true friend of the United States, who died on August 13 at the age of 59.

Manfred Woerner was the first German to hold the highest civilian post of NATO. Born in Stuttgart, he won a seat in the German Parliament in 1965 and rapidly established himself as a security expert. In 1982, Chancellor Helmut Kohl named Mr. Woerner Defense Minister at a time of great debate in Germany about the proposed stationing of American medium-range nuclear missiles in that country to counter a massive Soviet missile buildup.

Mr. President, this issue was a grave one, which caused mass demonstrations in Germany and threatened to split the Atlantic alliance. It was largely because of Manfred Woerner's determined efforts that the American initiative succeeded. The Atlantic alliance survived its most serious crisis, and less than a decade later the West had won the cold war over the Soviet Union.

In 1988, Manfred Woerner succeeded Lord Carrington as NATO Secretary General and in doing so became a symbol of democratic Germany's ultimate acceptance as a leader of the alliance. In his new position he once again proved his far-sightedness, advocating the strengthening of NATO's conventional forces and, more recently, calling for a firm response to Serbian aggression in the former Yugoslavia.

Manfred Woerner was a distinguished German politician, a leading European statesman, a fine gentleman, and a loyal, steadfast friend of the United States of America. He will be sorely missed by this country, which is deeply in his debt.

WOMEN IN COMMUNICATIONS

Mrs. HUTCHISON. Mr. President, I rise today to celebrate the 85th anniversary of Women in Communications, Inc.

In 1909, it was founded as Theta Sigma Phi by seven female journalism students at the University of Washington in Seattle. Women journalists had few opportunities at that time, but by the 1920's a Theta Sig, Dorothy Thompson, became the first overseas bureau chief for an American newspaper, and women have been creating new opportunities ever since.

The organization has grown rapidly since then, and has been renamed Women in Communications, but its mission has been consistent; to advance women in all fields of communications, to protect first amendment rights and responsibilities of communicators, to recognize distinguished professional achievements, and to promote high professional standards throughout the communications industry. Its members have included women in many fields, from Barbara Walters, to Eudora Welty to Helen Thomas.

Mr. President, as Women in Communications celebrate its anniversary, its members have dedicated themselves to extending their work to future generations by speaking and mentoring to high schools, colleges, and business groups. I congratulate them on their milestone, and invite my colleagues to observe October as National Communications Mentoring month.

STATEMENTS OF AUGUSTO RODRIQUEZ AND MICHELLE EDWARDS, BOARD OF YOUNG POLICE COMMISSIONERS, NEW HAVEN, CT

Mr. DODD. Mr. President, yesterday, I had the extreme pleasure of meeting with Augusto and Michelle, who are in town attending the National Youth Violence Conference. They had compelling stories to tell about how violence has affected their young lives. Their experiences put a face on the terror facing so many young people in our Nation—a terror that just a generation ago would have been impossible to imagine in our country.

But their stories are also laced with hope for what can be done to end the carnage. And, this is why I felt it was so important to include their statements in the RECORD. Both Augusto and Michelle are officers of the Board in New Haven. This unique program brings young people and their schools together with the New Haven police department to try and do something to stop the violence.

The program has worked wonders for the young people, police and citizens of that city and is exactly the type of program that could be expanded if we would just pass the crime bill. These kids understand the simple truth that we will never stop crime in this Nation until we give our kids some positive alternatives to the streets. So, I encourage any of my colleagues who think that prevention programs should not be a part of tough crimefighting legislation to read the words of Michelle and Augusto. Their stories illustrate the wisdom of this approach better than any of the rhetoric we hear in this town. Mr. President, I ask unanimous consent that the enclosed statements of Augusto Rodriquez and Michelle Edwards from New Haven, CT be printed in the RECORD.

There being no objection, the statements were ordered to be printed in the RECORD, as follows:

SPEECH TO NATIONAL YOUTH VIOLENCE CONFERENCE

(By Augusto Rodriguez)

Good morning! My name is Augusto Rodriguez. I am the proud President of the Board of Young Adult Police Commissioners. On behalf of the city of New Haven and the thousands of youth who reside in my city I wish to compliment you for providing us with a chance to face reality. I feel that this National Conference provides us with a necessary opportunity to voice our opinion on the fatal issue of youth and violence, which is taking away my friends and family.

I have an investment in New Haven as a resident and a senior at Career High School. I come from a single parent family who survives on a fixed income. My role has been that of a surrogate father to a good mother and family. The demands have added to my responsibilities while making me stronger.

Career High School has a valuable asset, its principal Mr. Williams. He demonstrates a keen interest in the student body as well as being approachable, friendly and very helpful. The student population is about 400. The most violent act during my junior year was when one female struck another in the face over what she said. Career High does not represent anywhere near the amount of violence that occurs in our city.

In the 1980 census, New Haven was ranked the 7th poorest city in the nation among cities with more than 100,000 people. Twenty-eight percent of New Haven's children under the age 18 live below the nation's poverty level. However, African Americans and Hispanics account for 41% of those living in poverty. While the 1990 Census indicates that New Haven ranks 39th now, we still continue to suffer the blight of being in dire need of economic growth.

In just the last year I have seen what this adds up to.

On my way to the store I saw a car drive by my brother and his 21 year old friend. I was half a block away when 2 windows rolled down. Six or seven shots where fired. The friend was hit in the left abdominal region and the right thoracic area. The friend hid behind a tree. He looked around and was shot again. This time he collapsed. My brother and I ran to him. When I got there, I heard the friend say, "It burns! It burns! Forget it I'm gone." He then started gasping for air. Police showed up and dispersed the large crowd. The paramedics ripped open his clothes and placed him on a stretcher. He died in the ambulance.

I was at a club with a group of friends. When I saw a female about 27 pull out a switch blade. She slashed my friend from the ear to the top of her lip. Her whole epidermis was hanging out. She said, "My face is shrinking. It burns." She was so beautiful at 21. But no longer.

I was visiting Fair Haven Middle School and saw three 8th graders beating up a 7th grader outside. One of the 8th graders had a bottle in his hand and struck the 7th grader in the head. He fell to the ground, and all 3 began kicking him. The school security guard grabbed two of them. the 7th grader ended up with 7 stitches.

During my sophomore year Chief Pastore visited my high school. My peers and I listened to the Chief's message about empowerment of youth. Before the Chief's departure he stated, "If you have any questions or concerns please feel free to call me."

At a drug raid next door, a narc pushed my younger brother and was disrespectful to him. I was really angry. This was not the message the Chief gave. I made an appointment to see him. My brother, the Chief, the narc and the youth coordinator were there. We all had a chance to talk and make our point. At the end of a good meeting my brother and the narc apologized and shook hands. They gave their word they would be more respectful. The Chief suggested I speak with the youth coordinator Detective Morrissey. We talked about the Board of Youth Adult Police Commissioners. He gave me information. I called him back. I said I was interested in joining. I now know that the Board was not just a front, but a real beginning. That was over a year ago.

Our Board is looking forward to interviewing the 60 community police recruits who will be coming on the next year. The Crime Bill, which I hope passes soon will help us with more police and drug/alcohol prevention and treatment. Over 80 community policy officers have been interviewed already by other commissioners. Now it's our turn. I am convinced this helps us bridge the gap between policy and youth. Lasting friendships have been made with commissioners and police.

My first committee assignment on the Board was planning the Holiday Jam. The Board met with our Chief to bring youth together for fun and a fund-raiser. We decided on the Thanksgiving weekend dance. I and other commissioners visited Hospice and meet with the President. The decision was made. Youth our age are dying right now from AIDS. Hospice allows them to die with dignity. Over 300 students from all over New Haven showed up paying $3 each. Three stores donated prizes to the dance contest. No cursing, no problems and a lot of respect. The only complaint afterwards was that people wanted to come but didn't know about it. We raised $800 and are planning the next dance.

The Board is composed of a President, Vice President, Secretary, Treasurer and 18 members. We are fully chartered and legitimate body of elected and appointed young people, representing the full cross section of the population in New Haven. Our Board meetings are run by Robert's Rules of Order.

Special committees are set up when needed. Six commissioners are elected from their respective high-schools. Sixteen others must submit a resume and be recommended by a commissioner. The Board then votes. All are sworn in by the Mayor.

We are serious about the quality of life. We know time has been wasted. Excuses are not the answer. You've have been leaving us out of this war far too long, that's why we're losing it. Only together can be win. Please don't ignore the facts.

Nick Pastore is more than a Chief of Police. He is our friend. He listens and works with us when it counts. Together we are improving life in New Haven for everyone. We are ready to spread the solution and are available.

Thank you for allowing our group to be heard today. It is commonly assumed that

adults fail to listen to our age group. Your presence here has proven that assumption to be incorrect. We are a prime example that police and youth can work together and make a difference.

I would now like to introduce our Vice President, Michelle Edwards.

AUGUSTO RODRIQUEZ,
President.

SPEECH TO NATIONAL YOUTH VIOLENCE CONFERENCE

(By Michelle Edwards)

Good morning! My name is Michelle Edwards and I am the Vice President of the Board of Young Adult Police Commissioners, and on behalf of the Board I want to thank you for inviting us to this very prestigious conference. Which we all know is addressing the urgent issue of youth and violence. The commissioners appreciate the respect you have shown the youth of this nation by hosting this important conference.

I am a resident of New Haven, CT. My father is a retired Msgt. of the United States Air Force. My mother works at American Linen. I am a 16-year-old junior at Wilbur Cross High School. There I am a member of the National Honor Society and captain of the volleyball team. I also have a part-time job at a local Shell gas station.

A positive aspect of Cross High School is it's diversity—with 17% Caucasian, 40% Latino, 40% African American, and 3% Asian American and other nationalities. Cross also has a number of dedicated teachers who provide students with a worthwhile education. However, in the 2 years of attending Cross, I have witnessed or have had direct knowledge of violent acts by students which has ultimately disrupted and destroyed social and educational opportunities. On one occasion, we had 4 students attack one of our assistant principals and rob him of a mere $18. Another time a 17-year-old young man who had a gun in his possession accidently shot himself during gym class. I remember sitting in my social development class and hearing chaotic screams and yells of "Oh my God," "He has a gun!" Within an hour, we had 4 television crews, 2 radio stations plus local newspapers ready to cover the incident. Unfortunately, during the National Honor Society Induction, a news crew could not be found. Two days before the final closure of school, 3 female students viciously attacked another female student with a mule bone, which they confiscated from a biology class, sending the victim to the emergency room. This incident was provoked because one of the 3 female students didn't like the other student's cousin. These random acts of violence have become so frequent that I and my classmates have become conditioned to expect them and accept them as normal behavior. Good teachers close and lock their doors in fear and continue on with their daily lesson plans. For the adults who are here today, I want you to think back on your high school days. Did you ever fear the gun or knife in your school? We do. If our roles were reversed and I were your parent I wouldn't let you go through this. Too many innocent people are being hurt. We need real action and genuine help now!

I was recommended and elected by the students of Cross to represent our school on the Board of Young Adult Police Commissioners. At first I was quite critical of the Board. I thought that the Board was a front for teenagers to just hang out. Now that I am a member of the Board and aware of it's accomplishments, I realize that I was mistaken. I understand that my fellow peers want to have a say in the decision making process. Being a Young Adult Police Commissioner makes this possible.

An example of this is the Board's Standing Committee on Residential Drug Treatment for Adolescents, which was formed in November of 1991. It's main purpose is to try to educate, prevent and treat drug abuse among the youth in New Haven. This committee conducted research and discovered that there were only 110 beds available in the entire state of CT. However, only 20 beds were available for non-insured (keep in mind that this is the ENTIRE state!). Our Standing Committee also discovered that the cost of placing someone in jail for a year, approximately $42,000 was far more expensive than putting someone through Residential Drug Treatment which is approximately $24,000. That's when the committee took action to get more treatment beds for adolescents. Two thousand students signed a petition to encourage more beds and we presented it to the General Assembly's Appropriations Committee. We also spoke in front of the Appropriations Committee asking for their help. Then we learned after seeing the Annual Budget that no more beds would be added. Instead that 10 beds would be taken away from the youth population creating more victims. We then decided to call Mr. Dyson, the co-chairperson for the Appropriations Committee, to ask for his personal help. We were successful in saving the 10 beds. Our question is how long does the line of victims have to get before funding for more treatment beds are available?

Since the Board's founding we have supported and continued to encourage Residential Drug Treatment. Glenn Johnson, a student at Amhurst, and also the first chairman of the Residential Drug Treatment Committee and the president of our Alumnae Association, along with 3 other commissioners, met with four recovering drug addicts in November of 1991. They discussed the reasons for needing treatment; it had to do with life or death. Recently former Vice President Melissa Annunziata and I attended a graduation of recovered addicts in Newtown CT (which is about an hour from New Haven). What we saw were 9 recovered addicts who went through with Residential Drug Treatment, received their diplomas and in turn changed their lifestyle. The Board feels that Residential Drug Treatment is the best transition from a negative environment into a positive atmosphere.

Recently, we have hired two consultants from Massachusetts to assist us with needs assessment, strategy planning, documentation and fundraising. We wrote a proposal to CSAP (Center for Substance Abuse Prevention) in September of 1993. We received 16 resumes from as far as California. We then narrowed our selection down to New England consultants only, We interviewed 3 consultants at the New Haven Police Department and hired Dan Jaffe and Hal Phillips. Since then we have organized two all day Sunday meetings. During these meetings we discussed ways to improve the Board's standing with the community, national linkages, fundraising, and community and police relations. Our main purpose of working with these consultants is to find strategies to achieve these goals.

President Augusto Rodriquez, Secretary Maya Castellon, Treasurer Chris Greene and I will be available until Wednesday to discuss real youth inclusion and empowerment within our system of government. Please feel free to come to me or any of the other officers. Once again, I want to thank those who worked so hard to put this conference together for this rare opportunity to be listened to intimately from a distance. I hope our words turn into action soon. We want to help that happen. Thank you.

MICHELLE EDWARDS,
Vice President.

CRIME

Mr. DOLE. Mr. President, one of the most extravagantly oversold provisions in the crime bill is the proposal that allegedly would put 100,000 new cops on the street. While few dispute the merits of adding to the ranks of our State and local police forces, it is also important to level with the American people.

The Heritage Foundation has concluded that the crime bill provides full funding for only 20,000 new police officers, not the 100,000 claimed by President Clinton.

This 20,000 figure is consistent with the analysis of Princeton University Prof. John Diiulio, who recently had this to say about the crime bill:

> The bill calls for 100,000 new cops. But when you read the relevant titles of the bill, what you discover is that that really means about 20,000 fully-funded positions * * * and if you are stouthearted enough to look at this bill in light of the relevant academic literature, you know that it takes 10 police officers to put the equivalent of one police officer on the streets around the clock * * * so that 20,000 funded positions becomes 2,000 around-the-clock cops. And 2,000 around-the-clock cops gets distributed over at least 200 jurisdictions for an average actual street enforcement strength increase of about 10 cops per city.

But, Mr. President, let us put Professor Diiulio's comments aside for a moment and assume that 100,000 new cops will, in fact, be hired as a result of the crime bill.

The Heritage Foundation estimates that creating 100,000 new police positions through the crime bill will saddle the States with a $28 billion unfunded liability over the next 6 years. Twenty-eight billion dollars is the difference between the total cost of hiring 100,000 cops for 6 years—$37 billion—and the amount of funding actually provided in the crime bill, nearly $9 billion.

Heritage estimates that the crime bill could result in 875 new cops for my own State of Kansas. While the crime bill would provide $77 million for this purpose, Kansas would still be stuck with a $250 million tab.

So, Mr. President, let us not oversell the crime bill. Let us not sell the American people a crime bill of goods.

Again, I support trying to put more cops on the street. More police generally means more security. But the crime bill will not put 100,000 new police officers on the street, as the President claims. It fully funds only a fraction of this amount—about one-fifth; 20,000 new cops. And even if we assume that 100,000 police positions will be created, it is the States and localities who will pay the lion's share of the cost.

Mr. President, I ask unanimous consent that the Heritage Foundation study be reprinted in the RECORD immediately after my remarks.

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

THE CRIME BILL'S FAULTY MATH MEANS A $28 BILLION UNFUNDED LIABILITY TO THE STATES

(By Scott A. Hodge)

President Clinton is making a last-ditch effort to revive the $33 billion crime bill that Congress rejected last week on a procedural vote. Among the arguments Clinton is using to sway lawmakers is the claim that if Congress passes this measure, the bills' $8.8 billion Community Policing grant program will add 100,000 new cops to local police forces over the next six years.

Clinton is wrong. The numbers just don't add up. The crime bill provides full funding for only 20,000 permanent new cops. Meanwhile, it saddles state governments with a $28 billion unfunded liability over the next six years if the bill is to result in 100,000 new officers. States such as California and New York will have to raise some $3 billion each to meet the Administration's promise.

The reason this happens is that the Community Policing grant program is intended only to provide "seed" money to local governments to hire new police officers, not to fully fund these positions. So the bill assumes that once these new officers have been hired with Washington's help, state and local governments will find the billions of new dollars needed to keep them on permanently. The bill provides just one-fifth of the funds needed over six years to hire and keep 100,000 new cops on the street in high-crime areas.[1] Thus, if cities do not cut back on the other services or raise taxes, the funds provided in the bill can keep at most just 20,000 permanent cops on the street over the six-year life of the bill. Even more problematic for state and local officials, if they use federal funding to hire the new police officers and then cannot raise the funding needed to keep them, officials will have to start laying off cops after the first year of the bill.

Another way to look at this financial sleight-of-hand is to calculate how much funding the bill provides per police officer per year. On average, the bill authorizes $1.475 billion per year for 100,000 new officers. This amounts to just $14,750 per cop per year—roughly the poverty level for a family of four. Police officers cannot, of course, be hired for minimum wage salaries, and so state and local governments would have to absorb the remaining cost of hiring and keeping each of these new cops.

To give taxpayers a better understanding of the total cost of the crime bill, Heritage Foundation analysts have calculated the amount of new resources states will have to raise over six years if they choose to apply for the federal Community Policing grants. As is seen in the following table, these calculations show that state governments will have to raise a total of over $28 billion of their own funds to meet Clinton's promise.

Eight states (California, New York, Texas, Florida, Illinois, New Jersey, Pennsylvania, and Ohio) will have to absorb more than $1 billion each in new costs over the next six years to fully fund their share of the 100,000 new cops. At the bottom end of the scale, the fourteen states likely to receive the minimum amount of federal aid for new police officers—and, of course, the fewest number of new cops at 500 per state—will still find themselves liable for over $143 million each in added expenditures to meet the bill's lofty goal.

Large states, such as California and New York, will be particularly hard hit. Although California is estimated to receive 10,827 new cops, it will have to absorb some $3.1 billion in new costs to keep them on the street. Similarly, New York is estimated to receive 10,407 new cops but will be burdened by some $3 billion in new costs. Neither of these states is in the fiscal condition to bear this expense. Texas could hire nearly 6,400 new officers but would face an unfunded liability of over $1.8 billion by doing so.

In reality, the unfunded liability for some large states will be even higher than these estimates suggest. This analysis assumes that the Community Policing grants will be distributed proportionately according to a state's share of the national police force (see technical notes in the appendix). But the crime bill allows 75 percent of the Community Policing funds to be distributed at the discretion of the Attorney General. This means that the Administration may play politics with these funds and reward loyal mayors and local politicians in politically important states—or House members the White House needs to win passage of the bill.[2] But, ironically, this will raise the taxpayer liability in these states even higher.

The dirty little secret of the crime bill is that it will not put 100,000 new police officers on America's streets unless the states raise taxes or cut other spending to finance a massive $28 billion unfunded liability. Once most states realize the magnitude of these new costs it is likely that far fewer permanent cops will actually be hired. However the computation is made, the result is the same: Bill Clinton's crime bill actually funds only a fraction of the promised 100,000 new cops.

THE CRIME BILL'S UNFUNDED LIABILITY TO THE STATES

State	Estimated new cops added per state by crime bill	Crime bill's contribution for new cops over 6 years	Liability to State taxpayers for new cops over 6 years
California	10,827	$958,224,360	$3,102,048,353
New York	10,407	920,993,894	2,981,522,608
Texas	6,386	565,124,889	1,829,472,098
Florida	5,630	498,252,127	1,612,985,699
Illinois	5,488	485,723,575	1,572,427,165
New Jersey	4,327	382,895,805	1,239,544,047
Pennsylvania	4,129	365,378,435	1,182,835,273
Ohio	3,683	325,952,244	1,055,201,331
Michigan	3,106	274,917,767	889,988,026
Massachusetts	2,707	239,592,416	775,629,687
Georgia	2,605	230,502,758	746,203,844
North Carolina	2,484	219,847,031	711,708,184
Maryland	2,190	193,805,079	627,402,882
Virginia	2,148	190,075,574	615,329,401
Missouri	1,885	166,859,004	540,170,675
Wisconsin	1,808	159,981,217	517,905,294
Indiana	1,743	154,217,437	499,246,278
Tennessee	1,732	153,281,024	496,214,842
Louisiana	1,651	146,128,771	473,060,936
Alabama	1,443	127,674,988	413,320,725
Washington	1,399	123,767,888	400,672,317
Arizona	1,380	122,137,239	395,393,435
Connecticut	1,324	117,132,276	379,190,929
South Carolina	1,273	112,660,100	364,713,205
Minnesota	1,266	112,062,733	362,779,357
Colorado	1,225	108,446,244	351,071,739
Oklahoma	1,157	102,391,853	331,471,932
Kentucky	1,046	92,543,378	299,589,580
Oregon	898	79,498,185	257,358,530
Kansas	875	77,415,474	250,616,196
District of Columbia	830	73,459,939	237,810,989
Iowa	818	72,394,366	234,361,423
Mississippi	762	67,453,984	218,367,981
Arkansas	696	61,561,043	199,290,835
New Mexico	595	52,648,980	170,439,920
Nevada	565	50,001,194	161,868,271
Nebraska	514	45,496,727	147,286,015
Utah	500	44,250,000	143,250,000
Hawaii	500	44,250,000	143,250,000
Rhode Island	500	44,250,000	143,250,000
West Virginia	500	44,250,000	143,250,000
New Hampshire	500	44,250,000	143,250,000
Maine	500	44,250,000	143,250,000
Idaho	500	44,250,000	143,250,000
Montana	500	44,250,000	143,250,000

Footnotes at end of article.

THE CRIME BILL'S UNFUNDED LIABILITY TO THE STATES—Continued

State	Estimated new cops added per state by crime bill	Crime bill's contribution for new cops over 6 years	Liability to State taxpayers for new cops over 6 years
Delaware	500	44,250,000	143,250,000
Alaska	500	44,250,000	143,250,000
South Dakota	500	44,250,000	143,250,000
Wyoming	500	44,250,000	143,250,000
North Dakota	500	44,250,000	143,250,000
Vermont	500	44,250,000	143,250,000
Total	100,000	8,850,000,000	28,650,000,000

TECHNICAL NOTES

These calculations have been made using a conservative estimate of the average cost of hiring and keeping a police officer on the beat in small and large cities. In small cities, such as Elkhart, Indiana, the total cost of putting a permanent cop on the beat is $50,000 to $55,000 per year. In large cities, such as San Francisco, this cost rises to $70,000 to $75,000. The average used in this analysis is $62,500. This figure includes salary and fringe benefits, training, and some administrative costs. It does not include equipment costs such as police cars and radios. In most cities, a new police cruiser is needed for every three or four officers hired.

This analysis assumes that the Community Policing funds and, thus, the 100,000 new cops, will be distributed proportionately among the states according to the current state-by-state distribution of roughly 534,000 police officers nationwide. The source for these data is the "Sourcebook of Criminal Justice Statistics—1992," published by the Justice Department's Bureau of Justice Statistics.

The crime bill requires that no state receive less than 0.5 percent of the Community Policing funds. Thus fourteen small states, whose share of the nation's police force is less than 0.5 percent, were automatically allotted this minimum share of funds for new officers. The remaining funds and new cops were then distributed proportionately among the other states.

The federal contribution per state for new cops is based upon the $14,750 per cop per year the bill authorizes. The state liability is then based upon the residual amount of $47,750 ($62,500–$14,750).

[1] For more information on these calculations, see Scott A. Hodge, "The Crime Bill: Few Cops, Many Social Workers," Heritage Foundation Issue Bulletin No. 201, August 2, 1994.

[2] Last year, Congress passed an emergency supplemental bill which included $150 million in aid to hire 2,000 new police officers. Nearly 45 percent of these funds went to four key states: California, Florida, Illinois, and Texas.

CONCLUSION OF MORNING BUSINESS

The PRESIDENT pro tempore. There being no further morning business, morning business is closed.

HEALTH SECURITY ACT

The PRESIDENT pro tempore. The Senate will resume consideration of the bill, S. 2351, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 2351), to achieve universal health insurance.

The Senate resumed consideration of the bill.

Pending:

Mitchell Amendment No. 2560, in the nature of a substitute.

Mr. KENNEDY addressed the Chair.

The PRESIDENT pro tempore. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, yesterday we enacted a guarantee that every insured child in America would receive comprehensive preventive benefits as a matter of right. Today we will be considering whether every child in America and every adult also should have at least the same reliable comprehensive benefits that every Member of Congress receives. The Mitchell bill is a triple guarantee.

First of all, in the Mitchell bill, you will not be cheated out of what you have today by insurance company fine print or loopholes in your policy that do not protect you when serious illness strikes. The examples of how that fine print has excluded the insurance companies from covering, whether it has been infants in their first days of life, or whether it is other individual families members that are in great need, has been illustrated time in and time out during the course of this debate. And the Mitchell bill addresses that particular feature of existing abuse that is taking place in too many insurance policy issues today.

Second, as long as you buy a standard insurance policy, you will never have less than the comprehensive benefits provided to every Member of Congress, and the President, too.

That has been the stated policy of the Mitchell proposal. There is a very similar concept in terms of even the Dole benefit package to make it actuarially similar to what we have in Federal employees health insurance. That is I think a standard which the American people would certainly be willing to accept. For 10 million Federal employees, including obviously the Members of the Senate and the House, it is a good program. I with a family pay $101 a month. It is an excellent program to provide for my family with two children. I daresay that most Americans having heard that would pretty much sign on for that program even today. It is certainly the objective of those of us who support health insurance reform to make that kind of a possibility for other Americans.

Third, the Government would never require you to buy less comprehensive coverage than you have today. You can always buy greater coverage if you want it. The basic concept is that a standard, not a Cadillac standard, or even a Gramm standard, but a minimum standard. In this case it is about the bottom quarter of the Fortune 500 in terms of the benefit package which would be the kind of minimal standard which can be added to, which can also be enhanced by individuals if they so desire because of certain kinds of needs; but a standard that would be available to Americans without the fine print of insurance policies that exist today.

I would like to review for the Members what the Mitchell bill does, and to contrast it to the alternatives. First of all, it establishes the comprehensive lists of benefits that must be covered. That is done on pages 95 to 104. In measures that were reported out of our human resource committee, we identified very, very precisely the benefits. The Federal employees programs are more general in terms of the types of benefits that ought to be provided. The leader reached I think a worthwhile adjustment in terms of those two ways of approaching this. It is illustrated on pages 95 to 104.

Second, it requires that these must be equal in total value to the Blue Cross-Blue Shield policy that covers most Members of Congress today. That is written into law at page 93.

It allows the vast majority of Americans to buy their coverage from the Federal Employees Health Benefits Program, the same program that provides coverage to every Member of Congress. That is at page 158. We will in terms of the two various pools be blending those, phased in over a limited period of time. But effectively that benefit package of benefit programs will be available to Americans and be consolidated in the next several years.

It also allows you to buy additional coverage if the standard benefits alone do not meet your needs. That is on page 88. It provides coverage for cost-effective preventive services without copays and deductibles. That is on page 123. We reviewed those in some detail over the period of the past days when we were considering the Dodd amendment.

I see the Senator from Delaware who supported that amendment on the floor at the present time. Basically, we were trying to ensure the kinds of preventive health care benefits which result in an enhanced health condition for individuals—particularly in the instance

of the Dodd amendment for children—which would enhance health conditions for all Americans. And the results have been illustrated several times by the excellent presentations that have been made by the two Senators from Hawaii, where they have very extensive preventive health care programs.

It is designed to better meet the special needs of women, children, and the disabled in many current insurance programs and insurance policies. This is addressed on various pages. The coverage as it relates to preexisting conditions is illustrated on pages 61 through 64. The Mitchell bill prohibits such abuses as the preexisting condition limits, lifetime limits, denial of coverage, rate hikes if you get sick, and exclusion of essential services.

The lifetime limits are addressed on page 124, and the other part is on pages 60 and 61 and the pages following. I daresay you could ask how many of the Members of this body would know what the lifetime limits are, or whether there are lifetime limits in their own Federal employees insurance. We had a meeting earlier in the morning talking about this with our colleagues here. And there are some tragic incidents where some of our colleagues talked about insurance policies that were available to their constituents, and then they would find out that they had some serious health needs and suddenly the insurance company would say, well, look, you have the lifetime limit and you have exceeded it. We found that particularly in examples used involving children—the kind of hardship was placed upon that family.

It guarantees you the right to choose a plan that provides free choice of doctor and hospital. This is included in both if you go through the cooperatives, page 151, or through employer programs at page 137. This is an essential part of the Mitchell proposal. Under the Dole provision, there is no reference to the choice of a doctor or a hospital.

So here is the contrast of the Mitchell bill to the status quo.

Today, any insurance company can, first of all, deny you coverage.

Secondly, they can impose a preexisting condition exclusion. They can say if you have a preexisting condition, we can exclude you for that coverage.

They can limit your lifetime benefits so that your protection runs out when you need it the most.

They can cancel your coverage when you get sick. We have had several examples in very recent weeks of employees with good companies that had their health care canceled for all of their employees because of the incidence of illness among just a few of their employees effectively canceled out within a 2- or 3-month period.

There is also the exclusion of any service from coverage, even a service that might turn out to be most important to you if someone in your family becomes seriously ill.

No American is guaranteed choice.

I think these following points are worthwhile to keep in mind. If your employer does not offer a plan you like, you can be out of luck. Eighty-four percent of employers offer only one plan. Of the employers that make available health insurance to their employees, they provide one plan, and you are effectively out of luck if you want an alternative choice. You can take it or leave it.

Second, if your employer does not offer a plan that allows you to keep your family doctor, you are also out of luck.

You say, look, I want to be able to keep my family doctor. The real life, real world today says: This is your plan. If your family doctor is not covered by that particular kind of plan, you are out of luck.

The Dole plan is better than the status quo alternative, but I do not believe it is good enough. The insurance companies can still impose preexisting condition limitations, and they can sell you a policy that does not cover the service you may need the most, because policies are not required to provide comprehensive coverage. You do not have the guarantee of choice.

We are likely to see an amendment offered sometime, perhaps today, or sometime in this debate, that will claim to protect the benefits the American people have today by effectively scrapping the requirement that every insurance policy must offer basic comprehensive benefits.

What it will do is effectively gut the protections that the Mitchell bill provides. It will allow every insurance company the abuse that exists today to continue with the preexisting condition limitations or the right of the company to terminate or not renew the policy.

There may very well be lifetime limits, inadequate protection for children and the disabled. One of the favorite provisions for many insurance companies, particularly those covering young families, is the exclusion of a child's coverage for the first 10 days of life. That is where about 93 percent of all medical complications arise.

I think of the scores of young couples that looked over the insurance policy and saw they got prenatal care, and then had these difficulties in the first few days of life, found out there was no coverage. That has been one of the continuing tragedies in too many instances.

Mr. President, any kind of an amendment that effectively would undermine the guarantee of at least a minimum package of benefits would undermine the amendment that we passed yesterday to protect children, because the guarantee of preventive services will turn out to be no guarantee at all.

The widely respected Actuarial Research Corp. estimated that because of adverse selection, if these benefits are available but not standard, it could cost a family an extra $450 a year. If they are included in what everybody buys, they would cost only $2 per month per child.

The supporters of this amendment will say that they are trying to preserve choice. But that is the same old argument that has been used to protect the profiteers of the status quo since the beginning of time. The opponents of change have always hid behind choice. Child labor laws deny children the choice to work 12 hours a day in mines and factories.

We will hear: Why should we have this standard benefit package available? Why do we know better than the people back home in local communities? Well, that debate was there at the time of the child labor laws.

In my own State of Massachusetts, in Lawrence and Lowell, you could go into the various plants and factories—and they still have museums up there containing little poems of children 10, 11, 12 years old, who used to work 10 or 12 hours a day, 6 days a week, and they would describe looking out the window at the parks, and so forth. Their life experiences had passed them by. They would generally last 8 to 10 years in those plants and no longer, for a variety of different kinds of tragic reasons. So when we hear, "We want to preserve choice," we can say that issue was addressed years ago. We had the child labor laws. They said, "Why should you in Congress pass child labor laws?"

Why do not we permit those who are in charge of the children have the choice of working more extensive time? Why deny us that kind of choice?

We have the same argument with the Fair Labor Standards Act which denies men and women the choice to work at less than the minimum wage. Why do not we permit men and women the choice of working less than the minimum wage?

There is basically a social compact which has been accepted by Republicans and Democrats alike that men and women who want to work 40 hours a week, 52 weeks a year ought to not be put in a position of poverty in this society. They ought to be able to have sufficient income to provide for their families, put a roof over their head, food on the table, afford a mortgage for their home, and live in some peace and in dignity. That was the concept.

We could say, well, let us eliminate any minimum wage laws. Let us just let the market go. Why do we know more than what is happening out in these local towns? We can find people who will work for less than the minimum wage.

We say, well, on the issues we have a sense of a common good about what our society is about. We care about

men and women who want to work, will work and will work for low wages, but they ought to be part of the American experience that they are going to live in some kind of peace and dignity.

We address the issues of choice on the Social Security Act, which denied people the choice to forgo pensions. Why not say, well, we had that debate. We are going to say under Social Security we are going to make that an option for people. We will give them the choice of having no Social Security, no pensions when they retire. Why not give them the choice of that so that they do not have to conform?

We have accepted the concept that we have a respect for those who have really been the architects of this great wonderful blessed land who really toiled in the fields and worked in the factories, fought the wars, built the country. They are part of our society. They are our parents. We are their children. And as a society, the only way that we could get it was the development of a Social Security system that was part of the social compact.

We have accepted in recent years what we call the lemon laws and deny the people the choice to buy cars that broke down all the time. Why not let anyone go out and buy whatever car they want, let it break down, touch the fender and it collapses, drive out of the parking lot and the engine is no good? Why not permit everybody the free choice to be able to do that? Why expect that there ought to be at least some requirement that would represent what the seller and the purchaser understand to be the value of it? We could say why have that kind of law, why have that kind of legislation, why have that kind of requirement? Let us just let the buyer beware when they go back out to those parking lots.

We had it for a period of time in the medical device legislation. We just said let women beware. Let women beware. We had 2,700 women who died from a perforated uterus. Let women beware, until we finally had some at least protection in terms of medical devices that were going to be implanted to show they were going to be safer and efficacious. We said there is at least some requirement and some responsibility.

So now the opponents of change want to give the American people the choice of substandard insurance coverage. They want to give the families the choice of denying their children preventive health care. They want to give mothers the choice of going without preventive prenatal care. They want to give people the choice to buy policies that will turn out not to cover the very people that it will need the most if they become sick. This kind of choice is really no choice at all. It is effectively an excuse to defraud the American people of the health security they deserve, and I believe it will be rejected.

Several days ago, one of the opponents of the Mitchell bill called it a health scare bill, and that is exactly what the proponents of this amendment are trying to do. They are trying to scare the American people into rejecting change. It did not work with Medicare a generation ago, and it will not work with the Mitchell bill now.

Mr. President, I yield the floor.

The PRESIDENT pro tempore. The Senator from Delaware [Mr. ROTH].

Mr. ROTH. Mr. President, for the first time in its history, the U.S. Senate has before it legislation to reform the Nation's entire health care system. Without a doubt, this is a historical debate. We must not lose sight that what we are debating will have tremendous repercussions on health care as we know it today.

The bill before us is immensely complex, in part, because it deals with an immensely complex issue. Even at this stage of the legislative process, it is not clear what direction the debate will take, and the final implications of whatever shape the legislation takes on are, therefore, unpredictable. In any event, let me make very clear that I strongly oppose the Clinton/Mitchell bill in its present form. Even the way this legislation was put together concerns me. And I am not alone.

In a recent column, Robert J. Samuelson quoted CBO chief Robert Reischauer, who warned that trying to find a compromise health care bill by combining provisions from different bills might make the health system worse. "You can't say I want a piston from Ford, a fuel pump from Toyota, and expect the engine to run." That is precisely what has happened with this bill.

There is a great deal that concerns me in this proposal. And I intend to look for answers, because what is contained in this legislation will not only dramatically affect the American people, but almost $1 trillion in medical services and about 15 percent of our economy.

At the top of my list of concerns is how this bill will affect the people of Delaware. In our State we have a population of about 660,000 people living in 3 counties. Right now, we have important and good health care services, delivered through partnerships and community involvement. Certainly, there are steps that we can take to improve access and affordability to these services, but they are delivering quality care—state-of-the-art care—to men, women, and children who depend on them.

Frankly, I am concerned with the effect this legislation will have on the balance of care now being provided—and, I am concerned with the effect the tax increases contained in the proposal will have on the economy and jobs in Delaware. This bill—one way or another—will have a dramatic impact on the system that currently exists. It will have a dramatic impact on employees, employers, as well as family security.

For example, in Delaware, the New Castle Chamber of Commerce, in cooperation with the University of Delaware's Bureau of Economic Research, conducted a study that shows:

> Mandated health care could lead to the loss of 27,800 jobs in New Castle County, due to layoffs and workers displaced by employers going out of business.

A second study, recently issued by the Family Research Council, states that families with children in Delaware bear the brunt of job losses due to employer mandated health care proposals. I would like to read from that study:

> Employer-mandated health care refers to the Federal government's requirement on employers to purchase 80 percent of their employees health insurance. * * * The impact of job losses in families is particularly acute when children are involved. The maximum number of impacted children would be in excess of the number of jobless parents with dependent children * * * Under the Clinton plan, 1,500 of the estimated 2,600 jobs lost in Delaware would be shouldered by families with dependent children * * *. Under the Senate Labor Committee plan, * * *, 3,200 of the estimated 5,600 jobs lost—would be shouldered by families with dependent children.

A third study, conducted by two Ohio University economists for the American Legislative Exchange Council [ALEC] projects that "Delaware would lose 3,200 jobs under the Clinton health care plan."

And a fourth study, conducted by CONSAD Research Corp., a firm that performs economic studies, estimates that "2,593 Delaware workers would lose their jobs, and another 72,977 would face reduced wages, hours or benefits" under the Clinton mandate.

These are real Delawareans with families that depend not only on a strong economy, but on competent health care providers. And as we consider legislation that will literally rearrange their environment we must see them in the most personal way and honestly determine how these 1,400-plus pages will alter how they live and do business. We must understand how this legislation will impact their health care providers. It is interesting to note that Delaware serves as a microcosm of America. In our State we have about every kind of health care practitioner, about every kind of hospital with their own unique services, characteristics, and needs. Rural hospitals, urban hospitals, religious, philanthropic, research hospitals, educational hospitals, veterans and childrens hospitals—we have them all. And it is revealing to assess this Mitchell-Clinton plan according to how it will affect these providers.

Let me give a few specific examples:

In our State, we have the Medical Center of Delaware, our largest facility which has a special relationship with

Jefferson Medical School in Philadelphia. I want to know how the medical education requirements of this proposal that will limit the total number of physicians in the United States will effect our medical center's ability to attract and retain new physicians-in-training.

We have Riverside Hospital, an osteopathic hospital serving northern Delawareans. I want to know the effect the bill has on osteopathic facilities.

We have St. Francis Hospital, which has a strong bond with the Catholic Church. The facility has a religious mission not to perform abortions. Again, this matter has not been clarified in the legislation before us.

We have Kent General Hospital in Dover and the military hospital on Dover Air Force Base—both of which serve Kent County. How will this legislation affect access to health care offered in both of these facilities for military personnel—active and retired?

We have a children's hospital heavily funded by an endowment from the Alfred I. du Pont Institute. In addition to the care it delivers to hundreds of children in the hospital, it has taken on a partnership with the State to expand access to care for Delaware's children. This is a creative partnership between public and private institutions. How will incentives for private groups to continue to donate and contribute toward providing needed health care be affected by both the tax and health policies contained in this legislation?

We have a veterans' hospital caring for thousands of veterans who have valiantly served our country. How will this legislation affect the continuity of care provided in that facility?

We have Beebe Hospital near our Delaware beaches which has an emergency room which must be able to serve both the year-round residents as well as the thousands who visit to our beautiful coastline each summer. Beebe serves a community where there has been an immense growth of individuals over the age of 65. Medicare reimbursements to the hospital have been, and continue to be, critical. How will the Medicare costs reductions included in this legislation affect Beebe's need to meet the needs of our seniors?

We have Milford Memorial and Nanticoke Hospitals serving rural populations in very innovative ways. It does not appear that this legislation will facilitate their abilities to create partnerships to share medical equipment and high-cost technology. Will this legislation continue to perpetuate the virtual medical arms race that is needlessly increasing the cost of health care delivery?

And, finally, we have the State hospital, which serves Delaware's chronically ill. What will be the State's future requirements to meet the needs of those now being cared for? Will there be an unafforable disruption in services?

In addition to these hospitals, we have many other organizations and people actively involved in the delivery of health care—three federally qualified community health centers, hundreds of physicians, nurses, chiropractors, psychologists, several medical research facilities, nursing homes, home health care agencies, hospice care givers, and many, many others. The list is very long—only exceeded by the numbers of men, women, and children who depend on the health care services they provide.

I am pleased to say that I have heard from Delawareans from top of the State to bottom; I have heard from these organizations. I have heard from many of our families. And I have benefitted from hearing their concerns. Their primary question is quite simple: How will all the new changes included in the Clinton-Mitchell plan affect me? Beyond this, they want to know how much will it cost. How many new Government employees it will require to run it. They want to know if it will limit their ability to choose the physicians they feel comfortable with. They are concerned about the future growth of such a program. Will it grow into an enormous and possibly unfundable entitlement with a life of its own? They want specifics concerning how Congress intends to pay for it with the deficit already so large. Others have asked if it is necessary to change the entire U.S. health care system—a system that currently covers 85 percent of all Americans—to reach the last 15 percent. They want to know if those remaining 15 percent could be covered in other ways.

These are all legitimate questions that must be answered as we move forward with this critical debate. And it is critical. We do need to make some important changes to our health care delivery system. The costs of providing health care are high. There are vulnerable Americans who are not receiving the coverage and medical care they need. Something must be done to control costs, to make health care coverage more affordable, to provide needed coverage to those now uninsured. I agree with this. As I have said many times, there are several very important steps that we should take to reform our Nation's health care system. Specifically, there are five points that we need to keep in mind as we move forward with health care reform.

First, that while there are major improvements that need to be made in our health care system, these improvements must be made without putting at risk the many good features that are working in our current system. As all doctors know, as we treat those conditions ailing the current system, we must first do no harm. Our health care system may have some shortcomings, but it is not broken. Consequently, it needs to be fixed or improved, not eliminated and substituted.

Second, acknowledging that improvements can, and should be made, we must focus on making those improvements. The areas that must be improved concern insurance coverage, removing the barriers that now exist. Reform should eliminate preexisting condition exclusions, and it should guarantee portability. Reform should empower small businesses in the marketplace and make coverage more affordable. These are all important steps, and I would like to address them individually:

Elimination of preexisting conditions: if a person has an illness or once was sick, they should still be able to get health care coverage;

Portability: Americans must not be locked into jobs, unable to change employment, because they may not be insured elsewhere;

Small business empowerment: small groups have very little leverage in the marketplace; any reform must provide them easier access;

Affordability: through the combined effect of cost containment measures—malpractice reform, cutting fraud and abuse, and administrative simplification—and an appropriately financed subsidy, real reform must assist low-wage workers in the purchase of health care insurance.

The third point we must keep in mind is that competition and choice have been fundamental influences in making our health care delivery system the world's flagship. Reform must build on market principles. Injecting more Government, creating more mandates, and hiring more bureaucrats is no way to make the system more efficient and effective.

Does this mean that Government has no place in this debate? Absolutely not. In fact, I have introduced a proposal that would put the strength and size of Government to work to benefit the small business man and woman. The Federal Government has the largest pool of privately insured individuals in the current system. Nine million Federal employees, retirees, and their dependents participate in the Federal Employees Health Benefits Program [FEHBP]. My proposal would put this pool to work by opening it up to others.

Small businesses and groups could buy into the Federal program, receiving the same rates that Federal employees receive. I understand that Senator MITCHELL's bill does contain a provision to use my idea to open up FEHBP, but as written, his utilization of my plan raises some concerns that I will address a little later.

Another measure that Government can and should make at this time is to give Americans the incentive to establish medical savings accounts, or MSA's. I have proposed legislation to establish medical savings accounts, and it has found broad support. Similar

legislation was even voted out of the House Ways and Means Committee.

A medical savings account is a savings account that is designed to pay for medical expenses. Under my legislation, individuals or families can convert the money that they and their employers spend on their health insurance policy into a less expensive catastrophic insurance policy, and put the balance into a medical savings account. For example, if a family has an average insurance plan costing $4,500 annually, they could convert those funds as follows: Part of the money would be used to buy a catastrophic policy for $2,000 to cover big expenses from, for example, cancer treatment or a heart attack. The balance of $2,500 would be put in a medical savings account. As long as the family spends less than $2,500 for routine health costs that year, all of their health expenses would be paid with pre-tax dollars from the MSA. In case of a medical emergency, the high deductible health insurance policy would begin paying the health costs once they exceed $3,000.

After a few years of low health expenses, excess MSA funds would be available in the account to pay for unexpectedly high health costs, for long-term health insurance or to make COBRA payments to extend coverage in case of unemployment. In fact, workers can use the money to pay for braces or eye care for their children, which often are not covered in a normal health care policy.

What makes my amendment work is the fact that Americans will know that whatever they do not spend on health care expenses, they can keep for themselves. Beyond offering patients choice, MSA's will help control health care costs.

The reason why is simple: it will encourage consumers of medical care to shop wisely, reject unnecessary treatment and conserve scarce medical resources because it is the consumer, not a third party such as an insurance company or the Government, who will be paying the bills.

In testimony before the Finance Committee, one company testified that in only 8 months after initiating an MSA program the average employee had savings of $602, and total savings for the company was $468,000. They stated that employees have been able to save because they are shopping around for medical care. In fact, one employee negotiated close to $4,000 off her hospital stay before she entered.

Already, six States have passed legislation enacting tax-favored medical savings accounts. They are Arizona, Colorado, Idaho, Mississippi, Missouri, and Michigan. Jersey City has implemented them as an alternative for their city employees, and the State of Ohio is contemplating a test program next year for State employees. Clearly medical savings accounts offer Americans a choice about their health care that should be fundamental in a country built on free market principles. It is the Federal Government that must now move ahead with this new idea.

Opening up FEHBP and creating incentives for Americans to participate in medical savings accounts—this is what Government can, and should, do. This is positive; it is achievable. It builds upon the proven strengths of the current program without creating mandates, without increasing taxes, and without creating large, overbearing government bureaucracies.

The fifth and final point we must remember is that America can ill afford new and higher taxes, new mandates, and new bureaucracies. The bureaucratic age is over. Small, lean, and efficient organizations—they are the future. It is no surprise that the engine of economic growth in America is small business. These businesses and the trends they set must be nurtured. Creating more Government won't do that; opening the benefits of a government program already in place to include them will.

Our answers to the the problems that do exist in our current health care deliver system must be innovative. But again, they must build on those principles within the system that are working. We must remember that in an entirely voluntary system, Americans still have reached a rate of almost 85 percent insured population.

Almost 20 million of the reported 38 million uninsured individuals are working, or are in a family where someone is working for a business which has 1 to 100 employees. What Government must do is make health care coverage more affordable for these small businesses.

One of the primary contentions of those supporting comprehensive national health care reform is that if we do nothing, our health care system will self-destruct. This is not true; it is a scare tactic. The truth is that in the past year, growth in health care costs have been at a 20-year low. Delivery of care is changing and efficiencies are emerging indicating that this is not a temporary trend.

The secret to successful health care reform is to build upon these trends and the principles that have made the American health care delivery system the foremost system in the world.

Mr. President, I would like to conclude by reading into the RECORD a letter of endorsement I received from the National Federation of Independent Business that supports my plan to open up the Federal Employee Health Benefit Plan. It reads:

On behalf of the over 600,000 members of the National Federation of Independent Business (NFIB), I am pleased to support your efforts to allow small business owners to purchase health insurance through the Federal Employees Health Benefits Program (FEHBP).

Since 1986, the cost of health insurance has been the number one concern of small business. Small firms often pay at least 30 percent more than large businesses for health insurance for their employees.

Your proposal to allow small businesses to voluntarily buy into an insurance pool with approximately 10 million people that offers a variety of plans is a terrific opportunity for many small businesses. It gives small businesses access to affordable health insurance.

Small business owners voluntarily buying insurance through the large FEHBP would have more purchasing power and lower administrative costs, leading to lower premiums. Pre-existing condition exclusions, sudden cancellation and rate hikes would no longer be problems—the risk would be spread over millions of people. In a recent survey of NFIB members, 70 percent believe small business owners should be permitted to buy health insurance through the federal program.

NFIB cannot support attempts to mandate small business participation in FEHBP. Additionally, businesses choosing to buy into the FEHBP should be able to purchase the same benefits at the same cost as federal employees and retirees, there should not be separate, higher rates for small business.

Thank you for leading the fight to help small business owners obtain affordable health insurance. We look forward to working with you. Sincerely, John J. Motley III, Vice President, Federal Governmental Affairs.

Mr. President, I yield the floor.

Mr. GRASSLEY addressed the Chair.

The PRESIDENT pro tempore. The Senator from Iowa [Mr. GRASSLEY] is recognized.

Mr. GRASSLEY. Mr. President, for a couple weeks now, the newspaper articles reporting on the debate in the Congress about health care reform have been permeated with the politics of Capitol Hill. There is always going to be some politics on Capitol Hill on almost any issue.

I would imagine that the people out there at the grassroots really do not care about the politics of this issue. By politics, I mean Republican and Democratic sides of the issue.

I firmly believe that the people do not care whether a Democratic bill passes or a Republican bill passes or a bipartisan bill passes. I think what the American people are concerned about is that if we are going to pass legislation—and I say if because there seems to be a growing tendency on the part of people to be a little more skeptical about what we do and whether we should do anything. But I think the American people feel that if we are going to pass something, that the measure of whether or not it is good is not whether it is Republican or Democratic or bipartisan, but whether it is, in fact, a good piece of legislation. I think that is what they want us to struggle to accomplish, passing a good piece of legislation.

On the other hand, I think there is a political situation in Washington in which the strategy for this bill is that the other side of the aisle, the Democrats, along with the White House,

must pass a bill that the President will sign and that we will stay in session long enough during this summer break to do that, or we will stay here long enough until the other side can blame the Republicans for not passing such a bill.

That sort of strategy does not produce good legislation. It is not going to enhance the credibility of our institution, and it is not a very good position to be in and one that I hope we can get out of but probably cannot. So this sort of strategy could bring us to a position where we pass a more partisan bill rather than a good bill.

I hope that if we pass a bill that is as massive as this 1,400-plus page bill, that everybody in the country who thinks about their health care and their health insurance, on that day that it is passed, would write down in their diary—and tell the truth in your diary—of how you yourself view the health care system in the United States in 1994. Write it down. Write it down for yourself, write it down for your children and grandchildren. Describe your view of the American health care system and everything that is associated with it, including insurance, your doctor, your hospital, because you may look back in your diary and compare what you wrote in 1994 to what you have in 2000 or 2010 and find that in the future, you do not have anything of the quality or the quantity and the satisfaction that you had in 1994.

I think we owe it to ourselves to write that down because when you talk about passing a piece of legislation this size, do not forget it deals, to some extent, with veterans care paid for by the Government, Medicare, and Medicaid. All of these costs of Government, plus the cost of the private sector, add up to $900 billion plus in costs. One dollar out of every $7 of our gross national product is spent on health care in America, and a bill this size—and a lot of other bills that have been introduced, as well, some of them even Republican—is going to redirect every one of those dollars, to some extent.

That is Congress passing one piece of legislation, attempting to do it for a segment of the American economy that equals the entire economy of the country of Italy. Think of the U.S. Senate since March or April 1789 being in session 205 years. I do not think the Congress of the United States has ever before in the history of our country passed one piece of legislation having such sweeping impact upon the economy, both the private sector and the public sector.

We have tried in health care areas to do a lot less, and we have come up short of accomplishing what we wanted to accomplish. Remember in 1988, we passed catastrophic health care reform, just a small segment of some of the things that we are trying to accomplish in this legislation. I voted for it. It passed, I think, 87 to 11. I voted for it feeling I was doing not only what was right, but I voted for it doing what I felt my constituents wanted me to do.

It was not long when we went home and all of us ran into a buzz saw of discontent about that legislation, and we were back here within 1 year repealing that by almost the overwhelming margins by which we passed it in the first place.

So in another area of health care reform legislation, we passed a lot less in the 205-year history of our country and were not successful at it. I think the public is skeptical of Congress' ability to pass such a massive piece of legislation and do good in the process and do good for everybody. I think that skepticism has permeated the thought that has been filtering up to us from the grassroots from our townhall meetings, from our telephone conversations and, most particularly, from our mail.

Whether or not Congress can pass such a sweeping piece of legislation, guaranteed for everybody, and move forward, redirecting $1 out of every $7 spent in America and they have questions about it, I believe those questions lead to skepticism, and that skepticism at the grassroots has been affecting the debate on Capitol Hill over the last several months.

That is why I feel that if we do pass a piece of sweeping legislation like this, that perhaps you ought to write in your diary your thoughts about health care today.

It is my view that you will look back and say you wish you had those days with you again, that sort of environment for the quality and quantity of health care in America, albeit not perfect, not equitable, not entirely fair, as some people might view it.

Massive pieces of legislation like this, 1,400-plus pages are being promoted by people who have great faith that Government always does good. People who have opposition to this sweeping enactment, plus, I think, a majority of the people at the grassroots, are skeptical, question that faith in Government and probably have a greater faith in the marketplace. And I will just use one example that has been thrown out here of one approach in this bill of an employer mandate or a trigger that could bring an employer mandate that is working so well.

It is thrown out to us that Hawaii for 20 years has had an employer mandate, and that sets a good example for us as a nation as a whole to have one. My State of Iowa does not have an employer mandate, and by the Current Population Survey of 1993, Hawaii has 80.1 percent of its population with private health insurance. Iowa, without an employer mandate, has 80.3 percent; 80.1 for Hawaii, 80.3 for the State of Iowa. So you can get high participation in health insurance without an employer mandate, because we do not have one in my State. I think that is probably why the Iowa poll, which is a Des Moines register poll, shows high opposition to an employer mandate. I believe that is why our Governor Branstad of my State and his health task force have come out against an employer mandate. But an employer mandate is an example of having great faith in Government as opposed to having great faith in the marketplace.

Well, as has been said so many times, Mr. President, this big bill that I have held up, 1,400-page bill, is the third 1,400-page bill, or I should say the third draft of a bill that has appeared since its original introduction 2 weeks ago, I believe. It is difficult for staff and members to keep up with these changes. Senators are often heard to say that complicated legislation should not be done on the Senate floor, that that is the job of committees.

Now, of course, we have a completely now wrinkle in the process here. Legislation is being made in some never-never land between the committees and the Senate floor, and I suppose it is proper; the majority leader wants to develop majority support for his bill both inside the Senate and outside, and I suppose that is why it is necessary for some of these changes to be made.

But there is a question that is very pertinent to the debate, whether it is on the first draft, the second draft, or third draft. Why is it, when we are about to act on reform of our health care system, which has so much potential for good, that so many Americans are fearful of what we might do? And they are uncertain and they are fearful, Mr. President. Recent polls show it.

The Wall Street Journal/NBC poll released August 2 found that 52 percent of the respondents disapprove of health care reform, only 40 percent approve. To the question of whether or not Congress should pass a bill this year or debate now but act next year, 61 percent in that poll said we should act next year. And a more recent Newsweek poll found fully 65 percent want us to come back to this matter next year.

On last Wednesday afternoon, CNN reported that 54 percent of their respondents had said they thought they would be worse off if Congress passed a bill, and 32 percent—only 32 percent—said that they would be better off. Other Senators have cited other polls with similar results on this floor.

It is not only the polls that are showing this uncertainty. I have heard it loud and clear in over 25 listening posts, or town meetings as some of my colleagues call them, that I have had in towns, large and small, all over my State. In many of the meetings I have had, not devoted just to health care reform but to any issue that might come up, this issue is always raised, and it is always raised with the same kinds of

concerns. I do not believe that this uncertainty and fear is just the result of propaganda campaigns of interest groups devoted to preserving the status quo. Certainly, such efforts are underway and have been made for some time on both sides of the issue. We know that. Certainly such campaigns can confuse and mislead. Maybe they are meant to confuse and mislead. But there are a number of reasons why our fellow citizens are justified in their concerns about this legislation. Our fellow citizens are asking whether we can possibly know what is in this big bill and, more broadly, whether we really know what we are doing with such a comprehensive proposal.

The Presiding Officer knows Chancellor Bismarck's quip about legislation-making and sausage-making being similar. That remark was made over 100 years ago, but it is pertinent today maybe even with this legislation.

As our fellow citizens focus upon this legislative sausage factory at work on health care reform, they have every right to wonder what in the world is going on in the Senate. And some of us wonder why the public holds people who are in politics in low esteem.

But citizens are also concerned about the fundamental changes that would result in our health care system were the Clinton-Mitchell bill or the Gephardt bill in the House enacted.

Maybe the way to begin is to remind those who are listening what it is that Americans value in their health care. I am referring to the choice of personal physician. I am referring to the physician's traditional patient-centered ethic. I am referring to ready access to the most advanced diagnostic methods and to quick and easy access to the most competent specialist. I am referring to easy and convenient access to high quality care in general, and I am referring to the flexible private health insurance tailored to individual and family needs.

Now, remember, surveys of the American people have always found that, whatever their concerns with the way the system as a whole works generally, large majorities say that they are satisfied with their doctor. Large majorities say that they are satisfied with their hospitals. And, yes, most are even satisfied with their insurance companies. Our citizens are concerned because they understand that very fundamental changes are being proposed that could profoundly affect these things that they value so highly. They understand that the Clinton-Mitchell bill is going to lead to too much Government involvement in health care as well as higher taxes, lost jobs, and rationing. They realize that there is a very big question as to whether these changes can really work in the real world. And the people are completely justified in their concern, Mr. President.

When I read the review of the Congressional Budget Office of the Clinton administration's health reform plan last year, I was struck by the skepticism that the writers exhibited in the face of the nationalization of health care system that plan called for. I want to say I have spoken about the skepticism from the grassroots, but now I am referring to the skepticism of Government analysts, people inside the beltway.

The CBO asks:

> . . . whether it would be possible to implement the Clinton purpose fully in the timeframe envisioned, and whether there might be unintended consequences that could affect the system's viability.

This is CBO-speak for: "Is it really possible to implement such a scheme, and could it possibly ruin the health care system?"

They went on to say, and these are their words:

> Policymakers and analysts can only speculate about such questions because of the magnitude of the institutional changes being proposed.

Continuing to quote:

> Thus, the potential for unforeseen consequences, both favorable and unfavorable, would be significant.

If I can put that into CBO speech, it would say this: "All we can do is guess what might happen if we implement this plan."

More recently, the CBO and the Joint Committee on Taxation finished reviewing the health reform proposal of the Committee on Finance, not the one that is before us. I do not want to mislead you; I am speaking of the committee's proposal.

I was struck in reading this analysis by the same note of skepticism that the earlier authors displayed about the Clinton plan last year.

The authors seem to appear as doubtful that the reform plan as envisioned, even by our Senate Finance Committee, could actually be carried out. What they said was that in CBO's judgment, however, there exists a significant change that the substantial changes required by this proposal and by other systematic reform proposals could not be achieved as assumed.

If I can put those words into CBO speech, it would say this: We have no real world example of this managed competition system, and it will not work.

So now we have Senator MITCHELL's bill before us, this 1,400-page bill, the third printing of it. Mr. President, it is another risky proposal to comprehensively transform the American health care system, redirecting $1 out of every $7 in America, to some extent, greater or less. Great effort has been made to claim that this bill has no relationship whatsoever to President Clinton's original bill that I quoted CBO's analysis of. But the Mitchell bill seems to have more than a passing resemblance to what President Clinton offered. The health insurance purchasing cooperatives are back. They are not in this bill mandatory. But let me predict on this very day that they will end up being mandatory.

A national board, which the President created, with very major and sweeping powers is in the Mitchell bill. The mandates are there, even though they would only be invoked if certain target levels of coverage were not achieved. The standard benefit package proposed by the President is in the bill. The budgets and the premium caps are there, or something darned close to them. The complicated subsidy schemes for individuals and families are there. When you talk about subsidies for business, and lower-income people to buy health insurance, remember when it comes to the Government they want you to accept a mandate because there is a subsidy connected with it. Remember that mandates are forever, but subsidies tend to be temporary.

Subsidies are supposedly going to soften the blow of the mandates. But after a period of time, the mandates continue. The subsidies are fleeting.

The Mitchell bill is at least as complicated as earlier bills. It is even longer than President Clinton's bill, 1,410 pages compared to 364 pages. I forgot, because now the bill is up to 1,443 pages.

There are at least 30 major healthcare related topics on which the bill proposes major changes. I want to list them to give our listeners some idea of the scope of this legislation.

Major change No. 1, employer mandates with triggers;

Major change No. 2, new subsidies for 100 million people;

Major change No. 3, a number of new taxes or tax increases, 18 at last count;

Major change No. 4, many new Government bureaucracies, 49 last count. That is my count. Yesterday I saw another count that it was up almost to 60;

Major change No. 5, a new Medicare prescription drug benefit;

Major change No. 6, abortion coverage;

Major change No. 7, administrative simplification requirements;

Major change No. 8, antitrust and medical malpractice law changes, including repeal of McCarran-Ferguson as it relates to health insurance;

Major change No. 9, changes in the employee benefits law;

Major change No. 10, new rules for health insurance plans;

Major change No. 11, proposals for rural and urban underserved populations;

Major change No. 12, proposals for Medicare reform;

Major change No. 13, integration of the Medicaid program into the private sector health care system;

Major change No. 14, major changes in the way that our medical teaching institutions do their work;

Major change No. 15, new proposals for medical research;

Major change No. 16, long-term care provisions;

Major change No. 17, antifraud and abuse provisions;

Major change No. 18, expansion of many existing public health programs, and the creation of some new ones;

Major change No. 19, changes in the workers compensation programs;

Major change No. 20, some changes in health insurance as related to automobile coverage;

And major change No. 21, for the Federal Employees Health Benefits program.

Each of these topics—and there are more, but I do not want to continue the list. All of these topics has any number of major topics. So we are in fact, Mr. President, contemplating literally hundreds of major changes that will affect our health care system.

In any normal legislative session, passage of a bill with provisions similar to those of Senator MITCHELL's bill on any one of these topics would be a major legislative achievement.

Do we all know what major items might be buried among these hundreds of subchapters? For example, how many of my colleagues are aware of the fact that the national benefits board created in this bill is specifically exempt from the Federal Advisory Committee Act? You want to remember that what that means is that the board is going to make decisions about what benefits Americans are going to receive through the standard benefits package. And this is the same Federal Advisory Committee Act the First Lady's health care task force refused to comply with, and the White House is now being sued in Federal court over because the meetings and records were not open to the public. This means that some of the most basic decisions of health care can be made in secret proceedings, with no notice of meetings and no access to information.

This might be Star Chamber health care, Mr. President, but it is not surprising coming from those who believe in Government-run health care, because they do not want that to be scrutinized by the public.

There is a question of access to the courts raised by the legislation. I do not know whether this has been discussed yet on the floor, but access to the courts ought to be very important to anybody. When you are passing this sweeping piece of legislation, it ought to be more of a concern. Colleagues who vote for this bill will have to tell their constituents that if those constituents believe that they have had a constitutional right violated, they are going to have to come all the way to Washington to vindicate that right—not there in the local district court of their particular State, but right here in Washington, DC.

I think that provision has some implications that ought to be elaborated on, because if a person believes that some part of this bill is unconstitutional, the first thing he or she will have to do would be to come here to Washington, DC, to appear before the U.S. district court here, and even if that person demonstrates that he or she will suffer immediate or irreparable harm as a result of some part of this act, and even if that person shows that there is a substantial likelihood that the act or one of its provisions is unconstitutional, this bill renders the court powerless to grant temporary relief.

When it comes to health care, Mr. President, I am sure that we can all think of examples where an individual might suffer irreparable harm. Maybe it is some needed treatment that this bill curtails; some may be denied choice of a particular physician. Whatever the case is we are talking about, we are in fact talking about people's health and their lives, and any delay could prove critical. But this bill prevents the court from granting immediate temporary relief by limiting its power to grant "any temporary order or preliminary injunction restraining the enforcement or execution of this act or any provision of this act."

So one whose health may be impaired will have to wait until a panel of three judges can convene, wait until they finally decide the merits of the case—wait, Mr. President, for who knows how long.

Yes, as unbelievable as that might sound, the Clinton-Mitchell bill engages in court-stripping and forum-shopping of the rankest kind. It even deprives the court of authority to issue injunctions against operations of the act that might be unconstitutional. So now we will have health care that can never be taken away, not even by a court that might think some parts of this bill violate the Constitution. Whether you are a liberal Democrat or liberal Republican, there are a lot of my colleagues who have spoken eloquently against similar attempts to strip court jurisdiction and to eliminate form shopping. I hope that those people will be consistent and read through this legislation and speak just as loudly against those provisions, whether they are in this bill or some other piece of legislation.

There is even more, Mr. President. How many know that squirreled away among these hundreds of provisions is what can only be described as a naked power grab by the American Trial Lawyers Association and its high-priced lobbyists? Although it is titled "medical malpractice reform," it would be more accurate to label this as medical malpractice "deform." Written of, and by, and for the trial attorneys, it would arguably preempt the laws of 21 States which placed some limit on noneconomic and economic damages and replace it with no limit on damages. I say arguably because the provision has changed in Clinton-Mitchell three.

Apparently, the trial lawyers' greed went too far and was too obvious, and they hope no one would be able to read this bill, the third version, and notice what they were up to. Make no mistake about it—because you should be concerned about the intent of this provision—it is a stealth preemption of State law, and those States with malpractice reform laws will be the ones which suffer.

While this bill may be a windfall for trial lawyers, it would be a disaster for the health care system and the American people. It would stifle medical innovation, reduce the accessibility of health care, particularly in rural areas, and keep more money out of the hands of injured patients. Those States like California, which have enacted progressive liability reform that has succeeded in reducing health care costs, would see their efforts go up in smoke under this bill. But even that is not enough. These lawyers have succeeded in putting into this bill new civil actions with unlimited punitive damages, which creates the potential for explosive litigation—again, to the benefit of the trial lawyers and to the detriment of cost containment within the health care system.

It just goes to show that those who scream the loudest about special interest groups are the ones who have the most to hide.

I want to make my position clear on this issue. While there is some genuine, meaningful medical malpractice reform language in the health care bill, it will have failed to address one of the primary causes of escalating health care costs, and for that reason alone, it should be opposed.

There is another provision in this 1,443 pages about which I am concerned, and that is the proposed modifications of McCarran-Ferguson. And as far as health insurance reform and workman's comp and hospitalization as it relates to car insurance, there is a preemption—I should not say a preemption—there is a repeal of those provisions of McCarran-Ferguson. This act recognizes that certain cooperative actions were essential to the nature of the insurance business and provided for State regulation of such actions. The enormous growth of State insurance laws and regulations show that the States have been performing that function, as intended by Congress 49 years ago, very well.

There are few industries as competitive as the insurance business: over 3,400 companies selling insurance with no company having more than 9.2 percent of the market. In my State of Iowa, the insurance industry is a thriving component of the State's economy

with many, many small firms competing for business. The net effect of repeal of this part of McCarran-Ferguson would be to drive the small- and medium-sized insurers of Iowa and other States out of business, leaving insurance concentrated in the hands of a few giant companies. Without industry-wide data collection and rate advisory services, smaller companies will not survive. This would be a severe blow to my State, and I am opposed to that provision.

Mr. President, there are some good provisions in this 1,410 page health care proposal, no doubt about it. But that is not really the point. Do we really have even the foggiest idea of how any of this would actually work in the real world were we to pass it? And I think, just like CBO said several months ago, we ought to stop kidding ourselves. We have absolutely no idea at all, because again I think we need to emphasize again that, in the 205-year history of the Senate, there has never been legislation that would redirect $1 of every $7 in the American economy.

Remember again what the Congressional Budget Office found in their analysis of Senator MITCHELL's bill. These are their words: "There is a significant" chance that the "substantial changes required by this proposal . . . could not be achieved as assumed."

As many Senators have pointed out, we really have not had sufficient time to study and analyze Senator MITCHELL's bill. But a quick review suggests that it has any number of provisions that are going to create serious problems for many Americans.

A quick review also suggests that it is very likely that the original bill proposed by President Clinton would have those same problems and that this bill is very much like that bill.

The bill includes a delayed employer mandate which we have to assume will go into effect and will have a negative effect on small business and the employees of small business.

It includes a complicated tax on the rate of increase of health care premiums. This tax on the rate of increase in health plan premiums is really the Clinton global budget and premium cap concept, however, in disguise.

It is a global budget concept because aggregate national per capita health care expenditures in 1994 would become the total amount of spending from which national health care spending could increase in the future.

Then the Congressional Budget Office at that time would determine the acceptable rate of increase for the years until 1997. Thereafter, control of health spending would be on semiautomatic pilot. When finally implemented, it would be allowed to increase only at CPI plus 2 percent, restricted by what the Congress said in this bill the country can spend on its health care.

These cost containment features of the bill are almost surely going to drive right out of the market plans that allow you to go to any doctor you want and pay, through your health insurance, for the care you and your doctor decide you need.

I heard the author last night take some exception to our reading of his legislation that way. I heard every word he said. I still stand by this statement.

Even if health plan sponsors are required by the Mitchell bill to offer such fee-for-service plans, such plans may cease to exist, or people will not be able to afford them. People are going to be driven by economic pressure into low-cost managed care plans, or insurers will no longer be able to offer fee-for-service plans. The remaining managed care plans are going to be under great pressure to vigorously economize in the delivery of health care services, and that is the beginning of rationing.

The health insurance purchasing cooperatives called for in this bill have been described as voluntary, but they are not really going to end up that way. They probably will end up in reality as mandatory. All employers with under 500 employees must enroll their employees in this cooperative and may offer a choice of 3 private plans. But why would an employer attempt to negotiate with other plans if the employees can take the employer contribution and join any plan in the local cooperative?

If I understand the bill correctly, no insurer may charge a premium different than that negotiated for that insurer's plan through any purchasing cooperative. So why would an insurer even bother to offer a plan outside of the purchasing cooperatives?

Mr. President, Iowa is a rural State, and I want to digress just a moment to view this legislation from the perspective of my State and any rural State of America. From this standpoint, I believe that Senator MITCHELL has worked hard to include in this bill many provisions designed to help rural areas. We on this side of the aisle may have some problems with this or that rural-specific provision, but those differences can probably be worked out between us. In fact, many of the rural-specific provisions that have found their way into Senator MITCHELL's bill were developed earlier by both Democratic and Republican Senators, including myself, and were included in the Finance Committee bill and the Labor Committee bill.

Many of these same or similar provisions, by the way, are in the Dole-Packwood bill.

Unfortunately, I have to say to my colleagues that the question for those of us who represent rural areas has to be whether the major elements of Senator MITCHELL's bill are good for rural States, even though some of those specifically directed to certain specific problems in rural America are very good. Are those good provisions offset by some bad aspects of this major bill? I think the answer to that is yes, that they will. I think Senator MITCHELL's bill, as a whole, will not be good for rural areas.

I wish I could say otherwise as an answer to that question. I want to tell you why I cannot give a confident yes to this question.

The bill continues to discriminate against the self-employed. It fails to provide 100 percent deductibility of health insurance premiums for the self-employed.

A greater percentage of people in rural areas are self-employed than in urban areas—around 13 percent compared to 7½ percent of urban workers.

In farm areas and all over main street, small town, America, there are ordinary self-employed people who buy individual insurance and pay for it out of pocket after tax dollars. Now there is that 25 percent deductibility today, but even that ran out at the end of last year. We have let it run out before so that cannot even be counted on.

So these people's ability to afford their health insurance would be considerably enhanced with 100 percent deductibility. For instance, the American Farm Bureau Federation has estimated that for a typical family of four at the 15-percent tax level a full tax deduction could generate over $1,200 in savings per year.

Now, as a matter of fairness, large businesses get to deduct what they pay for employee health insurance. The employees of large businesses get a health insurance benefit tax free. Why should not our rural citizens and small business people get the same tax treatment?

In addition, the bill does not include medical saving accounts, and the distinguished Senator from Delaware spoke well about that issue before so I will not go into that. But medical savings accounts would help very much, maybe even more so in rural America than in urban America.

The bill outlaws self-funding of insurance for any business with fewer than 500 employees. Many small businesses found in rural towns now self-fund and are doing a good job offering insurance to their employees and cost containment. This ban on self-funding for employee groups of that size is going to disrupt health care coverage of all of them. Why should we not retain the self-funding option for rural areas as one more way of getting people covered?

I just cannot understand when we have such a high percentage of people in America and particularly employers self-insured that we want to hurt that approach. It seems to me what we ought to do is build on what private initiative has already accomplished in America and not do harm to it.

If the mandates laid out in the bill do get triggered in and are eventually required of small businesses, I think it

could be devastating for more fragile lower wage economies of rural areas.

The cost of private health insurance in rural areas is almost certainly going to rise as a consequence of this bill. If I understand how some of the features of this program are going to work, it looks as though they will conspire together to seriously disadvantage rural residents.

Fee-for-service plans are still more common in rural areas. And they probably will be for some time to come. Medicare payments tend to be a bigger factor of health care life in rural areas than in cities. Under this legislation, the Government is going to continue cheating on what it owes for Medicare services even more than it does now. Thus, providers are going to cost-shift to the fee-for-service plans more common in rural areas. The premiums of those plans are going to go up. As the premiums go up, the total amount of money taken by the 1.75-percent tax and shipped away to the east coast increases. As the premiums go up, they run right into the 25-percent excise tax called for by Senator MITCHELL's bill.

Furthermore, this 25-percent tax is really a global budget and premium cap provision. This is going to unfairly freeze providers in low-cost States at low levels of reimbursement. It seems to me that the same thing is going to happen to some of these States, including my own State of Iowa, that happened when the Medicare Cost Containment System was put in place. Unfairly low reimbursement levels were put in place and held in place by Federal law and Federal agencies. Only this time it would be not just the Medicare Program that is affected, but the entire private health care system in some of these States.

This provision is probably going to kill any hope of private investment in health care systems in rural areas. It is well understood here in the Senate that a substantial investment in rural health infrastructure and in rural health workers is needed. In fact, most of the bills recognize this by including provisions designed to do exactly that, including Senator MITCHELL's bill and Senator DOLE's bill.

The problem is that private health plans are not going to want to incur the additional cost of investment in health care if they face a tax on their premiums when they try to achieve a return on those investments. This is going to be true generally, not just in rural areas.

But the problem is going to be more acute in rural areas. Those areas do not have the population density that could make it easier for health plans to get back a return on the investments they make. They will almost surely face higher costs if they wish to invest their own resources in rural areas. Those costs will have to be reflected in their premiums.

Why should a private insurer take the risk of investing in an underserved rural area if they are going to face a 25-percent excise tax on the premiums they have to charge to cover the higher cost involved in investing in such areas?

So I hope that we can do something about making that very clear.

I would like to call the attention of my colleagues to two letters, one from the American Farm Bureau and the other one from 115 other organizations. Those organizations have concluded just the Mitchell bill is not going to be good for rural areas. They include some of our most important national farm organizations.

Mr. President, I ask unanimous consent to have these letters printed in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

AUGUST 12, 1994.

Hon. CHARLES GRASSLEY,
U.S. Senate,
Washington, DC.

DEAR SENATOR GRASSLEY: On behalf of more than 100 farm and rural organizations we would like to voice our concern with the Health Care Reform Proposal offered by Senator Mitchell, as presently written.

We have spoken forcefully in favor of 100 percent tax deduction for the self employed and against an employer mandate * * * and against mandatory alliance.

We cannot support any plan that:

1. Does not achieve a 100 percent deduction.

2. Lays out the foundation for an Employer Mandate.

3. Sets up "required" participation in purchasing alliances, a "de-facto" Mandatory Alliance.

But there are other rural concerns that require bi-partisan attention.

Paperwork. It sets up administrative and reporting requirements that will be highly burdensome for small employers.

Cost of insurance may rise. Farmers traditionally buy plans with high deductibles. The Mitchell Plan limits this option. Community rating pools are broadly defined so that—in many instances—rural citizens will subsidize the health costs of their urban and suburban cousins, places where medical costs are not only higher, but so is utilization. In addition, age banding is unnecessarily restrictive. States have the option of setting up a community rate for the entire state.

It limits choice. It would allow states or the D.O.L. to determine, based on unstated definitions, that there is insufficient competition in certain rural areas so they are not required to even offer more than one plan to their employees. That one plan must always be the HIPC, and the HIPC must always include the FEHBP. This amounts to a potential back-door single-payor system for rural states.

Cost-shifting. It cuts into projected Medicare expenditures, which will hurt many rural hospitals, and because it shifts billions in Medicaid costs to private insurers, cost-shifting will take place. Net result: a massive, unintended cost-shift that will fuel insurance costs of fee-for-service plans—the primary insurance vehicle for rural communities.

Taxes. The new tax on plans with fast growing health premiums will hit fee-for-service plans hardest, especially those in rural areas, for reasons already noted in previous paragraph.

Association Plans. About 1 in 3 farmers and very-small rural small businesses have their health insurance through "association plans", which pool businesses or individuals in a form of voluntary cooperative. These plans are more likely to have begun to negotiate PPO and cost-savings with providers. However, these plans are essentially made ineffective by making them a part of a community rated pool, and not part of an experienced rated pool, despite the fact that many of these plans have more than 500, and some more than 5,000 individuals enrolled. Solutions: allow large association plans to be experienced rated, but require an annual open enrollment for members. The long-range impact of weaker private sector pooling arrangements is to eventually force very small businesses, and the self-employed into the state or federal-directed HIPCs—which may be the insurance of last resort for the poor.

Subsidies. Subsidies do not clearly distinguish the realities of farm income, in which it is true that farmers have relatively high "gross income" but "low net income". Careful consideration should be made for agricultural producers, especially young farmers, because "gross incomes" may not be the best determination.

Health Board. It gives enormous power to several new agencies, especially the National Health Board, but it does not include provisions that would guarantee rural representation on those boards. Health care is not necessarily better, or worse in rural America, but it is different. The composition of any agency with important health powers should include stronger rural representation.

Medical Savings Account. It does not include Medical Savings Accounts. Farmers would benefit from MSAs, and have been pioneers in the use of the MSA concept by blending high deductible plans with personally-funded tax deferral savings vehicles. MSAs are a proven "concept", the Mitchell Plan does not acknowledge their value in any way at all.

There are many positive enhancements to the recruiting of health professionals to rural areas and grants for demonstration projects, but on balance is not a plan we can embrace.

Sincerely,

American Agri-Women; American Dry Pea and Lentil Association; American Sod Producers Association; Communicating for Agriculture; Farm Health Care Coalition; Farmers Health Alliance; International Apple Institute; National Association of Wheat Growers; National Barley Growers Association; National Cattlemen's Association; National Contract Poultry Growers Association; National Cotton Council; National Cotton Council of America; National Council of Agricultural Employers.

National Council of Farmers Cooperatives; National Christmas Tree Association; National Christmas Tree Nursery; National Grange; National Milk Producers Federation; National Pork Producers Council; United Agribusiness League; United Egg Producers; United Fresh Fruit & Vegetable Association; Women Involved in Farm Economics; Agricultural Council of Arkansas; Agricultural Producers; Alabama Contract Poultry Growers Association; AZ Cotton Growers Association.

Arkansas Association of Wheat Growers; Arkansas Contract Poultry Growers Association; California Association of Wheat Growers; CA Cotton Ginners Association; CA Cotton Growers Association; California Farm

Bureau Federation; California Grape & Tree Fruit League; Colorado Association of Wheat Growers; Florida Contract Poultry Growers Association; Florida Fruit & Vegetable Association; Florida Nurserymen & Growers Association; Georgia Contract Poultry Growers Association; Idaho Grain Producers Association; Idaho Onion Growers Association.

Illinois Cattlemen's Association; Kansas Association of Wheat Growers; Kentucky Contract Poultry Growers Association; Kentucky Small Grain Growers Association; LA Cotton Association; LA Cotton Producers Association; Louisiana Contract Poultry Growers Association; LA Ginners Association; LA Independent Cotton Warehouse Association; Delmarva Contract Poultry Growers Association; Minnesota Association of Wheat Growers; Mississippi Contract Poultry Growers Association; Mississippi Delta Council; Montana Grain Growers Association.

Nebraska Wheat Growers Association; New England Apple Council; New Mexico Wheat Growers Association; North Carolina Apple Growers Association; North Carolina Small Grain Growers; North Carolina Sweet Potato Commission; North Dakota Grain Growers Association; North Dakota Stockmen; Ohio Contract Poultry Growers Association; Oklahoma Contract Poultry Growers Association; Oklahoma Wheat Growers Association.

Plains Cotton Growers Association; South Carolina Contract Poultry Growers Association; South Dakota Wheat Incorporated; Southern Cotton Growers Association; Southeastern Cotton Ginners Association; Tennessee Contract Poultry Growers Association; Texas Cattle Feeders Association; Avian Cooperative of Texas; Texas Citrus & Vegetable Association; Texas Wheat Producers Association; South Texas Cotton & Grain Association; Rolling Plains Cotton Growers; Virginia Agricultural Growers Association; Virginia Contract Poultry Growers Association.

Virginia Small Grain Growers Association; Washington Association of Wheat Growers; Washington Cattlemen's Association; Washington Growers Clearinghouse Association; Washington Growers League; Washington State Horticultural Association; Washington Women for the Survival of Agriculture; Western Growers Association; Western Pistachio Association; Wisconsin Christmas Tree Producers Association; Wyoming Wheat Growers Association; Curtice Burns Foods/Pro-Fac Cooperative; Dovex Fruit Company; Eastgate Farms, Inc.

El Vista Orchards, Inc.; Florida Citrus Mutual; Forrence Orchards, Inc.; Grainger Farms, Inc.; Grower-Shipper Vegetable Association of Central California; Hood River Grower-Shipper Association; Johnny Appleseed of Washington/CRO Fruit Company; Knouse Fruitlands, Inc.; Lyman Orchards Country; Newman Ranch Company; Nyssa-Nampa Beet Growers Association; Princeton Nurseries; Rocky Mountain Apple Products Company; Torrey Farms, Inc.

Valley Growers Cooperative; Ventura County Agricultural Association; Wasco County Fruit & Produce League; Yakima Valley Growers-Shippers Association.

AMERICAN FARM BUREAU FEDERATION,
Washington, DC, August 11, 1994.

Hon. HOWELL HEFLIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR HEFLIN: The Senate is poised to begin voting on the most important social question of this Congress and probably of the last 30 years. You have the responsibility to represent the views and best interests of America and your state's portion of the 4.2 million members of the Farm Bureau. Your constituents expect and deserve a health care reform law that remedies what is wrong and protects what is right with our present system.

Farm Bureau has closely followed and has attended numerous meetings on the subject of health care reform, from the early efforts by the White House to those of many members of the House and Senate, as well as with various organizations and coalitions. We have intentionally not joined any formal coalitions nor have we aligned ourselves with any of the many proposals that have surfaced. We have instead pointed out what, in our view, would be valuable or detrimental to the needed improvement of our system.

Farm Bureau members have made this a priority issue and are obviously users of the present health care system. As users, we have benefitted from the unbelievable advances in medicine and also have suffered through the unrelenting double-digit medical cost inflation of the last 20 years.

The farmer delegates to the American Farm Bureau Federation's annual meeting approved two full pages of policy regarding health care. The essence of Farm Bureau policy is expressed as follows.

We favor:

1. Reform of the current health care system;
2. Financial assistance to those unable to afford it;
3. One hundred (100) percent tax deductibility of health insurance costs paid by the self-employed;
4. Medical savings accounts;
5. Sensible insurance reform dealing with portability, prior existing conditions and modified community rating;
6. Malpractice tort reform;
7. Targeted rural benefits, such as incentives for medical professionals to locate and stay in rural areas, fair reimbursements on Medicare and Medicaid, and greater use of technology for modern "telemedicine."

We oppose:

1. Employer mandates, including triggers to impose them at some future date unless the Congress must vote for the imposition;
2. Government-imposed price controls on the various components of the health care delivery system;
3. Massive new taxes; and
4. Repeal of the McCarran-Ferguson Act.

We are not opposed to any of the proposals in their entirety and do not criticize any proposal completely. However, some of the proposals have more points with which we agree than others. Thus, we will support or oppose bills, amendments and substitutes accordingly.

The reform of health care in America is not a sporting event that has one side winning or losing. We will all win or we will all lose based on the outcome of this debate. We don't believe either the next congressional election or the next presidential election can be predicted based on this issue. Therefore, a purely political vote will benefit neither you nor America.

We urge you to consider AFBF's policy as you vote on this important question and support constructive change.

Sincerely,

DEAN R. KLECKNER,
President,
American Farm Bureau Federation.

[From Farm Bureau News, Aug. 15, 1994]

CONGRESS BEGINS DEBATE ON HEALTH CARE REFORM

Debate on legislation to reform the nation's health care system began last week in the Senate. It had been scheduled to start in the House this week, but House leaders have now postponed it for at least another week.

At the center of the debate are plans crafted by Sen. George Mitchell (D-Maine) and Rep. Richard Gephardt (D-Mo.) that contain controversial provisions requiring employers to pay part of the cost for their employees' insurance.

In the House, a bipartisan alternative that does not include employer mandates has been put forward by Reps. Roy Rowland (D-Ga.), Michael Bilirakis (R-Fla.), Jim Cooper (D-Tenn.) and Fred Grandy (R-Iowa).

Because of different rules in each body, the Senate is expected to consider dozens of amendments while the House plans to consider only a handful of major proposals. The first battle in the House will be a decision on the rule that governs debate. Farm Bureau is urging House members to adopt a rule that will give alternative plans a fair opportunity to be considered.

American Farm Bureau Federation President Dean Kleckner, in a letter to all members of Congress, noted that Farm Bureau does not oppose any of the proposals in their entirety but "some of the proposals have more points we agree with than others."

"The reform of health care in America is not a sporting event that has one side winning or losing," Kleckner told lawmakers. "We will all win or we will all lose based on the outcome of this debate. A purely political vote will benefit neither you nor America."

The Gephardt and Mitchell proposals as they are currently written fail to meet Farm Bureau policy, according to Hyde Murray, an American Farm Bureau Federation governmental relations director. The Rowland bipartisan measure comes closer to meeting Farm Bureau's objectives, he added.

Farm Bureau supports health care reform that provides financial assistance to those unable to afford it; 100 percent tax deductibility of health insurance costs paid by the self-employed; medical savings accounts; sensible insurance reform dealing with portability, prior existing conditions and modified community rating; malpractice tort reform; and targeted rural benefits including greater use of technology for "telemedicine."

Farm Bureau opposes employer mandates, government-imposed price controls, massive new taxes and repeal of the McCarran-Ferguson Act, which provides an antitrust exemption for the insurance industry. A provision to repeal the act is included in the Gephardt bill.

Mr. GRASSLEY. Mr. President, I believe that many Americans are concerned about losing some of those features of the American health care system that they value so highly which I listed at the beginning of my statement.

If the Clinton-style global budgets and premium caps go into effect, these things we now value so highly could be threatened. Health plans will have to strenuously economize in order to remain profitable. Economizing means that the quality of care could decline, access to care could be reduced and rationing could result.

Doctors are at risk of becoming employees of big insurance companies. In the new managed care plans, there could certainly be at work a financial incentive to underserve. Those who

serve as the gatekeepers through which people will have to pass to get health care will be under instructions to make people wait, to delay or deny access to specialists, to delay or deny access to sophisticated diagnostic procedures.

I do not fear for the young and healthy, the kind of people found disproportionately in health maintenance organizations. I fear for those with costly and life-threatening or handicapping illness. I do not want to see a state of affairs come about in which such people find that their care is delayed, or their access to advanced diagnosis is put off, or their access to the best specialists is restricted.

We all agree on the need for cost containment, Mr. President. I think all of us have presumed that cost containment is one of the major goals of reform.

But there is an obvious tension between vigorous cost containment and these things we value so highly in our health insurance and health care arrangements. This tension cannot be sidestepped just by claiming that we are going to eliminate unnecessary care and drive out waste, fraud, and abuse, as worthy as those goals are and as necessary as it is that they be accomplished.

Remember, in my opening comments, I said to write down in your diary the day this 1,400-page bill passes the Congress and is signed by the Senate what you think of your health care system. Because I do not think you will ever see it this great in the future.

I want to quote Rudolph Penner. We all know him, unless you are a recent Member of this body. I think everybody knows him anyway; a scholar today, but former director of the Congressional Budget Office and a respected economist. He gave an assessment of price controls in health care for the Alliance for Management Competition. He cited a comment from the Congressional Budget Office that puts this tension pretty well, the tension that I cited between cost containment and the reduction of the quality of care and access to diagnostic treatment and to specialists; in other words, where we do not have rationing today, where we might have rationing in the future. This is what Rudolph Penner quotes from CBO.

> In the process of changing the present health care system to achieve greater control over costs, some of the desirable features of the current health care system would be adversely affected. In particular * * * less spending on research and development, longer waiting times for access to new technology, and limitations on our existing choices of providers, health insurance coverage, and treatment alternatives.

Now, again, this person I quote is a person who understands Government. He understands the shortcomings of Government. If he has questions about these massive changes in our health care system, then is it any wonder people at grassroots America are skeptical of our deliberations and what we might do to that health care system with the passage of this legislation?

If there is one thing of which I am very confident, it is that the American people—that broad stratum of well-insured Americans who are pleased with their doctor, their hospitals, and their insurance companies—are very much not of a mind to give up these things that they value so highly.

With the power of Government behind you, it is possible to dream up practically anything in the mind's eye. It is possible to put those ideas down on paper. It is even possible to write legislation based on those ideas. Whether they will come even close, though, to working out there in the real world, that is a completely different matter. The plans offered by President Clinton, by the congressional committees which have reported bills, and by Senator MITCHELL, would launch our people on a wildly experimental venture.

As much as they want to see changes in our health care system, I am confident the American people do not want to be laboratory rats for some grand Government-dominated national social experiment. When people answer polls about wanting some changes made in the system I think it is summed up best by people in my State—and I will bet there are people like them in every State —who would say, in a very common sense approach, to their Senators or their Congressmen, something like this: "Well, we know that you have a problem out there in Washington. You want to do something about the health care system. You want to do something about cost containment. You want to do something about the people who do not have insurance."

In making that statement they are really asking a question: "If you have to deal with those things, can't you find a way of doing it where you do not screw up our health care that we have today?"

Many of our fellow citizens are, thus, trying to tell us they want improvements in the way our health care system works but they do not want to revolutionize that system. They want to see the uninsured are insured. They are moved, I think, by the plight of the uninsured. There was not one of us who listened to Mrs. Clinton last night, or listened to the people she had on the podium there with her, who had special problems, who would not be moved by that. But the people at the grassroots believe that these problems can be solved without vastly increasing the role of Government in the workings of the health care system. They believe these problems can be solved without throwing the entire system into turmoil. They want a reform that is done right. They do not want a contraption hurriedly stuck together with baling wire and chewing gum so we can throw something out to the voters this year to satisfy the electoral needs of politicians and that the bureaucrats in the Department of Health and Human Services will have to finish for us, fill in the blanks with regulations next year and for every year thereafter.

The American people are telling us they want to put this entire health care reform project off. That is what a majority of people are now saying in those polls. A year ago they did not say that. A year ago they did not know any more than we did what we were talking about in a 1,400 page bill. We know that they have now had a chance to look at it. I still do not think it has to be put off. I think we can pass some incremental legislation this year and build on it. We can have some useful reform this year, a good bill: Not a Democrat bill, not a Republican bill, not a bipartisan bill—but just a good bill. I am of the view we should not proceed with what might be called a big bang approach to health care reform. We should pass those limited reforms that will do some good. Then see what happens. Then we should return to the task next year and the year after, making adjustments that seem appropriate in light of what incremental reforms have been accomplished.

In other words, not to make the mistake we did in 1988, as sincere as that was. We had the ability to do this up right, pass one big bill redirecting $1 out of every $7 spent in America—the most massive impact on the economy of any piece of legislation ever passed in our history. If we could do that and people had confidence we could do it, that is one thing. But the people are skeptical about it now. That should cause us to be skeptical. But more so the track record of 1988 ought to signify to us we should make changes where there is very wide agreement among us on those things that can pass almost unanimously and then in the future—in the very near future—do more; in that very near future do some more. But do it slowly so we do not make mistakes.

I yield the floor.

The PRESIDENT pro tempore. The Senator from New Hampshire [Mr. SMITH].

Mr. SMITH. Mr. President, this has been and will continue to be a long, extended debate on an issue that is very, very important to the American people. As we look at where we are and why we are here, we started, of course, with health care being an issue in the last Presidential campaign. To the credit of the President and the First Lady, they made it an issue, and because of that we now have this debate at center stage.

Like most of my colleagues, I go out and get involved in the process, trying to understand the issue as much as possible. It is a very complex issue and

takes a lot of work to do it. My office has received thousands of phone calls and letters—more phone calls and letters, I think, on the issue of health care reform, both sides, than on anything since I have been in the Congress. I hosted a statewide health care conference earlier this year, in April, that featured leading policy experts from every facet of the health care delivery system. There were doctors, there were providers, nurses, patients—everyone who in some way had an impact or was impacted by any change or legislation in the health care industry was there. It was a fascinating seminar, to say the least, to listen to the concerns and the recommendations that were made by these people.

In addition to that I have 10 counties in my State. I held a town meeting in each of those counties. We do not call them town meetings in New Hampshire. There is only one town meeting in New Hampshire and that is the one held by the town. But I called them citizen forums. In these forums we were there to hear directly from constituents regarding the issue of health care reform. They spoke out. There were hundreds of them there in all of those town meetings, more than attended any of my citizen forums on any other issue.

In addition, as I said, I have met privately with numerous doctors, nurses, administrators of hospitals, insurance executives, private citizens and patients, as we have all done. This is not something that has been unique to me. All of us here in the Senate have tried to do this because of the complexity of the issue. In short, I guess the fairest thing to say is I have heard New Hampshire speak to me, and with me, on this issue. Overwhelmingly what they are saying is they do not want the Government any more involved in health care than it is already involved now. In other words, less Government involvement. I think there is a concern, unfortunately, that comes through as we listen to these constituents and providers and all of those who are in any way affected by this pending legislation—there is a concern that the Government is going to do something to me on this issue. I think that is coming through loud and clear, and it is a very valid concern. Rather than helping us, they are going to do something to me that may cost me my good quality health care.

The national polls—which have changed dramatically from overwhelming support for what President Clinton had proposed to the opposite, now—show America shares those same feelings as the people in New Hampshire.

(Mr. KERREY assumed the chair.)

Mr. SMITH. Mr. President, I do not think there is a great difference between the States—no matter what State you represent—on this issue.

I believe, based on what I have heard from the people I have talked with, that most Americans would oppose not only the underlying finance bill, which is technically on the floor, but also the Clinton-Mitchell-Gephardt or Clinton-Mitchell bill as we have here.

Fifty-three percent, according to the polls, worries Congress will pass a plan that gives the Federal Government too much control. And that is a very valid concern. They are suspicious because Government has proven again and again that it is not efficient, it is not compassionate, it is not thrifty; therefore, should not be trying to provide health care needs of people—least of all health care.

If a mistake is made by a Government official in perhaps the administration of the IRS or some other program, or the Post Office is late delivering the mail, it is a problem, maybe, but it is a minor problem compared to some slipup in the treatment of your health.

I think of the thousands of times—we all have done it—I tried to do an estimate, but it is in the thousands of people that have contacted my office in the past 10 years in the Congress to seek help with the Government bureaucracy. Sometimes we help them, and sometimes we cannot. It is as simple as that. It is a complex maze that citizens have to go through.

I think of those huge numbers of cases—veterans, Social Security, immigration—all of the things that we deal with. I think, OK, it is a hassle, it is a problem, it is a mess. We try to straighten it out. We go here, we go there and help them get straightened out to get them out of the country, back into the country, get their Social Security check, whatever. And they are important to them, but they are not as important as their health.

I cannot imagine having the caseload of our offices increased because somebody was having problems with the Federal Government's involvement in health care and seeking our office's help, or any help, to try to help them when they have been denied access or some other problem which may crop up.

They are worried. People are concerned. They are worried that they are going to lose their choice in their health care providers, they are worried that the quality of their health care will go down, they are very worried that their personal freedom will be diminished, and they are worried that they will be denied access to health care under certain circumstances, and that their costs will go up. These are very, very legitimate concerns: Costs, access, personal freedom, quality. These are concerns, and they are legitimate concerns of every single American.

I would also point out that this type of legislation we are discussing today is something that is going to impact every single American in one way or another. Very few people go through life from cradle to grave without having to meet a doctor along the way. It may happen, but not too often, if it happens at all. So somebody is going to be affected at some point in the chain. We need to understand that people are very concerned about that.

So that is why this is a controversial issue; it is a tough debate. People with good intentions on both sides have brought it to the forefront. The debate has been, I think, fair and pretty spirited at times, but I think it is necessary.

Let me talk a little bit about the process and what brought us here, and then get into the substance of the issue.

Because it affects every man, woman, and child in America in one way or another, I am a bit concerned about how we have gotten here in the process. I mentioned the fact it was brought up in the campaign. Then we had the White House Task Force on Health Care Reform, which essentially met in secret, as you all know, and for the most part precluded many who would like to have been involved, from being involved.

As a matter of fact it is now, probably, a violation of law and will be before the courts for a while to see how that will be resolved as to whether or not any laws were violated. Then after that, the so-called Clinton bill gets knocked around for almost a year, taking a downward spiral in the polls because of the debate that ensued. Then we have a meeting. Some decision is made by some in the Government—not on our side of the aisle from what I have been able to understand—that this bill, the Clinton bill, cannot make it, is not what the American people want. It is obvious. So there is a secret meeting or some type of meeting at the White House between the President and the majority leaders in the House and Senate, and then the decision is made to present two bills to the Congress: One the so-called Gephardt bill and one the so-called Mitchell bill.

I will just say, and I know there has been a lot of debate on this and I am not going to go into it to any degree, but this is a big bill. There are a lot of big bills that come through here, as Senator MITCHELL said the other day, and he is right. Do we get a chance to read them all? No. This is a bill with a huge impact on the American people. I might tell you, I started going through this thing. This is not a Tom Clancy novel we are talking about here, and it certainly is not John Grisham either.

This is tough reading. You need to have the television off and the music off and the kids in bed when you start reading this baby because this is really complex stuff. It takes a lot of time and it takes a lot of focus. It is 1,400 pages.

I just feel that when we talk about immediately moving to the bill, talking about threatening all-night sessions if we do not get amendments offered, if we do not do this, do not do that.

To the President's credit, his bill was debated for a year or longer out there. We knew pretty much what was coming down. Then suddenly the doors close, the President's bill is declared dead and out comes this one, out comes this thing. We now are told if we do not get to this thing and get it voted on shortly, we are going to stay in session all night until we do it. Then there was some blinking, and we wound up with some amendments being offered.

I do not have a problem with amendments being offered, but I want to make sure this thing is debated fully and every Member of the Senate has a chance to read it. What disturbs me even more, I would like to have the opportunity after I read it, after this debate, and before the vote, to go back to New Hampshire and talk with my constituents about it, because they have no idea what is in it.

They had some idea what was in the Clinton bill. That was done in a correct way. That was debated. This is not the Clinton bill. Not exactly. There are a lot of Clinton provisions in it. We do not know exactly what this bill is, nor do we know what the impact of it is.

I think the people all over the country—not just New Hampshire—ought to know what is in it. The only way that is going to happen is if we have the opportunity to go back and speak with them, after having read it and learned what is in it.

So we are now going to move to this bill, which we have done, with the threat of all-night sessions. So here we are. It is clear the push for health reform now has acquired a life of its own. It is no longer just a simple piece of legislation. It is breathing on its own.

Robert Samuelson pointed out in a Washington Post column last week that the Democrats are much more interested in putting together a bill that can pass for political reasons than doing what is right for our country. I do not know that I would totally subscribe to that, but I do think that the point is that what is politically expedient is not always necessarily what is right for the country.

So, again, I hope that reason will prevail; that perhaps those of us who have had to cancel plans might have the opportunity to get back home, talk with our constituents about this, come back here, take a few more weeks to allow this thing to be debated fully and make an intelligent decision. I am not optimistic that is going to happen, but I hope that it happens. We have to wait and see how that plays out.

Let us take a look at what some of the concerns are on this legislation. We know that this bill contains employer mandates. We know that the majority of businesses in this country, especially the small businesses, are opposed to that; that it is a problem. Whether you are talking about Clinton or Gephardt or Mitchell, they all have the employer mandates in one form or another.

The bill introduces a Government-chosen standardized benefits package. That is another provision. The Mitchell bill allows a commission to set the package with certain guidelines, so Americans will never know, really, until after the law is passed what is in there. This is another situation where we have not dealt forthrightly with the issue up front. We have just created a commission, and this commission now is going to establish some guidelines. So we are not going to know what is covered and is not covered until after the bill becomes law. That is not a good way to legislate.

The Mitchell bill does pave the way for direct Federal control of health care. There is no question about that. Any reasonable look at this is obvious. The Federal Government, under Mitchell, establishes an exclusive alliance for certain workers in areas where States do not create their own alliances and rules governing this system would be drawn up in Washington.

Washington. Why is it always Washington? The Mitchell bill introduces price or spending controls. It gives vague powers to a new national health care coverage and cost commission, which is going to recommend ways to hold down costs and require Congress to vote on its recommendations in an expedited up-and-down process. And then the bill claims a fail-safe provision to prevent any increase in the deficit. But if the bill's sequester mechanisms actually were invoked, according to CBO it could make previously eligible people ineligible for subsidies and would reduce the extent of health coverage.

Some problems. The bill is going to discourage self-insurance. No question about it. And the bill will create a huge new bureaucracy and place unfunded mandates on the States.

When we are courted, and we all are, on our votes, whether or not it is by the majority leadership—for the most part it would be the majority leadership courting votes, and not too many of us are getting courted on our side, although some are—there are claims being made that this is not the Clinton bill; this is something different. But do not be fooled by that because it is essentially the same. Supporters of the Clinton plan are trying desperately to gain votes for bills which in isolation and by careful reformulation have problems obtaining access to health services and need community health centers and other safety net programs. So there is a problem.

Now, this standard benefits package is a real problem. By adopting a comprehensive standardized benefits package approach rather than trying to assure that all Americans can obtain at least a basic catastrophic plan, this bill has chosen to ignore the fact that millions of Americans, millions of Americans, most notably the younger and the healthier ones, may not want and possibly cannot even afford such a "standardized" generous package. And those who need service not included in the standardized benefit package would have to buy the service out of their own pockets or buy supplemental coverage without any tax relief. Americans should be wary of a Congress or a commission to establish a comprehensive benefit system for all Americans especially in an era where medical technology is improving and making rapid advances. Senator DURENBERGER gave a very good statement on that point earlier in the debate.

There is a heavy burden on States under the Mitchell bill. For instance, the Mitchell bill requires States to oversee and enforce the complicated rules governing health plans under the new system. It would also require them to operate a risk adjustment system designed to transfer billions from health plans primarily serving healthier families to an unusually higher proportion of sicker Americans. So States would also have to assemble vast amounts of insurance and health data, would be responsible for creating a network of health purchasing cooperatives.

Here again we have essentially an unfunded mandate. Nobody really knows, nobody really knows how the Gephardt bill, the Mitchell bill or, for that matter, the Clinton bill, or the conference bill, how it is actually going to work. Some say pass Mitchell, pass Gephardt, whatever, get it to conference, and we will take care of it.

Well, you saw what happened with the crime bill. We passed that out of here, and that went to conference and look what happened. It is now the subject of national debate. Many Members of Congress are getting dinner invitations to the White House now to be pressured to change their votes. This thing fell to pieces because what passed the Senate was not what turned out in conference. A tough crime bill became a weak crime bill, and now they are trying to put it together.

What happens in conference, frankly, is a far cry from what the Founding Fathers thought about democracy. What happens in conference, my colleagues, is secret meetings, closed doors. We do not call them smoke-filled rooms anymore because not too many smoke cigarettes in the Senate. But they go into the conference and they close the door and nobody knows who put in these provisions. You cannot find out. You ask every conferee and nobody knows the answer. It just appears.

With all these changes, we are not going to know what is going to come out of conference. So if you are going to vote for Mitchell to get it into conference, good luck. That is the bottom line.

The more the American people found out what the Clinton bill did to their health care, the less they liked it. So my sense is that with the best of intentions, a bill moves into conference and then it is changed dramatically from what passed on the floor, and I would say dramatically changed for the worst.

So the very fact that this debate has inertia of its own that runs counter to the feeling of the vast majority of Americans —I did not talk to every American. I did not talk to a majority of Americans, but I talked to a large number of citizens from New Hampshire, and I have talked to some from around the country who have called, and they say that anything resembling the Clinton bill, anything resembling it—and regardless of your feelings on the majority leader's bill, it certainly resembles the Clinton bill —they say would be disastrous for the country.

Well, maybe they are wrong and maybe they are right. But they are the American people, and they are talking to us. They are talking with us. They are asking us to listen to them. It ought to at least give us a chance to pause, to step back and say, "Hold on. Wait a minute. Maybe we are going too fast. Let us not be concerned about moving too quickly."

Remember, 85 percent of the American people are covered by insurance, 15 percent are not. I saw Mrs. Clinton last night. As Senator GRASSLEY talked about, those people need help, and we can help them. There is not a person in the Senate who does not want to help them, or in the country for that matter, as far as I know, who would not like to help those people. But why do we have to throw out the entire system to make unhappy 85 percent of the American people to help the 15? Would it not be better to reform gradually and help the 15 percent? Does that not make better sense? That is what the American people are asking us to do. That is all they are asking us to do—to go slowly, help the 15 and leave the 85 percent alone that are covered. That is what they are asking us to do.

Now, given that fact, let me specifically discuss several things about the Clinton-Mitchell bill that I find particularly onerous and things that I cannot support and frankly I believe the majority of the American people do not support.

No. 1 is the bureaucracy. And again this publication has been put together by Senator COATS and Senator GREGG. It is entitled "Primer to the Clinton-Mitchell Bill, New Bureaucracies, New Mandates and New Federal Powers." It is something that has been shown here on the floor, and I am not going to read from it other than to simply say that just looking at the table of contents would give you some indication of what kind of a bureaucracy we are talking about here. We do not even have to read the book.

But I have heard it said on the floor that this is not a Government bureaucracy. Here is the table of contents. There are 50 new bureaucracies within the bill, there are 33 responsibilities for the national health benefits board, there are 25 responsibilities for the national health care cost and coverage commission, there are 177 State responsibilities, 815 powers and duties of the Secretary of Health and Human Services, 83 powers and duties of the Secretary of Labor, and 6 powers and duties of the Office of Personnel Management.

That is just the table of contents. You can read all about it. There will be more discussion on that at the appropriate time. But with 175 new mandates on States, this bill creates these 50 new bureaucracies. These bureaucracies range from the very trivial—I grant that some are very trivial and relatively meaningless and harmless—and go to the very powerful. They run the whole gamut. Let me pick one.

The National Health Care Cost and Coverage Commission; section 10002 of the Clinton-Mitchell bill establishes that the commission shall be composed of seven members appointed by the President and confirmed by the Senate.

That sounds relatively innocuous; another commission, seven people. Big deal. OK. Let us quote from the bill. The general duties of the commission are to—

> * * * monitor and respond to, one, trends in health care coverage; and, two, changes in per capita premiums and other indicators of health care inflation.

Then, the commission will also have the responsibility to determine whether or not mandates will be necessary to meet the coverage goals of the Mitchell bill. Then the recommendations of the commission would have to be considered by Congress under fast-track rules, which means there will be no opportunity for amendment on the floor of the Senate, and there will be limited debate. It is the fast track.

So my question is—I do not think anybody here can answer it—will seven people be able to do this all by themselves? What kind of people are they? Who are they? What is their stake in this? How much is this going to cost? Where will the commission be housed? Where are we going to put them? How many staffers does this commission need? How much research? How many dollars for research? What kind of research? How many computers? What do we need? Are we willing to invest such a huge amount of power to a bureaucratic entity not accountable to the taxpayers? We are going to create this commission. Who are they going to be accountable to? The President appoints them, we confirm them, and there they sit, a bureaucracy growing.

That is one bureaucracy out of the ones that I have cited. That is only one. I only picked one just as an example.

Are we willing to invest the power to the other 49, including a National Health Care Cost and Coverage Commission, a National Advisory Board on Health Care Work Force Development, a National Quality Council, and a Health Information Advisory Committee, and on and on?

In short, and, in fact, the Clinton-Mitchell bill will turn over the sensitive health care decisions of millions of Americans to bureaucrats, pure and simple. There is no other explanation for it. There is nothing else that you can say to deny it. It turns over the health care decisions of millions of Americans to bureaucrats. If those are efficient bureaucrats, if they do a good job, maybe it will not hurt you. Are you sure? Is there anybody out there who would want to take a chance when you watch some of the problems that we have seen in the Post Office, the IRS, the other agencies, and the EPA where there are problems which are constantly harassing towns and communities all over this country? Do you want those bureaucrats in between you and your doctor? Do you? If you like Uncle Sam, you will surely love Dr. Sam.

In the process, there is the bad news. Americans will lose choice. They are going to lose quality, they are going to lose access. They are going to lose their personal freedom, and they are going to see their costs go up. Not everybody; there will be some on the receiving end whose costs will not go up because they do not have any costs because they are receiving some type of entitlement from the bill.

But those who are working and carrying the load, it is going to happen. Those costs are going to go up. Clinton-Mitchell creates 17 new taxes. That is all I can find. There may be more. There is a 25-percent tax on plans to exceed the Government-set spending limit; 1.75 spending tax on all of the health plans. It is another tax. And there is a 45-cents-a-pack increase on the cigarette tax.

Then we have the Clinton-Mitchell community rating, which would raise rates on young Americans, which is, in effect, a hidden tax that forces the young to subsidize coverage for older Americans. It forces them to do it. They do not do it voluntarily here.

I have heard it said on the floor that this bill is a voluntary bill. Come on. There is nothing voluntary about this. It forces the young to subsidize the coverage for older Americans. Community rating is going to force insurance

companies to charge all of their customers, everybody, the same rate, regardless of their age. This means that older Americans will pay less for their coverage at the expense of younger Americans who lose care by comparison. It is not light. It is a bad plan. It does not work. It will not work.

How are you going to enforce it? Are you going to fine some 25-year-old young guy who says, "I am going to buy a Porsche. I am going to have fun. I am not going to get insurance. I am going off and do my thing." What are you going to do, chase him down with another Porsche, and, say, "You are going to pay some dollars in fines because you do not have health insurance"? Will you do that because he does not want to buy a plan that subsidizes somebody else who is 85 years old? Is that American? How are you going to do that? Are you going to have a bunch of bureaucrats chasing these people down?

I cannot imagine what this America is going to be like under this thing. Neither can the American people, and that is why they are opposed to it.

In addition, the issue of entitlements. Clinton-Mitchell creates, through new entitlement programs, subsidies covering those with incomes up to 300 percent of poverty, or $44,000-plus for a family of four. So, if you are a family of four making $44,000 roughly, you get a subsidy. That sounds great. Boy, that will pull in the votes, will it not? Because there are a lot of people out there in that category. So, if I can get something from the Government and I am making up to $44,000, I can vote for the plan. That is basically the rationale.

The American people are smarter than that. They can see through that.

There is prescription drug coverage for older Americans. It sounds great. Every drug is paid for. Who is going to pay for that? Who do you think is going to pay for that? Is it growing on trees? That is what we seem to think around here. We can pluck if off the trees like an apple. It is just Government money. Just send it down there, and everybody gets a free prescription. It does not cost anybody anything. Just ask them.

That will cost the taxpayers, for long-term care, prescription drugs, and subsidies, about $172 billion. That is with a "b." Add that onto your national debt, which is about $4.5 trillion now. Just keep adding it on.

The Senator who is occupying the chair right now is working on an entitlement commission for entitlement reform. I have thousands of postcards about him. I am depending on him, I might say, to do the job and to make a recommendation.

Here we are again with three new entitlements in this bill alone. At least 100 million people out of 260 million are going to receive some form of subsidy from the Government in this health care bill, the Mitchell bill, 40 percent. We are talking about entitlement reform because it is driving our country to economic ruin. And we are going to create this thing? Forty percent of Americans are going to have to deal directly with the Government when it is paying their health care. I hope they like it. I hope they like it. I hope they like their doctor. I hope they like wherever they are sent for that care. I hope they like the paperwork. I hope there is no objection to any of that, especially when you are sick, because you get what they give you. That is it. You cannot complain.

At a time when we recognize again that entitlements—and we have to recognize it, we know it, and every Member knows—are sucking the country dry; 50-plus percent of the budget of America is entitlements, and 16 percent is interest on the national debt. There is not much left for anything else.

What are we going to do about it?—adding three or four more entitlements, and adding billions of dollars, tens of billions, perhaps hundreds of billions of dollars more in Government spending in entitlements because it is all free. It is free. Just pick it off the trees, and send it down to somebody down there who will have their hands out eagerly waiting for some benefit.

We hear a lot of talk about special interests around here. The only people that do not have a special interest around here are the taxpayers. There is no taxpayer that gets a chance to testify before committees around here. It is always some other special interest. It would be nice to just pull a taxpayer off the street, and say, "Hey, Mr. Brown, would you like to testify today since you pay all of these bills?" That would be nice. That would be refreshing. But I have not seen it happen.

The obligations of these entitlements are going to be borne by our children. That is who is going to pay for this, if they can. I doubt that they can. Who do you think is going to pay for all of this debt that we keep piling and piling on? Who is going to pay for it? It is so sad and so irresponsible and so un-American to pass our debt on to our children.

As a father, I like to think that maybe, if I have anything left, when I die, if Uncle Sam has not gotten it all, I would like to say I would like to leave something of my assets to my children, not my debts. Not my debts, I would just as soon pay the mortgage off and leave my kids the house. They will fight over it, but I would rather leave it to them debt free.

That is not what we are doing here in the United States of America. We have run the debt now to $4.7 trillion, and it is rising. Every time we pass another entitlement, we raise it a little more. The entitlements and the interest are squeezing everything else down to this very thin little sliver of pie—about 30 percent it is now—and it is getting squeezed further and further every day. What is in that sliver of 30 percent? That is, you add the interest and entitlements and get approximately 70 percent. What is left in the 30 percent? What is it? Environment, education, national defense. And it is not getting any better. It is getting smaller and smaller.

How far do you want to squeeze? Do you want to bring it down to 1 percent? Do you want to increase interest to 90 percent? Where do you stop? If we do not stop, we are going to bring this country to its knees economically, and then nobody will get any health care—nobody—because there will not be any money left for anybody for health care, for national defense, for environment, for education, or anything. We will be broke, and our creditors will be in here picking up the pieces.

If that is what we want, that is what we are doing. We are creating a massive entitlement program, a massive new Government involvement in our lives. We are creating it here on the floor of the Senate if we vote for this bill. It will come back to haunt us for years and decades to come, I guarantee you.

I am willing to let my word stand on the record right now and say that this will come back to haunt us. It will haunt us in less quality. It will haunt us in larger expenses. It will haunt us with more debt. It will haunt us with rationing, and on and on and on. It will. A lot of people in here know it.

Samuelson, today, in the Washington Post had another very interesting article. But before going to that, I would like to read from a letter sent to me by a constituent regarding entitlements. I will not read the entire letter, but it is a sample of the hundreds of letters and phone calls I get. And I think the American people ought to be heard. I will not name the writers, but I think in concept they should be heard:

DEAR SENATOR SMITH:

I am writing to you to express my great fear that Congress will pass a health reform law that will harm our children. What I see at play in Washington is a desperate need by a group of elected officials to pass a law that, good or bad, they can claim shows they are so hard at work. The proposals that are on the table ignore the fiduciary responsibility we have as adults to the next generation. We will break our children's backs with new obligations. We cannot even meet our current obligations without borrowing from the rest of the world. The Clinton plan, the Mitchell plan, and the Gephardt plan are bonanzas to our industry.

He is a hospital CEO.

I suppose I could be crucified by my colleagues for writing you this, but the reason we have given so much support to health reform is partly because it will flood our coffers with new money. The health cost controls the Government has tried do not work.

The market forces that business and managed care are generating are working, however. For a real change in costs under Government's direction, health care must be nationalized, and we are not ready for that. I implore you to do everything you can to slow this process down.

And on and on. That is the point, and that is what we are hearing. What does Robert Samuelson say today? He is somewhat critical of the press in the sense that the press seems to have missed the point as to what is exactly happening. He points out:

In July, the bipartisan Committee for a Responsible Federal Budget issued a report warning that all health plans could involve huge spending increases. "Common sense tells us," the report said, "that everyone cannot consume more health care and pay less."

"Common sense tells us that everyone cannot consume more health care and pay less."

The committee includes two former heads of the House Budget Committee (both Democrats), five former heads of the Office of Management and Budget (three Republicans and two Democrats) and the ex-head of the Federal Reserve. The report wasn't covered by The Washington Post, the New York Times, the Wall Street Journal or any major TV network news programs.

It was not even covered.

To go on a little more, Samuelson says:

Unfortunately, the Times' coverage the following week ignored health costs. In midweek, the CBO issued a report on Senate Majority Leader MITCHELL's health plan. Previously, the CBO had estimated that health spending could increase to one-fifth of the Nation's income (gross domestic product) by 2004, up from a seventh today. The Mitchell plan, the CBO said, would increase it slightly more. The Times didn't report that.

Then he goes back to the CBO report:

The CBO found that much of Mitchell's plan is probably unworkable. States couldn't easily determine who would be eligible for insurance subsidies. A tax on insurance would be "difficult to implement." It would not "be feasible to implement" Mitchell's so-called "mandate" without causing severe "disruptions, complications, and inequities."

That is quoted out of the CBO report. Samuelson makes the point that he thinks that is "news" since this is the most significant piece of legislation to come before the Senate in 25 years, according to some. So he thought it should be covered.

"The New York Times ignored it," according to Samuelson, "and The Washington Post brushed it off with a couple of paragraphs . . .." And, "To their credit, the Wall Street Journal and Washington Times ran major stories; likewise, NBC 'Nightly News' reported these findings." But, the major media treat this as a coherent plan without practical problems. So be it.

So there is a paradox here. Samuelson says:

Many reporters seem infatuated with "reform" even when, by personal experience, they ought to know better. Journalists are supposed to be seasoned skeptics, and most Washington reporters are familiar with Government's defects. We have covered agencies captured by "special interests." We know of many worthy but unkept promises. We know that Congress evades difficult choices and, as a result, tends to march off in five directions at once.

I ask unanimous consent to have this article printed in the RECORD.

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

DID THE PRESS FLUNK HEALTH CARE?

As Congress debates health care, the press ought to be asking itself whether it has blown this story just as it blew the savings and loan scandal. The answer is yes, I think—though in different ways and for different reasons. We have not ignored this story, as we initially ignored the S&L crisis. But our vast reportage has not made health care any more understandable. We have not clarified in our own minds or the minds of our readers what the debate is ultimately about or shown sufficient skepticism about whether "reform" can work as intended.

In some ways, our problem is that health care is too many stories. It's about personal care, the economy, technology (high-tech medicine), ethics (who deserves expensive care?), styles of medicine ("fee for service" vs. "managed care")—and of course, politics and interest groups. We have written thousands of column inches on all these subjects and in the process have overwhelmed our readers and obscured some of the larger issues.

The most important of these is health spending. With good reason, this is what the "health crisis" was once about. Ever-higher spending is squeezing other government programs and, through employer-paid insurance, take-home pay. For example, Medicare and Medicaid now represent 17 percent of federal spending, up from 5 percent in 1970. President Clinton harped on high health costs in the 1992 campaign, and his initial plan did—on paper at least—deal with them. But the spending issue vanished as the Clintons focused on "universal coverage."

The press went along; the major media stopped listening to concerns about spending. In July, the bipartisan Committee for a Responsible Federal Budget issued a report warning that all health plans could involve huge spending increases. "Common sense tells us," the report said, "that everyone cannot consume more health care and pay less." The committee includes two former heads of the House Budget Committee (both Democrats), five former heads of the Office of Management and Budget (three Republicans and two Democrats) and the ex-head of the Federal Reserve. The report wasn't covered by The Washington Post, the New York Times, the Wall Street Journal or any major TV network news programs.

Sometimes editors and reporters don't even seem to read their own papers. On Sunday, Aug. 7, Robert Pear of the New York Times wrote a front-page piece saying that "the goal of cost control has been eclipsed by the furor over universal coverage." A solid story. Unfortunately, the Times' coverage the following week ignored health costs. At midweek, the CBO issued a report on Senate Majority Leader George Mitchell's health plan. Previously, the CBO had estimated that health spending could increase to one-fifth of the nation's income (gross domestic product) by 2004, up from a seventh today. The Mitchell plan, the CBO said, would increase it slightly more. The Times didn't report that.

Now obviously, I have a point of view. I think health spending matters and doubt that these "reforms," if enacted, would work as promised. But it is not necessary to share my views to think that these are legitimate issues that haven't been adequately aired in daily coverage. If a major "reform" is adopted and doesn't operate as advertised, people will ask: Where was the press?

Good question. There have been warnings. Return to that CBO report. The CBO found that much of Mitchell's plan is probably unworkable. States couldn't easily determine who would be eligible for insurance subsidies. A tax on insurance would be "difficult to implement." It would not "be feasible to implement" Mitchell's so-called "mandate" without causing severe "disruptions, complications and inequities."

This strikes me as "news." The New York Times ignored it, and The Washington Post brushed it off with a couple of paragraphs in a small story. To their credit, the Wall Street Journal and the Washington Times ran major stories; likewise, NBC "Nightly News" reported these findings. But in general, the major media tend to treat each of these health proposals as a coherent plan without practical problems. This makes the story a neat combat between "reformers" (implicitly good) and opponents (implicitly bad).

There is a paradox here. Many reporters seem infatuated with "reform" even when, by personal experience, they ought to know better. Journalists are supposed to be seasoned skeptics, and most Washington reporters are familiar with government's defects. We have covered agencies captured by "special interests." We know of many worthy but unkept promises. We know that Congress evades difficult (a k a, unpopular) choices and, as a result, tends to march off in five directions at once. Yet the skepticism that this ought to breed withers in the face of an appealing "reform."

What also has been missed is the basic political nature of this debate. Once government decrees what insurance must cover (by creating a standard insurance "benefits package"), it has effectively nationalized insurance. The obvious way of doing this would be a single-payer system that taxes people and provides government insurance. But that looks too much like a government takeover. The use of "mandates" and regulation disguises this and seems to have fooled many reporters. Hundreds of billions of dollars of spending would still come under federal control.

By now it's clear that the public is deeply puzzled by the whole debate. The responsibility for this falls mainly on our political leaders, President Clinton and his critics have not been candid. They won't acknowledge that the goals that most Americans share—better insurance coverage, personal freedom in medical choices and cost control—are, to some extent, in conflict with each other. In this sense, there can be no ideal reform; somehow, incompatible goals will have to be balanced.

But the conflicts will not vanish just because Democrats and Republicans refuse to discuss them. The press's job is to bring candor and clarity to issues where political leaders haven't shown much of either. We don't make society's choices, but we can illuminate what those choices are. On health care, we haven't.

Mr. SMITH. In conclusion, Samuelson says:

What also has been missed is the basic political nature of this debate. Once Government decrees what insurance must cover (by

creating a standard insurance "benefits package"), it has effectively nationalized insurance.

That is absolutely right. You can say it is not a Government-run system if you want to, but, in effect, you have nationalized the whole insurance situation when Government decrees what insurance must cover by creating a standard benefits package.

The obvious way of doing this would be a single-payer system that taxes people and provides government insurance. But that looks too much like a government takeover.

So we use the words "mandate" and "regulation," and this seems to disguise, basically, the issue of Federal control or takeover.

So it is clear that the public is deeply puzzled by the whole debate.

The responsibility for this falls mainly on your political leaders. "President Clinton and his critics have not been candid," Samuelson said. "They won't acknowledge that the goals that most Americans share—better insurance coverage, personal freedom in medical choices and cost control—are, to some extent, in conflict with each other. In this sense, there can be no ideal reform; somehow incompatible goals will have to be balanced."

Mr. Samuelson has gone right to the heart of the whole issue. He hit it right on the head, 100 percent accurate.

I urge my colleagues to take a look at that article.

Let us look at the benefits under Clinton-Mitchell. The Clinton-Mitchell bill will create a one-size-fits-all standardized benefits package and make most existing plans totally illegal. The plan that you have will be illegal in most cases. If you have a plan out there now, you like it, you have good coverage, forget it. Hopefully, it will be as satisfactory as the Government plan because you are going to lose it. So if you like what you have, you may want to let your Senators know how you feel before the vote because this bill is going to radically, radically diminish consumer choice.

We include in this so-called standard benefit package abortion coverage. I am not going to get into the abortion debate today. But a lot of the American people do not want abortion in the health care bill. It is stretching it a bit to call abortion health care.

In June 1994 a Gallup poll found 59 percent of Americans are against including abortion in the Federal health care benefits package. Again, this goes to the heart of choice—freedom. Is that not what America is all about? Is that not what for 200 years people have died for?

Think about this. A Catholic church cannot provide a health care plan for its parishes or its employees if it so chooses without having abortion in the package.

That is exactly what is going to happen under this bill. That just is not right, pure and simple. It is wrong.

You can bet that we will be down here in the future—we have already done it once—voting under fast-track rules to add more services. We just did it yesterday with the Dodd amendment, and tomorrow it will be the chiropractors or someone else. There is always going to be someone trying to get in here saying, "I have been left out. I want to get in here."

So what we are doing is the same thing we did with Social Security, Medicare, Medicaid, and all of it. It is just like taking a balloon and blowing it up. It is going to get bigger and bigger and bigger until it bursts.

It all sounds good. Get the kids covered. Get pregnant women covered. Get all these people covered, get everybody covered, because we cannot resist it. Congress could not resist yesterday. The Senate passed the Dodd amendment. So already we have found the first amendment mandating insurance companies cover specific services for pregnant women and children passes, whatever it was, 58 to 42, something like that.

There will be more. They are going to be coming. Believe me. That is just the beginning, and the Senate will find it very difficult, as it did yesterday, to vote against them, because these are services for the people who need them. Of course, there are people who need. But is this best way to help those people by breaking the United States of America with a huge entitlement that has no end, that according to Samuelson, and many others, is going to go from one-seventh to one-fifth of the economy? Is that what we want?

How can you vote against kids? I heard that yesterday. How can you vote against pregnant women? I heard that yesterday. How can you vote against immunizations?

How can you bankrupt the future of our country for all the children in all the future, who are going to have to pay for all of this? How can you do that?

I did not hear that stated by the supporters of that yesterday. We will be back here again and again and again and again, not just in this debate. We will be here for a while. Lord knows how long everybody has given up vacations? Anyway what difference does it make? We will be here as long as it takes until there is some blink and we decide to wrap it up and go home and come back. After that, after this thing passes, that is just the beginning. Wait until we try to implement this little guy. This is going to be really something. When we start implementing this thing and we find out what we have to do and how much it is going to cost, then we are going to be back here. We are going to be back here quite a few times, believe me.

Let me tell you what is going to happen. Either premiums are going to go up or care is going to be rationed because we cannot promise the American people more care for less money. You cannot do it. You cannot bring everybody into the system, into the package, into the care, and do it for less money. It is impossible. Common sense will tell you that.

If you do it, you are going to decrease quality, or you are going to ration it. Sure, you can put a cap on it. You can cap costs, and you can bring the quality down. You can cause rationing. And that is exactly what is going to happen. The American people better understand what this Senate and what this Congress is going to do to you and to your health care today and your children tomorrow if this thing passes.

They are going to be forced to obtain benefits that they do not need in the standard plan, and they are going to be forced to take benefits that they do not want.

Let us go to employer mandates. Millions of middle-class Americans, the very people that the President ran to help, millions of them are going to find their salaries cut, their benefits cut, and if they are not, most without a doubt in many cases will have their jobs lost. That is what is going to happen to middle-class America, because who do you think is going to pay for this? The poor do not pay for this. They are on the receiving end. They are not paying. The rich—do you think the rich are going to pay for it? Come on. Middle-class America is going to pay for it. That is who is going to pay for it. That is where all the dollars are. Only 1 percent of the people in America are rich. Look, the poor get the money. So who else is left? It is the middle class. That is who is going to pay for it. Do not be fooled by the debate how it is going to help the middle class. Come on.

As to employer mandates, in my State alone in New Hampshire, according to estimates it is liable to cost anywhere between 4,800 and 4,900 jobs. That is a lot of jobs in a State with a million people that has been hit hard in the past years. Over 100,000 New Hampshire workers face reduced wages or benefits if they did not lose the jobs. That is basically a decision the employer is going to have to make. Do I reduce the benefits, reduce the wages, or cut some jobs and leave the wages and benefits for the survivors as is.

I have two letters I would like to read that would make that point. I think they make it better than I do.

DEAR SENATOR SMITH: I am writing at this time regarding the ongoing battle over health care reform. As a small business owner, I was appalled by the recent remarks made by Hillary Clinton with regard to free loading small businesses. While it is understood that neither Mrs. Clinton nor the President has ever had to run a business, it seems hypocritical of them to ignore the very real concerns of small business owners who have risked everything to build a business. Employer mandates will cripple many

small businesses by adding a constantly escalating non-voluntary expense to operations. In addition, much time and expense will be lost to paperwork, regulatory compliance and administration. I fear the present administration has little regard for those of us who have already carried an excessive share of the tax burden.

Another letter:

DEAR SENATOR SMITH: Normally, I am not one who gets involved in the political process. However, since you will soon be voting on several different bills involving the reform of the health care industry, I feel it is necessary for my Representatives and Senators to know my opinion about the likely impact on small business if some of these bills passed. I am classified as small business. At present I employ eight people in various roles from administrative to technical design work. I am proud of the fact that I have been in business since 1988, and I have always tried to keep layoffs to a minimum even when it was not in the best interest of the company. For 5 of the 6 years I have been in the business, I provided company paid life insurance and made health insurance available to my employees with the company paying 50 percent of the premiums. I am currently in the process of adding disability insurance in a benefits package. You see health insurance and welfare of my employees is not something I consider lightly. However, I am concerned about the ramifications of instituting mandatory health insurance. Small companies with under 25 employees should not be forced to implement an insurance package for their employees. The end result will be increased company expenses by way of premiums and taxes which will yield an increase in layoffs, business failures, and decreased wages which in turn result in overall lower standard of living for all.

New Hampshire under these mandates of this bill will lose approximately a half a billion dollars in personal income, almost $1,500 for a family of four. The State of New Hampshire would lose over $60 million in much needed tax revenue. Clinton-Mitchell would ban self-insurance for companies with under 500 employees, and this will mean that 18 million middle-class Americans will suddenly find themselves without insurance and end arrangements that save some firms thousands of dollars in premiums.

Is that really what it intended? Of course it did not. It is not the intent of the majority leader to have people without insurance. The intention is to have them covered by insurance. But what is going to happen is suddenly 18 million middle-class Americans—I emphasis middle-class Americans—will suddenly find themselves without insurance.

There are 32,254 businesses, as best that I can count, in my State. Of these, 32,186, or 99 percent, have under 500 workers. Several of these are currently self-insured, with great success, I might add, that would no longer be able to do so.

Again, a brief comment from a letter I received from a constituent:

Our company provides insurance for its employees through a self-insurance plan. We are concerned that self-funding may no longer be an option for small businesses like ours if a 100-employee cap, or any cap, is imposed. By eliminating self-funding and increasing cost of health care, it is possible that many jobs will be lost. The same is likely if employee caps are imposed, which would also raise costs and jeopardize employee coverage.

He basically goes on to say small employers should not be penalized.

Mr. President, there are alternatives to this. We should not stand here on the floor and be totally critical of the majority leader's bill. He wrote the bill and brought it up in good faith, and we have to criticize it, if we are going to, in a responsible manner and have some alternatives.

I think those of us on our side of the aisle and many on the other side of the aisle are united in their support for actions that would help millions of Americans right now, today. You can do it without throwing out the best health care system in the world. You can do it by prohibiting insurance companies from dropping individuals due to sickness. You can do it by dealing with preexisting conditions.

If someone in my home area, the Lakes region of New Hampshire, in Wolfeboro, for example, has a daughter with cancer, that person should be able to get insurance at a reasonable rate. That insurance should not be canceled if that person moves to another job because his or her daughter or their daughter has cancer. We can stop that and that is what we should do. You do not have to throw out the entire health care system in America to do that.

Portability. If a person in Nashua, NH, wants to switch their job and move someplace else, they take their policy with them, just like you take your auto policy or your life insurance policy. You can extend help to the working poor through vouchers, which both bills provide for.

And perhaps, most importantly, and missing from the Mitchell bill—and this is something I feel passionately about; it is so important, and it is totally ignored by the Mitchell bill—and that is the establishment of a medical IRA, an IRA account; or, another way to say it, a medical savings account. It is one of the best ideas that has been brought forth in any of the debate, and it is totally ignored in the Mitchell bill—not a word.

The medical savings account would do more to help contain medical costs in our country than anything in the Clinton-Mitchell bill, anything at all, and would do so by relying on the market rather than Government bureaucracy.

People with medical savings accounts could purchase high deductible coverage to guard against catastrophic costs and they would pay for those out-of-pocket costs in the account that they set up. Most health care expenses would, therefore, be paid by the individual who set up the account, rather than a third party.

Let us get into that a little bit further. I believe that the main reason our current system fails to rein in runaway health spending is that it removes the consumer from the decisionmaking process.

When the tab for health care is picked up by somebody else, not you, a third party, either employers or the Government, for the great majority of Americans, the consumer has no incentive, none whatsoever, to keep his or her own health costs in check.

For most Americans, there is no financial reward for staying healthy. What is the reward? What is the reward for staying healthy? What is the reward for seeking preventive care? What is the reward for shopping around for the best available price? None. And under the Clinton-Mitchell bill, absolutely none.

To put this in perspective, let us compare health insurance just for the sake of debate—and we will probably hear some of my adversaries in the media say, "Now, Smith says auto insurance and health insurance are the same thing." Lest there be some temptation to do that, I will say up front, they are not, and I recognize that health insurance is more important to our well-being than auto insurance.

But I use the comparison for this reason. If I drive recklessly, get several speeding tickets, and cause an accident, my irresponsible behavior will be greeted with a higher premium. That is what is going to happen, and rightfully so. It is to my financial advantage to drive carefully, drive safely, avoid speeding, wear my seatbelt, whatever.

But if somebody else were paying for my auto insurance, I might not have the same incentive. What is my incentive? My insurance is not going to go up. If somebody else pays, I could care less if it goes up. I am not paying for it.

It is the same thing in health care. With another party bearing the responsibility for any costs, individuals have no incentive to keep themselves from incurring expensive health care bills. That is what medical savings accounts are all about. And they are totally ignored in this bill. Responsibility. Is that not what America is all about, responsibility?

Think back to the Founding Fathers and what they did when they founded this great country, and the numbers of people who were wounded and died in 200 years of war. Responsibility. Why cannot we take on some responsibility for our own well-being if we have the capability to do it?

And for those who say, "Yeah, but there are those who do not," I am willing to help those 15 percent. I am talking about the 85 percent right now.

It places the responsibility for health care costs where it should be—on you,

on the consumer. With a medical savings account, the consumer, not a third party, will have to make decisions that will have a direct financial impact on themselves.

If you want to drive a Porsche, you want to go out every night and drink, you want to spend your money, go ahead. If you want to buy a health premium, you want to buy an insurance policy, set yourself up a medical IRA and say, "I'm going to assume responsibility for me. I'm responsible for me. Not the Government, not my neighbor, me. I'm responsible."

Exercise some responsibility. Set up the medical IRA account. And then lead a healthy lifestyle, and you will save money, big time. If you lead a healthy lifestyle and you seek routine preventive care, you will be rewarded with accruing balances in your medical IRA.

Now, sure, something can happen. That is why you have an insurance policy. That is why you buy the policy, to protect yourself from injury or accident. However, you will accrue balances in that IRA if you take preventive care and you will have enough in there to pay for your insurance and still have money left over. Let it accrue, and this will defray future medical costs and even allow you to buy a catastrophic policy at some point when you are ready. You are holding down your personal health costs; individuals will help our country hold down our overall health costs. We will all do it as individuals.

Not a word, not a mention of medical savings accounts in this plan. This is too American. I guess it makes too much sense. It is common sense. God forbid, we could do anything that makes sense around here in Washington inside the beltway.

And, in addition, and in conclusion on medical IRA's, medical savings accounts will also unleash the market forces onto the health care delivery system; unleash, and that is exactly what we need to do, unleash the market forces on the health care system. Today's system encourages providers to bill for as many services as possible. With millions of individual consumers shopping around for quality care at low prices, providers are going to have to find ways to cut overhead costs and provide care in an efficient manner. That is the market.

And these adjustments in the marketplace could be made today as we speak, and they would help millions of Americans to obtain less expensive health care insurance.

In closing, we have heard many stories, many horror stories, about those who are not covered, about our current system and how tragic it is that 37 million Americans lack health insurance. And there are some horrible cases. There is not a person in the Senate or in the Congress that does not want to help those people, including this Senator. And we can.

There is a right way and a wrong way to do that. It is wrong that people are suffering because they cannot get coverage. But who are these 37 million people? They are people, sometimes, who are between jobs. They lost their job, they move to another job, their insurance gets canceled so they need portable insurance. We do that. They are people who have a preexisting condition, either themselves or someone in their family has perhaps a terminal illness, something that involves a lot of medical costs, they lose their job and the next provider says, "I am sorry, that is a preexisting condition. It would cost us too much and we are not going to insure you." That is going to need to be changed. And we do that in our bill. That is a large group of that 37 million.

We can take care of these cases through providing insurance market reforms and providing assistance to the working poor. But for some reason—I do not know what the reason is; I am not going to make any allegations about political reasons—but for some reason we are concentrating on disrupting the entire health care system which 85 percent of the American people are happy about for the sake of 15 percent. Why not just help the 15 percent when you can do it without disrupting the other 85 percent? It is going to be a grave mistake if we do this. We are going to regret the decision made in 1994 on the floor of the U.S. Senate, because we have the finest health care delivery system in the world. We know it because people come from all over the world to receive it. Doctors come from all over the world to learn medicine, to practice medicine. Everybody knows it. If you are sick, if you have a problem, where do you want to go? Guatemala? Mexico? Russia? Canada? Or the United States of America?

Let us take advantage of the quality and the innovation and the creativity of the best physicians and health care providers in the world. Let us take advantage of it. Let us not throw it out.

So now we stand, as I speak, at a fork in the road—and it is a fork in the road. We can go to the left, as the Senate considers a massive restructuring of one-seventh of the economy, which will probably make it one-fifth Government involved. We can take that path toward a health care system controlled by an inefficient, uncompassionate, expensive government bureaucracy. We can take that path. That is one choice we have. Or we can go this way, to the right, which will lead us to a more efficient marketplace that can meet the needs of all Americans. The left fork gives us bureaucracy, more taxes, job-killing mandates, rationed care, diminished quality. The right fork will help those who are truly needy while preserving the world's best health care for everyone. Access, low cost, personal freedom, quality, choice. That is what we get when we go to the right. Bureaucracy, mandates, less personal freedom, more controls, less quality, less choice—to the left.

What is the decision?

Let me read just a couple of lines from two more letters.

DEAR SENATOR SMITH, I am writing to you to advise in my opinion that health care as presently espoused by Washington will not work. We all would cherish an umbrella of universal care, but at a reasonable cost and especially at a cost which is no greater than we presently pay. This means no additional taxes. Unfortunately, the record suggests programs managed by the Government are many times barely effective or efficient.

Then he cites a couple of examples and goes on to say:

The warmth and general concern for our well-being are not well known as priority attributes in our Federal employees, IRS, FBI, et cetera. To have a government manage anything as important as health care is ludicrous. And to be bullied into this legislation is akin to lemmings heading with a blind eye for the cliff.

The first step, it seems to me, would be to analyze the problem of health care. The major problem is not the quality of health care. We have the best in the world. The problem is associated costs which are and have been out of control.

The last letter:

SENATOR SMITH, I am writing about my concern on the current health care proposal now in Congress. Improvements in health care are needed and desirable but I feel many of the plans include restrictions and mandates that are contrary to a good health care system and a free enterprise system that has made our country so successful and great.

I take the time to read these letters because these are the American people who are going to be impacted and affected by the decision that we make, sitting here inside the beltway, without talking with them, without having the opportunity to go out and speak with them. We are here making this decision that impacts them. They ought to be heard on the floor of the Senate. That is why I am taking the time.

Restrictions that would prevent you from choosing your choice of doctors is a horrible thought. Before I go to a doctor I check his dossier and I talk to people that know him. Let's face it, all doctors are not equal. Some are better than others. Not all ailments or illnesses fit into a standard mold. A doctor has to have a keen analytical or diagnostic ability to accurately identify, in a timely way, what is ailing a patient and what medication or treatment is best for that patient. It is not uncommon to change doctors when his or her prognosis does not render relief, or to get a second opinion before a serious medical or surgery procedure. Some doctors are more skilled than others and you want the doctor with the best track record and the one you can get along with.

These people are concerned. They are concerned. Let me put it even stronger—they are scared. They fear.

I am going to close with a quote from a gentleman who came to one of my 10

county meetings. We talked about health care, and he said to me, "Senator, I have known you more than 20 years. But let me tell you what bothers me. I am afraid of my Government. I am afraid of my Government. I don't want to be afraid of my Government. I want the Government to be afraid of me."

I yield the floor.

The PRESIDING OFFICER (Mrs. BOXER). The majority leader.

Mr. MITCHELL. Madam President, I want to address two subjects that were raised by the distinguished Senator from New Hampshire and several of our Republican colleagues with respect to the pending health care legislation. One involves the question of choice in health care. The other involves the role of Government in health care and the reaction of our colleagues to that.

The statement of the Senator from New Hampshire was filled with references to less Government involvement, no Government control, and fear of Government by Americans. That has, of course, become the dominant theme of the statements made by our Republican colleagues seeking to capitalize on a public sentiment of disillusionment with Government and even hostility to Government.

I would like to make two points with respect to that argument as it relates to this debate. First, it does not describe my bill. The statements are not correct as they relate to the bill which is pending before us. My bill does not provide for a Government-run health insurance system. It provides for a voluntary system of private health insurance. Indeed, in a significant respect, my bill is the opposite of what our colleagues are trying to portray it as. A large Government program is Medicaid, a Government program which provides health insurance to those Americans whose incomes are below the poverty line. Under my bill, that program would be virtually abolished and 25 million Americans who are now in one of the largest Government programs would be out of that Government program and would purchase their health insurance on the private market as do most other Americans.

It is simply inaccurate to characterize legislation which would virtually abolish one of the largest Government programs in existence and encourage and assist the people now in that program to purchase private health insurance, it is simply inaccurate to describe that as a Government-run program. It is not.

I recognize that our colleagues are having some success in this false portrayal. It is a pattern we have seen before. But success does not mean accuracy. We went through it just a year ago when we debated the President's economic plan, when the very same Senators now saying that this bill is a Government-run health insurance system said to the American people that the President's economic plan would raise everyone's taxes and was a tax on small businesses. They said it over and over again, it was reported by the press and, as a result, the American people believed it. Polls showed overwhelming majorities of Americans believed that their income tax rates would go up as a result of the President's tax plan, even though those statements were untrue and the beliefs were unfounded. It was an aggressive effort at misinformation which regrettably did succeed and, therefore, creates incentives for a similar campaign of misinformation now.

But I want to state clearly, so there can be no misunderstanding, the characterization is incorrect. My bill creates a voluntary system building on the current system of voluntary private insurance. It virtually abolishes one of the largest Government programs and takes 25 million Americans now in such a program and has them enter the private insurance market. So that is my first point. It is not a Government-run health insurance system.

But now my second point deals with the attitude of our colleagues toward Government insurance and Government health care and the vast gap between their rhetoric about it and what they do about it when it affects them and their families.

First, they say they are against Government health insurance and Government health care. Well, the largest Government health care system in the country, indeed the largest health care delivery system in the country, is the Veterans' Administration health care system. If they truly believed what they are saying here about Government health care systems, they would abolish the Veterans' Administration system. But, of course, they do not say that and they will not say that.

In fact, with respect to that Government health care system, their actions directly contradict their words. The very same Senators, our Republican colleagues who stand here and say, "We are against Government health care systems," when they go back to their home States, they go seek out the veterans and they run television ads promising the veterans that they will protect the veterans health care system, even though it is a Government-run health care system and it is the largest health care delivery system in the country. Their actions contradict their words.

The same is true with respect to Medicare. Medicare is a Government-run health insurance system, and nearly 40 million Americans, most of them elderly, participate in that system. And the Republican Senators who stand here and say they are against Government-run health insurance all support the Medicare system. They go back home and they seek out elderly citizens. They go visit senior citizens' centers and fall all over themselves in promising to their senior citizens that they will protect Medicare, and they run television ads seeking reelection, promising their senior citizens that they will protect Medicare, even though it is a Government-run insurance system. Their actions contradict their words.

The same is true with respect to Social Security, the largest of all Government programs, a Government-run system which includes health care by virtue of incorporating Medicare part A. Our Republican colleagues go back home and also seek out senior citizens and also run television ads promising to protect Social Security, which is a Government-run program.

So I hope the American people will not be fooled by the rhetoric they are hearing here today. And I hope the American people will also think about the irony of these Republican Senators getting up here day after day after day and denouncing Government health insurance and Government health care as bad for their constituents, even as they benefit from it themselves as individuals and their families. Every Member of this Senate participates in the Government-run health insurance system that is available to all Federal employees, and the Government pays 72 percent of the cost of that health insurance for these Republican Senators who are standing here telling their constituents that it is bad for the constituents even as they participate in it for themselves and their families.

You, American taxpayers, are paying through the Government 72 percent of the cost of health insurance in a Government-organized health insurance system for the very Republican Senators who are now telling you that you should not want Government-run health insurance. And you are entitled to ask yourselves: If it is so bad for you, why is it so good for them and their families?

Has one of them stood up and said, "My constituents, Government health insurance is bad for you, and to prove how much I believe that statement, I'm going to voluntarily drop out of the Government insurance system, and I'm going to put my family in the same place where your family is"? Have you heard one say that yet? No, and you are not likely to.

I urge you to listen to the debate, and as these Republican Senators stand up and tell you, Mr. and Mrs. America, that Government health insurance is bad for you, ask yourself, "If it is so bad for me, how come it is so good for them and their families? And if they really believe it is bad for me, if that is what their conscience and conviction tells them, why do they not drop out of it for them and their families and put themselves in the same position I am, an average American who doesn't have access to that?"

That is just the insurance. Now let us talk about direct care. If one of these Republican Senators does not feel well, if he gets a headache, or stomach ache, he walks a few feet down the Capitol and he goes to the Office of the Capitol Physician, a Government employee. He is greeted by a clerk who is a Government employee, checked by a nurse who is a Government employee and then goes in to see the doctor who is a Government employee.

If Government health care is so bad, why do these Republican Senators insist on having it for themselves? And then if they get sick, if the doctor says, "You've got to go to the hospital," they go to the Bethesda Naval Hospital or the Walter Reed Army Hospital—Government hospitals.

Well, my gosh, ask yourself, Mr. and Mrs. America, if these Government facilities are so bad, why do these Republican Senators want to go there themselves? And it is not just Senators. President Reagan and President Bush were, in their capacities as President, the most powerful men in the world. They were independently wealthy, and they could have gone anywhere in the world when they got sick. And where did they go? Why, they went to these Government hospitals. And who can forget the photographs taken of them waving out the window to the public and the press in those Government hospitals. Why are you telling us that it is good enough for Presidents but it is not good enough for ordinary Americans?

Mr. and Mrs. America, leave aside politics. Leave aside health care. When a fellow walks up to you and says, "I've got something, and its good for me and my family, but you really don't want it for your family," you ask yourself: Who is he thinking about? You or him?

This debate has not been about health care reform. This debate has been about slogans. When the first Republican Senator stands up and says I believe so much in my conviction that Government health insurance is bad that I am going to withdraw myself and my family from the Government-organized health insurance system and I believe so much that Government health care is so bad that I am going to promise if I get sick never to talk to a Government doctor and, if I have to go to the hospital, never to go to a Government facility, when that happens, pay attention to what they say thereafter.

But until that happens, you can take what is being said as slogans, separated from the reality of daily lives. If they want it for their kids, if they insist on having it for their kids, if they will keep it for their kids, then why is it so bad for your kids?

I want to repeat what I said at the outset. My bill is not a Government health insurance system. It is not a Government health care system. It is the opposite. It is a private system, voluntary, in which people are encouraged to purchase private health insurance. And I have mentioned this debate about individuals and health insurance here only to make the point of the inconsistency of the arguments being made by our colleagues.

To summarize, they are all for the Veterans Administration, which is a Government health care system. They are all for Medicare, which is Government health insurance. They are all for Social Security, which is the largest Government program. Therefore, their statements here against Government participation simply do not ring true because they will not stand up and say they oppose those programs, they want to abolish them. And then their actions in placing themselves and their families in a Government-organized health insurance system and getting direct Government health care for themselves, even as they say to their constituents, "That is not good for you," I say be aware, on guard, listen carefully.

Now, just the other day one of our colleagues came out here and said, well, the insurance program we are under is not a Government program because although it is organized by the Federal Government and 72 percent of the cost is paid by the Federal Government, it is really a mechanism where private insurance plans can be made available to Federal employees.

Mr. President, the denial negates the original claim, because that is essentially what my plan would do. It would create a mechanism whereby employers would offer to their employees a minimum of three different types of private insurance plans, and employees would choose among them. There would be no requirement on the employer to pay for any part of the cost unless we did not reach 95 percent coverage by the year 2000, as I believe we will.

And so it is ironic that the explanation about the Government insurance plan effectively negates the original allegation about my plan being Government insurance in the first place. So our colleagues cannot have it both ways. If my plan is not Government health insurance, then their original argument falls. On the other hand, if the Government-organized, Federal employees program is Government health insurance, they are all participating in it, willingly, taking it for them and their families while they tell their constituents it is bad for them.

Madam President, I will have more to say on that subject. I now want to mention just briefly the subject of choice. The Senator from New Hampshire said if our plan is adopted, "Americans will lose their choice."

That statement is untrue, categorically untrue. There are two types of choice in health care. The first is in choice of health care plans. How much choice does the individual American have in selecting a health insurance plan? Right now, almost none. Most Americans are insured through employment. The employer negotiates a plan with the insurance company and presents it to the employee, and the only choice the employee has is to accept or reject that plan, to either participate in it or not to participate in it.

Under my plan, the individual employee will be offered a minimum of three different plans. They will have the same standard benefits package, but they will deliver care in three different ways: either in the form of traditional fee-for-service, or a health maintenance organization, or in some other form. So in the first dimension of choice, that of health plans, my bill will dramatically expand choice for almost all Americans. For the first time, individual Americans will be able to choose from more than one health plan.

Second, the element of choice in physician or other providers. It is simply not true that choice will be denied under my plan. Since everyone will be offered at least three types of plans, one of which must be traditional fee-for-service, every American will have the opportunity to continue to have the fullest freedom of choice with respect to physicians. No one will be denied that opportunity.

Interestingly enough, the current trend in the country is in the other direction. As costs of health care rise, employers are increasingly turning to managed plans, HMO-type plans in which the individual's choice is limited. So if we do not adopt health care reform, more and more Americans will be denied choice in provider. So you have a reduction of choice in the one area where it now exists and continuing lack of choice with respect to health plans.

So I think it is important that Americans understand that my bill will do the opposite of what our colleagues have alleged. It will greatly increase choice in health plans and it will preserve fully choice of providers. Anyone will still be able to see any doctor they want, choose anyone they want to see in nurses or any other form of provider.

I hope that we all understand that.

Finally, the statement was made, "Don't throw out the entire system," thereby creating the implication, since the remarks were on my bill, that my bill does throw out the entire system. Madam President, it does not. It builds on the current system. It says that most Americans now receive their insurance through employment, and we should continue that. We should encourage those who do not have insurance to get it. And what we ought to do is to try to increase the number of Americans who have health insurance

through a voluntary system of guaranteed private health insurance.

Now, what my bill does do is to provide health security for the 85 percent of Americans who now have health insurance but do not have health security.

Right now many of them face the incredible situation where their health insurance could be canceled if they become sick. Think about that. A person buys health insurance to protect himself in case he becomes sick, and then when he becomes sick the policy is cancelled. My bill will prevent that from occurring. It will prohibit that from occurring.

Second, right now, a person can be denied health insurance on the basis of a preexisting condition, something that affects millions of Americans. My bill will prohibit denying on the basis of preexisting condition. By contrast, the Republican bill would permit that to continue on an ongoing basis. My bill will phase out the preexisting condition exclusion completely by a time certain in sharp contrast to the Republican bill which permits the denial for preexisting condition to continue.

My bill will make it possible for a person to change jobs without the fear of losing his or her insurance. That is a real problem today. My bill will make it possible for people who are between jobs, temporarily unemployed, to continue with insurance. The insurance will be private, it will be guaranteed, it will be renewable, and it will not be able to be canceled. I think that is what Americans want who have health insurance. Yes. They are happy to have health insurance. But many of them are concerned about their lack of security, the fact that they do not know for sure whether it is going to be canceled tomorrow, whether the premiums are going to be doubled, or whether it will cover what they want when they become sick.

So, Madam President, I emphasize that my plan will increase choice. It will prohibit current insurance practices which leave Americans who have insurance insecure, and it will encourage those who do not have insurance to get it. It will abolish one of the largest Government programs that have those people enter the private insurance market. It is a voluntary system. And I ask Americans to keep that mind as they listen to the debate.

Madam President, I yield the floor.

Mr. HATFIELD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. HATFIELD. Madam President, I would like to comment briefly on the majority leader's remarks, at least a few of them.

I think that it is the duty of the leader, as the majority leader or as the minority leader, to represent a party position or a political perspective. I admire both Senator MITCHELL and Senator DOLE for their able and professional way of carrying out those duties.

But I also think that the American people are alert enough and wise enough to know that the leadership of the U.S. Senate on either side of the aisle cannot easily categorize, as the majority leader has today, the Republicans all in one position and the Democrats all in another position. That is just an inaccurate portrayal of this issue, and the things that divide us on this issue.

I happen to be participating with what we call the mainstream coalition. These are at least nine Democrats who are not happy with the Mitchell bill. These are at least 9 or 10 Republicans who are not happy with the Dole-Packwood bill. But nevertheless, they are trying to seek to join together in a bipartisan effort to create a piece of legislation to lead us to wise, effective, economical health reform.

So I just want to clarify the record on that point, that my leader, Senator DOLE, as much as Senator MITCHELL's contingent of Democrats, are not easily divided as has been portrayed this afternoon.

Second, I would like to indicate just for clarification that somehow we have a coverage that is a Government operation, our own medical coverage. I would like to clarify that record to say that Blue Cross-Blue Shield is one of the many contractors with the Federal Government. I gain my health care from Blue Cross-Blue Shield where the Federal Government has a contract with the plan, and like many private industries, pays a portion of our health care premiums. Portraying that somehow the Members of the Congress, in particular Republican Members, are getting this great benefit out of the Government operation, as we have heard today, is just not accurate. So I want to clarify the record on that point.

I might also say we have thresholds, or we have deductibles. We have copayments. And yes we may go to see the Capitol physician but we pay a premium. I pay a fee for that kind of service. So this is not some broad-based freebie as that is being portrayed here today.

Madam President, the Senate has embarked on a very historic debate, and health care is probably one of the most important social issues that I think we will probably debate this entire century. During the last several months, we have heard a lot about the need for health security, that health care is a right that can never be taken away. I subscribe to that. And we have all heard the tragic stories of those who have fallen between the cracks in our health care system and have faced huge financial losses when faced with a health crisis. We have heard about the uninsured, and the cost shifting that occurs as between those of us who are insured to those who are uninsured who seek their health care services in hospital emergency rooms.

There is no doubt that our current health care system is not meeting the needs of a large segment of our country. We all share a commitment to achieve the finest health care delivery system possible in the United States to be extended to all in the United States. That is the purpose of this debate.

I would like to take the perspective as an appropriator. Let me use the old jingle that is often used, that authorizations—and that is what both the Mitchell bill and the Dole-Packwood bills represent, authorizations—are but a hunting license for an appropriation. We on the appropriations committees have found that there has been much action to authorize many programs in this century by the U.S. Congress, and then somehow it ends up in our lap to try to find the money for it. It is awfully easy to make promises. It is awfully easy to paint great broad brushes of new credits or new entitlements or new subsidies or new coverage. But someone at some point has to provide the money.

Let me say also that having been involved in Government for a few years, I am not willing to put my entire expectation and hope and trust on some kind of prospective savings. We have been through many of these experiences in the past. Under President Franklin Roosevelt, we had the Browley Commission; under President Truman we had the Hoover Commission I; and, under President Eisenhower, Hoover Commission II, studying the reorganization of the executive branch of Government and projecting the savings that could be achieved out of those reorganization proposals.

The first year out we found there were some savings that could be directly attributed to those reorganization efforts. But as time went on in the outyears, those savings disappeared pretty quickly.

So to undertake a program that is so heavily dependent upon prospective savings, of changes, and so forth, I am a little bit dubious. I am not saying we have not achieved some, of course, but to say that we are going to fund a portion of this health care program under the Mitchell bill out of those savings I think is a little risky business. And I know what will happen. If those proposed or prospective savings do not occur, it will be back on the Appropriations Committee to come up with the money to fund the commitments that have been made.

So I would like to focus a few comments on two key areas: The cost analysis of health care reform; and second, the nonmonetary issue as the legacy we are leaving for our children and our grandchildren. "Legacy" might be translated, also, into the word "indebtedness." We began this debate more

than 4 years ago when it became apparent that health care costs were rising at a rapid rate and would endanger the financial stability of our country. We are now at a point where national health care expenditures make up more than 14 percent of our gross national product and near $1 trillion.

By the year 2000, national health expenditures, at this continuing rate, are expected to reach more than $1.6 trillion; and by 2004, they will exceed $2 trillion. According to the estimates released on Tuesday of this week by the Congressional Budget Office—the legislative arm of the Congress—the legislation proposed by the majority leader, Senator MITCHELL, will exceed these estimates. I can only draw a conclusion that this does not represent cost containment.

Yes, we need health care reform, but we cannot forget the impact new Federal spending and new entitlement programs will have on our children and our grandchildren, who will be faced with paying the bills associated with these increases of today.

We have a bipartisan commission on entitlements and tax reform that recently released findings which showed that even if increases in health care costs were held to the growth of the economy by 1999, due to the aging and changing demographics of the aging population, Federal outlays for Medicare and Medicaid will still double as a percentage of the economy by the year 2030. In fact, they will increase from 3.3 percent of the economy today to 11 percent of the economy. Mark you, these findings and projections do not include the effect of the new health care entitlements envisioned by the Mitchell bill.

Let me stop here a moment and say, as I indicated in the very beginning, no leader in this body can speak for all the Members on his respective side. You have heard a lot of talk about Republicans saying "no new taxes." Well, this is one Republican who will vote for new taxes if it is to fund the high priority that I place on health care reform. I am not talking about depending it on the cigarette tax or the sin taxes; I am talking a basic tax increase, because I want to remind ourselves today that when we went through the throes of getting catastrophic illness and everybody wanted catastrophic illness, led by the AARP, when the people of this country found it was going to cost them $3 to $4 more a month in premiums, there was almost a stampede into the well of this Chamber to see who could be down there with the first bill to repeal the act passed by the previous Congress, in order to respond to the American public's outcry that they were not willing to pay a $3 to $4 increase for coverage of catastrophic health care. I am one Republican—and I am sure there are others—who will say that we put such a high priority upon covering all Americans with decent health care access that we are willing to stand and vote the tax to support it and to guarantee it and not make promises that cannot be guaranteed by saying prospective changes or prospective reforms are going to provide us with the money.

Let me also say that under the Mitchell bill, many are going to find themselves paying more for their health care. By the year 2002, all Oregonians will be paying the same rate for premiums regardless of age. According to a recent editorial in the Washington Post written by Neil Howe and Bill Strauss, this so-called pure community rate will increase costs for young people by 100 percent. Essentially, this means that we will be taking at least $40 billion yearly out of the pockets of young adults—those under the age of 35—and putting it into the pockets of adults over the age of 45. It is a cost shift.

While there is no doubt that reform needs to be made in the insurance industry—for example, to make insurance portable so you can take it with you when you change jobs and available to you regardless of your health status. In fact, I was recently chatting with a gentleman in my office who is now among the ranks of the uninsured. He changed jobs and became self-employed. Due to the change, he lost his employer-provided health insurance, and in the meantime he learned that he had diabetes and now cannot find health insurance because nobody will insure him with this preexisting condition. These are the kinds of problems we must address in our current insurance system. Yet, we must do so in a way that does not bankrupt our children and grandchildren. This is the challenge that makes this debate so difficult, because there is no easy answer. Again, what is the legacy we want to leave to the future generations?

As many of my colleagues know, the State of Oregon has taken substantial steps to enact health care reform which controls health care costs and achieves universal coverage. The Mitchell bill could negate the innovative Oregon health plan. Although Oregon's Medicaid waiver appears to be grandfathered, none of the other reforms Oregon enacted into law receive such protection against Federal preemption or Federal prescription.

For example, Oregon has developed a standard benefits package under the Oregon health plan. This unique benefits package explicitly recognizes that we cannot afford to provide every service to every person.

Madam President, there is not a plan out here that has taken the tough position to say we cannot provide every service to every person. What we are trying to do in Oregon is to provide everybody with standard primary health care. We are not going to separate every Siamese twin born in Oregon. We are not going to guarantee, in a sense, that everybody has a right to any medical procedure—over 9,000 of them under Medicare alone. We have prioritized them. People say, oh, that is rationing health care. Well, we are rationing health care, yes, but we are doing that today based on economics, which is certainly discriminatory, far more than saying to a person who is 80 years old, if you have a life expectancy added to your life by 1 year, are we going to engage in a very costly medical procedure as against covering 100 women with prenatal care? No, we cannot afford to do it. That gets down to where the real rubber hits the road in terms of having to make the tough decisions that somehow we are going to offer everyone any medical procedure or access to any medical procedure. That is the implication, because we have not addressed those thousands of medical procedures, and we have the attitude that any one of them—it is very clear—would be open to anybody.

Oregon focuses on the position of preventive health care services and provides an access to primary health care before serious health problems develop. It looks at the effectiveness of treatment and draws lines to exclude payments of services that are noneffective or add to the individual's quality of life.

I think we have to face this reality in the national picture as well. It was difficult for Oregon. It was complicated. But they gathered the best brains and representation of the people, theologians, philosophers, doctors, lawyers, humanists, people from all walks of life, people from all incomes, and they sat down and worked out this dialog.

Under the Mitchell bill, will Oregon be permitted to continue to offer this unique benefit package to all Oregonians? Oregon has also taken steps in the private insurance market which have completely changed the nature of health care in the State, and has contributed to a significant lowering of health care costs in Oregon compared to the national average. Oregonians are familiar with managed care, where they join a network of providers through whom they can access health care services.

These networks include primary care physicians, hospitals, specialists, and other health care providers. In fact, more than 60 percent of the 1.1 million Oregonians who have coverage through Blue Cross/Blue Shield of Oregon are enrolled in managed health care plans. And in addition to that, Kaiser Permanente has more than 400,000 subscribers in Oregon out of a total population of 2.9 million.

However, there is a provision in the Mitchell bill that threatens the ability to health plans, such as those that are

covering the majority of Oregonians, to manage health care costs by limiting ineffective treatment and care. Under the claims dispute mechanism which would be established if the Mitchell bill is passed in its current form, health plans will have no incentive to manage cost because every decision, every claim—and there are millions every year in this country—could be reviewed through an administrative process, or in Federal or State court where damage awards available would be "any appropriate relief"—underscored—"any appropriate relief" possible, a true lawyer's paradise. This could be called in a sense a lawyer's economic development act.

Let us be clear about this. The disputes we are talking about here are contractual disputes over service coverage in health plans. These are not malpractice claims, not malpractice claims. They are not disputes that arise over negligent medical care. The implications of this provision for our ability to control costs through managed care are erroneous and they become also more enormous. It will completely undermine cost containment efforts.

I have long advocated that we give States more flexibility to develop a database to assist us in formulating a Federal role in health care reform. Certainly, I agree that there need to be certain Federal standards that assist us in achieving the goal of universal coverage. However, I do not believe the Federal Government should be dictating a regulatory and prescriptive process to the States and that each State then must follow to reach these Federal standards.

This approach penalizes States such as Oregon that are progressive. Many States have been working on these issues for many years, and I believe it is wrong for the Federal Government to come in and undo the reforms that we have already established and are experiencing.

For example, the Mitchell bill includes a provision that will preempt all State laws in the area of medical liability reform that are different from the new Federal laws established if the Mitchell bill is passed. In Oregon, that would mean that our medical liability law which includes a cap on noneconomic damages and has contributed to a significant lowering of costs would be preempted because the Mitchell bill does not include a similar provision of a cap. The Federal Government should not be paternalistic in this realm. Some States, like mine, are years ahead in their reform efforts.

So you ask, what about the States that are not as progressive as Oregon? How do we get them to do the right thing?

I believe we must set minimum Federal standards and then provide those States with guidance—not mandates—about how to reach those standards. We should provide incentives and credits for innovation, not more regulation. In all areas, our Federal system penalizes States that are more progressive and reduces them to the standards of the lowest common denominator. Our citizens expect better, they deserve better, and Oregonians certainly demand it.

Madam President, I want to make it clear that I am committed to reforming our health care system. The concerns I have raised must be addressed before we pass comprehensive health care reform. This is not a stalling tactic. This is asking for the data and information. Let me digress for just a moment. I happen to have been Governor when Kerr-Mills was first established as a precursor to the Medicare Program. Under Kerr-Mills, the Federal Government indicated the States should develop a database upon which to designate, to define, and to analyze the health care needs of the elderly citizens. Oregon, I am proud to say, was the first State out there to start the process of developing this database to know what the Federal role legitimately and rightfully should be. There were those who wanted to rush through a Medicare bill which came to be known as the King-Anderson bill superseding the progress that was established under Kerr-Mills, and they pronounced as the ultimate statement of costs in 25 years it would not cost more than $10 billion under King-Anderson.

Madam President, in 25 years it was $65 billion, and it is going sky high. It is going to eat up our whole budget if we do not do something about cost containment.

My point is simply this, that we can prove at the State level and if we had the time to develop the base I am sure we would have a finer and a better, more efficient Medicare system than what we are now experiencing. Concerns I want raised must be addressed. We cannot legislate in the dark, afraid to face the reality that we may not be able to afford unlimited health care for everyone in this country. However, we must assure that everyone has access to preventive and primary health care.

As a Member of the Appropriations Committee, I have directly experienced the struggle we face to allocate funds for our complex array of domestic programs. This discretionary funding funds the operation of those all three branches of the Government. It pays for the roads and the bridges of our transportation infrastructure, the loans that go to provide public housing, student loan assistance and small business startup, our national parks, and many more purposes which have nearly universal support. These funds have been drastically diminishing over the years as the entitlement programs have grown. The programs authorized under health care reform will put further pressure on the Appropriations Committee to make funding decisions.

And do not forget that the budget caps we are now under require us to cut discretionary spending next year by $5 billion. And as entitlement programs continue to grow, less and less will be available to discretionary programs. We are literally facing choices between running the Government and paying for our biggest entitlement programs—Social Security, Medicare, and now a new health care bill.

I return to the premise with which I began—what kind of a legacy are we leaving for future generations? Because I have this in common and have this with many of my colleagues and I share their concern. I made a commitment to work with this bipartisan mainstream coalition, which includes Democrats and Republicans, to try to improve upon the reforms in the Mitchell bill.

We are not rejecting either bill. We are just saying we cannot accept either bill in its current form.

I want to repeat again that I am one Senator who is willing to pay the bill to improve our health care system. But let us face the responsibility for paying for it now rather than later. We have an obligation to future generations to approach this issue of cost up front. We have all seen the illusory nature of projected savings over the years. This time we cannot afford to saddle future generations with mistaken cost estimates and glossed-over realities of the fiscal tradeoffs.

We must be conscious of the costs of such a system and make a commitment to control these costs. If we are up here getting ready to adopt a new health care plan and engaging in all sorts of rhetoric, political and otherwise, I think we have to understand that we have an obligation to tell the American public precisely how it is going to be funded. To only dodge that issue to me represents more a fraudulent approach than an honest approach.

We must make a commitment also in this or any other bill we adopt to funding medical research. We must assure that we make sufficient provisions to address the needs of our rural and underserved areas.

It is very interesting to note that rural America was left out of the original proposals that were called upon to be adopted in the Congress. It was only after pressures from within the Congress that rural America was seen as having a very special problem of rural health care because of the gravitation of medical resources to the urban centers.

We must enact meaningful malpractice reform. We must pass a bill that is less prescriptive and regulatory on State Government. And finally, we must encourage innovative and creative approaches to health care that are occurring in our States and private

health care markets now. We are not going to write a bill in concrete. We cannot do so because of those changes that are occurring now, even before legislation is adopted. Meaningful reform is possible if we keep these goals in mind.

I look forward to working with my colleagues to fashion a bipartisan solution that addresses these goals.

We cannot afford to pass a health care bill that has 51 votes from one side of the aisle or 50 plus 1.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Madam President, I would like to speak today about an amendment I intend to offer, or a couple of amendments, to the health care reform bill.

I will not go on at great length. I know that others wish to speak.

The PRESIDING OFFICER. The Chair would note that the Senator from North Dakota stood on his feet and his voice was heard and he was recognized. He was on his feet first and that is the reason the Chair recognized him.

(Mr. WELLSTONE assumed the chair.)

Mr. DORGAN. Mr. President, I would observe that I have been here since 12 o'clock, with the exception of about 10 minutes when I left the floor, and I believe I watched for about an hour and a half or an hour and 45 minutes on the other side and about 15 minutes on our side.

But, nonetheless, I will be very brief.

I want to talk about an amendment that I intend to offer with my colleagues—in fact, two amendments.

THE FEDERAL RESERVE BOARD

Mr. DORGAN. Mr. President, before I do that, let me say again, just on another subject, the Federal Reserve Board action of yesterday is very disappointing. Today, we have all read the newspapers about that.

I was thinking about maybe suggesting we cut off the air conditioning down at the Federal Reserve Board. Somebody suggested if I did that legislatively, somebody would get up and suggest that we cut off the air conditioning in the Capitol Building.

But clearly we need to push some different air into the Fed to see if we cannot get some better decisions on interest rates.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. DORGAN. Mr. President, let me discuss briefly the amendment that I and a couple of my colleagues will offer to this piece of legislation.

I discussed yesterday the number of health care proposals that are before the Senate. I discussed the fact that there is great merit and need in discussing universal coverage. Universal coverage is essential. No American should wonder whether they have the ability to take their child to a doctor when their child is sick. It should not be a function of how much money you have in your pocket when you decide to get health care for a sick child. So it is clear we need better access to health care.

We need universal coverage. That is not something that I question. It is a goal we must move to, and as quickly as possible.

It is also clear to me, as I mentioned yesterday, that we must do something about the cost of health care. If we do not put the brakes on skyrocketing costs, we will be chasing the target of coverage forever and we will simply not be able to obtain it.

Yesterday on the floor I used a chart which shows what is happening to the cost of health care and I would like to show the chart again. The United States spends much more on health care than any other country in the world. We spend more than 14 percent of our gross domestic product on health care; Canada is at 11 percent; and no other country is even at 10 percent.

The fact is U.S. health care costs are growing and growing exponentially. And every single plan that is before us—the Dole plan, the Mitchell plan, the Clinton plan, the mainstream plan, the Finance Committee plan—every single plan, at the end of it, in the year 2004, will see the cost of health care as a claim on the gross domestic product of this country increase by nearly one-third.

Instead of keeping health care at 14 percent or 14.5 percent, which is much more than any other country in the world spends on health care, at the end of every plan, by the year 2004, according to the Congressional Budget Office, we will be at 19 or 20 percent of gross domestic product.

That is not success. We will not achieve universal coverage unless we find some method by which we put the breaks on skyrocketing costs. We, I think, need a thoughtful debate about how to do that. I think there would be great differences. Some would suggest cost controls, cost containment mechanisms that are real; others would suggest a market that might incentives cost containment. The fact is, if we do not dig in with cost containment devices that work, whether it be in the private or the public sector, we will not obtain universal coverage under any condition.

Again, let me say, every plan that I am aware of, including the Republican plan, will, at the end of the plan, mean that we will spend a third more than we now spend on health care as a percent of our gross domestic product. That cannot and will not be viewed as a success by the American people.

On one part of this issue, I am going to offer an amendment that I want to discuss today. It is an amendment on the issue of the cost of prescription drugs. It would be hard to find a better heeled industry than will fight this amendment, I am sure.

The pharmaceutical industry is a very, very large industry with an enormous amount of resources. They do a lot of good things. They produce wonder drugs, manufacture life-saving drugs, invest a lot of money in research and development. And I salute them for that.

On the other hand, they produce products that are a necessity, not a luxury. People need, as a matter of course in their daily living, to take the medicines and prescription drugs that are prescribed by their doctor.

The way they price prescription drugs in this country in my judgment defies all good sense. And I have used these charts before. I am going to use a couple of them again, just to describe why this amendment is necessary.

The biggest selling drug in America is Premarin, used for estrogen replacement. Here is the price for Premarin by the same manufacturer, for the same pill, put in the same bottle. I have held up on the floor before the bottle of pills for which it is $93 in Sweden, $100 in England, $113 in Canada, and nearly $300 to the U.S. consumer. Why? Why would we be charged more than triple the price for the drug Premarin when compared to Sweden or England?

Xanax, for anxiety, $10 in Sweden, $56 in the United States.

Zantac, a drug that is used for ulcers; a wonder drug, as a matter of fact, saves the need for a costly operation. But why do we pay $133 for the same size bottle, for the same pills, produced by the same manufacturer, when it costs $64 in Sweden and $84 in England?

When I offer the amendment, I will show chart after chart after chart that shows exactly the same thing—two different sets of pricing data. A price for people who live in Italy, Germany, France, England, Sweden, and Canada, and then a separate price, a higher price, for the United States consumer. Why? By what justification should we believe the U.S. consumer should be charged double, triple, 5 times or even 10 times the same price than other consumers around the world pay?

I intend, with my colleagues Senator PRYOR, Senator SASSER, and Senator FEINGOLD, to offer two amendments, one which would have the Secretary of Health and Human Services do a survey, to collect information, and require the pharmaceutical companies to furnish the information, on the wholesale prices at which they market their drug in various countries. And from that, construct an index that is released periodically to the American people so

that we know what price we are paying for the same drug that is being consumed at a lower price by other people in other countries.

That is number one. It simply requires the drug companies to provide the information and requires the Health and Human Services Secretary to get it, to compare it, and to produce an index so that we have public information and allow the public to put the pressure on the pharmaceutical manufacturers for fair pricing.

The second amendment would be exactly the same step leading to the acquisition of these prices and the comparison of these prices, and then a determination based on the results. If they find that a drug is sold in this country for 25 percent more than the average price at which it is marketed in other countries, more than 25 percent above the average price at which it is marketed in the rest of the world, then it would result in a show cause hearing at HHS. If the drug companies could not show cause that was justifiable, then the Federal Government would only pay, under the Medicaid contract, the average price of which that drug is marketed in all the rest of the world.

Those two amendments, I assume, will provoke a substantial amount of debate. There is certainly room for disagreement about drug pricing. But I do think that we ought to have a discussion about that component piece of the cost of health care.

I would like to make one final comment, and then yield the floor.

There is, I know, great rancor, anger, cynicism by some about this health care debate, about Congress generally, about the Government, about Washington. All of us see it and hear it. We feel it every day from the phone calls we get and contacts when we are back home. Times have changed, and part of it is understandable and very real. Part of it bothers me some—I listened carefully this morning to some of the discussion—the notion by some in this Chamber that somehow Government is awful, Government is untrustworthy, Government cannot do anything. The fact is, Government is a system by which we put together the schools and educate our kids, we construct our roads and a police force to keep us in safety, and a force of firefighters to fight fires. Government is all of those things. Government was, when it constructed REA, and rural telephone system, the instrument by which we electrified rural America and brought telephone service to rural America. We have done a lot of remarkable and good things through our Government, together—things that work. Things that work well.

I respect the fact that there is great disagreement about how to respond to the health care issue. I do hope that, as we move down this road, we will, in a thoughtful way, disagree without being disagreeable. Even though there are substantial differences in public policy between us, all of us now serve in government. I hope we all aspire to make government effective. Whatever we do, let us make it effective. Let us do it right.

It may be, some think, we should do less of it. That is perfectly legitimate. But we ought not make it our fulltime occupation to denigrate everything done. I am telling my colleagues, there are plenty of people doing that these days. I hope those of us who work here, Republicans and Democrats, and who care about public policy will tone down some the description of what we are. I was told recently by a person that we are all liars and all a bunch of frauds in Congress.

I said, "You know, I do not think that". I work with the Senator from Arizona, Senator MCCAIN. I work with Senator DOLE. I work with Senator COATS. I do not know of one person in this Chamber I work with that I think that of.

Every person here, in my judgment, is here because they care a great deal about public policy. They might have widely divergent views about what that policy may be, but they come early in the morning and work late at night because they care about public policy and honestly want to address it in the right way. I hope, as we move forward in this health care debate and as we talk about crime and other things, we can always keep in mind that all of us are trying in our own way to do the right thing.

I have indicated yesterday that I desperately believe when we turn out the lights for a recess—if we have a recess here—and we have done something about health care, if we do not do something about the cost of health care, then we will have failed. Costs are skyrocketing. I frankly do not think any plan presented at this point will get costs under control. I have indicated that. I have some notions about how we should try to do it.

But no one in this Chamber, in my judgment, has the divine wisdom to come here with a piece of paper and say, "Here is the answer. Here is the right answer. Here is the only answer. Here is the answer that works for America." It is just not possible that one person has that kind of wisdom.

What we ought to expect from this Chamber is a debate in which we get the best of what everyone has to offer instead of the worst of what each has to offer. If we can get the best of the ideas from the Republicans and the Democrats and the conservatives and the liberals and the mainstreamers and the upstreamers and whoever else is out there streaming these days, maybe we can construct something that the American people will respect and say: Yes, they did a pretty good job. They understood the problem. They searched for the best possible solution. We respect them for that.

I hope that will represent the tone of the debate.

Mr. MCCAIN. Will the Senator yield for a comment?

Mr. DORGAN. I will be happy to yield.

Mr. MCCAIN. First, I express my apologies for my impatience to the Senator. I was unaware he was on the floor since noon. When I came to the floor he was not there, and I expressed some impatience. I hope he understands I have waited a number of days to give my opening statement.

Second, regarding his statements concerning the level of rhetoric. There should be a statement that each of us, even though we may take different approaches to this very critical issue, we should be partisan but not personal in our remarks and in our debate. I think it is a fortunate admonition, since most of us had anticipated being home at this time with our families, and from the looks of things, things are going to get perhaps more tense around here rather than more relaxed. I hope all of us can take the words of the Senator from North Dakota to heart. I thank the Senator from North Dakota.

Mr. DORGAN. Mr. President, I appreciate those remarks. Senator COATS is on the floor, and he and I have talked about the fact that this is not a family-friendly place. When people say that Government cannot be trusted and we are all lazy—the people like Senator COATS and Senator MCCAIN, like so many others who work late at night and come in early in the morning and spend half their weekends back in the home State make enormous sacrifices. I think all of us with young children would prefer to be able, during an August break, at least in some small measure be able to spend some time with them. But this is not a very family-friendly place. I hope we can change that, too, at some point in the future.

I will be happy to yield the floor. I appreciate the patience of the two Senators.

The PRESIDING OFFICER. The Senator from Indiana [Mr. COATS].

PRIVILEGE OF THE FLOOR—S. 2351

Mr. COATS. Mr. President, on behalf of Senator WELLSTONE, I ask unanimous consent Alexandra Clyde, E. Richard BROWN, Ellen Weissman, and Mark Anderson be accorded the privilege of the Senate floor for the duration of consideration of health care reform legislation.

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

Mr. COATS. Mr. President, I only intend to take a few moments. Then I trust my colleague from Arizona could be recognized, who has waited very patiently for a number of days in order to make his comments and statement regarding the health care bill that is before us. I want to take a brief amount

of time to respond to the comments just recently made by the majority leader.

The majority leader has on several occasions now, the latest of which was just moments ago, come to the floor in defense of the bill that he has introduced, which is obviously his right. And we would expect him to do that. What I am responding to, however, is that the rhetoric of the majority leader does not seem to square with the reality of the legislation. I am one of those Senators who took the pledge, the pledge to read the entire bill. I wish I could say I have completed the reading and understand every line and every word of this 1,448-page document. I am well into it. I think I understand a great deal of it. But much of it is technical and references other sections of the United States Code and other sections of the bill.

So I am still plowing through it. But as I listened to the majority leader make his rhetorical statements, I began to scratch my head and think, are the statements relative to the same bill that I am reading? I know we have had three bills submitted by the majority leader. We label them Mitchell 1, Mitchell 2, Mitchell 3. I have been focusing my efforts now on the bill that is before us, Mitchell 3.

But as I hear comments made by the majority leader and then try to square it with what I have just read, there seems to me somewhat of a disconnect. For instance, on the subject of consumer choice, yesterday and repeated again today, Senator MITCHELL came to the floor and attacked Republicans claiming that Republican Senators had misrepresented the facts about an individual's choice of plans under his bill. But in reading the bill, it is clear, at least to this Senator, that employers are severely penalized for offering health plans that are more generous or less generous than the standard benefit package that will be determined by the National Health Board and that employers of under 500 employees are prohibited from self-insuring. Those are limitations on choices.

So while the majority leader says, and I quote from a floor statement made on August 2, 1994, "The bill would expand the choices Americans have for their health care," the bill that I have read, Mitchell 3, says this on page 145, section 1309: Employers are subject to a civil penalty of $10,000 per employee if they offer a health plan that is more generous than the standard benefit package.

Let me quote from that directly. I want to make sure I am not mischaracterizing, or attempting to misrepresent, what the majority leader has said. The majority leader said this would expand choices for Americans in health care. But on page 145, section 1309 it says:

In the case of a person that violates a requirement of this subtitle, "the Secretary of Labor may impose a civil money penalty in an amount not to exceed $10,000 for each violation with respect to each individual."

The requirements under this subtitle are that a standard benefit package, determined by the National Health Board, be offered. And, if anything less or more than that is offered—if it is more, it has to comply with the supplemental plan— there is a $10,000 fine that may be imposed by the Secretary of Labor.

That does not sound like an expansion of choices to me. On page 1,170 in section 7112, the bill imposes a 25-percent excise tax on high-cost, high-growth health plans. That 25-percent tax is assessed on the difference between the premium and the reference or target premium.

On page 137, section 1301 of the Mitchell bill, despite what the majority leader said about expanding choices for Americans, it says "Employers with fewer than 500 employees are prohibited from self-insuring, cost-sharing benefits." Their provision alone would deny choice to the 400,000 firms in America that insure 16 million Americans today under self-insurance plans. This is when the employer sits down with the employees and says, "We're going to write our own plan. We will form our own group. We will determine what benefits best fit this company, and we will self-insure."

Those firms under 500 employees will now be prohibited from doing that. They will be prohibited from offering plans they now offer that cover 16 million Americans. That is not expanding choices.

It seems to me, Mr. President, that consumer choices are severely limited under the Mitchell bill because employers are strongly penalized for offering anything other than the one-size-fits-all-Washington-designed standards benefits package.

Senator MITCHELL has claimed that his bill would not raise taxes, nor tax small business. On August 15, 1994, on this floor, just a couple of days ago, he said, and I quote:

> Over and over again, our colleagues said of that plan that it would raise everyone's taxes and be a tax on small business. Neither of these statements are correct.

That is the majority leader's statement. But the words of the majority leader do not conform with the words of his own bill. This bill contains numerous new taxes and tax increases. Let me just name three.

In section 7111, page 1,158, the bill imposes a 1.75-percent tax on all health insurance premiums for insured and self-insured plans. So whatever your plan now is, as an American, you are going to have a 1.75-percent tax on that plan.

Section 7112, page 1170, imposes a 25-percent excise tax premium cap on high-cost, high-growth health plans. Section 7132, page 1205 imposes a 15.3-percent tax increase on income of certain service-related subchapter S corporations, shareholders and partners.

Mr. President, these are three of the 17 taxes included in the Mitchell bill. I will not take the time, in deference to my colleague from Arizona, to go through the others, but I have a list of all the taxes imposed under the Mitchell bill.

Senator MITCHELL, when he spoke about the impact on business, was correct when he spoke about the plight of small business owners. In a floor statement on August 9, he said, and I quote:

> These are typical small business people trying to create their own stake in society, building their own enterprise and doing what the rhetoric of entrepreneurship is all about. And yet their efforts are being devastated by something entirely beyond their control.

I agree with those words. But what is entirely beyond their control is where I disagree. What is entirely beyond their control are the 49 new responsibilities that they are being burdened with. I have a list of employer responsibilities under the Mitchell bill. I will not take the time to read them, but I ask unanimous consent to print them in the RECORD.

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

EMPLOYER/PLAN SPONSOR RESPONSIBILITIES UNDER THE MITCHELL BILL

RESPONSIBILITIES AS AN EMPLOYER

Sec. 1301: Offer at least 3 certified standard health plans.

Sec. 1301: Forward the name and address of each employee to the certified standard health plan in which the employee is enrolling.

Sec. 1101: Maintain records and provide states with data to audit certified standard health plans.

Sec. 1301: Provide payroll withholding of employee premiums upon request.

Sec. 1301: Provide employees with information on all certified standard health plans in the community rating area.

Sec. 1301: Provide employees residing in other community rating areas, information on all certified standard health plans in these other community rating areas.

Sec. 1111: Provide 180 day notice to participants of plan non-renewal.

Sec. 1111: Comply with regulations concerning transfer of plan sponsorship from one employer to another due to acquisitions.

Not available: Modify plan documents and SPDs to reflect legislative requirements.

Sec. 1486: Maintain certified Wellness Programs to be eligible for premium discounts.

Sec. 4522: Comply with Nondiscrimination regulations.

Sec. 1302: Maintain data on standard health plan premiums and employer contributions.

Sec. 10113: If trigger mechanism goes into effect, employers must contribute 50% of premiums for all employees.

Sec. 7202: Loss of Section 125 FICA exclusion.

RESPONSIBILITIES AS A STANDARD HEALTH PLAN SPONSOR

Sec. 1001: File application for plan certification in each State.

Sec. 1201: Comply with Standard Benefits Package.

Sec. 1111: Comply with regulations concerning guaranteed issue, availability, and renewability.

Sec. 1113: 6 Tiers of premium rates required.

Sec. 1002: Open enrollment required.

Sec. 1111: Allow disenrollment for cause.

Sec. 6006: Provide enrollees with individual subsidy applications.

Sec. 6006: Forward subsidy applications to states.

Sec. 5001: Supply data to the National Quality Council at both a state and national level for:

Sec. 5002: Quality of health care service and procedure measurement;

Sec. 5002: Determination of access to care;

Sec. 5002: Determination of appropriatenes of care;

Sec. 5002: Determination of population health status;

Sec. 5002: Health promotion/disease control initiatives;

Sec. 5004: National surveys of plans and consumers;

Sec. 5005: Consumer report cards;

Sec. 5007: Additional information requests for health care researchers; and

Sec. 9000: Workers' Compensation data must also be supplied.

Sec. 5009: Supply data to the State and National Centers of Consumer Information and Advocacy on plan performance and consumer report cards.

Sec. 5111: Comply with the standards of the National Health Information Network for electronic transmission of the following health information:

Sec. 5112: Standard unique health identifiers for each enrolled individual, employer, health plan, and health care provider;

Sec. 5121: Eligibility data;

Sec. 5121: Enrollment data;

Sec. 5113: Enrollee and provider signatures;

Sec. 5114: Claim forms;

Sec. 5114: EOBs;

Sec. 5121: Premium Payments;

Sec. 5121: First Report of Injury;

Sec. 5121: Claims Status; and

Sec. 5121: Referral certification and authorization.

Sec. 5301: Comply with Attorney General data requests for fraud and abuse enforcement.

Sec. 1124: Issue Health Security Cards to all enrollees.

Sec. 1101: Participate in state guaranty funds.

Sec. 1101: Comply with grievance procedures.

Sec. 1117: Participate in National Reinsurance Program for multi-state employers.

Sec. 1118: Comply with solvency requirements.

Sec. 1122: Comply with performance standards.

Sec. 1122: Communicate quality outcomes to enrollees and providers.

Sec. 1125: Provide enrollee communciations in a variety of languages.

Sec. 1126: Provide information on patients rights.

Sec. 1128: Coordinate additional payments to providers for individuals with cost sharing subsidies.

Sec. 1128: Verify provider credentials and licensing.

Sec. 1128: Demonstrate that sufficient providers are available both in and out of network.

Sec. 1129: Demonstrate that sufficient specialized treatment expertise is available.

Sec. 1129: Disclose utilization review protocols to enrollees and providers.

Sec. 1129: Disclose provider incentives to enrollees to make them aware of potential quality of care issues.

Sec. 1141: For supplemental plans, maintain a loss ratio of at least 90 percent.

Sec. 1305: Complying with requirements in single payor states.

Sec. 2106: Conduct quality case review of sample records.

Sec. 2106: Reporting instances of abuse, neglect, and exploitation.

Sec. 2106: Reporting of enrollee/provider complaints.

Sec. 3093: Special reporting requirements for employers of health care workers.

Sec. 7111: Pay 1.75 percent Premium Tax.

Sec. 7112: Conduct test for 25 percent assessment on high plans.

Mr. COATS. Mr. President, 49 new responsibilities, mandates on business under the Mitchell bill. Yes, small business people are being burdened by health care, but they are being burdened by the mandates that are being placed on them on the so-called proposal to undo that burden. Those are the new responsibilities that are beyond their control.

I will skip naming some of those, but there are 49 of them. Senator MITCHELL said in regard to bureaucracy, and he has said it over and over and over again, this bill, he says, the Mitchell bill, is not a Government-run program. I heard him say that just a few moments ago.

Believe it or not, we have counted the word "shall." The word "shall" means it is not discretionary, you do it. If a piece of legislation enacted into law and codified into law says "shall," you have to do it. If you do not do it, there are penalties, and this bill is full of the penalties.

We have counted the number of "shalls" in this legislation—2,681 times it does not say this is what we recommend insurers do, this is what we recommend businesses do. It says this is what "shall" happen; this is what "shall" take place. The States "shall" comply with these requirements. Small business "shall" comply. The National Benefits Board "shall" do these items.

So when we say this is not a Government-run program, it does not square with the bill.

I have compiled a primer to the Clinton-Mitchell health care bill's new bureaucracies, new mandates, and new Federal powers. This list identifies by section number the mandates, the requirements, the new agencies, the bureaucracy that is outlined in this 1,448-page bill. This is 81 pages of print so small that my eyes can no longer read it, but this lists the 55 new bureaucracies that are created, a mixture of Federal and State government bureaucracies that are required under the Mitchell bill—55.

This lists the 815 new duties that are given to the Secretary of Health and Human Services; probably a new office for every one of those and who knows how many employees and how much money to fund that; 815 duties and powers, new to the Secretary of Health and Human Services; 83 new duties and powers to the Secretary of Labor.

I could detail what some of those are—overseeing State plans, requiring certain submissions by medical providers, and on and on it goes. If that is not a Government-run program, I do not know what is.

Mr. President, I hope every Member will have a chance to leaf through this. This is not political rhetoric. This is language taken directly from the bill and referenced to section numbers. Every word in these lists is taken directly from the bill and referenced to the section number. So Members do not have to see this as just Republican rhetoric, Republicans trying to scuttle the Mitchell health care proposal. This is factual, it is there for everybody to see, it is there for everybody to reference for themselves.

The worst thing I have ever done and the best thing I have ever done, relative to the legislation that is before us, is to take the pledge to read this bill, because the rhetoric sounds wonderful and there is plenty of rhetoric to go around on both sides. Oftentimes, that just is lost in the discussion, and pretty soon it all starts to sound alike and everybody is saying the same thing.

The reality is this legislation. The reality is this legislation, and I just challenge every Member of the U.S. Senate to read this bill. If you read this bill, you will see it as the single greatest expansion of Government in the history of this Nation. You will see it as Government control run amok.

The goals of the majority leader are honorable goals. They are goals shared by Republicans. The reforms that are outlined in terms of health security, of keeping your plan, of not losing it when you change jobs, not being denied coverage when you are sick, of the small business reforms and the insurance reforms, they are all incorporated in ideas and plans submitted by Republicans. We all agree on that.

Senator Bentsen, not a Republican but then Senator Bentsen, a Democrat, leader of the Finance Committee, submitted legislation 2 years ago. Had we enacted that, the rhetoric would have been solved. The problems that the rhetoric discloses would have been solved. Would it have solved every problem in the health care field? No. But it would have taken us a long way towards health care reform. Millions and millions of Americans today would have health security they now do not have because we are presented with this or nothing.

The President has drawn the line in the sand and said, "You enact this and nothing less or I will not accept it." And so those of us who have worked together to provide meaningful reform

and health care for millions of Americans have nowhere to go. This is the bill before us. So if it is this or nothing, then we are determined to show the American people and our colleagues what this is. And this has been detailed now and outlined in section-by-section form for Members to check for themselves. I just think that the rhetoric needs to match the reality of that with which we are faced.

With that, Mr. President, I yield the floor.

Mr. McCAIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. McCAIN. Mr. President, first I would like to note the presence of my friend from California, Senator BOXER. I would say to the Senator, I intend to speak for about 25 minutes, if that is agreeable to her, so that she could adjust her schedule accordingly. And I appreciate her many courtesies which have been extended to me for many years. I wish to assure her that if I am ever in the majority I will try to extend the same courtesies to her that she has to me. And I am very appreciative not only of her courtesies but her friendship. She and I came to the House of Representatives together longer ago than she would care for me to recollect. So I thank the Senator from California.

Mr. President, one of the most oft-used adages I know is that those who ignore the lessons of history are doomed to repeat them. History teaches us many things about the prospects for this legislation, and in my view none of them are favorable. For the sake of our Nation, I believe we should avoid the errors of the past.

Among history's most important lessons—and I would cite five of them—as far as health care legislation is concerned are, first, a major piece of legislation that fundamentally alters our basic institutions requires strong bipartisan endorsement, not a narrow 51-percent majority; second, any major health care bill must be understood and endorsed by the public before it is passed if it is to have any chance for successful implementation; third, Government-run approaches to providing health care are overly bureaucratic and do not result in quality services or consumer satisfaction; fourth, health care access problem is fundamentally a cost problem, and any bill that does not strongly address the cost of health care through market forces in my view will be doomed to fail; and fifth, the cost of entitlements are always underestimated when first proposed, and it is politically impossible to remove them once they are enacted.

I would like to discuss each of these lessons to ensure that we do not ignore them in the course of this debate.

First, health care reform requires strong bipartisan support. Mr. President, this is not an issue that should be decided on a party-line vote with 51 votes in favor and 49 against. This is an issue that will affect every American in a very personal manner. It will fundamentally alter an industry that comprises one-seventh of our economy, and history shows us that from major civil rights legislation to the creation of new Government social programs, if we are to truly succeed in changing the status quo, it must be done in a manner that is supported by the broadest cross section of Americans.

It is clear that this bill is not bipartisan. The objective is to pass it, even by a single vote. The Clinton-Mitchell bill does not have a strong bipartisan support because it does not have the support of the American public.

To try to force through a bill that the public does not understand, in my view, will result in disaster and will further undermine the credibility of the Congress in the eyes of the American people.

A second lesson of history is that the public must understand and support the health reform bill that ultimately becomes law. History assures us that a bill that is not understood by the public will not be successfully implemented.

I would like to remind my colleagues of the last time we passed a major health care bill that the public did not understand that was when the Congress enacted the Medicare Catastrophic Coverage Act of 1988. Once senior citizens learned that they were being forced to pay substantially more for benefits that did not meet their top priorities and were not worth it for many, they stormed our offices with angry letters and calls, and I am proud to have been the sponsor of the bill that repealed this legislation.

I think it would be useful to review the political history of that doomed legislation. In 1987, the Medicare Catastrophic Coverage Act was introduced to provide seniors with protection against the spiraling costs of illness requiring long-term or frequent hospitalization.

On July 22, 1987, the Senate passed the measure by an overwhelming 86-to-11 vote, the House measure bearing the same title was passed 302 to 127. As the bill moved through the legislative process, what happened? Benefit after benefit was added. The scope and cost of the legislation changed dramatically from the original legislation. Good intentions were once again paving a road to a destination the public did not understand, want or support. But that did not matter to the Congress. We did not seek the consultation and endorsement of the American people who would have to live with our reforms. We were going to give them what we decided was best, and we did, with the aid and abetment and efforts of the AARP. The conference report on the catastrophic bill passed the Senate 86 to 11 and the House by 328 to 72. I voted against the conference report even though I was a prime cosponsor of the original bill. I did so because I listened to the seniors of Arizona.

I was looking back in the RECORD of the congressional debate at the time of passage of the conference report on June 8, 1988. I said at that time—now, nearly 6 years ago, over 6 years ago:

> In a speech in my State earlier this week at a typical middle-class mobile home park I came to find that none of the 80 to 100 seniors present supported the conference report. First, they protested the fact that the cost of the supplemental premium had risen by 50 percent over that of the supplemental premium under S. 1127.

That is the original legislation.

> Second, they were extremely upset about the fact that participation in the benefit was mandatory, regardless of whether or not they already had private coverage. Third, 80 percent of them cited a desire to seek coverage of long-term care and they were willing to pay an additional $500 to $600 a year for such coverage. And last, only 5 percent of them supported the prescription drug coverage provided in the bill.

That is what I learned back in 1988. That is why I voted against the catastrophic bill, and that is why inside the beltway, by overwhelming numbers, this bill was passed. And what happened? What happened, Mr. President, 1 year later, after the seniors realized what the bill did not do, a veritable revolt ensued. Still Congress balked. Notwithstanding the public outcry, amendments offered to delay implementation of the catastrophic bill on April 1, June 7, and July 27, 1989, were defeated. Each vote, however, received broader support as public reaction swelled. By October of that year, public outrage had reached a fever pitch. On October 4, I introduced a bill to repeal the onerous portions of the bill. The measure was passed on October 6 after 11 hours of debate and after the defeat of 8 substitute amendments by a vote of 99 to nothing.

Why was the repeal passed, Mr. President? Because the American people demanded it. Democracy may take time but inevitably it works. So we have a very clear example of how a major change in our health care system started and how it ended.

That is history, Mr. President. We should all learn from it. I will tell you what I am hearing from the seniors and younger people and middle-aged people in Arizona, and that is they do not understand this bill. They do not understand it. They do not know what it is about. They want it explained to them before they sign on to it. And by a 2-to-1 margin they are saying we prefer a gradual approach. We prefer a gradual approach because we do not want to be saddled with Government intervention in our health care systems that we do not understand.

Now, maybe, Mr. President, in the long run the American people and the

people of my State may accept something along these lines. I doubt it. I do not think so. But right now they clearly do not understand it. How can you possibly ask the average American, who is working, 8, 10, 12, 16 hours a day, 5, 6, 7 days a week to understand the ramifications of this bill?

Now, Mr. President, they did not understand catastrophic. It was done inside the beltway, with AARP. They do not understand this. And I do not know if this is going to pass or not.

I do not think anybody in this body knows whether this legislation is going to pass. If it does, I can predict one thing. It will have the same result as the catastrophic bill did, only it is not going to be the seniors who will be lying on the hood of the car of the chairman of the House Ways and Means Committee. It will be not be seniors who knock the chairman of the House Ways and Means Committee over the head with a sign in protest. It will be all the American people.

So I strongly suggest that we learn the lesson of history concerning catastrophic.

While we do not know how much more senior citizens will have to pay for these new benefits, preliminary estimates suggest that over 50 percent of beneficiaries will still have to pay for their prescription drugs out-of-pocket because they will never exceed the cost-sharing requirements. They, and the many other seniors who currently have prescription benefits from other sources than Medicare, will still pay higher part B premiums for the new benefit. This is just one of the thousands of new provisions in the Clinton-Mitchell bill that we do not fully understand.

I would note that the catastrophic bill had even more public debate in open forums than the current bill. Yet, it failed.

During debate on catastrophic, CBO estimates of the cost were woefully inaccurate. The costs of a new skilled nursing benefit was increased by 642 percent in just one year from the original CBO estimate. Standard benefits packages and making people pay for benefits that they may not want like the catastrophic bill is a recipe for disaster. All of these concerns are applicable to the Clinton-Mitchell bill.

Mr. President, the American public must know what is in the Clinton-Mitchell bill. We cannot afford another fiasco like the Medicare Catastrophic Act.

The third lesson of history is that Government-run approaches to providing health care do not work well. They are overly bureaucratic and do not result in quality services or consumer satisfaction. Supporters of the Clinton-Mitchell bill are fond of asking Republicans whether we would want to repeal Medicare, which is a Government-run program. Well, of course we would not want to repeal Medicare. However, if we were to pass Medicare over again, we certainly would have designed it very differently. Every day, I receive letters and calls from seniors about problems they have with the Medicare bureaucracy and the arbitrary rules that it imposes.

Perhaps as important, the original estimates of the combined costs of Medicare and Medicaid for the 1990 was $18 billion. The reality was that the actual costs had been 10 times that. There has not been an entitlement program in history that has not vastly exceeded the estimated costs at the time of passage. Sometimes, as in the case of Medicare and Medicaid, by a factor of 10. I have had the opportunity to deal with other Government-run health care systems.

Other Government-run health care systems are even worse. As a member of the Armed Services and Indian Affairs Committees, I am constantly informed about the horror stories associated with the veterans health care system and the Indian Health Service and their bureaucracies. The Clinton-Mitchell bill would make their bureaucracies pale in comparison. It includes 50 new bureaucracies, 17 new taxes and penalties, 177 underfunded State responsibilities, 818 powers and duties of the Department of Health and Human Services, 83 powers and duties of the Department of Labor, and hundreds of new Federal regulations.

I am not sure we can fit all of these on the T-shirt that we made up in response to the Clinton health care bill. We may have to make sure they are all extra, extra large.

Fourth, history tells us that any bill that does not strongly address the cost of health care through market forces will be doomed to fail. Our access problem is basically a result of rising health care costs. Costs are simply not affordable for many Americans. There is nothing in the Clinton-Mitchell bill that significantly addresses the problem of rising health care cost, and, in fact, it actually makes the situation worse.

For example, the way in which community rating is achieved in the Clinton-Mitchell bill, which substantially limits premium differentials based on age, will dramatically increase the cost of coverage for younger individuals. This enormous cost shift to those who can least afford it will induce many young people to drop their coverage.

Also, the Clinton-Mitchell bill will do very little to address our malpractice crisis, which is an important cause of rising health care costs. Our malpractice system is seriously dysfunctional. Only 43 cents of every dollar spent in the system goes to injured patients. The majority goes to administrative expenses and legal fees. The cost of malpractice insurance has grown dramatically, increasing by 15 percent each year from 1982 to 1989. It may increase by 19 percent this year. These costs, which exceed $6 billion annually, are passed on to patients. They are creating major access problems in certain areas, particularly underserved rural areas.

Thus, it is clear that we need serious malpractice reform in this country. Unfortunately, the Clinton-Mitchell bill does not include any significant malpractice reform, and may actually move the country backward at least a decade. Incredibly, it could negate positive State laws that have significantly addressed our malpractice crisis.

The first version of the Clinton-Mitchell bill contemplated a total preemption of State malpractice law. Such complete preemption of the malpractice laws of every State would be incredible.

It basically says that Congress knows better than all the State legislatures in the country.

It is unclear from its language whether the current version of the Clinton-Mitchell bill totally or partially preempts State malpractice law. The language implicitly suggests that it totally preempts the field, and nothing in the bill states explicitly that it does not preempt State law.

Whether or not it preempts State law, the malpractice and medical liability reforms that are proposed are extremely weak. They only apply to cases against a health care provider or professional, but not to claim concerning a medical product. The most significant reforms limit lawyer contingency fees to about what lawyers are now charging, and permit periodic payments of awards.

While these particular provisions are also in the Dole bill, the difference is that they are the strongest provisions in the Mitchell bill. The Dole and Gramm bills contain other vitally needed reform.

Mr. President, everyone knows the status quo. Some unfortunate individual becomes injured, files a lawsuit and seeks compensation in court, wins, and before he or she is able to use the money to pay medical bills or put his or her life back together, the lawyers get paid. The fact is that while the injured party is still suffering and trying to make better his or her lot in life, the lawyers get paid first and foremost. They often receive large contingency fees for settling a case with a minimum amount of effort.

The most egregious example I know of was the agent orange case where millions of dollars were awarded in the case of victims of those who suffered from agent orange in the Vietnam war. The lawyers got paid first. Many of the victims of agent orange died before they ever received a penny in compensation for the damage that was done to their health as a result of

agent orange. You tell me, Mr. President, why the lawyers should have been paid first while American veterans were suffering.

And what does the Clinton-Mitchell bill seek to do: Codify the status quo. Are our priorities that misguided? The status quo is not in anyone's interest, except for the trial lawyers. It is the injured, not the lawyers, who we should help and protect. The medical malpractice sections of this bill are wrong and must be corrected.

The Clinton-Mitchell bill requires each State to set up alternative dispute resolution mechanisms and requires exhaustion of these mechanisms before a court action may be brought. While alternative dispute resolution, such as mediation and arbitration, is generally a good idea if engaged in voluntarily, the mandatory way in which it would be imposed in this bill would be highly inflexible and bureaucratic.

While the President is fond of lashing out at the so-called special interests, such as the NFIB which represents the many small businesses that create jobs in our country, it is interesting that he has not spoken out against the enormously powerful trial lawyer lobby or its well-funded political action committee.

In fact, President Clinton is only concerned about those special interests that are not supporting his plan or contributing to his political interests. Groups such as the Trial Lawyers Association that support him are interestingly exempt from the pejorative classification as special interests. Coincidentally, the largest contributor to the Democratic coffers is also the largest beneficiary of their ineffectual malpractice provisions.

Compare the Mitchell bill's weak or negative malpractice reforms with the powerful reforms in the Republican alternatives, which include limits on noneconomic and punitive damages, statutes of limitations for brining claims, improvements in standards for bringing claims, and consumer protections. Our reforms are based on precisely the innovative State laws that the Mitchell bill could nullify. These reforms are working, and should be allowed to continue to work and to be expanded throughout the country.

In addition, the Clinton-Mitchell bill is replete with new and unjustified burdens on both the private and public sectors, including new taxes, mandates, regulations, and legislative pork or other waste.

The Senator from Indiana has described many of those in detail. So I will not.

One of the most important innovations with respect to cost containment that is in the Dole bill and many of the other bills is the medical savings account. Medical savings accounts are a market-oriented approach which would substantially increase the cost consciousness of consumers while allowing them to stay in control of their health care decisions rather than having some government bureaucrat make the decisions for them.

Unfortunately, the Mitchell bill does not authorize medical savings accounts. Overall, the bill does nothing to contain costs and therefore, in my view, will fail in the long run in its goal to enhance access.

Fifth, Mr. President, history teaches us that the cost of entitlements are always underestimated when first proposed. When Congress passed Medicare in 1965, it predicted that Medicare costs in 1990 would be under $10 billion. In fact, they were over $100 billion. The estimate was wrong by a factor of 10. I cannot think of an entitlement program that we have passed that has not cost substantially more than originally projected. Once they are in law, they develop powerful constituencies that ensure they are never, ever, cut back.

It is particularly ironic that we are considering a bill with $1 trillion of new entitlements just as the entitlements commission is submitting its recommendations to do precisely the opposite. I can understand specifically targeted subsidies for low-income individuals to obtain coverage, but a new entitlement for medical schools is incomprehensible. What is the American public going to think when they learn we are trying to increase their taxes to pay for this nonsense? I commend the Senator from Nebraska for his leadership on the entitlements commission and his warnings about the new entitlements in the Clinton-Mitchell bill.

Again, let us learn from history. The exercise we are going through today is frighteningly similar to the catastrophic bill, with one very important exception: The reach, scope, and impact of the Mitchell health care bill dwarfs the Catastrophic Coverage Act.

While I am on the subject, I wanted to again mention the entitlement in this bill which is for graduate medical education accounts—a new entitlement for graduate medical education. For that account, the Mitchell bill authorizes expenditures as follows: For the academic year 1997, $3.2 million; in 1998, $3.6 million; in 1999, $5.8 million; in 2000, $6.1 million; in 2001, $6.5 million. In this section of the bill, we are authorizing a staggering $23 million for graduate medical education and physician training. It appears as if our goal here is to make every medical school in America a public school. It also helps explain why there is so much academic support for this legislation.

Our medical schools are the finest in the world and 62 percent of all medical students already receive financial aid from guaranteed student loan programs. Yet, here we are appropriating money for medical research, and we are creating a multibillion-dollar entitlement program to supplement our medical schools.

Just like with catastrophic, we started this effort with good intentions to address real and fixable problems with our health care system.

Just like with catastrophic, and in the classic fashion of Congress, we are seizing an opportunity to address difficult and complex problems with the same old and ineffective answers, more taxes and more bureaucracy.

Just like catastrophic, we are ignoring the will of the American people. Polls show that Americans want us to tread lightly, go slowly, and do this right. But the answer they receive is best summed up in the words of one of our colleagues that the American people were going to get health care reform whether they liked it or not.

Just like catastrophic, politicians are lauding the plan with great fanfare and moving speeches which are long on rhetoric and short on reality.

Just like catastrophic, those who question whether the American people would support the new programs it would create seem to be voices crying in the congressional wilderness.

But I am afraid that, unlike catastrophic, staying the present course is not something we can undo. Drastically changing the way one-seventh of our national economy operates is an enormous undertaking. The changes Congress would effect with this bill—17 new taxes, vast entitlements, 50 new bureaucracies, a job destroying employer mandate, and extensive new State mandates—are enormous changes that, once started, will be very difficult, if not impossible, to undo.

History demonstrates that the Clinton-Mitchell bill would be a major mistake for this country. Before we make this mistake, we should take the time to fully understand the bill, educate the public about what is in it, and when it is rejected, like the original Clinton health care reform bill, pass a sensible bill that has the support of the Nation. We can still pass a good bill this year that enhances access by containing costs. There is much that we all agree on. However, we must not pass legislation that places our excellent health care system in the hands of the Government.

As we debate the Mitchell health care reform bill, I implore my colleagues to remember history and not doom ourselves to repeat it. The American people deserve better.

I appreciate the patience of my friend from California.

I yield the floor.

Mrs. BOXER. Mr. President, before my friend from Arizona leaves, I want to thank him for his kind remarks. The Senator from Arizona and I sometimes disagree, and sometimes we agree. But in either case, we never are disagreeable with one another. I think that says a lot, because these are difficult times and these are rough issues. I appreciate his friendship and his decency to me at all times.

Mr. President, the reason I decided to speak this afternoon—and it was not in my plan—is I was carefully listening to the debate and listening to the words of the Senator from New Hampshire, my Republican friend from New Hampshire, for whom I also have a great deal of respect. He used a word in his speech, and he said it really from the heart, and I believe he feels it. What he said is, "I am afraid of my Government." He said, "I think people are beginning to fear their Government." He said, "I want the Government to fear me." In other words, he wants the Government to fear the individual. He does not want the individual to fear the Government.

Mr. President, I find that a very disturbing statement. America is not about fearing one another. It is not about us being afraid of our Government or our Government being afraid of us. We are the greatest country in the world, and the reason that we are the greatest country in the world is because we come together to solve our problems. We come together as a community, as a nation, to set aside our partisan differences and to find answers to the problems that plague us.

So I was very disturbed to hear all this talk about fear and, unfortunately, Mr. President, a lot of fear is being injected into this debate, somehow setting up the Mitchell bill as something to be afraid of.

I think it is important to, once in a while, take out the preamble to the Constitution. I do it a lot because I think it sets out the reasons why we have a Government, and they are the most beautiful words. I am going to read them. Why do we have a Constitution? Why do we have a Government? Here is the answer:

> We the people of the United States, in order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity * * *

That is why we have a Government. That is why we have this U.S. Senate and the House of Representatives over on the other side, where I was proud to serve for 10 years. And together we work—men and women of goodwill—and we compromise, and we debate and argue, and we do the best we can for those reasons: "to form a more perfect Union, establish Justice, insure domestic Tranquility," and all of the other things I just read.

When we say that we fear our Government, I think that kind of talk undermines what we are. We are a Government of, by, and for the people. What is domestic tranquility? I have already said that it is one of the main reasons that we have a Government. Domestic tranquillity, to me, means peace at home, peace in our own homes, peace in our cities where we live, in our counties, our rural areas, peace in our Nation, and peace in our States. Domestic tranquillity.

How does the health care reform debate coincide with the reasons that we are here for domestic tranquillity? Mr. President, you have long worked to bring about health care reform for this country, and I think you and I, and many Members on both sides of the aisle, understand that it is very difficult to have domestic tranquillity when we have the kind of crime that we have in our country today. That is why it is so important to pass that crime bill. You and I know it is hard to have domestic tranquillity when you cannot get a job for your family and provide for them and you cannot afford a decent education for your kids.

And, yes, Mr. President, it is hard to find domestic tranquility when you are so afraid that you are going to go broke if someone gets sick because your insurance for health is canceled. Or when you go to the doctor and find out you have "a preexisting condition," say, high blood pressure, and then the insurance company says, "Sorry, we cannot take you until you pay an inordinate premium," which you cannot afford. It is very hard to find domestic tranquility under those circumstances.

How about when an insurance company disappears out of your life when you need it most? Can you find domestic tranquility when you counted on health insurance and suddenly the company walks out on you because you get sick? That is what happens to a lot of our people. I have met them. I have seen them. I bet every one of us knows such a case.

It is hard to have domestic tranquility when you suddenly find out that in the small print of your health insurance policy it says that there is a lifetime limit. So if someone gets sick in your family and it is a catastrophe and it bleeds every dollar, you are told by your insurance company, "Sorry, you are out; you have reached a lifetime limit."

I have seen people who have had that problem. They did everything right. They paid their premiums. They are hardworking. All they did was get sick, and the sickness was a devastating one, and they reached the lifetime cap.

I have seen it where little children who get a serious illness reach the lifetime cap at age 6, 7, or 8.

It is hard to have domestic tranquility when you may be forced to divorce your spouse so that one of you gets to keep some assets and then the other one appeals to the Government for help. You cannot have domestic tranquility under that circumstance.

So I say that if we are about anything here, it has to be about the Constitution. How can we avoid a situation that leads to our families being worried, if they have insurance, worried that they lose insurance; if they have a job that gets insurance, worried if they change their job they will not get insurance; worried if they get sick they will be kicked out.

I say it is our constitutional obligation to fix this problem. And, yes, we have been debating for 50 hours—50 hours—one amendment, a good amendment. We are ready to amend this bill. We are ready to make it better. Senator MITCHELL himself voted for the Dodd amendment. He is willing to amend his bill. He is willing to make it better.

(Mr. REID assumed the chair.)

Mrs. BOXER. Mr. President, I remember when I was over in the House, a young man came to see me. I have told this story a couple times. His name was Andy Azevedo, 16 years old, a strapping young man. I was so proud that the majority leader actually told the story when the majority leader introduced his bill. At that time —it was many years ago—I did not know that much about the insurance crisis. This young man came to see me, and he said: "You know, Congresswoman"—I was a Congresswoman at that time from the San Francisco Bay area. He said:

> Congresswoman, I am worried. I have had cancer, but I am OK now. I know when I am off my parents' policy when I graduate from college I will not be able to get insurance because they will say I have a preexisting condition. Can you help me with this? Can you do something about it?

That is when I got involved in this issue.

Later, Andy had an occurrence of the cancer. His insurance policy would not cover certain treatments that he needed. I went to bake sales in Petaluma, CA, to help his family raise money for him.

This is a proud family. This is a farm family. This is a hardworking family. They did not have domestic tranquility for a long time, and then they lost Andy. I promised his mother that we would, in fact, pass health insurance reform.

It is hard to be tranquil when you watch the talking day after day. And why am I doing it? Why am I participating in it? It is because I feel it is important to answer some of the words on the other side that deal with fear, because I know people are watching this debate. I want to have a chance to tell people, if we do nothing, you should be afraid. If we do nothing, you should be afraid. If we do something, you should have heart because we know what the problems are. Everyone knows what the problems are. It is not the sole province of a Democrat to know what the problems are. The Republicans know. They know what it is like to worry about a child. They understand.

The question is, when do we write this bill? You know in the Senate we amend every bill that comes before us.

I have yet to see a bill, very few—maybe on very small issues—I have yet to see a major bill that was not amended and made better or sometimes made worse. And then we decide if we think it was made better or made worse and do we feel it is worth voting for. That is what legislating around here is about.

You know, I was also interested the other day when the Senator from Missouri, a very respected Senator, took to the floor and said that he was upset about the Mitchell bill because it provided a new benefit to Medicare recipients. It provided actually two new benefits, and he did not think we could afford to do it. One of them was prescription drugs, the other inhome care. And he felt even though he knew these were important benefits, we simply could not take that on. It was too difficult.

I remember when my kids were young I read them a little book about the Little Engine That Could. Everyone said, "It can't be done, it can't be done, it can't be done." But the Little Engine That Could said, "It can be done, it can be done, it can be done."

Yes, it is hard. It is hard for a little engine to go up a steep hill. It is hard for this Congress to solve the health care reform battle. But we are in it, and I think we can figure out a way to do it in a cost-effective manner. And if there are those who feel we should not have a prescription drug benefit to our elderly, let them vote against it. Let them make the amendment. But let us not hear them say we cannot work with the Mitchell bill. We can amend the Mitchell bill.

I like the prescription drug benefit. I like the fact that we will have inhome care for our seniors. Yes, they will pay for some of it. But let us help them. I do not want to see grandmas and grandpas have to go to a nursing home when it is actually more humane and more cost effective to keep them in their homes. And the Mitchell bill starts us on that road. That is sensible.

You know, it is hard to see our people feeling tranquil—and we talked about domestic tranquility—when they see Senators on this floor, who belong to the Federal Employee Health Benefit Plan, stand up here and say it is good for us but we do not think you ought to have it. And I think the majority leader pointed that out in a brilliant fashion. We have it. It is a good plan. What is it? It is organized by the Federal Government. It is private insurance. We can choose the plan we want. We get options and choices galore. Our employer pays 72 percent of it. We pay the rest. And we have peace of mind.

I want to see that for my constituents. I want to see that for all Americans—a chance to get access to that plan. In the Mitchell bill, you get access to that plan if you want it. It does not force you to, but it makes it available.

So I have to say that I welcome reasonable debate, and I see some of my colleagues are here so I will finish up in the next few minutes, probably another 5 or 6 minutes. I welcome reasonable debate and we all do. I want to start debating amendments. We debated a good amendment last night. As I said, the majority leader voted for that amendment; so did the Senator from New York, Senator MOYNIHAN; so did the Senator from Massachusetts, Senator KENNEDY. They did not say we are not going to vote for this amendment because it did not come out that way in our committee. The Senator from South Dakota, another leader in this battle, supported the Dodd amendment. We are open to change. We are open to amendment. We are open to making this bill better.

Mr. President, could we have order?

The PRESIDING OFFICER. The Senator from California is right. The Senate is not in order. Senators will refrain from speaking in the Chamber unless addressing the Chair.

The Senator from California will continue.

Mrs. BOXER. So we need to solve the problems of our Nation. Read the preamble of this Constitution. It is real clear on what we are supposed to do. In short, the message is tranquility. Very important. And part of that is making sure our people are not scared—scared that they many lose their health insurance; and, by the way, Mr. President, scared that they will not be gunned down in the street by an assault weapon.

And we have our Republican friends over on the House side, except for 11 of them, voting against the rule to bring up the crime bill, saying that there was pork in it. One-hundred thousand police on the streets, is that pork? I say it is a necessity. Billions of dollars for prisons? I say it is a necessity.

The violence against women act, which is included in that bill, is an absolute necessity. Every 6 minutes a woman is raped in our country. Every 15 seconds a woman is beaten; 1,400 a year are killed by a boyfriend or a spouse, and they are stalked. The crime bill is a comprehensive solution, Mr. President, to a national disgrace.

So they talk and talk over there, but they do not get to the guts of it. The guts of it is, they are afraid of the National Rifle Association. That is the guts of it. And they want to bring down our President. That is the truth of it. I hope the American people are waking up, waking up to the truth, the reality of what is going on here.

In closing, Mr. President, let me say this. The majority leader has set out a framework. It is not a perfect framework. I have some amendments I am going to offer. I am looking forward to making the bill better.

But I have to tell you, from the largest State in the Union, when you look at numbers like this: 6 million uninsured Californians. Nearly one in four Californians under the age of 65 is uninsured. Of the uninsured, over 5 million are from families in which at least one spouse works. So we are talking about working people who do not have insurance. We are talking about 1.3 million uninsured children in California.

So I will tell you, I will stay here night and day, I will stay here around the clock for those children and those women and those men and those hard-working families. I will work. I will support some of the amendments that come forward. I will work against others.

But, it is time. It is time to vote on the crime bill. It is time to fix a broken health care system.

Let us stop injecting fear into this debate. We should not fear our Government and our Government should not fear us, because we are a Government of, by, and for the people.

It is our job to get on with it, and provide the domestic tranquility for each and every American.

Thank you, Mr. President.

I yield the floor.

Mr. BRADLEY addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. BRADLEY. Mr. President, the Senate's effort to reform the American system of health care has important consequences for all Americans. It will determine the availability and the extent of health care for each of us. It will determine in part how long our parents will live and how healthy our children will be.

As we debate this issue, let us remember what brought us here in the first place. We are not debating this issue by chance. There is a reason why we all speak of this effort as health care "reform." In dozens of living rooms and conference halls, in emergency rooms of hospitals, and on the street corners, the message that I hear from the people of New Jersey is that we need reform. Our current system is not working as it should. Those who have health coverage are paying too much for it and those without health coverage deserve it.

Mrs. BOXER. Mr. President, the Senate is not in order.

The PRESIDING OFFICER. The Senator from New Jersey may proceed.

Mr. BRADLEY. Mr. President, what people want the most is some control of escalating health care costs. What people fear the most is losing their health care if they change jobs or get laid off or lose a job because of a corporate bankruptcy. What perplexes them, as well, when they are confronted with all of these escalating costs of health care, is the power of the insurance industry.

Want coverage for your heart problem? The insurance company says no,

because it is a preexisting condition. In other words, the insurance company will insure you for everything but the heart condition that is most likely to generate the health costs for your family.

In confronting skyrocketing health care costs, small business is left to the mercy of insurance companies. Small businesses have no leverage to negotiate with insurance companies. Too often, they are presented with a take-it-or-leave-it choice that only offers exorbitant costs for health care coverage.

Each of us can enumerate countless occasions in our States when we have had interactions with small business people who simply said they cannot afford to cover the workers in their particular small business. They cannot afford to cover because they were told by the insurance company that it is $6,000 or $7,000 a person and they have no leverage to negotiate with the insurance company.

If you get open heart surgery, the tab is $49,000; a caesarean section birth, $7,500. Remarkably, women of higher income have more cesarean section births. I do not think that is related to a differential in the size of the birth canal. It is related to the ability to afford to pay.

And a visit to an orthopedist, $300 for the first visit, $175 for each visit after that.

Most people have become accustomed to good health care, even with these costs, but health care simply costs too much; more than it should cost.

When President Clinton proposed health care reform last year, none of us thought he was imagining the problem. There was a consensus that we should act; that we should do something. The political noise of the last 12 months aside, health care reform is as needed today as it was then. The families who need it are still in New Jersey and all of our States. The families that do not have the health coverage need it as much today as they did a year ago. All of us who are paying health costs are paying too much today just as we were paying too much a year ago.

Real problems—and these are real problems—deserve and demand real reform. But just as we cannot forget what brought us here, neither can we forget how our political economy optimally functions. To allocate resources and services through the market ensures the greatest efficiency. It gives the consumer the highest quality, the greatest selection, the lowest price.

To ask the Government to replace the market generates bureaucracy and reduces individual freedom, as the state makes decisions that previously were made by the individual. At the same time, it is the responsibility of the State to ensure that the market's destructive effect does not wreck the lives of human beings. The so-called creative destruction, as Schumpeter referred to the phenomenon of inefficient firms being put out of business by efficient ones, cannot be translated to the individual level when it comes to health care, workers who lose their jobs, or move to another job. Workers who lose their jobs, or move to another job, or for whatever reason have lost their health insurance, should in fact not lose their health care.

These individuals need some help, some assurance that their health and lives will not be endangered by unfettered market forces. It is the job of Government to protect the public health and welfare in the short and long term of its citizens. How to do this in the area of health care is the essence of what this debate is all about.

Our fundamental goal should be to enable a competitive health care marketplace to keep people healthy but take care of them when it does not. By and large, America's health care system is an excellent system, but it does have a few glaring faults. We should not block or undermine those elements that work in our current system. We should fix those areas that do not work and, in so doing, improve the overall system.

Recent trends suggest the health care markets are becoming more competitive and efficient. We can spur that process by ensuring that insurance companies compete on price and quality, not on their ability to omit high-risk patients. Managed competition is beginning to bring better health care at lower prices to many Americans.

The bill that is before us at this moment, offered by Senator MITCHELL, is really the result of many conversations with many individuals and builds on the work that was done in the Finance Committee, addresses some of the persistent problems. For example, it eliminates preexisting conditions from insurance coverage considerations. It assures portability so that the loss of a job or the pursuit of a better job will not mean the loss of health care benefits. It allows small businesses to bargain for insurance as purchasing units, giving employers and employees needed leverage to drive their health care costs down.

These are good steps but they do not attain the level of reform that is needed. Two specific problems are foremost in defining the health care crisis. I stated them earlier. Too many people do not have health care coverage, too many people cannot afford to get health care coverage, and costs are accelerating.

The greater the number of people who are not covered, the more the rest of us pay. It is a fairly simple elemental principle of insurance. When an uninsured person shows up at an emergency room, he is not turned away. He receives care and the rest of us pay his bill in the form of an increase of our premiums. It is as simple as that.

The only real answer to the crisis of 37 million uninsured Americans is universal health care coverage. It is the only answer for the nearly 1 million uninsured individuals in the State of New Jersey. There is human misery of enormous proportions in our country because people cannot get health care coverage. In all the talk about CBO, HMO's, fee for service, triggered mandates, premium caps and so on and so forth, we must not forget our simple moral obligation. Expanding coverage and making health care affordable are the only ways to address the crying need of our fellow citizens for basic health care coverage.

The bonus here is that by assuring coverage, we will also reduce costs by eliminating the shifting of costs from the uninsured who show up at the emergency room, to all those of us who are lucky enough to have health care plans but have to pay for the uninsured through our higher premiums.

I also believe the only proper way to achieve universal coverage is through a system of shared responsibility. I have said this from the beginning of this debate. That means everyone contributes: Employers and employees. No one is solely responsible for our health care crisis and no one should be solely responsible for solving it.

The bill before us has a provision that does embody that shared responsibility. Nor is the promise of the shared responsibility and universal coverage an empty promise in this bill. The bill provides subsidies that will make coverage a reality for millions of Americans who today do not have any. It recognizes that without these subsidies, millions of American families simply cannot afford the coverage and do not have the coverage; 37 million Americans, and more each year.

Still, there will be difficulties with the overall cost of health care coverage if we do not properly contain these spiraling costs. The rest of our good work could be in jeopardy. Without cost containment, the promise of universal coverage is a hollow promise. Without cost containment, our workers will continue to see their take-home pay stagnate. But the issue of cost containment is the elephant in the room that everyone knows is there but no one wants to acknowledge.

You can stand up on this floor and promise this new benefit and that new entitlement and this new program and pledge to cut this tax, and that tax, and pledge to cut this spending program, and that spending program, but no one wants to address the reality that stares us in the face, which is the need for cost containment. It is an issue that is simply not going to go away.

In that context, the proposal before us offered by Senator MITCHELL addresses the issue of cost containment, and he deserves credit for attempting

to do so. I have a number of concerns with the bill that is before us related to bureaucracy, related to the unintended consequences of well-intended provisions, related to the method of cost containment put forward in the proposal, and the number of people upon whom it could place a financial burden.

I hope it is possible over the next several days and weeks to work with Senator MITCHELL and others to craft an alternative that is more equitable and more efficient in containing costs. I have spent a lot of hours meeting with the so-called mainstream group in which I participated from the beginning. I agree with some of the things that the group has discussed. I disagree with other things the group has discussed.

I have worked with Senator MITCHELL in putting forward his bill. I agree with some of the things he has suggested and disagree with other things that he suggested, as I have enumerated. The fact is, we have come up to the issue of national health insurance any number of times in the last 50 years and every time that we have gotten close to doing it—meaning a White House that is interested, whether it is a Republican or a Democrat, and a Congress that seems to be amenable to considering some of the tough choices embodied in providing national health insurance—something has happened and we always have backed away. We have always backed away in my opinion because the people who say "my way or no way" have always won.

At some point in this process, the dialog that is necessary for successful legislation has broken down. Maybe it is partisanship in some cases. Maybe it is the strength of a particular interest group in other cases. Maybe it is personality conflicts in some cases.

For whatever the reason, whether it was 1977 with modest hospital cost containment, whether it was 1972 with catastrophic health insurance for all Americans, or whether it was any other time when the issue has reached the point where it actually was within our grasp, one of several things has occurred.

It is my hope that there will be no non-negotiable demands and that we will recognize the legislative process for what it is, which is a chance to address the basic questions. If you rigidify and confront, you have neither the fluidity nor the flexibility to get to the answer that is at the core of the problem, which in this case is cost and coverage.

So, Mr. President, our challenge is complex, but our purpose is clear and simple: It is my hope that the Senate will rise to this challenge and fulfill this purpose, and that when our work is done, we will have produced legislation that works for New Jersey and for the Nation. I yield the floor.

Mr. MOYNIHAN addressed the Chair.

Mr. KERREY. I wonder if the Senator will yield. I wonder if the Senator from New Jersey will answer a couple of questions.

The PRESIDING OFFICER. If the Senator from Nebraska will withhold, the Senator yielded the floor and the manager of the bill sought recognition.

Mr. MOYNIHAN. If my good friend will withhold a moment, I would like to propose a unanimous-consent agreement, and then we will resume this matter. Is that agreeable to the Senators?

The PRESIDING OFFICER. The Senator from New York, the manager, has the floor.

UNANIMOUS-CONSENT AGREEMENT

Mr. MOYNIHAN. Mr. President, I ask unanimous consent that upon the completion of the exchange of questions between the Senator from Nebraska and the Senator from New Jersey and a 10-minute statement by the Senator from Colorado on an unrelated matter, that we proceed to the Nickles-Moynihan amendment; that Mr. NICKLES, in the first instance, be recognized to offer that amendment striking section 1309 of the Mitchell substitute; that there be 3 hours for debate on that amendment, equally divided between Senator PACKWOOD and myself; that no amendments to the language proposed to be stricken be in order; that at the conclusion or yielding back of time, the Senate vote on Senator NICKLES' amendment with the expectation that that will be the last legislative business of the day with respect to the bill before us.

The PRESIDING OFFICER. The Senator from New York has propounded a unanimous-consent request. Is there objection? Without objection, it is so ordered.

Mr. MOYNIHAN. I thank the Chair.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. KERREY. Mr. President, I just wanted to ask the distinguished Senator from New Jersey, who has just given a thoughtful presentation on health care and I think a very powerful argument for using the forces of the market to control costs.

The market in the last 3 years has done an unprecedented job; in fact, there has been an unprecedented shift in the marketplace to managed care and that management of care has produced reduction of costs. I have sat here and listened to people come to the floor, particularly I say with all due respect to my friends on the other side of the aisle, with whom I think I agree on this issue, that we should move away from Government regulation and Government controls, but I hear some statements being made on the other side of the aisle that I think are, in fact, in conflict with other principles that they are espousing.

I ask the distinguished Senator from New Jersey, if we move to the marketplace, does it necessarily mean—using market forces—that an individual is going to have a complete and unrestricted choice of doctor or any other sort of thing that they want?

Is it not true that for those on the other side of the aisle, with whom I agree I believe on this issue that we ought to allow the market to work and move to managed care and use the management of care, that we need to disclose that part which means that we do accept in a voluntary fashion, presumably, some limitation, some restriction of our choice of doctors? Is that essentially what goes on if we use the marketplace? Are we not to a certain extent accepting that there is going to be some limitation on choice?

Mr. BRADLEY. Mr. President, I say to the distinguished Senator from Nebraska, it depends on the ultimate form of this legislation. If we were to lock people in to managed care with no point-of-service option, then they would have a restriction on choice. If we have a point-of-service option, it means that they can join a large group based upon the doctors that are in the group. They will often make the choice as to which group they would like to be a part of because their family physician is in the group, or good heart doctors are in the group, or whatever. That group could be as large as the Mayo Clinic; it could be as small as a major urban area. If they join, they join because of the doctors that they see in that group; therefore, they have chosen to join the group because of the doctors.

If you have point of service, you have the option. God forbid something strikes and you get a disease that none of the doctors in the group you feel are adequate to treat you, and you want to go see somebody else someplace else in the United States. You have that option, under a point-of-service plan. You will pay a little bit more, but you will have that option.

But the basic thought involved, as the Senator has suggested, that managed competition forces the consumer to make choices is correct.

Mr. KERREY. Just to be clear on this so my colleagues understand what I am talking about, I am a service-connected disabled veteran. I was injured in the war in Vietnam in March 1969 and lost the lower part of a limb. As a consequence of that disability, I am considered to be eligible for care from a Veterans' Administration hospital.

The Government does not make my prosthetic devices. I am allowed to choose and go wherever I want. They authorize it. I have to wait in line sometimes. I hear people talking about that. It is true. I cannot just go and get whatever I want. I have to get it authorized, I have to get it approved, but I choose wherever I want to go.

If I was in an HMO without that point-of-service option, which is a market alternative—to be clear to my

friends on the other side of the aisle, understand, I intend to come here and challenge you every single time if you come here and say that I want the market to take care of it. If you are not prepared to engage in a discussion of what that market does, that market taking care of it means as people move to managed care, somebody, not in the Government, but somebody in the private sector is going to say no to them, is that not true?

Is it not true what happens? It is not a Government bureaucrat? I heard my friends on the other side of the aisle come down and blister the Mitchell proposal—and I am not a supporter of the Mitchell proposal. I have identified a number of areas where I think it does vest too much power in the Federal Government to make decisions—but do not come to this floor and expect to be unchallenged with a statement that says that the market gives you unrestricted choice. It does not.

I have an increasing number of citizens in Omaha, NE, for example, that are finding themselves choosing HMO's or PPO's. They are finding themselves all of a sudden not with a Government bureaucrat saying no to them, they are finding a private sector bureaucrat saying no to them.

I just want to make it clear that the point I am trying to make with the distinguished Senator from New Jersey—with whom I agree; I agree we ought to use the market to control—but is not inherent in that that somebody is going to be managing the care and making some decisions independent of what I might think I want?

Mr. BRADLEY. If the so-called managed care providers in my State are any example—and New Jersey is not as well developed as a State like Minnesota, for example, or Oregon—there is a phase this goes through. First there is a managed cost. That is a dangerous phase because you are telling people you cannot continue to spend the way you have spent on health care. Then you move through that to managed care, where the group has as its purpose maintaining and enhancing the wellness of its members. And that is the hope of the market, as a mechanism to improve the health of the American people.

Now, you should not be under any illusion, and the Senator's example of the Veterans Administration is one example—the other example is the continued existence of Medicare. No one is proposing eliminating Medicare. That is a very big Government program.

Mr. KERREY. It is $160 billion a year.

Mr. BRADLEY. It is a very big purchaser out there. So we are going to end up with a mixed system where you have a managed competition, but you also have Government as a very big purchaser of health care, either in the Veterans Administration or through Medicare, and as a result because it is such a large purchaser, it will have an influence on all of health care in the country.

So I would say to the Senator that we will end up with a mix of private managed competition as well as Government involvement.

Mr. KERREY. Mr. President, I say to my friend from New Jersey that I find myself almost equally irritated sometimes with Democrats who are willing to vote for things that provide new benefits without any money attached—I voted last night against the Dodd proposal because I saw it doing that—and Republicans who come to the floor and suggest somehow that the market is going to increase choice. It does not necessarily follow that that is the case. If we believe that costs are the number one problem, that cost containment needs to occur, you cannot contain costs without affecting either somebody's income or somebody's desire for unrestricted opportunity in the health care marketplace.

I think it is very important in this debate that we come to the American people and try to tell them not only the truth about what works and what does not work, but it seems to me the truth about where Government's role ought to be in all this.

Mr. BRADLEY. I thank the Senator for his question, and I agree with him. As I tried to say in my statement, cost containment is the elephant in the room that nobody wants to acknowledge. It is there. And I think before this debate has concluded, we are going to have some very interesting discussion about cost containment because we will not be able to avoid it. Right now we are avoiding it.

We will not be able to avoid it because it is my prediction that there will not be enough votes in this Chamber to pass a bill if it is avoided, because the old days of simply adding more and more benefits without worrying about costs are, frankly, over. I do not think you are going to find 51 votes saying let us move ahead with a lot of new benefits but not pay for them. I think that there will then be several options, several opinions as to how best to control those costs, and that will be a debate for another day. But right now I have to yield the floor to the distinguished Republican manager, my colleague from Oregon.

The PRESIDING OFFICER. The Senator from Colorado is recognized for 10 minutes.

Mr. BROWN. I thank the chair.

U.S. VISIT BY GENERAL XU

Mr. BROWN. Mr. President, let me express my appreciation for being allowed to interject into this debate. I wanted to make comments with regard to the visit of General Xu to Washington, DC. And I rise because I think this is a matter that freedom-loving people around the world have a right to be concerned about.

General Xu arrived in Washington yesterday. He is attending meetings at the Pentagon, our Pentagon, both today and tomorrow. After leaving Washington, he will travel as a guest of our Defense Department to tour our Naval and Air Force facilities. General Xu will then visit the U.S. Naval Academy in Annapolis and will conclude his trip with a stop in Hawaii, meeting with the U.S. Commander-in-Chief of the Pacific.

Mr. President, according to the Defense Department press release, on August 15 General Xu will be met upon his arrival at the Pentagon by our Secretary of Defense Perry, who will host an honor cordon.

An honor cordon is literally a red carpet arrival ceremony in General Xu's honor.

Who is this general that we honor? General Xu fought with the Chinese and the North Koreans in their invasion of South Korea. He has held the No. 2 position in the Communist Chinese army since 1987. And even though he is No. 2 in the army, he is considered by many Chinese experts to be the most powerful officer in the Chinese People's Liberation Army. He literally has day-to-day responsibility for the PLA operations, and has primary responsibility for the People's Liberation Army plans with regard to Taiwan and Hong Kong. He was the primary drafter of the Chinese defense law.

Mr. President, we are trained from the time we are children to be gracious as hosts, to welcome visitors to our home and our country. But this individual, General Xu, is one of those who bears primary responsibility for ordering the Tiananmen Square massacre of peaceful Chinese prodemocracy demonstrators.

Mr. President, to welcome into this country the Butcher of Beijing, to literally roll out the red carpet at the Pentagon for someone who masterminded the slaughter of innocent children in Tiananmen Square when they spoke out for democracy, is an outrage. It is a mark of shame upon everyone associated with this kind of ceremony.

I have enormous respect for our Secretary of Defense, and I cannot believe that he would be comfortable with this decision if he were familiar with General Xu's background and past. It is an almost unparalleled flip-flop of policy. The President of the United States said this in "Putting People First."

> We will condition favorable trade terms with repressive regimes—such as China's Communist regime—on respect for human rights, political liberalization, and responsible international conduct.

How do you square this red-carpet welcome of the Butcher of Beijing with that statement? Mr. President, you cannot do it. This Nation is entitled to have our leaders act respectfully toward foreign leaders. I have no question about that. But to roll out the red

carpet for the Butcher of Beijing, when we have just gotten through refusing to allow the democratically elected President of Taiwan even to stay overnight in this country, is incredible.

Over 20 major U.S. newspapers have editorialized in favor of allowing President Lee, the President of Taiwan, to visit, including the New York Times, the Washington Post, the Los Angeles Times, the Wall Street Journal, the Rocky Mountain News, and the Baltimore Sun. To welcome to this country with a red carpet the Butcher of Beijing and to refuse to allow the democratically elected President of Taiwan to stay overnight is the kind of foreign policy I do not understand, and I do not think the American people understand. It is duplicitous and it adds shame where there should be honor.

Mr. President, more important than anything else, we need to be true to ourselves in the conduct of foreign policy. The Butcher of Beijing does not deserve the red-carpet treatment, and our friend in Taiwan, who stands side by side with us, does not deserve to be prohibited from visiting.

I yield the floor.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. Under the previous order, the time is now allocated equally between the two managers of the bill, with the Senator from Oklahoma to offer an amendment.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

AMENDMENT NO. 2563

(Purpose: To provide for general enforcement of employer requirements)

Mr. NICKLES. I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Oklahoma [Mr. NICKLES], for himself, Mr. MOYNIHAN, Mr. PACKWOOD, Mr. CRAIG, Mr. COATS, Mr. GREGG, Mr. D'AMATO, Mr. GRASSLEY, Mr. DASCHLE, and Mr. STEVENS, proposes an amendment numbered 2563:

The amendment is as follows:

On page 145, strike lines 1 through 5.

Mr. MOYNIHAN. Mr. President, might I ask to address the Senator. That is to be an amendment for himself and for the Senator from New York.

The PRESIDING OFFICER. The record will reflect that the amendment is offered on behalf of the Senator from Oklahoma and the Senator from New York, Senators NICKLES and MOYNIHAN.

Mr. NICKLES. Mr. President, I thank my friend and colleague from New York for cosponsoring this amendment and also for his cooperation on it.

I ask unanimous consent that Senators PACKWOOD, GREGG, COATS, D'AMATO, GRASSLEY, and DASCHLE be added as cosponsors.

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

Mr. NICKLES. Mr. President, on August 3, President Clinton had a press conference and had an opening statement encouraging enactment of health care. And in his opening statement he stated:

You can keep your own plan, or pick a better one.

Mr. President, that statement was not correct if you read the Mitchell-Clinton bill. That statement has bothered me a lot because I think it is awfully important when we talk about health care that we be factual. I know a lot of people maybe have said that one side or other distorts the facts. I would like to talk about that.

I had a press conference yesterday where I was critical of this statement because I think the statement is flatly incorrect. It is not true, because, frankly, under the bill we have before us, there are a lot of health care plans and a lot of proposals—actually the majority of the proposals—that are in the country today that would be illegal under the Clinton-Mitchell proposal. They would not be allowed. I will mention several of these.

One, if you have a plan that is less generous—in other words, if you do not offer the standard benefits package, something significantly less than the standard benefits package, you cannot keep it. I refer to the bill.

I would like to keep my comments very factual. I would just refer my colleagues to page 137 of the bill. It says an employer shall make the plan available which provides the standard benefits. It does not say less than the standard benefits.

Keep in mind that under the Mitchell-Clinton plan, you can offer a standard benefits package, and an individual can also buy an alternative standard benefits package with the high deductible. But it is still the Government-defined standard benefits package. You cannot come up with a different plan, one that is less expensive than this package.

I make mention of that because I think it is important. I know some people said that statement is not correct. It is correct.

I also said you cannot offer a plan that is more generous. If you have a plan that is more generous, it still has to be a governmental plan. It has to be a standard benefits plan or it has to be a Government-approved supplemental plan.

So, again, you lose a lot of flexibility. Right now you could offer a multitude of different plans. You really cannot do that under the Mitchell-Clinton plan.

Also, the President said you can keep your own plan. That is not the case if you have a cafeteria plan because in the bill, if you look at page 1224, section 7202, cafeteria plans which offer health benefits will be hit with a heavy tax. Four million Americans currently have cafeteria plans. They like them. They are happy with them.

Under the bill that we have before us, you lose your flexible spending account. We have a lot of Americans who do not have the exact number, but now have flexible spending accounts that include health care. On pages 1218 through 1221, section 7201, the Clinton-Mitchell bill states that if an employer provides health benefits under a flexible spending account, those benefits would be taxable to the employer at the highest corporate rate and to the employee at their own individual rate.

If you happen to be self-insured and you have less than 500 employees, you cannot keep your plan. Your plan is illegal. I feel kind of strongly about this because I used to manage a company. We had a self-insured plan. I designed the plan.

I remember asking Mrs. Clinton a long time ago when she had her first meeting with a Republican group. I said, "Can we keep our plan?" The answer was no. She said "No." It is still no under this bill.

Just to recite the section, on page 137, section 1301 of the Clinton-Mitchell bill, if your company has less than 500 employees, you cannot self-insure. So I mention that.

I will just add the final one.

If you have benefits that are different from the Government-mandated benefits, you cannot have it. Your plan will not be allowed. That is under the provision that I am dealing with. This bill is very clear. It says the employer shall have the standard benefits package. Under the standard benefits package, you can have an alternative, if you are an individual, that costs maybe a little less because it has a higher deductible. It still has the same benefits. You have to have the Government benefits.

It also says you can have a supplemental plan to provide additional benefits. But, again, that has to be a Government-approved plan. That very much limits your ability to offer additional benefits, maybe with a different deductible.

There are limitations, too. If you have a supplemental plan that deals with cost sharing, you cannot self-insure for that cost sharing. Let me give you an example.

This is something that should drive unions crazy, it is something that should drive anybody crazy that has a plan that offers a little extra benefits. If they want to sell self-insurance for those extra benefits, they cannot do it. They have to purchase insurance to provide for those extra benefits.

So, again, the President's proposal, the Clinton-Mitchell proposal, eliminates a lot of optional plans and optional benefits. It eliminates plans that

have benefits different than the Government-imposed, mandated benefit plans. And it eliminates cafeteria plans and, as I mentioned before, the flexible spending accounts.

The self-insured plans. There are over 400,000 employers that carry self-insured plans, covering 16 million people. They lose their plan. They are not going to be able to have a self-insured plan. They will have to buy a Government-designed benefits package. They have no option, no choice. That is their choice. They have to buy what Government deems appropriate. Whatever they had, they cannot keep. I disagree with that.

I heard the majority leader, Senator MITCHELL. I looked at his comments from the floor yesterday. He talked about his plan was voluntary and so on. This is not really the case. If the company that I manage self-insures, I do not have a choice. If I am going to have insurance, I have to have the Government plan. I have to buy the so-called community-rated plan. I do not have a choice. I do not get to continue self-insuring. That is not voluntary.

I thought, what if I did not participate. What would happen? What is Government going to do to me or my company, or when is the Government going to tell me I cannot do this?

There is a little section in the bill which says,

> In the case of a person that violates a requirement of this subtitle, the Secretary of Labor may impose a civil money penalty in the amount not to exceed $10,000 for each violation with respect to each individual.

So if you are an employer—and my company has about 65 people—well, if we did not comply, if we wanted to stay with our self-insured plan, our penalty is $650,000. Mr. President, that is more money than we made last year. That is more money than we made the last several years, probably. Unfortunately, we turned into a good, nonprofit organization, not by design.

An employer that has 100 employees, that is a $1 million penalty. That is a big penalty.

In other words, the heavy hand of Government is coming in and says you have to offer this standard benefits plan designed by Government. You have no choice whatsoever.

The reason a lot of people have different plans is because they want economy. They think they can do a better job.

I look at the cost under the Clinton-Mitchell health care bill. The cost for a two-parent family, according to CBO, is $5,883, almost $6,000. Those are 1994 figures. I will tell you that cost exceeds what a lot of us are paying in the private sector. A lot of people in the private sector pay a lot less than this. Yet they would have no option under this bill. They are going to have to have this Government-imposed standard, mandated benefit package as designed by this bill.

This bill turns enormous power over to the benefits commission to design the deductibles, the copayment and so on. But the package estimated by CBO is going to cost about $6,000.

I again do not want to use personal examples. But in our company, we provide insurance for about $2,400. I just met with the president of a major university in my State. They provide benefits for their employees. I think he said they have 1,100 employees. It is a private university. He said they were providing health care benefits for the teachers, professors, staff, and so on, I think for an average of about $2,800. Wait a minute. We are all ready to mandate something like $6,000. You are going to have to provide that. He said, "What if I don't?" I said, "Well, there is a little section in here called 'enforcement' where the Secretary of Labor can fine you up to $10,000 per person if you do not offer the standard benefits package."

If you do not do what Government says you should do, then you will be subjected to those kinds of fines and penalties. Mr. President, there are a couple of other things that people would be shocked to find are in this bill. There is a prohibition on offering an alternative package. This gets confusing. But under the bill, it says you have the standard benefits package, and we will make this available, and everybody is going to have to have it. Everybody is going to have the same benefit. But for individuals, we are going to allow them to have an alternative benefit package, as defined in the section. It has a higher deductible, and it presumably will be cheaper. That is availability to individuals, but it is not available to companies. If you read on page 138, it says no employer may offer an alternative standard benefit package established under subtitle (c).

That is a high deductible plan. So an individual can have a high deductible plan and presumably save on some premiums. But a company—if anybody is working for a company, they are out of luck. They do not get to have the high deductible plan. They have to have the more expensive plan. The employer cannot offer a higher deductible plan. If they did, they are subject to a $10,000 fine—per employee.

I mentioned that in my company we self-insured. We happened to have a high deductible plan. We self-insure for that portion. Those plans are illegal under the section that says you cannot have a self-insured plan, because on page 138 they prohibit an employer from even offering an alternative benefit. So you lose freedom, and you lose your choice and, frankly, you do not get to keep your own plan.

Again, I think it is important that we go back and think of statements that are made on the floor. People say these plans are voluntary. They are not voluntary, not if there is a $10,000 fine if you do not comply and certainly if you do not get to keep your own plan, if you have a cafeteria plan or if you have a plan with different benefits than those mandated under this proposal.

Mr. GREGG. Will the Senator yield for a question?

Mr. NICKLES. Yes.

Mr. GREGG. Am I to understand what you are saying here is that there are approximately 200 million Americans today plus who have an insurance plan or participate in an insurance plan; that to the extent that their insurance plans do not conform with the standard benefits package and they pursue the use of that claim, they would be fined, or the businesses they work for would be fined $10,000 for each one of those 200 million Americans, adding up to $20 billion in potential fines?

Mr. NICKLES. The potential would be there. I tell my colleague that it says the Secretary "may," not shall. But it gives the Secretary the discretion if anybody does not provide for the standard benefits package or—I will saying standard benefits package, when you consider there is a standard, alternative and supplementals. If you do not provide what the Government says you can, or if you can provide more or less, you would be liable to a $10,000 per-employee fine.

Mr. GREGG. If the Senator will yield further. To take this to specifics, under the standard plan package that originally came from the President, and as it was originally introduced here, the President's plan, there was only one mammogram allowed for people who are under age 50. I think that was the rule. If, for example, your company had enrolled in—let us say that was the standard plan that was settled on—but it probably would not be because it was such a ridiculous proposal—but say that was settled on by some Federal bureaucracy that designed what the standard plan would be. If your employer decided that one mammogram under age 50 is not appropriate, that there really should be two or three, or the opportunity to have two or three, you or your employer offering a greater benefit in this area would be subject to, potentially, a $10,000 fine per employee because they had not met this precise, one-size-fits-all plan proposal?

Mr. NICKLES. The Senator is correct. The only way that you can provide that extra benefit is if you purchased a supplemental benefit through a carrier. But I will mention that you cannot provide a supplemental that duplicates coverage that is in the standard benefit plan. So it is a heavily regulated supplemental benefit option. One can buy some additional benefits on top of the standard benefit, but again it is a Government-approved benefit package that is very constrictive.

I will go a little further. Most people do not understand the supplemental

plan, and I have spent a little time trying to figure it out myself. If you want to buy additional benefits, you can, but it has to meet the Federal regulation and also the State's, and then likewise, if you want to say, wait a minute, in our plan we want to have greater cost share, so I will help pay some of the deductible, because most of the supplemental is on an 80–20 basis, and I worked it out with my employees over the years and we do 90–10; so I want to have a lower deductible, and it was agreed to in collective bargaining or something. According to the cost-share agreement, you cannot self-insure on the supplemental cost share. Crazy. Under this bill, you cannot self-insure for the cost-sharing supplemental. I just cannot believe some of the provisions that are in this bill. You are prohibited by law. If you did self-insure, you would be subject to a $10,000 fine.

Mr. President, I want to be clear that I am not eliminating all of the abuses that are in this bill. I am trying to eliminate—and will with the concurrence of the Senate—the $10,000 penalty for noncompliance. We are going to take away some of the heavy Government hammer that is in this bill. When I say in this bill—a lot of people were not aware of this provision. I was not aware of it until not too long ago. This provision, or part of this provision, was included in the Labor Committee bill, but not in the Finance Committee bill. I understand in the Finance Committee bill when they originally had a mandate to keep on standard benefits, they were going to say that if you do not have a standard benefit, you ought to be subjected to a 50 percent premium penalty. But that was dropped in the Finance Committee. It was in the markup, but it was dropped. That is a very punitive penalty, but that is a lot more reasonable than a $10,000 penalty. That is a penalty of $1,500, or something, for most people; $1,500 is still too heavy, in my opinion, but it is a lot more reasonable than $10,000.

Again if you look at a small employer with 100 employees, maybe they are self-insuring and want to continue doing so. Maybe they are self-insuring and doing it for $3,000 an employee, and the employees are happy with it, and the employers are happy with it; it is working well. They may say: Oh, no, I am not going to go with this Government-designed standard benefits plan. We have a good package of benefits. We worked it out, and it is successful, and we are keeping costs down. The Government is saying you cannot keep that package, and if you do, we are going to sock it to you with the $10,000 fine.

Mr. President, I plan at a later time to offer an amendment that is going to allow employers and employees to keep the plans they have that they like. That is the so-called grandfather amendment. I am working on that, and I want that to pass. One of the reasons we decided to go with this amendment first was to educate some people, because a lot of people were not aware it was in here. A lot of people did not realize that, wait a minute, the Government has so much power that if you did not comply, you could be subject to a $10,000 per-employee penalty. That is a very heavy penalty.

I am delighted that it looks as if—since Senator MOYNIHAN cosponsored this amendment, and others—it will be deleted from the package. My concern is that we have a lot of amendments, a lot of provisions in this bill, and the people do not know about them. When they find out about them, I am thinking that a lot of people will be quite upset.

Mr. KENNEDY. Will the Senator yield?

Mr. NICKLES. I think I have the floor.

Mr. KENNEDY. I was wondering if the Senator would yield on my time for a question.

Mr. NICKLES. I will be happy to.

Mr. KENNEDY. Just following the issue of the amendment and also the presentation the Senator has made, I know about the standard benefits package. I know that S. 1743, the Nickles bill, outlines the standard benefit package. You have a standard benefit package in your own bill. The only way that you receive any tax credit for any of the employers is to receive a tax credit to purchase insurance, but only if they get the standard benefit package.

I am just trying to understand why you are arguing—I appreciate the fact of the elimination of the $10,000 penalty, which I am going to support, because I believe there are other provisions in the legislation that will provide sufficient remedy. I think what is actually going to happen is that they will be offering the standard benefit package. But you appear to be arguing against the standard benefit package here on the floor of the Senate, and the bill that you introduced requires it and indicates that the only way you are going to get favorable tax treatment is if you use it.

Mr. NICKLES. The Senator asked me a question.

Mr. KENNEDY. I just asked how the Senator can possibly rationalize that position with his presentation here.

Mr. NICKLES. I appreciate the Senator's question.

Mr. President, I will be happy to answer my colleague, and I also want to finish and conclude my statement.

Mr. KENNEDY. On whose time, if we can just agree?

Mr. NICKLES. This will be on my time.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. The Senator alluded to the plan I cosponsored on consumer choice of health plans. We say give everyone a tax credit who qualify for the tax credit. You have to offer something. We do not give tax credits for people doing nothing. So you had to have some kind of health expense, basically defined by IRS, to qualify for a tax credit, just like you qualify for a tax deduction right now. You have to have a certain health care benefit operation to get the tax deduction. You also have to do certain things to get the tax credit.

The Senator's question is not relevant. What my bill did not do is say everyone in America had to replace their insurance with Government-defined insurance.

Mr. President, this is a big issue because the whole title of my bill was consumer choice. The whole purpose of my bill is to give consumers lots of choices with different options, different benefits. Under the bill I sponsored with 25 of my colleagues, we have a multitude of options.

Mr. KENNEDY. Mr. President, will the Senator yield?

Mr. NICKLES. I will not yield. I want to finish.

Mr. KENNEDY. Will the Senator yield just on this point?

Mr. NICKLES. I will not yield.

My bill made a multitude of options. We called it consumer choice for a purpose because we wanted everyone in America to have the maximum number of choices.

Unfortunately, some alluded to the Clinton-Mitchell package and say it has choices. Let me tell you the choices you have under the Clinton-Mitchell package. You have Government plan A, Government plan B, and Government plan C, and they are all the same, one fee-for-service, one HMO, and one preferred provider. But they are all the same. They all have exactly the same benefit. You could not offer a different benefit if you wanted to because the Government defines that benefit package. The benefit advisory group defines the package, and you could not offer something different.

There are thousands of companies, hundreds of thousands, millions of Americans who have health care a lot less expensive than what is mandated under the Clinton-Mitchell bill.

I am trying to preserve peoples' rights to be able to buy less expensive insurance or more expensive insurance.

They cannot do it under this package. And under the package we have before them, if they do not do it, they are subject to a $10,000-per-person penalty. Big Government is here. Big Government is saying no. "This is voluntary. If you do not participate, here is a $10,000 fine."

I just happen to disagree with that. That fine happens to be more than double the cost of insurance for most people.

So the heavy hand of Government is here. I know it passed the Labor Committee, and maybe that is not surprising. But it should not become law.

(The PRESIDENT pro tempore assumed the chair.)

Mr. NICKLES. Mr. President, the reason I offered this amendment is it is saying two things. I want to educate people because, as I stated before, people do not know what is in the Clinton-Mitchell package. They do not know what kind of freedoms they are going to lose. They do not realize that under this bill, if they have a cafeteria plan those plans are taxed heavily. They do not realize if they have a flexible spending account those plans are taxed heavily. They do not realize if they have a self-insured plan that covers 16 million people, those plans are illegal. I said cafeteria plan. The cafeteria plan covers 4 million people. The self-insured plan covers 16 million people. And those plans under the Clinton-Mitchell package—there are lots of people in West Virginia and Oklahoma who are happy with the plans and like the plans.

Mr. President, they are a whole lot less expensive.

Mr. KENNEDY. Mr. President, will the Senator yield?

Mr. NICKLES. No, I will not yield. I want to continue.

They are a whole lot less expensive. They do not cost $5,800. As a matter of fact, $5,800 is a lot of money in West Virginia and a lot of money in Oklahoma.

I am interested. The company we have or I have been involved with provides insurance for $2,400. If we follow this prescription for disaster, those plans are going to cost $6,000. Maybe we will be subsidized, or maybe some of our employees will be subsidized. I do not want to be subsidized. We are doing a decent job providing health care for our family and our company. Why in the world should the Federal Government get involved?

I make a comment that a lot of people do not realize this. This is a massive mandate. I have heard people say the Clinton-Mitchell bill does not have a mandate. It does. It mandates you have a very expensive package. If you cannot afford that package, guess what some employers are going to do? Employers in West Virginia and Oklahoma are going to say, "I cannot afford it. I am going to drop it. It is not mandatory now, so I am going to drop it. Employees, you are on your own."

Some of those employees will qualify for subsidies. I heard the majority leader say we are going to eliminate the Medicare plan and replace it with the private plan. What he is also not telling you is under his bill 57 million new people will be eligible for subsidies; 57 million people will be eligible for subsidies in a few years that are not eligible today, more than double the number of Medicaid people who receive subsidies, but they will be receiving Federal subsidies. You are having a massive Federal subsidy program because people cannot afford this.

So employers will be dropping the plan. Employees will be getting subsidies to buy health care. And then guess what, Mr. President? And this is very interesting. Then an employer can come back and say, "I want a subsidy so I can start this over." And they can start again, and the employer can get 5 years of subsidy with the Federal Government paying about half of their health care costs.

This is almost an encouragement plan for people to drop their health care, put people out on subsidies to get their health care on their own, and then the Federal Government will come in and subsidize that employer for them to pick it back up.

I think that is a disaster. We should not be making those mistakes.

What does this amendment do? It does not eliminate the standard benefit package. I wish we would, and we will probably try to do that later. I am going to try to allow all the missing plans to stay in existence. If the people and employees are mutually satisfied, they ought to be able to keep the plan. We should not have the heavy hand of the Federal Government saying your plan is good enough and we are going to replace it with a Government-knows-best plan; we are going to replace it with a plan that costs $6,000 per family.

We should not do that. This is a serious mistake and serious infringement on freedom. And that is exactly what happened in this bill. Then they have the heavy hand of the Federal Government coming in and saying, "There is a $10,000 penalty if you do not comply. So we are going to make you comply whether you want to or not."

Then I read in the RECORD where Senator MITCHELL stated this is voluntary. How is it voluntary? "It provides for a voluntary system in which Americans would purchase private insurance." That statement was made yesterday. How could it be voluntary if you had a $10,000 penalty if you did not comply?

I just cannot believe that we would go down this route. So I am delighted that we will delete this one section. We are deleting section 1309. That is one paragraph on page 145 of a bill that is 1,443 pages long.

Mr. President, I think this is vitally important. I thought it was vitally important for a long time. This section that we are deleting, this section 1309, page 145, I will read again:

> In the case of a person that violates a requirement of this subtitle, the Secretary of Labor may impose a civil money penalty, in an amount not to exceed $10,000, for each violation with respect to each individual.

So if you have 100 employees, that is equal to a $1 million penalty that the Secretary of Labor could impose.

Mr. President, we need to strike this section. I am delighted that the Senator from New York and the Senator from Oregon are cosponsoring this amendment. I look forward to improving the bill, at least by taking this very serious mistake out of the bill.

Mr. President, I yield the floor.

The PRESIDENT pro tempore. The Senator from New York [Mr. MOYNIHAN].

Mr. MOYNIHAN. Mr. President, I thank the Senator from Oklahoma for taking this initiative.

I point out that we join him in it in a bipartisan manner. We considered the matter at some length most of this morning.

Mr. President, we came to this judgment, which was that in the legislation that Senator MITCHELL has put forward it is clearly in the interest of employers to provide the standard benefits package. It makes them a more attractive employer and more attractive to employees they would hope to have, but most important, elementary and indispensable, providing the standard benefit package is the condition of receiving the subsidies that the bill provides for low-wage employees. With that package you get the subsidies. Without it you do not. We have incentives. This is an incentive-driven bill. We think that it is in the best interest of firms and their employees to have health care.

The Senator from Massachusetts speaks with great emphasis on the importance of preventive care, and, indeed, if there is anything salient in our medical situation today, it is the degree to which behavioral patterns lead to illness as against the random disasters of typhoid fever or cholera of the past.

Professors of medicine teach behavior, inculcate behavior that makes for health. And already we begin to see some of this effect being shown up in the slackening of the health care cost increases. But, most importantly and essentially, the subsidies are the incentive to which we are absolutely convinced employers will respond.

I regret to hear my friend from Oklahoma has established a nonprofit activity. That was not the plan, and it need not be the case once this legislation is enacted. I look forward to a thriving, healthy, and profitable work force in Oklahoma.

And so, Mr. President, there is no great need to expand on this position. The Secretary of Labor does not need this particular sanction, and when a sanction is not needed it is best excised.

We are not in the business of running around and policing the health care plans of the Nation's employers. We set the standards, we provide incentives, and we expect to see a response. And we will know that response and we will keep track of the coverage, but not in

a mode that is threatening or indeed punitive. We are not trying to hurt anybody here. We are trying to help our country and help its employers and its workers.

So I think this is a nice bipartisan note on which to conclude today's behavior.

I see we will alternate, but would the Senator from Oklahoma mind if my friend——

Mr. PACKWOOD. I believe I am controlling the time.

Mr. MOYNIHAN. Would the Senator from Oregon mind if the Senator from South Dakota speaks now?

Mr. PACKWOOD. I am happy to have him speak now.

The PRESIDENT pro tempore. Who yields time?

Mr. NICKLES. Will the Senator from South Dakota yield?

Mr. DASCHLE. Yes.

The PRESIDENT pro tempore. The Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I ask unanimous consent that Senators DURENBERGER, SHELBY, MACK, GORTON, ROTH, and LOTT be added as cosponsors of this amendment.

The PRESIDENT pro tempore. There being no objection, it is so ordered.

Who yields time?

Mr. MOYNIHAN. Mr. President, I yield to the Senator from South Dakota such time as he may require.

The PRESIDENT pro tempore. The Senator from South Dakota [Mr. DASCHLE] is recognized for such time as he may require under the control of Mr. MOYNIHAN.

Mr. DASCHLE. Mr. President, I will be brief. I thank the distinguished chairman of the Finance Committee, the manager of bill, for yielding me some time.

Let me make several points as quickly as I can.

First of all, let us make sure what this amendment does and what it does not do. What this amendment does is to strike the reference to $10,000.

I have indicated that I intend to support the amendment because, as the chairman stated so well, there are other ways with which to ensure that we can achieve the compliance we want. There are carrots and there are sticks. Let us try the carrot approach. Let us do as much as we can to ensure that throughout this bill, whatever it is we do, we encourage using the incentives that are in the bill. We are certainly willing to try that approach in the manner of this bipartisanship cooperation, and I think that ought to be stated up front.

But the Senator from Oklahoma makes a second point in defense of his amendment that I frankly do not support. I think that most members on this side of the aisle, in fact, I would guess many Senators on both sides of the aisle, would have difficulty supporting. Namely, the deletion of some need for standardized benefits.

It is very clear in the bill offered earlier by my friend, the Senator from Oklahoma, that on three pages—pages 33, 34, and 35—there are direct references to standardized benefits and a recognition of the need for compliance with those standardized benefits.

Senator CHAFEE, with all of his cosponsors, had a bill that specifically delineated a number of standardized benefits. The Finance Committee, the Labor Committee, all of the bills, for the most part, even Senator DOLE's, have references to standardized benefits. At least for the past several months, every one of us has been working under an understanding that standardized benefits are a good thing.

In fact, I will go back and find what the record states with regard to the Medigap proposal we passed several years ago. As the author of that amendment, I clearly recall there was a widespread recognition that Medigap policies—that is, policies in addition to what we get through Medicare—were standardized. I recall there was virtual unanimity that standardization of Medigap policies was a good thing. There was strong bipartisan support, I think unanimous support, in the Finance Committee. But I will go back and check the record on that.

Now, why is standardization of benefits important? It is important because if we do not have it, this bill might as well be called the Fine Print Protection Act. That would be exactly what we would be doing. We would allow the insurance companies to do what in many cases they are doing right now. Not all of them, but many of them are putting in the fine print contingencies that can scare people to death. That fine print keeps people from getting the benefits they oftentimes thought they had.

I do not know about most of the Members of this Chamber, but I know I am not as familiar with my plan as I wish I were. I frankly cannot tell you this afternoon whether I have a lifetime limit in my plan or not. But they are in a lot of plans. People are caught by complete surprise once they bump up to that limit, because they did not know the fine print, buried somewhere in the plan itself, had a limit on what the insurance company would pay.

Exclusion of important services, including durable medical equipment, rehabilitation services, mental health treatment, and preexisting conditions clauses are all there. Exclusions of preexisting condition clauses are in many plans. That is something else we are trying to eliminate. There is widespread recognition of the importance of eliminating preexisting condition exclusions.

Service limits, such as a limit on days in the hospital or no more than a certain number of physician visits per year—these are also in a lot of plans.

Hidden gaps in coverage are also there. For example, no coverage for congenital conditions and no coverage for illness in the first 10 days of life are major exclusions. In fact, a high percentage of the plans covering pregnancy have a provision that limits coverage in the first days of life after a baby is born.

Exclusions of certain providers can also occur, like coverage for psychiatrists or other mental health practitioners.

Mr. President, the point is that one of the reasons we are here in the first place is that people are just caught unaware too often. So many times, when we need the benefits the most, they are not there. We are surprised. We find out only too late that the plan we were counting on, the plan we paid thousands and thousands of dollars for, is not there when we need it the most.

And so, let it be understood that what is in the fine print is really what we are talking about here. There is no discussion, no debate about eliminating the $10,000 fine. I suspect that a majority of Members on both sides of the aisle will probably agree that, as the chairman said, there are other ways to ensure we get as much compliance as we can.

But I can give—and I will do this for the RECORD—a number of examples. Allen Fuller lives right here in Washington, DC. He allowed his name to be used in discussing his own situation. His family lost their insurance when his wife started her own business. Eventually they bought private insurance for the family. Two weeks later Allen thought he had pulled his back out. When he went to the doctor, tests showed he had cancer of the lungs and spine.

Allen started chemotherapy immediately and found that his insurance policy only covered accidents in the first month but did not cover illnesses. The insurance company said his cancer was a preexisting condition and refused to cover his bills. Allen Fuller was left out, in spite of the fact that he had paid thousands and thousands of dollars for a policy he thought was going to be there when he needed it the most.

Barbara Elsas-Patrick, another person here in Washington, DC, has health insurance through her professional association. She is a teacher. She paid $500 a month coverage for herself and her daughter. The policy had waivers for preexisting conditions. She was not aware of that. It was buried in the fine print. Barbara is reluctant to go to the doctor now because every time she has another condition, according to this particular policy, it is not covered the next time she goes to the doctor.

This is really what we are trying to avoid here. The point is very clear. Do we want to protect the fine print in plans in the future? If we do not, then let us recognize, as Senator NICKLES

recognized, as Senator CHAFEE recognized, as Senator MITCHELL has recognized, that there ought to be some recognition of a need for standard benefits and elimination of the fine print in this bill.

I yield the floor.

Mr. LOTT. Mr. President, under this bill, any business that tries to provide health insurance for its employees, but not the high-priced, Government-mandated insurance plan, could be fined $10,000 per employee.

Now, we have heard many speeches in support of the Clinton-Mitchell bill, saying how the bill would help all Americans, and help businesses.

If you read the bill though, the situation is quite different. The Clinton-Mitchell bill makes the Secretary of Labor a bounty hunter, searching for firms who are doing the right thing, but not the Government-mandated thing.

We are not talking here about mean old businesses that do not care about their employees. We're talking about small, sometimes struggling firms, which under the Clinton-Mitchell bill could be destroyed by fines or have to lay off workers.

That is why I rise today in support of the Nickles amendment. This amendment says the Government should not penalize businesses for doing the right thing. The amendment nullifies this $10,000 per employee bounty.

Again, the Secretary of Labor under Clinton-Mitchell will be able to destroy businesses at will without the Nickles amendment. Let us say you have a small business. You are struggling to make payroll, and pay for, say, a catastrophic insurance for your employees, so they would not be left holding the bag of unlimited health care costs.

Under Clinton-Mitchell, the Government comes along and says, hey, that is not enough insurance you are giving your employees. They need drug counseling services. They need abortion services. They need psychiatric coverage. The Government's telling you that your business has to buy a Cadillac insurance plan, when you only can afford a Pinto health plan.

If you cannot afford it, and even if your employees do not want all of these benefits, the Government under Clinton-Mitchell will make it very expensive for you.

In fact, the Secretary of Labor could assess your business at $10,000 per employee fine, if you do not go out and buy the Government's standard benefits package. Now think about this: If you do not buy the expensive, Government-mandated plan, then you are fined heavily, and your corner store, or computer startup, or farm, goes belly-up. If you do buy the plan, you probably would have to lay off workers. Again, if your employees like the insurance plan you provide them, then that is too bad. You have to go out of business, or you have to lay some of these happy employees off.

Under the Clinton-Mitchell bill, you would have to make a choice between the Government, and your employees, probably middle-income employees who need work.

The Nickles amendment says you will not have to make that choice.

But the Nickles amendment is about choice. If employees for a small company like their insurance plan, but it is not the plan the Government has mandated, they should be able to keep that plan.

Most Americans are happy with their health insurance—85 percent to be exact. Everyone agrees that whatever reform we try to achieve in this Chamber, choice in health plans should be maintained. This is what the American people want.

Several times in his Presidency, President Clinton has promised the American people that the insurance they have, that they are happy with, will not be taken away.

We see in Clinton-Mitchell, though, that choice is taken away.

The President has been telling Americans that the Government would not take away the insurance plans Americans are pleased with.

The Clinton-Mitchell bill does not maintain consumer or business choice—at least not the type of choice Americans are used to. The Clinton-Mitchell bill says yes, you can have choice—if you have the money. If you are able to pay $10,000 per employee, if you are able to cough up a 25-percent surcharge, if you are able to swallow the cost of a nondeductible health plan—yeah, you can have choice. Some choice.

Americans in general, and middle-income Americans and businesses who employ middle-income people specifically, can not ante up the money the Clinton-Mitchell bill would squeeze out of people. Under the Clinton-Mitchell bill, the Government will take away choice, and will force Americans to pay for a government plan—or pay through the nose.

That is why I rise today to support the amendment by my friend from Oklahoma, Senator NICKLES. His amendment does what the President says he wants done—maintenance of consumer choice. The amendment takes the Secretary of Labor out of the bounty hunter business.

This is an amendment for all Americans, especially middle-income Americans. The Clinton-Mitchell bill, with its 17 new taxes, 55 new bureaucracies, and its almost $1.4 trillion cost is not middle-income friendly. The Clinton-Mitchell bill penalizes those who work hard and play by the rules.

The Nickles now Moynihan amendment is a little bit of sanity and fairness. This amendment does not nullify those few good aspects of the Clinton-Mitchell bill: aspects like allowing Americans with preexisting conditions to get and keep insurance, and allowing portability of insurance.

The Nickles amendment does nullify this anti-middle-income and anti-business part of the Clinton-Mitchell bill. The way to better access to our health system is not to destroy families or businesses. The Nickles amendment, with that maxim in mind, seeks to maintain choice.

Several Senators addressed the Chair.

Mr. NICKLES. Will the Senator from Oregon yield me 4 minutes?

Mr. PACKWOOD. I have a number of other speakers who want to speak and I would like to speak.

Mr. NICKLES. Four minutes?

Mr. PACKWOOD. All right.

Mr. NICKLES. I thank my friend and colleague from Oregon.

Mr. PACKWOOD. Could I ask the indulgence of my good friend from New York? Would he mind if I spoke after the Senator?

The PRESIDENT pro tempore. The Senator from Oklahoma is recognized for 4 minutes.

Mr. NICKLES. Mr. President, I wanted to respond because both Senator KENNEDY and Senator DASCHLE alluded to the plan I was the principal sponsor of, the consumer choice plan, and said that we have a standard benefit.

What we had in our bill was strictly voluntary, that said if you want to qualify for tax credits you had to have at least catastrophic, which is basically hospitalization, which makes sense. We were telling everybody we want individuals to have their opportunity to choose whatever they want so they would have a tax credit. But to qualify for the tax credit they had to have at least hospitalization. But they choose the benefits. They could have anything above that they want. They could choose from any of a multitude. There was an unlimited number of choices under our proposal for individuals to choose. That was the whole idea, consumers could choose and the tax credit would go directly to them. It would not be just tied to their employer.

This is in stark contrast to the Clinton-Mitchell proposal that says it is illegal for somebody to buy a benefit that is outside the standard benefit package; you cannot offer less, you cannot offer more. You can offer a supplemental but only if it is Government approved. You have to have every benefit that they determine, and some of the benefits are not very popular; to some of the benefits there are a lot of objections. To some of the benefits some have moral objections. They are going to mandate everybody buy those. We did not do those. We said individuals should be able to choose the benefits, have maximum number of choices on the benefits in stark contrast to the Clinton-Mitchell proposal.

I yield the floor.

Several Senators addressed the Chair.

The PRESIDENT pro tempore. The Senator from Oregon.

Mr. PACKWOOD. Mr. President, I yield myself such time as I may need.

I was going to use this chart until the Democrats agreed to this amendment. "Warning to employers: Providing health insurance to employees may be hazardous to your financial health." The reason I was going to use that is I do not think this provision, as it was originally in the bill, Senator MITCHELL's bill, was put in by accident. And now that it has been accidentally discovered, it is being taken out in a great spirit of comity. As a matter of fact, I think the finding that—it takes almost a Houdini, as we go through this bill.

But I think perhaps the more analogous story is one that relates to Winston Churchill.

He was at a dinner party one night and an admiral was there, an admiral of significance in the British fleet. The admiral, admiring the flatware, pocketed a rather expensive gold spoon, which bothered the hostess no end because she had seen it but she was not quite sure how to approach the admiral and suggest that he give back the spoon. So she went to Winston Churchill, explained her situation, and asked what she should do.

He thought for a moment. He went over to the table and he took another gold spoon off the table, a larger one. With the handle sticking out of his pocket he walked over to the admiral and said, "Oh, Admiral, I think we have both been discovered. We will have to give the spoons back."

What has happened here is, we have caught the Democrats with the gold spoon in their pocket. Now they have to give it back. We have heard them say, "Oh, well, there are other ways to enforce this. We do not need this." Why was it ever in the bill to begin with if they do not need it?

Did they know it was there? You bet they knew it was there because when this bill, Mitchell 1—when Mitchell 1 was drafted there was not only this $10,000 penalty but, in addition to the $10,000 penalty, a 35 percent tax. And it was levied upon your health insurance premiums. If you have six employees, you are a little laundromat paying $2,500 apiece for health insurance, $15,000, 35 percent tax, roughly a third, roughly $5,000 you were going to pay in addition $10,000 times six employees. That is $65,000 for a little laundromat owner. Now you can say you do not have to offer the standard benefit package, but $65,000 is a whale of an incentive not to offer anything else.

What happens when we get to Mitchell 2? The 35 percent has been dropped out, so they knew it was there. The $10,000 was not dropped out. Now the poor little laundromat owner is only going to have to pay $60,000, instead of $65,000; the $5,000 incentive removed, he can go ahead and offer what he wants—and pay the $60,000. Did they know it was there? You bet. They knew it was there.

Why was it there? It was there so the argument can be made, you do not have to offer the standard benefit plan. You can offer anything you want. You can have any plan you want under this bill. There is no employer mandate until the year 2005 or 2002 or whatever it is, and up until that time the employer can offer anything he wants. But if he wants to offer anything other than the standard benefit package it is going to cost him $10,000 an employee.

Let me give another example. The little laundromat owner with six employees is paying $2,500 a year for health insurance for his six employees. The standard benefit package, husband and wife with a couple of kids, is $5,500-$6,000. So now comes along this bill and the little laundromat employer cannot afford $5,000 or $6,000 for the standard benefit package. And if he offers any insurance and does not offer the standard benefit package, he gets fined $10,000 per employee.

What does the little laundromat owner do? I will tell you what he does. He drops his health insurance. He cannot afford $6,000 per employee and he certainly cannot afford $10,000 per employee penalty, so he drops it. Now they have no coverage.

This $10,000 was designed deliberately to be, not an incentive—coercion, Mr. President; $10,000 an employee is not an incentive, it is coercion. And because the Democrats have been caught with the gold spoon in their pocket, they are now allegedly giving it up and saying we never needed it anyway.

As we go through this bill, Houdini like, looking for other gold spoons, my hunch is they will agree with many other amendments we bring up because they knew they could not defend this. They knew they could not defeat it. So they co-opt it.

I am delighted to have them on board. I would be interested, if they have an explanation, as to why the $10,000 was ever in there to begin with. They knew it was there. Why they took out the 35 percent penalty, having gone through this bill themselves, but never took out the $10,000.

There is only one answer. We are going to force you to voluntarily provide the $6,000 standard benefit package or nothing. For too many employees the answer will be nothing. I thank the Chair.

Several Senators addressed the Chair.

The PRESIDENT pro tempore. The Senator from New York.

Mr. MOYNIHAN. I yield to the Senator from Massachusetts such time as he may require.

The PRESIDENT pro tempore. The Senator from Massachusetts, [Mr. KENNEDY], is recognized for such time as he may require.

Mr. KENNEDY. Mr. President, we have been involved in this debate and discussion on the bill for some 2 weeks, now. And we had a good debate and discussion on the children's amendment over a period of several days. Then the Senate went on record to advance the protections for children.

I think that was an important improvement over the Mitchell bill. And I think we understood that after we had the consideration of an amendment on this side, we were going to go to the other side in order to consider an amendment. So many of us who have a desire to get into the substance of these measures—and there are strong policy differences on many of these measures—we were hopeful that we would be able to reach some kind of accommodation.

I think all of us are still hopeful we will, even with those individuals who have expressed reservation about the Mitchell proposal. I think most of us were somewhat hopeful that we would have a proposal or an amendment here that really was going to be at least somewhat defining in terms of the direction of this debate.

When I first saw the amendment of the Senator from Oklahoma earlier in the day, I was somewhat interested in the fact that he was going to make an amendment to strike the $10,000 penalty that employers might be required to pay if they did not provide the standard benefit package. We reviewed that measure and reviewed the other provisions of the legislation. Those of us who are for universality of health care are not into just trying to find areas where we are going to penalize employers. We are interested in universality and cost containment and trying to develop some consumer protections.

As far as that $10,000 requirement, I felt that if you are going to have—and we can come back to this in a moment—a standard benefit package and you are going to have to have some kind of remedy. I did not think, quite frankly, that $10,000 was an unreasonable penalty. I was persuaded in the spirit of bipartisanship that we ought to try and find some common ground. So I indicated, at least as far as this Senator is concerned—and, of course, all of the Members have views and their views are entitled to an equal amount of credit—that this was something that I could support.

I was listening earlier to the debate on what we are really talking about here—on whether we are going to have a standard benefit package or whether we are not going to have a standard benefit package; whether the Mitchell bill is going to require it, or not require it, and then the reasons for it. Then there were charts pulled out to talk about what the costs were for the standard benefit package.

It is interesting that what those figures basically reflect is the actuarial value of the benefit package that Members of the House and Senate have in this institution. Obviously, we know the values change in different parts of the country, so we know using those charts might alarm people in different parts of the country. They were intended to illustrate what the costs were in an actuarial way for programs that we have in the Congress of the United States, that we have as Senators, and to emphasize that we are trying to make those same kinds of benefits available to the American people.

Ten million Americans have them, including Members of the House and of the Senate of the United States and the President of the United States. In the Mitchell bill, we give the same opportunity to working families and other families across this country so they will have these benefits, too. I pay $101 a month for a program as a Member of the U.S. Senate. I bet most Americans who are watching this program with very comprehensive protections—I doubt there are many other programs that are any better, and I think most Americans would say, "I'd like to have what you have, Senator," or what any other Member here has.

That is in the Mitchell bill. Just store that away as we are talking about all of these other factors and that program is evaluated because it costs differently for Federal employees in different parts of the country to reflect local costs. We have what is considered to be at least a standard package. It can vary a bit in terms of the copayments and deductibles, but the essential elements are there.

Now we have a debate on the question of the role; why are we requiring a standard package and raising the serious question of whether any bill at all ought to have a standard package.

I was somewhat interested in the remarks of my friend from Oregon who was the principal sponsor of President Nixon's program, which had a standard package. As one of the principal cosponsors of that program, I do not remember him saying at that time, as it was being debated and discussed, "Oh, no, we don't want a standard package." That was an essential part of the Nixon program. But time moves on, and we have to consider that.

Then I was interested to hear my friend from Oklahoma, Senator NICKLES, say, "We don't want a standard benefit package. How are we going to deal with the problems that many of the businesses are going to have to deal with?"

So we looked through the Nickles legislation, cosponsored by 25 Republicans, and we found out that it outlines a standard benefit package on page 33. I referenced this in some earlier comments. The Nickles legislation talks about providing for all necessary acute medical care described in subsection B; it talks about physician services; it talks about patient cost sharing, deductibles and copayments. He has a standard benefit package effectively described in words. And his legislation said that you had better conform with his standard benefit package or else you will not get the favorable tax treatment. The message better go out to all Americans that unless you have the Nickles proposal and his standard benefit package, your taxes are going to go up. The message better warn every American that the only way to keep their taxes down is to adhere to the Nickles standard benefit package.

It is so interesting how some people use these hot-button items like taxes, the Mitchell program on taxes. I think most of us believe that, with $68 billion a year in health care costs that are directly related to smoking, there ought to be some increase in taxes relating to cigarettes.

Well, here it is, right here in the Nickles proposal. Unless you provide the Nickles standard benefit package outlined in the Nickles bill with 25 Republican cosponsors, you do not get the tax consideration. And yet, they say, isn't it terrible under Mitchell when they say you have to provide the standard package, make sure you make it available to consumers, because if you do not conform with the law, there will be a penalty. And now under the Nickles proposal, if you do not do exactly what Senator Nickles wants you to do, you are not eligible for the favorable tax considerations and it will continue to go up.

Now we look over to what happens in the Chafee proposal.

Mr. NICKLES. Will the Senator yield?

Mr. KENNEDY. When I finish. I will be a few minutes and then I will be glad to yield.

On S. 70, on the Chafee proposal, each plan must offer one or more of the following: Standard benefits package or a catastrophic package. That is on page 89, and that is section 1301.

I am going to be interested in how Senator CHAFEE is going to do it, because if you do not conform with the Chafee proposal, you pay $100 a day in penalties. Is that not interesting, $100 a day in penalties under the Chafee proposal? That could certainly add up.

Many of us have been willing, as a matter of conformity, to say, "All right, we will eliminate the $10,000." But yet under the Chafee proposal, it provides under the standard package a catastrophic package. It has covered items: Medical surgical services, medical equipment, prescription drugs, preventive services, rehabilitation services, substance abuse services, hospitals services, emergency transportation, and it goes on and on.

If you do not conform with his proposal, you are penalized.

And under Breaux-Durenberger, you must offer the uniform set of effective benefits, and that is effectively a standard benefit package. I am not surprised, Mr. President.

One of the thoughtful members of our community on health policy, Alain Enthoven, has followed these issues closely, and there may be those of us who differ with some aspects of it, but we have enormous respect for Mr. Enthoven. He served in the Defense Department in the early 1960's. I can remember his very considerable public service in the Defense Department.

He has taken on this issue and written extensively about how to reach universal health care. I have had the opportunity to listen to him and to read his comments.

He has been very much involved, I think, in helping to shape the thinking of many Members. Here is Alain Enthoven:

> There are powerful reasons for as much standardization as possible.

This is the free marketeer.

> The first is to facilitate value for money comparisons and to focus comparisons on price and quality. The second is to combat market segmentation, the division of the market into groups of subscribers who make choices based on what each plan covers, such as mental health, efficient care rather than price.
>
> The third is to reassure people that it is financially safe to switch plans for a lower price, with the knowledge that lower-price plans do not realize savings by creating hidden gaps in coverage.

Hidden gaps in coverage. Hidden gaps in coverage. That is the point that the Senator from South Dakota has made. That is the point which other Members have made, the hidden gaps in coverage.

What are those hidden gaps? Those are the gaps which exclude from the prenatal services any complications for children for the first 10 days after birth. Mr. President, 93 percent of infants' health needs come when? Interesting. The first 10 days after birth. Those are the kinds of life limits, those are the other kinds of exclusions, the hidden lines, the fine print, all of the things that we have talked about which our Republican friends have talked about, which we have talked about over here, all of which I thought about as we listened to those eloquent statements for the past few days—talking about eliminating preexisting conditions, eliminating the kinds of unfairness in the various standards under insurance reform, that all of us were attempting to try to address, that Alain Enthoven, who is one of the key thinkers in terms of the whole market force approach on health care, has identified as one of the very great dangers.

Mr. DASCHLE. Will the Senator yield for just a minute?

Mr. KENNEDY. I will be glad to yield and then I was asked to yield over here. I will yield here, just make a very brief final concluding comment, and then either yield the floor or respond.

Mr. DASCHLE. I would only ask the Senator from Massachusetts whether Mr. Enthoven also mentioned that part of the cost shifting occurs through lifetime limits? The Senator mentioned the lifetime limit problem. What happens when people bump up against lifetime limits? They have catastrophic illnesses with costs that their insurance plans do not cover. Who pays for this? Is it the taxpayer? Is it the insurance company? Is it the individual? Is it the small business? Is it another family? Somebody is going to pay for those costs.

So ending cost shifting is an added benefit in having coverage delineated in all health insurance policies, is it not? Unless you eliminate these fine print provisions, unless you eliminate things like lifetime limits, do you not continue to prolong the cost shifting that goes on in the system today?

Mr. KENNEDY. The Senator is absolutely correct. When you begin to have these exceptions, and these loopholes written into it, and then you run into these other kinds of costs associated with these illnesses and sicknesses, someone ends up paying for it. And it will be those that have played the game by the rules and received the standard benefit package.

I see others waiting, and the time is moving along, so let me just be brief in a final comment or two.

The logic that we have heard from our friends on the other side of the aisle is basically the same logic that was heard in the Senate years and years ago when the Senate was considering the child labor laws. Why should we here in the Senate take action to protect children? Why should we? It is an argument today you find difficult for even the best of Members to try and be able to make. No one would absolutely buy it.

You read the history. Do we know something here on the floor of the Senate that people do not know back in local communities? The same argument. The same argument was made in the debate on the lemon laws. Why should we be establishing some standards? If the purchaser of an automobile drives it out of the lot and it falls apart, why should we care anymore? Why should we make sure that the representations that are made to that consumer be accurate in terms of the sale of a particular commodity? Is that so unusual? The same arguments are being made over here. They say, look, I bet we could get people to work below the minimum wage. Why do we say that we want $4.25 an hour to be a minimum wage? The reason that we do is we say we are a caring society and we believe that men and women who want to work 40 hours a week, 52 weeks in the year ought to be able to have sufficient revenue to live in some dignity and some peace with a roof over their house and food on their table and be able to afford a mortgage.

We do not say, why do we establish that floor? Republicans and Democrats alike have moved the minimum wage up. We are not saying we can find people that will work for a buck an hour and if they want to go for a buck an hour why not let them work for a buck an hour. Why should we in the Congress interfere with that? And if they want to exploit children, why not let them do it? Why should we in the Congress do it? And if someone wants to sell a lousy car, why not let them do it? Why should we in the Senate provide protection?

It is the exact same argument, Mr. President. What we are establishing is the standard benefit package. And it is interesting, when we were discussing and debating this issue in our Labor and Human Resources Committee, the principal difference between Republican and Democrat was not essentially what was going to be in it but whether we were going to outline it in detail or describe what was going to be in it and give greater flexibility to the national health boards so that there could be adjustments and squeezing of those elements in case of the economic exigencies that might occur.

But we did not have any debate, any real discussion about the nature of the preventive services or hospitalization. There may be some difference in terms of some of the aspects of mental health. But we did have agreement conceptually about what should be in that standard package.

To hear in the Chamber of the Senate this afternoon, when we are just entering this program, that those who have been either principal sponsors or cosponsors of legislation, piece after piece of legislation going back historically even to the 1970's, who have supported a standard benefit package, come out and say, well, we really do not need it, we are not going to provide those protections, Mr. President, we know the reasons for that in terms of providing the protection so that the consumers can have real choice, so that they are able to compare, so that they will be able to compare quality, so that they will be able to do the evaluation on the basis of medical report cards, so they can talk to other consumers and find out whether they are getting good quality, so that there is no fine print in there, so that they will know what the real costs are, so they will know the various elements of that program. It can be a standard package. You can have different deductibles. You can have different co-pays. You can have different features, but you and I know the competition will not be on the basis of the standard opinion. It will on the delivery of services, the efficiency of the services and the quality of the services. And that is what the consumer ought to have the ability to buy.

I will be glad to yield briefly, and then I see two or three of my colleagues on the floor, to try to respond.

Mr. PACKWOOD. Mr. President, is the Senator done?

The PRESIDING OFFICER. The Senator from Oregon.

Mr. PACKWOOD. Mr. President, how much time would the Senator from New Hampshire like?

Mr. GREGG. Ten minutes.

Mr. PACKWOOD. I yield 10 minutes to the Senator from New Hampshire.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized for 10 minutes.

Mr. GREGG. I thank you very much, Mr. President.

We have just heard a speech by the senior Senator from Massachusetts which has been one which really has not been material to the issue at hand, which is not too surprising because when you consider what has happened here it is that a point within the bill has been discovered, of which there are, I suspect, hundreds like this, that has a devastating impact on the American people and on the way they relate to their Government, a $10,000 fine that could be assessed against up to 200 million Americans if they refuse to follow the dictates of a small cadre of bureaucrats directed by people here in Washington. People would be outraged, and they are outraged when they learn of this.

So when it is discovered and brought to light, it is immediately abandoned because the folks who put this language in here recognize that it is not defensible in the public eye. That is, of course, what the debate over the last few days has been about, trying to analyze what is in this massive document, which will have a dramatic impact on the day-to-day lives of Americans, about which we have not been told. Regrettably, there is a lot of it in here.

The Senator from Oregon used the nice story, the very fine story, about the golden spoons being discovered now. I would look at it more as something my children are involved in recently that I have noticed. They bring these pictures home. I think they are called Magic Eye pictures. You hold them up, and they are a maze of different designs. As you move that design closer to you or back from you, you suddenly see the pictures within the design. I understand this is a best selling book, called Magic Eye.

That is what this it. That is what it takes to use this document. You have to use a Magic Eye approach. As you move it closer to you under section 1,300, what you see is a great, big, huge truck coming at you which is going to run you over if you happen to be an

employer in this country who wants to maintain a plan that is not consistent with the plan that you were told to comply with by some bureaucrat here in Washington.

Let me point out some other things that this fine applied to that has not been mentioned. We have been talking about the standard benefits package. This is just one of the items that this hit before it was discovered.

Think of some the other things this fine did. There is a section 1331, and a $10,000 fine will apply, if you as a commuter go to another job in another community-rated area and do not take the community-rated plan in that area. So what does that mean in real terms? It means that you are going to get stuck with $10,000?

What it means is, if Mary Smith and John Smith lived in Nashua, NH, and John Smith worked in Boston and Mary Smith worked outside of Boston, in Nashua, which would be reasonable—and I suspect it would be reasonable in many parts of this country—they would be in two different community-rated areas. If John Smith wanted to be on Mary Smith's policy in Nashua, because it was a cheaper policy or because they were more comfortable with that provider group in Nashua, he would be subject to a $10,000 fine. He does not have that option. He has to take the plan in Boston.

That is one point where the $10,000 fine kicks in. It does not happen to be mentioned. It just sort of appears.

Another point where the $10,000 fine appears to kick in, under section 1308, under this section, there is some language put in for the purposes of litigation relative to losing benefits. The way this works, the section establishes two different standards of proof and requires that courts without the requirement of any additional showing to promptly order the retiree's benefits to be reinstated. The practical effect of this is that the Secretary of Labor could fine a judge, who did not comply with this section, $10,000.

There is another point that this $10,000 fine affects if you are running a cooperative, and there are a whole series of obligations which you need to undertake, and you do not undertake. There are sections 1322, 1323, and 1324. They involve things like membership agreements, agreements with plans, allowable fees. Under this section, the cooperative could be subject to a $10,000 fine for every member that it had in it—remember, a cooperative could have hundreds of thousands of people in it—if it did not meet one of these technical requirements on an issue of membership agreements.

The list really goes on and on in this area. For example, one of the ironies is the way this $10,000 fine was designed. It is a compliance obligation which is enforced by the Secretary of Labor against regulations created by the Health and Human Services Secretary. The practical effect of that is that the Secretary of Labor could theoretically fine the Health and Human Services Secretary for not going forward in a manner that the Secretary of Labor thought was reasonable. I do not think that would happen. But that is the way this is drafted.

The point I am making here is that within the language of this bill there are many complex, unintended consequences generated by this language. There is one little paragraph that is in here that the pond into which this stone has been dropped of a $10,000 fine causes ripples to occur throughout the society generally, and they are unanticipated. Yet, they are in this bill.

So when we go through this bill section by section, and ask let us take a harder look at this section, let us take a harder look at that section. I think it is a reasonable request. It is not reasonable for other people to say, "Well, you are just delaying the process." In fact, we are not delaying the process. What we are trying to do is point out to the American people some of the very serious flaws in this piece of legislation.

I think it is nice that when we point these out on occasion and raise them as an amendment, the drafters on the other side recognize immediately that the golden spoon has been found in their pocket, that the picture has come into focus on the Magic Eye, and that people have figured out what they are up to.

What they are up to in this $10,000 fine is essentially to create an act of intimidation and coercion against employers in this country, the purpose of which is to make it unalterably clear that if you do not comply with the bureaucratically demanded health care structure, you would basically be put out of business or be threatened with such a fine of such an extended nature that your business and the viability of your business would be seriously threatened.

So that is the issue, the issue of the fact that you have a situation where Government has reached the point where in order to assert this plan, it feels it must intimidate, it feels it must coerce by threatening this level of fine. It is a philosophy that runs through this entire bill, Mr. President, a philosophy of we know best here in Washington. If you do not agree with us, that is because you are not just smart enough to understand it, or compassionate enough to sense it. And therefore, please American people, stand back, and let us design your lives for you, and specifically let us design this health care plan. If you do not stand back, we are going to run over you with that truck that just appeared as a result of analyzing the bill that looks like a Magic Eye.

I yield the floor.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER (Mr. CONRAD). The Senator from Oregon.

Mr. PACKWOOD. Mr. President, I know the Senator from New York wants to yield to the Senator from Delaware. I wonder if 2 minutes might be given to Senator NICKLES to respond.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I ask unanimous consent that Senators BURNS, EXON, MURKOWSKI, and SMITH be added as cosponsors.

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

Mr. NICKLES. Mr. President, the Senator from Massachusetts has alluded to the bill that I am the principal cosponsor of as the consumer choice bill, and said it has a standard benefits package. That is not correct. What we did in this bill, just to clarify, is we replaced the tax exemption that people now have for their health care plans with tax credits. But we said if people want to get tax credits for health care, they have to have at least a catastrophic health insurance plan that covered primarily hospital and physician patients. We did not define everything else but they had to have this.

The individuals could have a maximum choice. It would be the individuals that would choose. That is kind of a new concept. They would not have to take what the employer offered. They could choose anything they wanted. But, they have to have it to have the tax credit. They to have to have the health care. We had a nice tax credit, a 25-percent tax credit, so the Federal Government would help everybody.

Frankly, the Federal Government uses the Tax Code right now to subsidize your health care by saying you do not have to pay taxes on it if you are an employer that subsidizes. A lot of people do not have a job. So they do not get any benefit from the tax credit. That is not fair.

We said the tax benefits really should not be dependent on whether or not somebody has a job with a generous employer. They should be universal to everyone, just like we give tax benefits to people who buy a home. We do not define the size of the home, but we allow them to deduct the interest expense. But it has to be on the home.

Likewise, we said only a tax credit. We are willing to help everybody buy health care. We will give everybody a tax credit. But they have to buy health care with it, and in health care we said hospital and physician services.

They had an unlimited number of options. That is unlike the proposal that we have before us, the Mitchell proposal. That is unlike the proposal we had before us that says it is illegal for you to offer different benefits.

The Government mandates a very expensive package. You have to have

this. If you do not have the benefit in your package, you are out of luck, or you are subjected to fines and penalties and excessive taxes.

That is not what we had. We said we will give everybody a tax credit, and we will not define your package. You can choose your package. That is consumer choice.

I think that is significant reform.

I thank my colleague.

Mr. MOYNIHAN. Mr. President, I yield 30 minutes to the distinguished chairman from Delaware, who wishes to address the Senate on another matter, but one of equal urgency.

The PRESIDING OFFICER (Mr. DASCHLE). The Senator from Delaware is recognized.

THE CRIME BILL CONFERENCE REPORT

Mr. BIDEN. Mr. President, I realize that I have been on the floor in the midst of this health care debate speaking about the crime issue more than once, and with the indulgence with my colleagues—at least on this side—I will continue to do that for a few more days.

Mr. President, my friend from New Hampshire said that in relation to the health care bill, it is important to go section by section to look at the bill and see what it means and debate the meaning of the bill. I wish my Republican friends would go section by section on the crime bill, because if they were going section by section in the crime bill, they would understand that what they are saying—unintentionally, I am sure—is inaccurate.

The distinguished Republican leader spoke on the floor this morning, and I assume a copy of the speech I have before me was the one that was delivered or placed in the RECORD. If, in fact, I am incorrect in that assumption, I apologize, but I am told by staff, and by the Republican staff, I believe, through the Democratic staff, that this is what the Republican leader delivered this morning. I think that today I am going to be speaking to what the Republican leader said. Tomorrow I would like to speak about what the hired actor for the NRA on television is saying, which is even more inaccurate.

Let me take Senator DOLE's statement as written here and respond to pieces of the statement, or all of it, if I may.

Mr. President, on page 2 of the statement—and I do not know where that will appear in the RECORD—the Senator says:

> I hope we have signaled and that President Clinton now finally understands that last Thursday's vote was not a procedural trick or a politically inspired attempt to hurt his Presidency, but rather a vote to improve the crime bill.

Mr. President, if that is true—and I am sure the Republican leader believes that—I ask my friends why 65 Republicans in the House voted for the House-passed crime bill that had approximately a half billion more dollars in spending for programs they now call pork and social programs than the conference report that I negotiated and sent back to the House and they voted against?

Said another way: How could we go from 65 Republicans voting for a bill that had more than a half billion dollars more in exactly the programs they now say are the reason for voting against the bill. Sixty-five of them voted for that. Only 11 voted for the bill that I negotiated with the chairman of the Judiciary Committee in the House, which had more than a half billion dollars less of what they say they do not want.

The Republicans over there are saying that this is not about guns or about assault weapons. I do not want somebody back home to think I want you to manufacture all these Uzis and street sweepers. It is not that. It is that there is this awful social spending in there. Well, I cut the social spending they voted for by half a billion dollars, and then they decided they were still against the legislation.

So I respectfully suggest that the Republican leader on the Senate side should ask the 54 Republicans who voted for more pork, as they characterize it, and now are saying they voted against the conference report because it has too much pork, what happened if it was not politically inspired? Maybe there is another reason. Maybe they did not know how to read the first bill. Maybe they did not know. Maybe they did not understand the House bill they voted for the first time. That is possible—regrettable but possible. But just maybe I am right when I say it was politically inspired. Just maybe.

The Republican leader says that they want a no-nonsense crime-fighting plan for America.

I am quoting from his statement:

> And here are some of the improvements he should support * * *.

Meaning the President, I assume.

> Number one, increased prison funding to the House level of $13.5 billion and tighten the language so the prison funds will definitely be used to build prison cells rather than halfway houses, or other prison alternatives, and require truth in sentencing for first-time violent offenders.

Again, maybe I have an incredible disadvantage. I have been responsible for managing this legislation for 6 years. But one of the advantages is that I have the requirement of having to know the bill inside and out. I do not know the health care bill inside out, or any other bill. So I can understand how Senators may not know every provision, and if a staff person tells them something is in it, they may think it is in it or not in it.

To set the record straight, the bill that the distinguished Republican leader and almost all of his Republican colleagues voted for that we passed in the Senate—the Senate crime bill—which Senator HATCH stood up on the floor and referred to, if I am not mistaken, as the Biden-Hatch crime bill, which I was delighted to hear. For one, I was delighted to have it be called the Biden-Hatch crime bill. I think the Republican leader voted for that bill.

That bill that we passed out of here that went to conference had $6.5 billion in it. That bill did not have $13.2 billion, nor did anyone ever suggest, to the best of my knowledge, nor did any Republican ever suggest, that there was a need for more money for prisons than $6.5 billion. As a matter of fact, the distinguished Senator from Texas [Senator GRAMM], if I am not mistaken, negotiated the number with me.

All of a sudden, this thing that they all voted for is now flawed because it has something in it they never asked for, never wanted, never spoke to. So we went to conference, and what did we do? We added $2 billion more; to be precise, we added $1.8 billion more than any Republican ever asked for on the floor of the Senate.

So now the total is $8.3 billion for prison construction, $6.5 billion of which will provide 105,000 new hard prison cells, paid for, given to the States to build and maintain. I find it fascinating that one of the things that would prove we have a real tough crime bill is that we need $13.5 billion. Were they weak in November?

Did these Republicans all of a sudden see God and say,"Oh, my God, this is not tough enough; we were mistaken," as we say in my church, "mea culpa, mea culpa, mea maxima culpa?" Is that what happened to them? Or did the little political bird fly into their window and say, "Hey, the Democrats are going to pass a bill"?

I will let you all be the judge of which it is.

Now, the Senator also says that he wants tougher language, truth in sentencing. Let me remind everybody what truth in sentencing was.

Right now, there is no parole in the Federal system. If you get nailed in the Federal court, you go to jail. Why do you go to jail? Because Senator KENNEDY, myself, and others, including Republicans passed a law a decade ago saying no parole federally.

We want the States to do that, too. They should. But guess what the States do? The States only keep their violent criminals in prison about 42 percent of the time to which they are sentenced. In the State of X or Y, when you get sentenced to 10 years in jail in a State prison, you serve on average 4.2 years. In the Federal system you serve a minimum of 8½ years.

So the Republicans said, "We want a tough bill—truth in sentencing." I made it a commitment on this floor, and I never break a commitment. I said

it is a crazy idea to force the States to do this, because they will never spend the money because they will have to double the number of prison cells they have out of their own pocket before they get to seek Federal money. If that is what you want, I promise I will do it. Then, not that they did not trust me, to reinforce it, we had an instruction, as we say on the floor of the Senate. We had a vote. My Republican colleagues instructed me as the leader of the conference on the Senate side to insist on that language staying in.

So guess what? We went to conference. We got to this issue. We raised the spending by almost $2 billion, and I insisted and asked for a vote on truth in sentencing.

That is what the Senator from Kansas says he wants. He says he wants more truth in sentencing. OK, great. I insisted on it.

Guess what happened, Mr. President? The Republicans in the conference voted against it. I offered it, and Senators HATCH, THURMOND, GRASSLEY, and SIMPSON voted against it. On the House side, the House Republicans voted against it. They did not even get to vote, quite frankly. We rejected it. I supported it; the Republicans knocked it down.

Now, out of the blue, I am told go back to conference and put in truth in sentencing because that will make a tough crime bill.

If we do go back to conference, pray the Lord that they instruct the Republicans, the conservative Republicans to be for it now. They were against it, not me, not the Democrats. They voted it down. With good reason, by the way. Republican Governors throughout the country says this is crazy. So apparently they listened to the Republican Governors instead of the Republican national chairman.

So we have this straight now. One of the first conditions is for a tougher crime bill, want more money spent, and want truth in sentencing.

I put in another $2 billion beyond what we had. We got more money than anybody voted for here, and the Republicans rejected truth in sentencing.

What is the second point to make this a stronger crime bill according to Republican leadership? Well, cut at least half of the spending on social programs. And they cite some, they call, social programs. They, first of all, start off with the Model Intensive Grant Program. The Model Intensive Grant Program is the same program as the Drug Emergency Areas Act that Senators D'AMATO and GORTON, and other Republicans, have cosponsored in the past.

I wish they would make up their mind. It is not the same exact thing, not called the same thing. I think what makes them angry, and I am surmising here, is that the Model Intensive Grant Program is the name given to the program by Mr. SCHUMER, a Democrat, and we do not have the name Drug Emergency Areas Act, which we have had in every crime bill I have introduced. There are some marginal differences, but we are talking roughly the same money and for the same purposes.

What happened here? What happened between the time it left here that it was a good idea and the Republicans asked me to put this in the bill? I supported it. By the way, I still do, and now it has to be out.

We also have midnight basketball. Gosh, we are going back to midnight basketball. I hope everybody saw CNN last night. They went out to a place in suburban Washington, DC, in Maryland, and guess what? It works. Let me quote. I am quoting. This was stated in 1991.

> The last thing midnight basketball is about is basketball. It is about providing opportunity for young adults to escape drugs and the streets and get on with their lives. It is not coincidental that the crime rate is down 60 percent since the program began.

You might ask yourself who said that, who made this outrageous claim that where they had this midnight basketball program the crime rate dropped among youth by 60 percent? I never made that claim when I put it in this the legislation. I just said it will get better. Who made this claim, which I think is probably accurate? Let me tell you who made the claim. His name was George Herbert Walker Bush. It was his 124th point of light. Remember those points of light. Well, every once in a while even he was right. He was right a lot of times. So I took his point of light and I put it in the bill.

[Disturbance in the visitors' galleries.]

Mr. MOYNIHAN. Mr. President, may we have order in the gallery.

The PRESIDING OFFICER (Mr. MATHEWS). The Senator is correct. The Sergeant at Arms will see that there is order in the gallery.

The Senator from Delaware.

Mr. BIDEN. Mr. President, I put this point of light in the bill, the Republican point of light.

Now, I understand it sheds darkness and doom. It is a terrible thing, $40 million to have basketball leagues where kids not only play basketball, and they must stay in school, and some programs even require they keep a C average, and they must be off the street. There are other programs to keep the high schools open, so you use the gymnasiums—a Republican idea, not a Democratic idea.

Senator DOLE goes on to say, and I quote: "But now 9 months later, the conference report authorizes a staggering $33 billion, a 50 percent increase," over the Senate bill, "a 50 percent increase" that is over the Senate bill, he means. "Obviously, somewhere along the way the crime bill was hijacked by the big dollar social spenders."

Boy, they love this language. Let me tell you what the big dollar social spenders did. We went in, and we added $1.8 billion for prisons. Remember now. His first point he wants more money for prisons. So we added $1.8 billion more for prisons. What did we do next? We added another billion dollars for the Byrne grants. Remember what the Republicans did when the President said he was going to cut the Byrne grants? They came to the floor. They said it was outrageous, that the best thing that happened at home was the Byrne grants. They are great, by the way.

What did we do? We put in these big social spending Byrne grants. Do you know where the Byrne grants are? They are where the Federal drug enforcement agents work with local law enforcement agents and nail drug dealers. That is a big spending social program.

Now, we are up to $2.8 billion, we added.

What else did we do? We added to the Treasury Department for enforcement, $380 million for new T-men. Folks, men and women, with guns, who go out and get bad guys, counterfeiters, bad guys, $380 million. We added $1 billion for the INS to go and nab illegal aliens. It is a big social program, is it not? Tell that to the illegal aliens. They think it is a great social program.

In total for Federal law enforcement we added $815 million.

Then we added another $100 million for drug courts.

Do you know how the drug courts work?

And my friend from New York—and I am not being solicitous—knows more about this issue than any person that I know. I might add, by the way, when we all stood and watched New York and other cities burn, figuratively speaking, he said nearly 10 years ago, "The crack epidemic is coming. We better do something about it." And nobody did anything about it. They did not listen to him.

So what happened? It used to be for every four men that used drugs, there was only one woman. Along came crack and, to use that Virginia Slims ad, "Women have come a long way, baby," because crack now has made it about 1 to 1. It is about 1.4 to 1.

Guess what. Now we have more homeless children. Now we have more AIDS. Now we have more prostitution. Because these women cannot afford this, what do they do? They go to a pimp. He gives them crack, they do his dealing, they get drugs. AIDS spreads.

No one listened to the Senator from New York.

We added money in here for drug courts. Now drug courts do not deal with the crack dealers. It deals with another aspect of the problem. There are 600,000 young people, adults, who last year were drug addicted offenders,

convicted for a nonviolent offense, who never saw a day of prison, a day of counseling, a day of anything. There were a total of 1.4 million arrested and convicted; 800,000 got something, probation, or random drug tests or something, 600,000 because there are no counselors, there are no probation officers, there is no prison space, got nothing.

So we put in money for drug courts. Big social program.

Do you know how that works, Mr. President? The way it works is that if you get arrested and convicted in a drug court—you are a first-time, nonviolent offender, you are a young person, you are an adult, but your in your twenties. What happens is, you must either demonstrate that you are in school, in a job, be subject to random testing, and employment counseling. If you do not do any one of those things—you either drop out of school, you lose your job, or you flunk the test—you go to jail. Now, I have never heard that of a social program.

But so we are talking about billions of dollars added.

Let me tell my friend that more than $7 out of every $10 in this bill are for cops, prisons and Federal and State law enforcement.

So I think someone should tell him that did not get hijacked by big dollar social spenders. It got hijacked by the FBI, as it should. It got hijacked by the DEA, the Drug Enforcement Agency. It got hijacked by drug courts. It got hijacked by police SWAT teams in cities and counties and rural areas, working with State people. It got hijacked by $1.8 billion for more prisons.

I guess you did not know that, but that is where the hijacking came in.

Now, the third point that is necessary, I am told, for us to have a tougher crime fighting bill is:

Third, plug the so-called safety valve provision which could result in the early release of 10,000 convicted drug offenders. A get-out-of-jail-free card, brought to you by the United States Congress.

Let me tell you what that is.

First of all, the so-called safety valve was insisted upon by the Republicans in the conference. I did not have it in the bill. When it passed the Senate, it was not in the bill. But, Mr. HYDE and Mr. MCCOLLUM, both fine men—and substantively they are right on the issue, by the way—insisted that this be in the bill.

Now let me tell you what it does.

No one gets out of jail under this narrowly drawn safety valve, which applies only to nonviolent drug offenders and permits them to ask that their sentence be reconsidered under the guidelines.

As the Senator from New York knows, the guidelines are now tougher than the minimum sentences in most of the cases.

And do you know what the Bureau of Prisons says about who will qualify for this, this get-out-of-jail-free card as my Republican friends call it? As my Republican friends tell me 10,000 convicted drug people?

Do you know what they say, the Bureau of Prisons? Minimum, 100; maximum, 400 people will be eligible for release.

Do you hear what I just said? Minimum, 100; maximum, 400. Ten-thousand? Kind of interesting.

And, by the way, those who get out will all be nonviolent, no crime involving a minor—and this is all listed in the bill, but in the interest of time I am not going to take the time now to go through it—no use of a weapon, no threat of force, no threat of deadly force or any force. On average, they will have served 4 to 5 years already. And all they get to do is ask to "reconsider my sentence" under this mandatory requirement that was built in. And the Bureau of Prisons says, first batch out of the box, the only people that qualify now, 100 to 400 people.

Now, I am told then the fourth thing that makes this bill tough—I am reading now from the leader's statement, the minority leader.

Fourth, no cuts for the FBI or drug enforcement agency.

I am quoting now.

No crime bill should cut staffing at our Nation's top law enforcement agencies.

Guess what? We agree with him. That is why it is in the bill.

Now, I am a strong supporter of the FBI and the DEA. I want to increase it. But let me give credit where credit is due. Senator DOMENICI insisted that this be in the Senate bill, and I insisted that it be in the conference report.

So, the crime conference report specifically provides money to the FBI and the DEA for additional agents; $250 million for the FBI will buy approximately 500 additional agents and $150 million for the DEA will buy approximately 300 agents.

In addition, the conference report, in section 320915, specifically states that we should exempt Federal law enforcement personnel from the Federal work force reduction fund that supports the crime reduction trust fund.

So the way we are funding this bill is cutting bureaucrats. We explicitly say in the law we are asking them to pass, "When you cut, do not cut the FBI or the DEA." And then we add $400 million to hire 800 new agents. So I am sure the Republican leader will be happy to know that we have also met point four that he insists upon.

Now, No. 5. "Restore some of the tough provisions adopted last April by the House, including" —and then they go on to say, "Megan Kanka's law."

Now, there was a God awful thing that happened in the neighbor State of New Jersey, my neighboring State and the neighboring State of the distinguished chairman from New York.

This young woman, because sexual offenders—I will call them predators—who had already served their time were released into the community and were in a house across the street, living across the street from young Megan. Everybody thought they were regular old people who moved in the neighborhood.

One of them, allegedly—the trial has not been held yet—allegedly brutally murdered young Megan. There was an uproar. The distinguished Governor from New Jersey is insisting that there be a registry—as she should.

Well, let me remind everybody. This is something—I guess people just have not had time to read this bill.

In the conference report, the thing that the House would not let get voted on because all but 11 Republicans and 48 progun Democrats and 10 members of the Black Caucus, adding up to enough to defeat the bill—there is a provision we put in the bill, tougher than either the House or Senate passed. It says anybody who is convicted of a sex offense against anybody any age—not just a child—must, when they are released from prison, appear on a State registry. The States are required to set up statewide registries. If they do not, they lose Byrne grant money. It costs them millions of dollars. That is the incentive, the only one we have available to us, federally. And we say, "Set up a registry."

Then, when John Doe is released, the sex offender—he does not have to be a violent predator, just flat out having been convicted of any sex crime, he goes on a registry. Then what happens? As we wrote the law that is in the bill the Republicans killed, they are required to then notify the local police agency. And they are required wherever they move to wear the scarlet A. And every time they move, they are required to notify the registry. And, we made sure that when the police tell the community—as they are allowed to do—they would not be subject to prosecution. This is something incredibly unusual. We gave immunity to the police department.

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

Mr. MOYNIHAN. I have 4 additional minutes.

Mr. BIDEN. Could I ask for 1 additional minute?

Mr. MOYNIHAN. You may have 4.

Mr. BIDEN. I thank my colleague. Anyway, it is in the bill. It is in the bill.

No. 6, the leader says restore some of the tough provisions, minimum mandatory for those gun laws. He should read title XVIII. There is already minimum mandatory. Do you realize if you commit a crime that is under the Federal jurisdiction, and you have a gun, whatever crime you committed if it has 10 years, you automatically get 5 more? Minimum mandatory, no probation, no parole, no discussion.

Now he also says we have to have mandatory restitution for crime victims. It is in the crime bill that the Republicans voted down. There is a provision allowing, for the first time, victims to show up at the sentencing procedure to say, "Judge, by the way, when you are sentencing that guy I want to remind you what he did to me"—giving some empowerment back to the victims. There is mandatory restitution, where the person who committed the crime committed the crime of violence against a woman or against a child.

And then he says, "And we have to restore Senator SIMPSON's provision requiring swift deportation of criminal aliens."

We do.

The conference report includes the summary deportation provision from the Senate bill—with slightly modified language. This provision would speed deportation by eliminating the requirement that a hearing be held and by eliminating layers of appeals.

The conference report also includes $160 million for the Immigration and Naturalization Service to hold deportation hearings in prisons—so criminal illegal aliens will be ready to be deported as soon as they have finished their sentences.

Last, he says we need flexibility and quotes Chief Fred Thomas of Washington, DC, saying there is not enough flexibility for the cop money coming into the cities. I called the chief. It surprised me. Let me quote the chief. He said, "I support the bill a thousand percent. Senator DOLE must have misunderstood me."

So I hope I have set the record straight for my friends and made it very clear that now that they know that all they wanted is in the bill, they can be for it. They can be for it. Let us find out. Let us find out whether this is politics or whether it is not.

Let me tell you, had they not delayed for 6 years, had we passed the registry law, which is in that bill, maybe, just maybe, young Megan would be alive today. Had the registry existed—she got killed the day after the House finished the conference. In fairness, she would not be alive because we could not get it done in time. But let me tell my colleagues something. If we delay, there are going to be more Megans, there are going to be more people in that situation because the bill now has those provisions.

I sincerely thank my friend. I know I keep intruding into this debate, but I want to tell him something, it is frustrating. If it is this frustrating on the crime bill, getting the facts out, I cannot fathom the difficulty my friend from New York as chairman of the Finance Committee is going through.

Mr. MOYNIHAN. Keep intruding.

Mr. BIDEN. I yield the floor and thank my colleagues.

The PRESIDING OFFICER. Who yields time? The Senator from Oregon.

Mr. PACKWOOD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. PACKWOOD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. PACKWOOD. Mr. President, much has been said that the Mitchell bill does, in essence, not upset anybody's present plans, is not compulsory, or nobody has to change very much. It overlooks, however, three groups that between them have someplace between 35 million and 40 million people covered with insurance, almost all of whom are satisfied with their current plans.

First, employers with 500 or fewer employees who self-insure. I will explain the difference on that.

You can cover your employees in, really, one of two ways: You can go out, buy insurance from Metropolitan Life or Continental Casualty or Blue Cross or Kaiser. They provide the benefits. You pay an insurance company to carry them.

Or you can do what is known as self-insure. You think to yourself, I am a stable enough employer. Rather than paying premiums to an insurance company, I, the employer, will pay the benefits myself. I will run that risk. Sometimes on occasion the employer will say, I cannot afford a catastrophic loss, and maybe they will insure for a loss over $15,000 or $20,000 or $25,000 or even $100,000 and say we will pay under that amount. They do not worry about negotiating with the insurance company. They manage their own plan. They can have their own wellness policies. They do not have to live with others' dictates. You have about 20 million employees who get their insurance from businesses with under 500 employees who self-insure.

Under the Mitchell bill, they will not be allowed to self-insure. That is out. They will have to buy through what is known as the community-rated pool. I am not going to get into a discussion of that tonight. But in essence it says, "all small employers will have to be thrown in. Five hundred, it is not small—500 or less, it has that pool. It has an interesting—I do not know if it is an intended or unintended effect, certainly on California. But my guess would be on other States also. Because this rule of 500 or less also applies to cities and counties and fire districts and school districts. California has Los Angeles and San Francisco and Oakland and San Diego and San Jose. California in many respects is like many States of the Union. They have scores and scores and scores of towns that have 5,000, 10,000, 15,000 people in them and they do not have 500 employees working for that town or that fire district or that school district. Yet they may be self-insured or they may buy insurance. They are out. They are going to have to come into this community pool.

I think most local governments are unaware of that in this provision, because most States do have some kind of a program that allows all of the municipal employees in the State from all kinds, big governments and small governments, to insure through one plan.

So there are 20 million people who are going to have to change.

Second, you have, and we refer very frequently with acronyms around here, MEWA, M-E-W-A, multiple employer welfare arrangements.

These are basically health plans that are offered by businesses, similar kinds of businesses. In my State, for example, the Timber Operators Council has a multiple employer welfare arrangement. We have about 26,000 enrolled people in it from all kinds of different companies—big companies, small companies. These are prohibited. They are out under the Mitchell bill. It does not matter what size they are, they are out. This has nothing to do now with the standard of 500. They have to go into the community pool, and buy their insurance.

And then you have association plans—Association of Building Contractors, Coca-Cola Bottlers. Here you have a community of interest, maybe franchise employees, but they are all in the same franchise as opposed to a MEWA where you have all kinds of different businesses. They have some business relation. But here you will have—Chamber of Commerce can have one, if they want. They are out. There are in some places between 10 and 20 million people in the multiple employer welfare associations and the trade associations that are now covered that will lose their form of insurance and have to go into the community pool.

I do not think most of them know this yet. So when the argument is made there is not going to be much change under the Mitchell bill, there is significant change for roughly 35 to 40 million people—employers with 500 or less, multiple employer welfare associations, trade associations—that are simply written out of existence and thrown into a common pot pool.

Mr. President, I yield to the Senator from Texas—how much time would he like?

Mr. GRAMM. I would like 10 minutes.

Mr. PACKWOOD. I yield 10 minutes to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas is recognized for 10 minutes.

Mr. GRAMM. Mr. President, let me thank my colleague from Oregon for yielding. I want to thank him for what he has done to let America understand the health care bill currently before us. I am a firm believer in the old Biblical admonition: You shall know the truth and the truth will make you free.

I am convinced that the more the American people know about this bill, the more they are going to be against it. I think we are going to see the same phenomenon we saw with the original Clinton health care bill. With the original Clinton bill, the President's rhetoric was so reassuring and so wonderful that it took time for the American people to discover that there was no relationship between his rhetoric and the provisions of his bill. What we are finding here, as we look at the health care bill pending before us now, is that the rhetoric continues to sound good, but the actual bill language continues to be bad.

Mr. President, I would like to focus on what the Nickles amendment is about. We know now the amendment is supported by the other side. They are not willing to defend the provision in the Mitchell bill that the Nickles amendment will strike, and for good reason: It is indefensible. But the amendment is important, nonetheless, because it focuses our attention on one of the two major issues in this debate.

One issue, as we all know, is the incredible cost contained in the Mitchell health care bill, a bill that when fully implemented will cost the American people $194 billion a year. Except for Ross Perot, nobody knows what $1 billion is. I know eyes glaze over when people at home hear me say that this bill, by Senator MITCHELL's own numbers, costs $194 billion a year when fully implemented. Their eyes glaze over when they hear that it provides taxpayer subsidies to 110 million people, when they hear that it sets up 45 new Government agencies, when they hear that it has over 170 mandates on people and local government and State government, when that hear that it imposes 18 new taxes to fund all of this new spending, and then it imposes costs directly on the consumer.

But since nobody knows what $194 billion is, let me give you a number that people will understand. For every family of four in America, that is over $3,200 a year that they are going to pay in taxes and indirect costs imposed on them to fund the Mitchell bill.

So the relevant question for people back home is not whether it be wonderful to give all these new benefits to 110 million people? Certainly it would be wonderful to provide these benefits. But the question that working Americans have to ask back home is, is providing these benefits worth $3,200 a year to me and to my family? And will the benefits be worth $3,200 a year to me?

Mr. President, I believe that when the people who do the work and pay the taxes and pull the wagon in America—not the people who have organized groups here clamoring for the passage of this bill—but the people who are calling up our offices opposing this bill, the people who are writing in overwhelming numbers against this legislation, when these people come to understand that—when fully implemented—the Mitchell bill is going to cost their family roughly $3,200 a year, they will conclude that this bill will not be a good buy for them. They will still pay for their health insurance, and the new mandated benefit will be between $5,000 and $6,000. I am talking about new costs for all the new government created in this legislation. Most Americans I know, especially those in Texas, already think we have too much Government.

The second issue is freedom. The second issue is whether this bill allows people to make choices? The President used to argue that his old bill preserved consumer choice. But the American people came to understand that under the original Clinton bill that was not so. If you did not work for the Federal Government—people in the Government were going to be treated differently than everybody else—or if you did not work for a company with 5,000 or more employees, which for a 1 percent tax could ransom you out of the system, your health insurance was going to be canceled and you were going to have to buy health care through a Government-run cooperative.

And the final kicker that finally awakened America was the $10,000 fine. I am sure my colleagues remember the $10,000 fine in the original Clinton bill imposed on anybody who tried to sell you private health insurance in competition with the Government.

The President went on and on about how free choice existed in his bill. But because the President was so convinced people would buy, given the choice, a private alternative, he put a $10,000 fine in his bill to prevent people from going outside the Government program to buy private health insurance. Once people came to realize that, despite the fact that many of our colleagues for a long time denied that that provision was in the bill, the Clinton plan was deader than Elvis.

The Nickles amendment has pointed out a new $10,000 fine, and this $10,000 fine is in the Mitchell–Clinton bill. It is a $10,000 fine imposed if you and your employer decide against the health insurance policy that the Government says you ought to have.

Let me explain basically how this works, and if this is what free choice for you and your family is about where you are from, then probably you do not have a problem with the Mitchell bill. But if the American town in which you live—not Washington—does not define free choice this way, maybe you have a problem with the Mitchell bill.

Under the Mitchell bill, the Government will tell you what has to be in your insurance. If you are a 64-year-old widower, the Government is going to tell you what coverage you will have to carry in your insurance policy. You will have to pay for pregnancy services and for newborn services. Even if you do not smoke and you do not drink, you are going to have to pay 12 percent more for alcohol and drug rehabilitation coverage. The Government is going to make you buy all of this insurance whether you want it or not.

Second, if you and your employer are buying other benefits, the Government is going to tax those benefits. It is going to impose a 35-percent tax on the benefit that you got in your health plan that the Government says you do not need. Then over time it is going to impose an income tax on you by treating your health benefit as income.

For example, if you were in the 31-percent tax bracket, and you already had an insurance policy you liked better than the Government's plan without alcohol and drug rehabilitation coverage because you do not drink and you certainly do not use drugs, you will have to pay 12 percent more for that coverage anyway. But if your plan covers services you do want, like orthodontist care for your children, the company that provides that benefit to you is going to have to pay a 35-percent tax on it, and if you are in the 31-percent tax bracket, you are going to have to ultimately declare it as income. You are going to have to pay a tax. So the Government is going to impose a 66-percent tax on that benefit.

Now, tell me if in your hometown this is freedom of choice. The Government tells you what you have to have. Whether you want it or you do not want it, you have got to buy it. The Nickles amendment takes out the $10,000 fine for not buying it, but you are still required to buy it. If adopted, the Nickles amendment simply removes the $10,000 fine, but it is still illegal not to do it.

Third, if you want health benefits the Government says you should not have, you can pay as much as a 66-percent tax on those benefits.

I was thinking, Mr. President, what do I own that I would be willing to pay a 66-percent tax to keep. Well, I do not want to get in trouble by saying I own my children and I own my wife, but I do own my dog, and I would pay a 66-percent tax to keep my dog. But there is nothing else I own—and I am a U.S. Senator—on which I would choose or could afford to pay a 66-percent tax to keep. I would not keep my house if there were a 66-percent tax imposed on

it. I would not keep my truck if there were a 66-percent tax imposed on it.

Now, you could say that I am free to keep my benefit if I am willing to pay that tax. But am I really free? Is the average working American really free when you say you can keep it but you have got to pay a 66-percent tax on it?

I do not think so.

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

Mr. GRAMM. That is why this bill needs to be defeated.

I yield the floor.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, the manager on this side, Senator PACKWOOD, has authorized me to speak up to 10 minutes.

The PRESIDING OFFICER. The Senator is recognized for up to 10 minutes.

Mr. SPECTER. Mr. President, I have sought recognition to support the amendment offered by the Senator from Oklahoma because I think it is excessive and punitive in calling for a $10,000 penalty for each violation with respect to each individual, and that the appropriate remedy here comes from the incentives in the bill on the subsidies and not from this kind of a punitive measure.

Having been involved for a long period of time as a district attorney, this kind of a punitive measure is very excessive compared to what we do when we talk about willful, deliberate criminal violations.

Perhaps of even greater importance, Mr. President, than an analysis of the punitive measure here, is the limitation on choice, a limitation on what the free market does by way of having individuals and employers and insurance carriers fashion policies which meet the needs of specific people far beyond what can be contemplated by Government on an elaborate statute or by a national health board.

The benefits which are outlined in the Mitchell bill on the benefits package do not include what some people might want to have if they are given freedom of choice.

We are struggling through as this debate is proceeding to analyze and figure out exactly what the consequences of this bill would be. As I understand the bill there are limitations on the benefits package offered by the Mitchell bill on dental care, on vision care. There is no provision for chiropractic services, podiatry, and there is no provision here for long-term care.

Now, some of these might be obtainable in a supplemental package, but why not allow people—employees and their employers—to structure a plan which people might want under what is called a cafeteria approach, which simply means that people can pick and choose from a longer list of options?

If someone is not of childbearing age, why have the limitations which would be for people who are of childbearing age?

This goes back to the amendment which was considered last night, the Dodd amendment, which was another example of bureaucratic limitations where the Government is going to tell people what they are going to buy, instead of allowing people to make their own choice for what their particular needs might be. The Dodd amendment provided that there could not be any policy sold which did not cover maternal care and child care. Now, that is fine for people who are of childbearing age, who need maternal care and who need child care. But if someone is out of that category, is beyond the age of giving birth or does not have that requirement, why should the Government mandate that no insurance policy can be sold unless it covers those kinds of services?

Now, on its face, you would think that it really does not mean what I have just described, but as we analyzed this bill, as best we can figure it out, that is precisely what it does.

Now, what is the rationale? What is the reason for that?

The reason would be to require people who were in their seventies to have an insurance policy which provides for maternal and child care, so as to lower the cost for other people who may want those services. But in a democratic free society we really ought to let people choose what it is they want.

The Congressional Budget Office—getting back to the Mitchell plan—has estimated that the costs of the Mitchell plan are considerably higher. For example, on a two-parent family, the Mitchell plan would cost $5,883 contrasted with $5,565. This increased cost, which does not include any of the premium taxes in the Mitchell bill, is primarily for the cost on a group of services which many people may not want.

The Mitchell plan also has total costs which are estimated, as best we can determine, at 30 percent higher than what the average American is currently paying, what employers are currently offering. So that an employer may be offering a lesser plan and be making up the difference to the employee in real wages.

Under the Mitchell plan, if you offer any health care at all, it has to conform to the rigid proposal of the Mitchell plan. So that an employer might decide that he is going to offer nothing at all rather than pay 30 percent more. So instead of getting more health care, we are actually receiving less health care if that choice is made. The mandate, that is, the requirement that the employer have coverage, does not become effective until a later date if 95-percent coverage is not achieved in a given State.

Mr. President, as I worked through the amendments and as I worked through the Mitchell plan, there is an amazing degree of complexity as opposed to the tradition in our society where an employer, in consultation with his employees, decides to offer a certain line of benefits. The employer then deals with an insurance company which can offer a wider variety of benefits than those which are enumerated in the Mitchell plan.

Then you have the discretion in a national health board to make certain changes with the benefits under the Mitchell bill.

We have all had experience in trying to deal with the bureaucracy. When individual needs, or an individual's desires, change, it would be nearly impossible to have to deal with a national health board. These are some of the inevitable consequences which arise when you have elaborate statutory requirements which establish rigid patterns instead of letting the market take care of itself, instead of letting people make their own individual choices.

So why not have people with the option to choose a basic benefits package of long-term care instead of prenatal care, if somebody is in the 65 to 70 age category instead of being bound by what this statute provides?

Similarly, with the Dodd amendment from last night where as a matter of statute there cannot be any cost-sharing requirements, it may well be that the Secretary of Health and Human Services might want to have some level of copayment. So that, if someone is very, very wealthy, they ought to have to contribute for services. Every time we turn around and take a look at the fine print, we discover that there are limitations on what people will be able to do by way of their own individual choice.

The Nickles amendment, which focuses only on the penalty which is excessive, comes back, analyzes the underlying provisions where there is a basic benefits package, which may not suit a given individual or a given employer. And under the present system, that kind of choice might be allowable.

As we speak, Mr. President, there are other plans which are in the process of being formulated, proposals by the so-called "mainstream group" where I have attended their meetings—some 19 Senators were present yesterday and today—trying to find something which is less bureaucratic than the Mitchell proposal, less bureaucratic than the 140 new agency boards and commissions created by the legislation advanced by Senator MITCHELL even more than the legislation proposed by President Clinton last October 27.

There are other proposals which are under consideration. The so-called Nunn-Domenici legislation which would be a much less onerous bureaucratic scheme. These proposals are designed to try to allow the maximum of choice so that people can buy the kinds

of programs they want without having some rigid standard imposed by the bureaucracy, and by the Federal Government.

So I support the Nickles amendment. I hope as we work through the complexities of the underlying legislation that we can improve upon it and give more people more choices with less rigidity and less bureaucracy.

Mr. President, I ask unanimous consent that Senator THURMOND be listed as cosponsor to the Nickles amendment, and that I also be listed as a cosponsor of the amendment.

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

Mr. SPECTER. I yield the floor.

Mr. DECONCINI addressed the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. All time is allotted on our side. Will Senator SPECTER yield 5 minutes on his side?

Mr. DECONCINI. Will the Senator yield 7 minutes?

Mr. SPECTER. I do.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MOYNIHAN. Mr. President, may I ask that the Senator from Pennsylvania [Mr. WOFFORD] be added as cosponsor?

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

The Senator from Arizona is recognized.

Mr. DECONCINI. Mr. President, I thank my colleagues. I did not think the time had all been allotted on our side.

I thank the Chair.

(The remarks of Mr. DECONCINI pertaining to the introduction of S. 2401 are located in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

Mr. NICKLES. Mr. President, I yield myself such time as I may use.

The PRESIDING OFFICER. The Senator has 14 minutes remaining.

Mr. NICKLES. Mr. President, I have a couple comments about the underlying amendment. It strikes the section that imposes civil penalties up to $10,000 for violations of this section. And that section would include offering a plan other than the standard benefit plan as defined by the Government.

It also has a couple of other sections that I want to let my colleagues know about, because I think I will try and do an amendment on this as well. Individuals that work for employers are prohibited from being offered a so-called alternative package. That is a package that has a high-cost deductible. Individuals can buy it, but employers cannot provide it for their employees. That is absurd. Yet, it is in this bill. It needs to be eliminated. I thought about doing that amendment first, but we decided to go with the fines. We need to remove that provision, which is on page 138.

I noticed with interest that my colleagues say it is the fine print. It is fine print, but it is one of the reasons that we have said we need to spend a little time on this bill. This bill was introduced—or at least brought to the Senate floor Friday at 5 o'clock. I believe only a couple of copies were available. The copies were produced en masse, I guess, and available on Saturday. The majority leader wanted to vote on Saturday and Monday, and that did not happen. So he was insisting on a vote on Tuesday. Some of us were saying we were not so interested in voting, not because we wanted to filibuster or hold the bill up, we wanted to find out what was in the bill.

This is a provision I found that troubled me, mainly because I was an employer. I had a self-insure plan, and I find out that if that plan is illegal, then if I tried to do some cost sharing on that self-insure plan, I would be subjected to a $10,000 fine per employee. We have about 65 or 70 employees. That is about $650,000 because I was not complying with this so-called section.

I am delighted that we are going to be successful in cleaning up this one amendment, but we still have not removed the provision that would prohibit an employer from offering an alternative package, one that has a higher deductible. We need to fix that. We still have not fixed the fact that we are going to tell everybody in America, no matter how happy they are with their plans, frankly, they have to be replaced with a Government-designed plan, the so-called standard benefit package.

I also want to respond to my colleagues who said some of these plans have standard benefit packages and some do not. The plan that I am a principal sponsor of is not a standard benefit package. It says, wait a minute, let us reform the Tax Code and give everybody a tax credit. That makes sense. If you are going to get the tax credit, you have to provide health benefits. We replaced the current income exclusion that excludes—if you are a generous employer and have health care, you do not have to pay a tax. That benefits people working for generous employers. But it does not do anything for anybody who does not subsidize the employees' health benefits, or anybody who does not have a job. The Tax Code, if it is going to help subsidize insurance, should be able to subsidize it for every American, whether they have a job or not. They need health care.

So that was the purpose of our bill. Well, to qualify for the tax credit, you have to provide health care, and we said, basically, just any catastrophic plan that would cover basic hospitalization and physician services.

Mr. President, as I mentioned, it is important to read the fine print because you might find something you do not like, like this enormous fine that was imposed if you did not comply with the dictates in the standard benefit package. Hopefully, we will take that out. I noticed in looking through the bill—and this will be subject to an amendment that I or one of my colleagues will offer. Maybe it will be a bipartisan amendment, and we can be successful in deleting this. I hope my friend from Massachusetts, who is on the floor, will join me in this amendment. That is section 10135 on page 1432. It says "no loss of coverage."

In no case shall the failure to pay amounts owed under this act result in an individual or family's loss of coverage.

In other words, individuals do not have to pay their premiums and they do not lose their coverage. That is an interesting concept. I think a lot of people will find out that is in the law. If you do not pay, you do not lose your coverage. I think that may be very attractive. It may encourage a lot of people not to pay.

Who does pay? This bill calls for——

Mr. KENNEDY. Mr. President, will the Senator yield on that point?

Mr. NICKLES. Mr. President, let me finish my point and then I will be happy to yield.

On page 1430, it says, "The shortfall will be paid half by the family," and on page 1422 "the other half by employers."

I think that is a ridiculous provision. It needs to be taken out. We have an amendment to take it out. I hope it can be done in a bipartisan fashion.

This bill requires a lot of reading. I have been reading quite a bit. I have not read it all yet. I am still working on it. There is a lot of fine print and a lot of provisions in this bill that really do not make sense, that really do not work very well.

Again, it is a conglomeration between the Labor Committee package and the Finance Committee package. We do not even have a report on the legislation. Most significant legislation that is reported out of committees has a committee report. The committee tells the Congress and tells the American people what it is comprised of. What does it mean? What does it mean in layman's language? We do not have that for this bill.

So the American people really have not had an explanation. When I had a press conference yesterday and I said under the Clinton-Mitchell package as presently drafted you are subjected to a $10,000 fine if you do not have your plan conform to the Government's standard mandated package, that is fact. We are going to eliminate the $10,000 fine but still have not eliminated that standard, mandated package.

So the cost of that package, which I alluded to earlier, is $5,888 per family. That is enormously expensive. A lot of plans in Tennessee, a lot of plans in Oklahoma, a lot of plans all across the country are not that expensive.

When I hear my colleagues say this bill does not have a mandate in it, an employer mandate, until the year 2000-something, I disagree because this is telling every employer that has a health care plan they have to have a very expensive health plan, one more expensive than many of them have today. And many employers are used to providing health care for employees. They want to continue to provide health care for employees. All of sudden now they are mandated the plan, the Government-defined package, which is enormously expensive, and they do not have lesser expensive options. They do not even have the option that individuals have as far as buying the alternative standard plan, one that has a bigger deductible. Individuals have that option under this bill, but employers do not.

I think that is a serious mistake. Who pays? Someone might say you are doing that trying to protect employers. No, because, frankly, if we do not make it more affordable for a lot of employers, a lot of employees are going to lose their jobs. A lot of employees will see a reduction in their take home pay because the Federal Government is mandating the plan that costs $6,000 per family and that business does not generate enough economic reward for that to happen or economic return for that to happen.

So the net result is either the individual loses the job, they have fewer employees, or have a reduction in pay. They do not get an increase or maybe even have a pay reduction to pay for this high Government mandate, this expensive plan.

I think that is a serious mistake. So we have eliminated it. If we are successful with the amendment—I expect we will be—we will eliminate the $10,000-per-employee fine, or at least we will eliminate it when it goes through the Senate. I am always concerned what will happen when this bill goes to conference and what will come back. But we eliminate the penalty.

But if we still mandate to employers, if you are going to provide health care, you have to provide the Government-designed plan, that is a mandate on all employers and in many cases it will dramatically increase their costs.

I know a lot of employers who have health care for families that costs $2,400 or $3,000, and if you mandate they provide insurance that costs $6,000, you have just increased it. That is the same thing as a tax of $3,000 per family, or per employer. It is a tax on jobs. It will cost jobs, and that is a mistake.

We have not remedied that with this amendment. We will eliminate the penalty, but we have not eliminated the mandate.

What happens if we do not eliminate the mandate is a lot of employers will find that it is in their interest to drop the plan. There is nothing to keep them from dropping the plan, so they will drop the plan.

What happens then? Well, unfortunately, when they drop the plan, a lot of those employees will go on subsidies, and the number of people who are subsidized under this bill rises by 57 million. I hope people are aware of that. Under this bill we will have 57 million more people on subsidies.

What about those employers who drop the plan? They can come back later, and the employer can qualify for subsidies and Uncle Sam will start paying almost 50 percent of the employer's cost share of those premiums. So there is a great incentive for employers to drop plans, employees to go on subsidy, and then the employer to come back and be subsidized later.

I think that is a serious mistake, and I hope we will not follow that.

I am delighted and hopeful that our colleagues will adopt this amendment. At least eliminate this very punitive, unfair fine that is in this proposal of $10,000 per employee if you do not conform to this plan.

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

The PRESIDING OFFICER. The Republican leader is recognized.

Mr. DOLE. Mr. President, let me say that given the broad support for the Nickles amendment, obviously bipartisanship is still alive and well in the Senate.

I think this is a very important amendment because they have been saying this plan is voluntary and what it boils down to is, if you do not volunteer for the one-size-fits-all standard benefits package, you can be fined $10,000 per employee.

Let us get this straight. The bill as presently written tells employers who are already providing coverage to their employees—coverage employees bargained for and may be completely satisfied with—that maybe they are in the wrong and they should be punished. You must provide coverage that carries the National Health Board seal of approval. It is not enough that you are satisfied.

I think the point that he is making with this amendment, I might say to the Senator from Oklahoma, is not that the fine is too high—it would be too high if it were 10 cents—it is just another example, it is just one small fix in this 1,400-some-page bill, that I do not think we will have time to fix. Every time we stumble across or someone reads about it and someone calls about it, oh, yes, that is right. We ought to fix this. And I just do not know how you do that in a few days.

I also want to include in the RECORD—it may already have been included in the RECORD—that in the crime bill we use the word "criminal" 437 times and 30 times in health care. We use the word "limit" 211 times in the health care and 33 times in the crime bill. We use the word "penalty" 112 times in health care and 53 times in the crime bill. We use the word "require" 755 times in the health care bill and only 207 times in the crime bill.

There are a lot of numbers in there. I thought maybe we were on the crime bill. This is the health care bill, right?

I want to put in the RECORD these figures put together by the National Taxpayers Union, because they use all these restrictive words. The crime bill uses 1,361 restrictive words and the Clinton-Mitchell health care bill uses 1,488 restrictive words.

Maybe the crime bill is not tough enough. I have to believe the health care bill is tough enough. If you violate or do not do this or do not do that, we have a penalty for you.

I think we ought to put those in the RECORD because I think a lot of taxpayers might like to know what they might expect, if by some strange event this bill should pass.

Mr. President, I ask unanimous consent to print this information from the National Taxpayers Union in the RECORD.

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

NATIONAL TAXPAYERS UNION FOUNDATION—NEWS

RESTRICTIVE LANGUAGE: THE CLINTON-MITCHELL HEALTH CARE BILL VS. THE CRIME BILL—AUGUST 15, 1994

An analysis by the National Taxpayers Union Foundation has uncovered a possible reason for last week's failure of the crime bill and the grave difficulties for the Clinton-Mitchell-Gephardt health reform bills: the health bill is too focused on criminalizing medicine, while the crime bill is too focused on providing care and services to criminals. Word counts on the different bills reveal that in many ways the Clinton-Mitchell health bill introduced 10 days ago uses much more restrictive language than the crime bill.

Highlights on the textual analysis include:

The "Crime" bill uses 1,361 restrictive words, while the Clinton-Mitchell Health Care Bill uses 1,488.

While the "Crime" bill uses the word "limit" 33 times, the Clinton—Mitchell health care bill uses it 211 times.

The "Crime" bill uses the term "penalty" 53 times, but the Clinton-Mitchell health care bill uses it 112 times.

While the "Crime" bill uses the term "require" 207 times, the Clinton-Mitchell health care bill uses it 755 times.

The term "restrict" was found 3 times in the "Crime" bill and 34 times in Clinton-Mitchell.

"Sanction" was found eight times in the "Crime" bill and 22 times in Clinton-Mitchell.

The word "violate" occurs 63 times in the "Crime" bill and 113 in Clinton-Mitchell.

WORD COUNTS: CLINTON-MITCHELL HEALTH CARE BILL VERSUS CRIME BILL

	Clinton-Mitchell Health Care Bill	"Crime" Bill
Ban	0	1

WORD COUNTS: CLINTON-MITCHELL HEALTH CARE BILL VERSUS CRIME BILL—Continued

	Clinton-Mitchell Health Care Bill	"Crime" Bill
Criminal	30	437
Enforce	104	221
Fine	13	46
Limit	211	33
Obligation	44	9
Penalty	112	53
Prison	14	219
Prohibit	36	61
Require	755	207
Restrict	34	3
Sanction	22	8
Violate	113	63
Total	1,488	1,361

NTUF uncovered last week that besides substantial use of this language of control, the Clinton-Mitchell health care bill also imposes seven new federal racial, ethnic, and geographic quotas on those going into medicine, and the specialties; creates 109 new crimes and penalties (compared with 89 in the original Clinton bill); and implements price controls.

JOHN E. BERTHOUD,
Vice President for Research.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. Mr. President, I yield 5 minutes to the distinguished Senator from South Dakota.

The PRESIDING OFFICER. The Senator from South Dakota is recognized.

Mr. DASCHLE. Mr. President, let me just make sure everyone understands what it is this amendment does.

First of all, it deletes the reference to $10,000. That is all it does. We have all cosponsored this particular amendment because we believe that there are other ways in which to achieve compliance, in the hope that we can begin working together on many of the issues. We will continue to find ways with which to try to work on many of these things together.

Mr. President, I want to go back to, again, the concerns expressed by many of our colleagues on the other side with regard to Federal requirements. Let me read again from the bill offered by the distinguished Senator from Oklahoma. I have great admiration for him, but it is as clear as clear can be. They eliminate the entire exclusion for employer-provided health insurance in this bill, page 31, probably the single biggest tax increase of any bill offered on health this year. If we are going to eliminate the entire deductibility for employers for health insurance, I cannot think of a bigger tax increase than that.

Second, I am reading now from the bill, subtitle B, federally qualified health insurance plan.

A federally qualified health insurance plan is a health insurance plan offered, issued or renewed on or after January 1, 1997, which is certified by the applicable regulatory authority as meeting the minimum requirements of sections 112 and 113.

Mr. President, if that is not what we are talking about here, benefits delineated, benefits required to be observed and adhered to, I do not know what is.

Let us go to the bill offered by our distinguished colleague from Rhode Island, Senator CHAFEE. I am reading the following from page 217. They were talking earlier about the concerns about taxes and the fines imposed for failure to comply. Here is what Senator CHAFEE would propose. I am reading from the bill:

There is hereby imposed a tax on the failure of any person or plan to comply with the requirements of section 1004 or 1201. The tax is $100 a day for lack of compliance.

Here it says the amount of the tax imposed shall be $100 per day, per employee.

Mr. President that is a $35,000 tax per year for failure to comply. So I think we better understand.

Mr. KENNEDY. Will the Senator yield?

Mr. DASCHLE. Yes.

Mr. KENNEDY. That means, if they had 10 employees, if they eliminate that for 10 employees, just that 1 employer, under this provision, it would be some $36,000.

Mr. DASCHLE. That is what it says on page 217 and 218.

Mr. KENNEDY. They describe that as a tax.

Mr. DASCHLE. And they call it a tax. The point is, in fact, we do not disagree, necessarily, with the need for some compliance. The bottom line is, we all recognize that we have all written bills that state the importance of having some minimal expectation of what these plans will do. Why do we do that? We do that very simply because we have been told over and over again, "If you fix one thing, take out the fine print. Take out the big surprises."

Let us make sure we do not pass a fine print guarantee here in the legislation we are passing. That is really what we are trying to do here.

There are too many cases where people have been adversely affected by the surprises that they are encountered with every time they need their insurance. We want to take the surprises out. We want to make sure there is competition, not on how we can confuse the public but how we can take benefits side by side and compare them adequately, just as we did with Medigap, just as we have done on other occasions, other consumer protections.

We recognize the need for forthright information, for truth and honesty in marketing. And that really is what this standard benefits plan will do.

Again, let me emphasize that is not the issue in this amendment. This amendment is simply one which deals with the $10,000 fine. We will deal with it. We will find other ways with which to ensure compliance. But let us make sure we all understand the importance of having minimal expectations for whatever plan we pass for health reform this year.

Mr. MOYNIHAN addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, my friend, the Republican manager, was generous in yielding time to the Senator from Ohio for discussions on another matter.

Their time having effectively expired, I would like to yield the balance of our time to the Senator from Oregon.

Mr. COATS. I do not know how much time we have, but I wonder if the Republican manager of the bill would yield me 1 minute.

Mr. PACKWOOD. The chairman has been very generous in yielding the rest of his time. I just want to find out how much it is.

The PRESIDING OFFICER. Four and a half minutes.

Mr. PACKWOOD. I want to yield some time to respond for the Senator from Oklahoma. I yield 3 minutes to the Senator from Oklahoma and the remainder of the time to the Senator from Indiana.

Mr. NICKLES. Mr. President, I would like to respond to my friend and colleague from South Dakota.

He alluded again to our consumer choice plan. I appreciate the attention it has received today and I hope it receives a lot more.

He said, "Well, he eliminated the tax exclusion. That is a large tax increase." What he fails to mention is we replaced it with a tax credit, a tax credit that was more generous than the tax exclusion. The tax exclusion on health care applies to people who work for employers. And if your employer subsidizes your health care, you do not have to pay taxes on what they pay. It is a nice benefit, if you have a generous employer. But it does not do anything for somebody that does not have a job and it does not do anything for somebody that works for an employer that does not pay or subsidize your health care.

So we say, let us replace that exclusion that has only been to a certain portion and make it a tax credit and make it universal, so I would like to correct my friend and colleague.

Then we say, to qualify, you have to offer tax benefits, but we do not define the benefits. We let people choose whatever they want.

Unfortunately, under the Clinton-Mitchell plan, you have to offer a Government-defined, mandated standard benefits package and if you offer something else, you are subject to a $10,000 fine. We are going to get rid of that $10,000 fine. But we still have the Government mandating that you have to provide a very expensive, extensive health benefit of about $6,000 per family, which, unfortunately, a lot of families cannot afford.

I thank my friend and colleague from New York for yielding the time.

Mr. President, I ask unanimous consent that Senator COVERDELL and Senator THURMOND be added as cosponsors.

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

The Senator from Indiana.

Mr. COATS. Mr. President, I find it somewhat ironic that, just a couple of days after the majority leader and others of our colleagues criticized the Republicans for trying to take some time to find out what is in the bill, now we are told that we ought to find out what the surprises are in the Mitchell bill and eliminate those surprises. I think that is what we were trying to do. We were trying to work through this 1,443 page bill.

We have learned that graduate medical education is a potential serious problem. We have learned now that there is a $10,000 fine that no one even knew about.

It is hard for me to understand how our colleagues, on the one hand, can say you have had plenty of time to understand all of this, and now they are standing up, saying, "Well, we did not know about this, either, so we will join with you in taking it out." I just do not think you can have it both ways.

The bottom line is, this is a massive bill, full of surprises. The more we read it, the more surprises we find.

And so, our request for some time to understand what is in this bill before we impose it on the American people, I think, is a legitimate request. I am glad we are now working through the process. I just wonder how many more surprises we are going to find.

But I am pleased that our colleagues are joining us in exposing the problems in the Mitchell bill and beginning, piece by piece, to eliminate those surprises so that we understand what it is we are voting on when we finally have this vote.

If there is any time remaining, I am happy to yield it back.

The PRESIDING OFFICER. Who yields time?

Mr. PACKWOOD. Mr. President, I yield back the remainder of the time I have.

The PRESIDING OFFICER. All time is yielded back.

Mr. PACKWOOD. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There appears to be.

The yeas and nays were ordered.

VOTE ON AMENDMENT NO. 2563

The PRESIDING OFFICER. The vote now occurs on amendment No. 2563, offered by the Senator from Oklahoma [Mr. NICKLES].

The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 100, nays 0, as follows:

[Rollcall Vote No. 289 Leg.]

YEAS—100

Akaka	Boren	Bumpers
Baucus	Boxer	Burns
Bennett	Bradley	Byrd
Biden	Breaux	Campbell
Bingaman	Brown	Chafee
Bond	Bryan	Coats
Cochran	Heflin	Murkowski
Cohen	Helms	Murray
Conrad	Hollings	Nickles
Coverdell	Hutchison	Nunn
Craig	Inouye	Packwood
D'Amato	Jeffords	Pell
Danforth	Johnston	Pressler
Daschle	Kassebaum	Pryor
DeConcini	Kempthorne	Reid
Dodd	Kennedy	Riegle
Dole	Kerrey	Robb
Domenici	Kerry	Rockefeller
Dorgan	Kohl	Roth
Durenberger	Lautenberg	Sarbanes
Exon	Leahy	Sasser
Faircloth	Levin	Shelby
Feingold	Lieberman	Simon
Feinstein	Lott	Simpson
Ford	Lugar	Smith
Glenn	Mack	Specter
Gorton	Mathews	Stevens
Graham	McCain	Thurmond
Gramm	McConnell	Wallop
Grassley	Metzenbaum	Warner
Gregg	Mikulski	Wellstone
Harkin	Mitchell	Wofford
Hatch	Moseley-Braun	
Hatfield	Moynihan	

So the amendment (No. 2563) was agreed to.

Mr. MOYNIHAN. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

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

The motion to lay on the table was agreed to.

Mr. MOYNIHAN. Mr. President, I would just like to observe that on this, the second vote on the Mitchell amendment, we have had a bipartisan vote of 100–0. A bipartisan measure has been adopted. It is a good sign.

I yield the floor.

Mr. PACKWOOD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. FEINGOLD). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. FORD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

THE CALENDAR

Mr. FORD. Mr. President, I ask unanimous consent that the Senate proceed en bloc to the immediate consideration of calendar Nos. 568 and 574; that the bills be read three times, passed, and the motion to reconsider be laid upon the table en bloc; further, that any statements relating to these calendar items appear at the appropriate place in the RECORD; and that the consideration of these items appear individually in the RECORD.

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

WARREN B. RUDMAN U.S. COURTHOUSE

A bill (S. 2073) to designate the U.S. courthouse that is scheduled to be constructed in Concord, NH, as the "Warren B. Rudman United States Courthouse," and for other purposes, was considered, ordered to be engrossed for a third reading, read the third time and passed as follows:

S. 2073

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

SECTION 1. DESIGNATION OF WARREN B. RUDMAN UNITED STATES COURTHOUSE.

The United States courthouse that (as of the date of enactment of this Act) is scheduled to be constructed in Concord, New Hampshire, shall be known and designated as the "Warren B. Rudman United States Courthouse".

SEC. 2. LEGAL REFERENCES.

Any reference in a law, regulation, document, record, map, or other paper of the United States to the courthouse referred to in section 1 shall be deemed to be a reference to the "Warren B. Rudman United States Courthouse".

THOMAS F. EAGLETON U.S. COURTHOUSE

A bill (H.R. 4790) to designate the U.S. courthouse under construction in St. Louis, MO, as the "Thomas F. Eagleton United States Courthouse," was considered, ordered to a third reading, read the third time and passed.

Mr. FORD. I thank the Chair, I thank my colleague and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. DASCHLE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

HEALTH SECURITY ACT

The Senated continued with the consideration of the bill.

AMENDMENT NO. 2564

(Purpose: To improve the access of individuals in rural areas to quality health care)

Mr. DASCHLE. I have an amendment at the desk. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from South Dakota [Mr. DASCHLE], for himself, Mr. HARKIN, Mr. ROCKEFELLER, Mr. BAUCUS, and Mr. REID, proposes an amendment numbered 2564.

Mr. DASCHLE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

On page 112, line 6, insert "including residents of rural areas" before the period.

On page 215, line 10, strike "(c)" and insert "(d)".

On page 215, between lines 9 and 10, insert the following new subsection:

(c) TRANSFER OF DUTIES.—Effective January 1, 1996, the functions, powers, duties, and authority that were carried out in accordance with Federal law by the Office of Rural

Health Policy in the Department of Health and Human Services are transferred to the Office of the Assistant Secretary for Rural Health in the Department of Health and Human Services.

On page 612, line 24, insert before the period the following: ", at least one of whom resides in a rural area".

On page 613, line 9, insert before the period the following: ", at least one of whom resides in a rural area".

On page 647, strike lines 25 and 26, and insert the following:

"For purposes of carrying out section 3341, there are authorized to be appropriated $15,000,000 for each of the fiscal years 1997 through 2001.".

On page 664, line 10, strike "or health professional shortage areas" and insert "area, health professional shortage area, or other rural underserved area (as designated by the Governor)".

On page 651, between lines 9 and 10, add the following new paragraph:

(3) SUBPART F.—For the purpose of providing funds under subpart F, there are authorized to be appropriated $10,000,000 for each of the fiscal years 1996 through 2000.

On page 652, line 18, strike "and".

On page 652, between lines 18 and 19, insert the following new paragraph:

"(7) rural health clinics, except that for-profit rural health clinics shall only be eligible for direct loans and grants under subpart C; and".

On page 652, line 19, strike "(7)" and insert "(8)".

On page 653, after line 23, add the following new subsection:

(f) PURPOSES AND CONDITIONS.—Grants shall be made under this part for the purposes and subject to all of the conditions under which eligible entities otherwise receive funding to provide health services to medically underserved populations under the Public Health Service Act. The Secretary shall prescribe comparable purposes and conditions for eligible entities not receiving funding under the Public Health Service Act, including conditions with respect to the availability of services in the area served (as provided for in section 330(e)(3)(A) of such Act), and conformance of fee and payment schedules with prevailing rates (as provided for in section 330(e)(3)(F) of such Act). With respect to federally qualified health centers, such comparable purposes and conditions shall include conditions concerning sliding fee scales under section 1128B(b)(3)(D) of the Social Security Act and waivers of deductibles under section 1833(d) of such Act.

On page 672, line 1, strike the subsection heading and insert "FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS".

On page 673, line 3, insert "and rural health clinics" after "Act)".

On page 675, between lines 16 and 17, add the following new subpart:

Subpart F—Rural-Based Managed Care Grants

SEC. 3467. RURAL-BASED MANAGED CARE GRANTS.

(a) IN GENERAL.—The Secretary shall award grants for the development and operation of rural-based managed care networks that integrate the medicare population of the area served.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an applicant organization shall—

(1) prepare and submit to the Secretary an application, at such time, in such manner and containing such information as the Secretary may require;

(2) be based or provide services in rural or rural underserved areas; and

(3) be currently operating or in the process of establishing a provider network serving the nonmedicare population .

(c) USE OF FUNDS.—Funds provided under a grant under this section may be used—

(1) for the development and implementation of rural-based managed care networks;

(2) for data and information systems, including telecommunications;

(3) for meeting solvency requirements for a risk-bearing entity under the medicare program under title XVIII of the Social Security Act;

(4) for the recruitment of health care providers; or

(5) for enabling services, including transportation and translation.

(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to—

(1) applicants that will use amounts received under the grant to develop and operate rural-based managed care networks that would serve at least one rural underserved area; and

(2) applicants that involve local residents and providers in the planning and development of the rural-based managed network.

(e) DEFINITIONS.—As used in this section

(1) RURAL AREA.—The term "rural area" means a rural area as described in section 1886(d)(2)(D) of the Social Security Act.

(2) UNDERSERVED RURAL AREA.—The term "underserved rural area" means a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e) or an area designated as underserved by the Governor of a State taking into account—

(A) financial and geographic access to health plans by residents of such area; and

(B) the availability, adequacy, and quality of qualified providers and health care facilities in such area.

(f) STUDY.—The Secretary shall study different risk-bearing approaches for rural managed care and payment methodologies that differ from or modify the medicare average area per capita cost payment methodology.

Beginning on page 675, strike line 24 and all that follows through line 4 on page 676, and insert the following: "priated $314,000,000 for fiscal year 1996, $285,000,000 for fiscal year 1997, $365,000,000 for fiscal year 1998, $382,000,000 for fiscal year 1999, $386,000,000 for fiscal year 2000, $91,500,000 for fiscal year 2001, $53,350,000 for fiscal year 2002, $38,100,000 for fiscal year 2003, and $38,100,000 for fiscal year 2004, of which $2,000,000 shall be made available in each of the fiscal years 1996 through 2000 to carry out section 338L of the Public Health Service Act.".

On page 676, line 10, strike "NURSES" and insert "ADVANCED PRACTICE NURSES AND PHYSICIAN ASSISTANTS".

On page 676, line 20, strike "nurse anesthetists" and insert "nurse anesthetists or physician assistants".

On page 676, lines 21 and 22, strike "nurse anesthetists" and insert "nurse anesthetists or physician assistants".

On page 677, between lines 13 and 14, add the following new parts:

PART 4—ANTITRUST SAFE HARBORS FOR RURAL HEALTH PROVIDERS

SEC. 3491. ANTITRUST SAFE HARBORS FOR RURAL HEALTH PROVIDERS.

(a) IN GENERAL.—The Attorney General, in consultation with the Commissioner of the Federal Trade Commission, shall clarify existing and future policy guidelines, with respect to safe harbors, by providing additional illustrative examples with respect to the conduct of activities relating to the provision of health care services in rural areas.

(b) DISSEMINATION OF INFORMATION.—The Attorney General, in consultation with the Commissioner of the Federal Trade Commission and the Assistant Secretary for Rural Health, shall develop methods for the dissemination of the guidelines established under subsection (a) to rural health care providers.

PART 5—EMERGENCY MEDICAL SYSTEMS

SEC. 3495. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d-51 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

"(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

"(b) APPLICATION AND PLAN.—

"(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

"(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

"(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

"(B) demonstrate that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

"(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

"(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

"(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

"(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

"(G) demonstrate that the State, in utilizing the grant proceeds, will—

"(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received; and

"(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year

preceding the fiscal year for which the financial assistance is received;

"(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan; and

"(I) contain such other information as the Secretary may determine appropriate.

"(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

"(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

"(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

"(d) STATE ADMINISTRATION AND USE OF GRANT.—

"(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

"(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

"(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

"(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

"(f) REPORTS.—

"(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

"(A) a description of the manner in which the grant proceeds were utilized;

"(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

"(C) such other information as the Secretary may require.

"(2) TERMINATION OF FUNDINGS.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

"(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for fiscal year 1995, and such sums as may be necessary for each for fiscal years 1996 and 1997.".

Beginning on page 718, strike line 23 and all that follows through line 5 on page 719, and insert the following new paragraph:

"(8) with respect to the National Health Service Corps program referred to in section 3471, $314,000,000 for fiscal year 1996, $285,000,000 for fiscal year 1997, $365,000,000 for fiscal year 1998, $382,000,000 for fiscal year 1999, $386,000,000 for fiscal year 2000, $91,500,000 for fiscal year 2001, $53,350,000 for fiscal year 2002, $38,100,000 for fiscal year 2003, and $38,100,000 for fiscal year 2004, of which $2,000,000 shall be made available in each of the fiscal years 1996 through 2000 to carry out section 338L of the Public Health Service Act;".

On page 720, line 22, strike "; and" and insert a semicolon.

On page 720, between lines 22 and 23, insert the following new paragraph:

"(14) with respect to the development of rural telemedicine under section 3341, $15,000,000 for each of the fiscal years 1997 through 2001; and".

On page 720, line 23, strike "(14)" and insert "(15)".

On page 725, strike lines 7 through 11, and insert the following:

"(6) in subsection (l), by striking paragraph (1) and inserting the following new paragraph:

" '(1) IN GENERAL.—The Secretary shall use amounts made available under section 3471 of the Health Security Act to carry out this section in each of the fiscal years 1996 through 2000.' ".

On page 777, line 18, strike "and medical assistance facilities".

On page 780, line 3, insert "In the case of payment under this subsection to medical assistance facilities, the lesser-of-cost-or charges provisions under subsection (j) are not applicable." after "services.".

Beginning on page 808, strike line 16 and all that follows through page 809, line 4, and insert the following:

(2) by inserting "described in paragraph (2) and services furnished by a physician assistant, nurse practitioner, or a clinical nurse specialist described in such paragraph that would by physicians' services if furnished by a physician" after "physicians' services",

(3) by inserting "physician assistant, nurse practitioner, or a clinical nurse specialist" after "physician",

(4) by striking "10 percent" and inserting "the applicable percent", and

(5) by adding at the end the following new paragraph:

"(2)(A) The applicable percent referred to in paragraph (1) is—

"(i) in the case of physicians' services that are primary care services, a percent determined by the Secretary that may not be less than 10 percent and may not exceed 20 percent,

"(ii) in the case of services furnished by a physician assistant, nurse practitioner, or a clinical nurse specialist described in such paragraph that would be physicians' services that are primary care services if a physician furnished the services, a percent to be determined by the Secretary that is equal to the percent determined in clause (i) and determined so that the total amount of such payments under this clause and clause (i) is equal to the amount that would have been paid under clause (i) if the applicable percent for such clause was equal to 20 percent, and

"(iii) in the case of physicians' services other than primary care services furnished in a health professional shortage area located in a rural area (as defined in section 1886(d)(2)(D)), 10 percent.

On page 873, line 20, insert "urban and rural" after "representative of the".

On page 874, line 1, insert ", at least one of whom resides in a rural area" before the first period.

On page 874, line 4, insert ", at least one of whom resides in a rural area" before the first period.

On page 1390, line 22, insert "and that at least one member of the Commission is a resident of a rural area" before the period at the end.

Mr. DASCHLE. I have a lengthier statement that I wish to make, but I will yield to the Senator from Iowa because I understand his time constraints and would yield at this time whatever time he may consume.

Mr. HARKIN. Mr. President, I first want to compliment my friend and my colleague from South Dakota for introducing this amendment. I am pleased to be a cosponsor of it.

I wish to thank again Senator DASCHLE for all of his hard work not only on the whole issue of health care reform in America but for his paying especially close attention to the needs in rural America to be addressed specifically in any health care reform that we pass.

Rural America is not like urban America, and too often we lose sight of the fact that what may work in New York City or Boston or other places like that will not necessarily work in a rural State like South Dakota or Iowa or many of our rural States. And so the amendment offered by the Senator from South Dakota builds on the provisions in the Mitchell bill that will expand coverage for Americans in our rural towns and communities.

Mr. President, perhaps nowhere else is the health care crisis more acute than in rural America. Rural Americans are more often poor, more often uninsured, and more often without access to health care.

Now, the Mitchell bill provides funding to build up the health care infrastructure in rural areas. It provides grant money and loans to help local communities develop health care networks and plans. There are many provisions in the underlying Mitchell bill and in the Daschle amendment that speak to the different needs in rural America. There are many provisions in the Daschle amendment that strengthen those underlying provisions.

I wish to focus my remarks particularly on one of those provisions included in the Daschle amendment, and that is that part which provides funding for a grant program that will expand access to health services in rural areas through the use of telemedicine.

Over a year ago, I introduced similar legislation and have worked with Senator CONRAD from North Dakota to develop what is now in the underlying Mitchell proposal. The amendment now under consideration will ensure that this grant program is funded.

The grant program in the Mitchell bill would encourage the development

of telemedicine networks which can play a critical role in ensuring that people in rural areas have access to high quality health care. Telemedicine puts technology to work to improve the delivery of health care. It uses technology to link patients and their doctors in rural or remote hospitals with highly trained medical specialists in state-of-the-art medical technology located hundreds or even thousands of miles away. These linkages will allow more patients to receive care in their community and will ease the burden on specialists in underserved areas. By increasing the education and training opportunities for providers in these areas, these links will also help underserved communities recruit and retain physicians.

Telemedicine will help ensure that people who live in small towns and rural communities have the same access to quality health care as people living in Beverly Hills or in Palm Beach. As I said, Mr. President, by having these telemedicine networks, it will certainly help provide for the training, the education, and I think, the recruitment and retaining of physicians and other health specialists in rural areas.

Too often, doctors who might otherwise want to serve in a rural area feel they do not have access to the latest technology and the latest diagnostic services. They are sort of out there on a limb in many cases when people need emergency medical care and they may not have that kind of ready access to the special care that they would otherwise be able to get in an urban area.

Well, telemedicine can provide to that primary care physician or a physician's assistant or a nurse practitioner, a nurse midwife, other health care professionals can provide for them that kind of backup they need.

Rural hospitals and other facilities can benefit from the cost savings and the access to specialists that telemedicine provides.

For example, a family doctor in Muscatine, IA, could immediately consult with a specialist at the University of Iowa for an instant diagnosis in a life or death situation. A specialist at Mercy Hospital in Des Moines could provide emergency advice and even help oversee a difficult surgery taking place in a small hospital in Centerville, IA, and a radiologist at Methodist Hospital in Des Moines could help examine x rays just taken in the small town of Jefferson, IA.

My home State of Iowa, Mr. President, has developed a world-class fiber-optic system that holds great potential in the area of telemedicine. These fiber-optic cables greatly enhance the potential of telemedicine because they carry not only more information than traditional copper wires but they also provide more clarity—clearer pictures, higher resolution—than copper wires.

The Iowa Legislature just this year, Mr. President, voted to extend our fiber-optic system to all of the hospitals in Iowa. That should be done I think by next year sometime. With that kind of system, here is what telemedicine will provide, for example.

Let us say that there was a car accident in a remote, rural area of Iowa. They had access to a small clinic or a small rural hospital but with no special care there. X rays could be taken, and those x rays could be sent over fiber-optics to be read immediately by a radiologist, say, in Des Moines or Omaha, maybe even at the Mayo Clinic in Rochester for northern Iowans and a decision could be made whether or not that person needed to be moved to a more intensive care unit or whether that person could remain in the smaller rural hospital, thus saving great amounts of money.

There are all kinds of possibilities for rural doctors to use telemedicine to ensure that they get the latest information and the latest diagnostic techniques to a rural clinic in a small town.

Telemedicine will allow patients to stay close to home for support. For most people, one of the most traumatic times is when they are sick or injured, and we should be helping them stay with their family and friends.

I am not saying there will be times when people will not have to go far away from home for treatment, nor am I saying that telemedicine will replace local doctors or the need for specialists. But whenever possible, telemedicine will facilitate local care and provide needed relief for overworked small town doctors, nurses, and other health care providers.

I have looked over very carefully Senator MITCHELL's bill because on the Labor and Health Committee I was very much involved with other Senators in putting in very strong provisions for rural health care, and those provisions basically have been adopted in the Mitchell bill—not all of them, most of them. Those positions are strengthened now by the Daschle amendment.

Senator MITCHELL's bill will expand access to care for rural Americans, access to the Federal Employees Health Benefits plan, or another purchasing cooperative will help keep the cost of coverage down for rural residents. Many people in the rural areas are either self-employed or work in small businesses, and currently pay much more than big businesses for the same benefits. And they face much higher administrative costs.

The insurance reform provisions in the Mitchell bill are critical for rural residents, particularly for our farmers. Farming is now the most dangerous occupation in America with annual death rates at 52 per 100,000 workers, almost five times the national average. Under the Mitchell bill, farmers will have access to a community rated plan. This means that farmers in a given area will be charged the same premium for health insurance regardless of their occupational risk. In addition, health plans will not be able to deny coverage because of preexisting conditions.

Under the current system, the self-employed can only deduct 25 percent of the cost of health insurance while, of course, corporations can deduct the full cost of coverage. The Mitchell bill would raise the deduction for the self-employed to 50 percent. I support this increase. Senator WOFFORD, who I see is on the floor, and I intend to offer an amendment that will raise this to 100 percent.

I again want to compliment the Senator from Pennsylvania for his leadership. He understands that our farmers and our self-employed ought to have the same kind of tax deduction as a large business would have in providing for their own health insurance. I congratulate Senator WOFFORD for taking a leadership position in this area.

Allowing the self-employed to deduct the full 100 percent of the costs of the premium is critical in rural areas where the only health plan available is often a more expensive fee-for-service plan. It is time that we put the self-employed and corporations on equal footing. Again, that is not addressed in this amendment but will be addressed in the amendment to be offered by Senator WOFFORD.

To address the critical need for health care providers in rural areas the Mitchell bill focuses on training more primary care doctors, and also provides incentives for health providers to locate in rural areas.

The Mitchell bill would increase funding for the National Health Service Corps, which places about 55 percent of their providers in rural areas. The amendment offered by Senator DASCHLE would expand support for this program. Forty National Health Service Corps members are currently providing care in 20 sites in Iowa. And yet there is still a shortage of providers in many of our Iowa communities. We have 18 counties in Iowa that do not have a doctor that will deliver babies, and an additional 14 counties have only one doctor who will deliver babies. Right now with the National Health Service Corps we have 47 bases in Iowa right now. These are communities who are eligible, and who have applied, and are on the waiting list to get a National Health Service Corps provider.

The need to expand funding for the National Health Service Corps is very clear. Last year there were 4,000 applications, and yet we were able to fund only 406 of those applications. The funding provided by the Daschle amendment will allow us to return the National Health Service Corps to its strength prior to 1980 when the program was gutted.

Again, I point out that there are provisions in the so-called Dole bill that would provide authorization for expanded funding for National Health Service Corps.

Mr. President, with the budget caps and the ceilings that we have on right now, that authorization is worthless. It is meaningless. It sounds nice. But it does not do anything. So the Dole bill really does not address the need to fund the National Health Service Corps. The Daschle amendment does. It provides a stream of funding for the National Health Service Corps.

So some get up and say perhaps this is the same as in the Dole bill. It is quite a bit different, Mr. President. This provides the funding. The Dole bill only provides the promise.

In order to recruit doctors and nurses to rural areas, the Mitchell bill also provides tax credits for primary care providers serving in underserved areas.

I am also pleased that the amendment offered by Senator DASCHLE would expand support for rural health clinics. Rural health clinics are located in health professional shortage areas, and are often the only source of care in a community.

I have visited a number of these in Iowa, including the Redfield Clinic in Redfield, IA. Most of the patients in this clinic are seen by Ed Friedman, a physician's assistant, who also sees patients in five area nursing homes. Physicians visit the clinic once a week, and are always available by phone.

Over one-half of the patients seen in this clinic are Medicaid or Medicare patients. Of course, with telemedicine, Ed Friedman, a physician's assistant, will have ready access at all times to specialists in Iowa, and perhaps even in other States to back him up.

This rural health clinic in Redfield is an essential element of the health care system in rural Iowa. I am pleased that the amendment offered by Senator DASCHLE will provide assistance for clinics such as this one.

Mr. President, I am pleased to support the amendment offered by Senator DASCHLE.

I urge its adoption by my colleagues.

Again, I will close my remarks by complimenting the Senator from South Dakota by focusing our attention on rural health care.

I believe the bill that we reported out of the labor and health committee addressed these issues. Now for whatever reason they were not as tightly formed in the Mitchell bill. But this amendment addresses that, brings them up to speed, and brings these back up to the level we had in the labor and health bill, but for the provision of the 100 percent deductibility, and for which, as I said earlier, an amendment will be offered to correct that by Senator WOFFORD from Pennsylvania.

Mr. President, as we continue the debate on the health care reform bill, and we continue all the talking about this amendment, and that amendment about employer mandates and other things that we are going to be talking about, let us not lose sight of the fact that people who live in rural America, as I said, are more often poor and more often underserved than anywhere else in this country.

If any group of Americans need health care reform, it is the people who live in our small towns in rural America. They are not getting access because they do not have the providers. They do not have the providers because the system is skewed against providers being able to serve in underserved areas.

The Mitchell bill addresses all of that. It does it in a very forthright manner. The Daschle amendment enhances that and strengthens that, especially, as I point out one more time, in funding for the National Health Service Corps. That is most critical to make sure that our people in rural areas have the kind of access and quality of care that they not only need, but they deserve.

Mr. President, I thank the Senator from South Dakota for yielding this time.

I yield the floor.

STATEMENT UNDER SECTION 27 OF THE CONCURRENT RESOLUTION ON THE BUDGET

Mr. SASSER. Mr. President, on behalf of the Committee on the Budget, under section 27 of the concurrent resolution on the budget, House Concurrent Resolution 218, I hereby submit revised budget authority and outlay allocations to the Senate Committee on Finance and revised aggregates in connection with the Daschle amendment to the Mitchell substitute amendment (number 2560) to S. 2351, the Health Security Act.

Section 27 of the budget resolution states, in relevant part:

SEC. 27. DEFICIT-NEUTRAL RESERVE FUND IN THE SENATE.

(a) * * *

(2) BUDGET AUTHORITY AND OUTLAY ALLOCATIONS AND REVENUE AGGREGATES.—In the Senate, budget authority and outlays may be allocated to a committee (or committees) and the revenue aggregates may be reduced (as provided under subsection (c)) for direct-spending or receipts legislation in furtherance of any of the purposes described in subsection (b)(2) within that committee's jurisdiction, if, to the extent that this concurrent resolution on the budget does not include the costs of that legislation, the enactment of that legislation will not increase (by virtue of either contemporaneous or previously passed deficit reduction) the deficit in this resolution for—

(A) fiscal year 1995; or

(B) the period of fiscal years 1995 through 1999.

* * * * *

(b) * * *

(2) PURPOSES UNDER SUBSECTION (a)(2).—Budget authority and outlay allocations may be revised or the revenue floor reduced under subsection (a)(2) for—

* * * * *

(B) to make continuing improvements in ongoing health care programs, to provide for comprehensive health care reform, to control health care costs, or to accomplish other health care reforms;

* * * * *

(c) REVISED ALLOCATIONS AND AGGREGATES.—

(1) UPON REPORTING.—Upon the reporting of legislation pursuant to subsection (a), and again upon the submission of a conference report on that legislation (if a conference report is submitted), the chairman of the Committee on the Budget of the Senate may submit to the Senate appropriately revised allocations under sections 302(a) and 602(a) of the Congressional Budget Act of 1974 and revised aggregates to carry out this section.

(2) ADJUSTMENTS FOR AMENDMENTS.—If the chairman of the Committee on the Budget submits an adjustment under this section for legislation in furtherance of the purpose described in subsection (b)(2)(B), upon the offering of an amendment to that legislation that would necessitate such a submission, the chairman shall submit to the Senate appropriately revised allocations under sections 302(a) and 602(a) of the Congressional Budget Act of 1974 and revised aggregates, if the enactment of that legislation (as proposed to be amended) will not increase (by virtue of either contemporaneous or previously passed deficit reduction) the deficit in this resolution for—

(A) fiscal year 1995; or

(B) the period of fiscal years 1995 through 1999.

(d) EFFECT OF REVISED ALLOCATIONS AND AGGREGATES.—Revised allocations and aggregates submitted under subsection (c) shall be considered for the purposes of the Congressional Budget Act of 1974 as allocations and aggregates contained in this concurrent resolution on the budget.

On August 9, 1994, I submitted an adjustment under this section for S. 2351, the Health Security Act. Within the meaning of section 27(c)(2) of the budget resolution, the Health Security Act constitutes "legislation in furtherance of the purpose described in subsection (b)(2)(B)."

The Daschle amendment to the Health Security Act also meets the other requirement of section 27(c)(2) of the budget resolution that

the enactment of that legislation (as proposed to be amended) will not increase (by virtue of either contemporaneous or previously passed deficit reduction) the deficit in this resolution for—

(A) fiscal year 1995; or

(B) the period of fiscal years 1995 through 1999.

As the Daschle amendment to the Health Security Act complies with the conditions set forth in the budget resolution, under the authority of section 27(c)(2) of the budget resolution, I hereby submit to the Senate appropriately revised budget authority and outlay allocations under sections 302(a) and 602(a) and revised aggregates to carry out this subsection.

Note that, as this reserve fund submission accommodates an amendment, it covers the time that the amendment

is either pending or adopted (if the amendment is adopted). If the Senate rejects the amendment, this reserve fund submission shall lapse, and the allocations and aggregates shall revert to the levels they would have in the absence of this reserve fund submission.

There being no objection, the tables were ordered to be printed in the RECORD, as follows:

RESERVE FUND FILING PURSUANT TO SECTION 27 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FY 1995—DASCHLE RURAL AMENDMENTS

[Adjustments to aggregates and allocations; dollars in billions]

Aggregate totals	1995	1996	1997	1998	1999
Budget authority	$0.000	$0.125	$0.165	$0.180	$0.205
Outlays	0.000	0.060	0.130	0.168	0.190
Revenues	0.000	0.060	0.130	0.168	0.190

	1995	1995–99
Finance Committee allocations:		
Budget authority	$0.000	$0.675
Outlays	0.000	0.548
Revenue allocations	0.000	0548

AMENDMENT NO. 3: DASCHLE RURAL AMENDMENTS (NO.)

[In billions of dollars]

	1995	1996	1997	1998	1999	15-year
MANDATORY CHANGES						
Budget authority	$0.000	0.125	0.165	0.180	0.205	0.675
Outlays	0.000	0.060	0.130	0.168	0.190	0.548
Revenues	0.000	0.000	0.000	0.000	0.000	0.000
Deficit	0.000	0.060	0.130	0.168	0.190	0.548
SOCIAL SECURITY						
Revenues	0.000	0.000	0.000	0.000	0.000	0.000
Outlays	0.000	0.000	0.000	0.000	0.000	0.000
Deficit	0.000	0.000	0.000	0.000	0.000	0.000
RESERVE FUND ADJUSTMENT						
Finance:						
Budget authority	0.000	0.125	0.165	0.180	0.205	0.675
Outlays	0.000	0.060	0.130	0.168	0.190	0.548
Revenues	0.000	0.060	0.130	0.168	0.190	0.548

AMENDMENT NO. 3: DASCHLE RURAL AMENDMENTS (NO.)

[In billions of dollars]

	2000	2001	2002	2003	2004	6–10 year
MANDATORY CHANGES						
Budget authority	0.249	0.015	0.000	0.000	0.000	0.264
Outlays	0.223	0.132	0.034	0.002	0.000	0.391
Revenues	0.000	0.000	0.000	0.000	0.000	0.000
Deficit	0.223	0.132	0.034	0.002	0.000	0.391
SOCIAL SECURITY						
Revenues	0.000	0.000	0.000	0.000	0.000	0.000
Outlays	0.000	0.000	0.000	0.000	0.000	0.000

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, the bill before this body that was introduced by the majority leader I believe provides a sound strategy for addressing many of the health care problems that face rural Nevada and rural America. Senator MITCHELL's bill will guarantee a comprehensive set of standard benefits for all Americans. It will expand coverage—extremely important for rural America where there is a disproportionate number of underinsured people, and Medicare and Medicaid populations—and will channel resources to rural areas.

The Mitchell bill also increases access to care by designating rural health clinics as essential community providers and in providing funding for enabling services like transportation, education, and outreach.

The bill also provides funding for community health programs, increases funding for the National Health Service Corps, and encourages cooperative relationships among urban and rural providers.

Mr. President, the amendments that are being offered today will build on the strong foundation laid by the majority leader's legislation. This amendment that is authored and sponsored by the Senator from North Dakota, and the junior Senator from West Virginia, the senior Senator from Montana, and the Senator from Nevada and, of course, Senator HARKIN who just spoke so eloquently about a provision of the rural amendment that is certainly the wave of the future—that is, telemedicine, so that people in rural America can have access to the finest care available.

These amendments are necessary because the health care crisis facing this Nation is felt every day by the millions of people across this country who live in rural areas, where there are few, if any, primary care physicians. The lack of access to qualified primary care providers in rural areas is a critical symptom that our current system is badly broken.

Unfortunately, Mr. President, for the rural population in the State of Nevada, health profession shortages are a daily fact of life. Nevada is much different than many of the other States in the Union. Even though it is the seventh largest State, including Alaska and Hawaii, in area, it is a small State in population. I think we are 36th or 37th in population. But unlike many of the other counties—I hear my colleagues here in the Senate talk about going back to their States and visiting dozens of counties on a weekend. Well, you cannot do that in Nevada. Nevada is about 80 million acres, consisting of only 17 counties. We have many counties larger than States. Thirteen of these seventeen counties are identified as health profession shortage areas. Eleven of our seventeen counties are classified as frontier. What does that

mean? It means there are six persons or fewer per square mile, and more than 45 miles between medical service sites.

The loneliest road in the United States has been designated to be in Nevada. Four of the seventeen counties are classified as rural. So we have, Mr. President, 11 counties that are classified as frontier and 4 counties that are classified as rural. So we have 15 of the 17 counties that are sparsely populated, and most of them are very large. The only two counties in the State of Nevada that have large cities in them are the counties of Clark and Washoe. Clark County is where Las Vegas is located. Washoe County is where Reno is located. The rest of our counties are—except for Storey—large in area and sparsely populated.

In the State of Nevada, distances between major rural towns average 100 miles, with distances of 180 to 200 miles in more isolated areas. There are some people within the sound of my voice who have driven from Las Vegas to Reno or vice versa, and that is a long, lonely drive. But as long and as lonely as that is, it is still not the loneliest road in Nevada. We have a number of roads that are longer and more isolated than that area.

As an example, Pershing County, encompassing greater than 6,000 square miles, has only one physician and no physician assistants to service this population of almost 5,000 people. Recruitment efforts have been complicated by intense competition for the limited number of primary care graduates. Esmeralda and Storey Counties have no resident physicians. Other health professionals are also scarce. Rural acute care hospitals have experienced nursing vacancy rates of 17 percent.

I have given this illustration about rural health, Mr. President, and especially focused on Nevada, to indicate that we do have problems in Nevada and in our country with rural health. But no one should think that rural America is only the western part of the United States. There are many rural communities in a State like Massachusetts. There are rural communities in almost every State of the Union. So this legislation is not select legislation for the people of the State of Nevada or the State of Idaho, the State of West Virginia, the State of Montana, or the State of Iowa.

Mr. President, because of the unique characteristic of rural areas and the geographical and resource limitations faced by rural providers, I believe it is imperative that rural providers, consumers, and patient advocacy groups are represented on all of our national advisory committees. One of the amendments in this package, submitted as the rural amendment, deals with that.

Rural health care needs are much different than those of urban areas. A recent study done by the National Rural Electric Cooperative shows that although both urban and rural residents average 7 restricted-activity days resulting from illness, rural residents miss more days from major activity than those in urban areas. Rural workers experience more health problems at work.

As the Senator from Iowa stated, agriculture is a very dangerous occupation. But, also, in Nevada we know how dangerous mining is. It is not as dangerous as it used to be because there is limited underground mining in Nevada. In the State of South Dakota, though, there is a very deep underground mine, and that is very dangerous. Agriculture and mining are America's most dangerous occupations and, of course, they are done in rural areas. Rural residents are also more likely to lack health care coverage than their urban counterparts. These differences should be understood and taken into account when developing policy recommendations and implementing quality standards.

Part of this package that was written by the Senator from Nevada deals with this. That is, when we develop health plan and policy recommendations and implement quality standards, there should be some input from rural America. That is what my part of the amendment deals with.

This amendment would require at least two rural representatives, one representing rural physicians and health care providers, and one representing rural consumers and members of patient advocacy groups on the Advisory Committee on Medical Technology and the National Quality Council. The Advisory Committee on Medical Technology is made up of experts in medical technology assessment, health statistics, and economics, as well as representatives from the durable medical equipment industry, pharmaceutical industry, and the biotechnology industry. The advisory committee must also have representation from consumers, members of patient advocacy groups, and health professionals, two of which must be from rural areas. This committee will assist in preparing a study of the impact of medical technology and treating disease.

Certainly rural America should be involved in this. The use of medical technology in treating disease and injury is especially important to rural areas. As an example, defibrillators are rarely used in urban areas. Why? Because they can get them to an acute care facility, emergency room, so quickly. But in rural America, our emergency medical technologists must know how to use defibrillators. Why? Because it takes them a long time to get the patient to an emergency room. So this is just one example of why we need input from rural America.

Rural input on the advisory committee would ensure appropriate consideration of the accessibility, impact, and use of medical technology in rural areas. The National Quality Council, consisting of 15 members, 2 of which must be from a rural area, will oversee a national program of quality management and improvement designed to enhance access and quality of care. The council is made up of individuals representing consumers, insurers, States, and health care providers. Many of the quality components in Senator MITCHELL's health care proposal are private, nonprofit-based programs.

Again, I repeat, the programs generally speaking, in Senator MITCHELL's legislation, do not create Government bureaus, agencies, but rather they are, generally speaking, private, nonprofit, State-based programs, a design that will streamline quality measures, and because of its local nature, will benefit from rural input on quality issues facing rural America.

This rural package of amendments will also place at least one rural representative on the seven-member National Health Care and Coverage Commission.

Rural America must be actively involved in the delivery of health care services assessing the role of medical technology and ensuring health care and recommendations regarding coverage and health care costs. The perspective of rural America is necessary to guarantee quality and affordable care to rural residents.

Let me say one more time the Mitchell bill does work to get rid of Government agencies and activities. I do not want to get into a debate at this time over comparing Mitchell's rural proposals and the Dole rural proposals. If anyone cares to enter into that debate, I will be happy to participate in that because clearly the Mitchell bill favors rural America as compared to the Dole bill.

In addition to that, while we are talking about boards and commissions, if you compare, as I would be happy to do it at some subsequent time, if someone cares to do so, if you want to compare the commissions and boards established in the Mitchell proposal, you will find that he has done a great deal to eliminate bureaucratic redtape.

But this is not the time to debate that. Perhaps one of the most important amendments in this package that I would comment on in addition to that that I talked about rural representation on boards and commissions is the one which provides full funding for the National Health Service Corps.

As I stated, there are two Nevada counties with no resident physicians and one county with only one physician for its residents spanning 6,000 miles. Recruitment efforts have been extremely difficult. Currently Nevada has 11 National Health Service Corps

participants providing health care services to rural residents. They are essential. They are very important. They are imperative.

Fully funding the National Health Service Corps will greatly increase the availability of primary care health care providers to the underserved areas in my State and across this country.

In closing, let me say that rural health care delivery in America is important. There are 7.7 million rural Americans who now lack basic health insurance. Fourteen percent of rural residents are without health insurance at some point during the year. Almost 27 percent of the rural uninsured are children. Thirty-two percent of the non-elderly rural uninsured have family incomes below the poverty level.

We can make a case as to why we must reform our health care delivery system simply for rural Americans. If we came to this body and said we want to reform health care only for rural Americans, I think it would and should pass overwhelmingly. But we are coming with a package that not only takes care of rural Americans but urban Americans as well, and the amendment that we have submitted, Mr. President, will improve greatly the Mitchell bill as it relates to rural America.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I want to speak on the pending amendment and the subject of rural health care which relates to the entire issue of the Mitchell bill.

Mr. President, on the subject of the pending amendment I have not had a chance to study it all in great detail, but large portions of it are provisions that have been worked on by the Rural Health Caucus over a long period of time and are in fact very necessary to make sure that rural areas are treated fairly. in any massive reorganization of health care reform that we could pass yet this year.

However, I think we ought to consider why we have to give some special consideration to rural America in almost any bill that we pass. I do not care whether it is a Republican bill or a Democrat bill or a bipartisan bill, any massive reorganization of health care in America that is proposed by the most comprehensive bill, including President Clinton's own bill, ought to raise a red flag for people in rural America.

The reason is, very simply, without change of the health care delivery system in America, there are problems of the quantity and quality of the delivery of health care in rural America. There is already a problem. OK, maybe you would think, well, if you are passing a comprehensive bill, you are going to solve these problems.

There is too much in a comprehensive approach of health care reform that fits into the "one size fits all" pattern of things that we attempt to do in Washington, DC, I think, not only by some of the things we have done in past Congresses that have had a negative impact on the delivery of health care in rural America, and one of those is putting restrictions on Medicare reimbursement—that has had a very negative impact on rural America—but also if you look at national schemes in other countries, you find in these countries, as you have seen in some of the slight things we have done in rural America on Medicare and the impact on rural America, that rural areas of these countries come up short.

And so, I think a long time ago, when we first started talking about comprehensive reforms, even in 1992, as we were working, some of us Republicans were meeting every other Thursday morning for breakfast to work on what eventually became the CHAFEE bill and what we were hoping to get President Bush interested in doing, we felt that we had to have some special considerations for rural America.

Mr. REID. Will the Senator from Iowa yield for a question?

Mr. GRASSLEY. Mr. President, I would be glad to yield for a question.

Mr. REID. Mr. President, I say to my friend from Iowa, I have listened to the few minutes he has spoken. I think it is important that, on this issue alone we do not talk about the underlying bill, but on the issue of rural health care. It is something that those us of who represent States that have rural populations should recognize. During the last 10 years we have had 330 hospitals in rural America that have gone out of business.

Is the Senator aware of those figures like that that are prevailing?

Mr. GRASSLEY. Mr. President, I believe that the Senator from Nevada is making a case with statistics that I am prepared to agree with and make as well.

As I was saying, it is it is a situation in rural areas of any country that have adopted national plans. I can show you a newspaper article I have here that, within the last 10 months, there was a major reorganization of health care in Saskatchewan because of the limit on funds that were available, that they just closed 52 hospitals in one move, one decision by the Health Minister of Saskatchewan.

Mr. REID. Will the Senator yield for one further question?

Mr. GRASSLEY. Yes.

Mr. REID. I believe, as the Senator's statement indicated, one of the reasons we had 330 rural hospitals closing between 1980 and 1990 is how we have handled Medicare. The fact of the matter is that hospitals have not been reimbursed properly. They have gotten less for doing the same procedure in a rural hospital. They are given less money than if it were done in an urban hospital, and it should be just reversed.

So I really very much appreciate the Senator's statement. I think, if the Senator looks closely at our amendments, that consists of this one amendment, he will find significant information in the amendment that came from the work that he and some of the others have done on the rural health care caucus.

So, through the Chair, to the Senator from Iowa, I express my appreciation for the statement and the work that he has done in the years gone by in rural health, and I look forward to working with him on this issue. I think the importance of this issue to a lot of us is evident in the fact that this is one of the first amendments we brought up to make sure that rural health is taken care of if, in fact, we do major legislation dealing with health care.

(Mr. CAMPBELL assumed the chair.)

Mr. GRASSLEY. I do not disagree with anything the Senator from Nevada has stated. I think, for the most part, as we have read the outline—we have not studied the language of the amendment yet—that most of what is in there we would agree with.

I was hoping to set the stage for the fact that when you have massive reorganization of health care, as is evidenced by this 1,400-page bill that we have before us, you do, in fact, have to commit yourself to taking very special care for rural America or, with that massive reorganization of health care, we are going to come up further short than rural America already is when it comes to the delivery of health care in rural America, both from a quantity and quality standpoint.

I referred to the situation in Canada where, because of lack of money and reorganization, they found it necessary to close 52 rural hospitals. It is a situation you get into when you have a potential for limiting the amount of money that is going to be spent on health care in America.

Even though there is not in this bill before us, as there was in President Clinton's bill, proposals for global budgeting and premium caps, there are some things in the bill, like the 25 percent assessment on high cost plans, which are going to eventually work like premium caps and which are eventually going to lead us to a point where there is going to be limits on what can be spent and plans are going to have to live within those limits.

And those plans are going to lead to some rationing. And the impact of that rationing is going to be much more seriously impacted in rural America than in urban America. I think that is what we want to take into consideration.

I have a letter that I want to refer to about the impact of some of these bills and the bill before us on rural America.

And, the letter says:

On behalf of more than 100 farm and rural organizations we would like to voice our concern with the Health Care Reform Proposal

offered by Senator Mitchell, as presently written.

We have spoken forcefully in favor of 100 percent tax deduction for the self employed and against an employer mandate * * * and against mandatory alliance.

We cannot support any plan that: 1. Does not achieve a 100 percent deduction. 2. Lays out the foundation for an Employer Mandate. 3. Sets up "required' 'participation in purchasing alliances, a "de-factor' Mandatory Alliance.

But there are other rural concerns that required bi-partisan attention.

Paperwork. It sets up administrative and reporting requirements that will be highly burdensome for small employers.

Cost of insurance may rise. Farmers traditionally buy plans with high deductibles. The Mitchell Plan limits this option. Community rating pools are broadly defined so that—in many instances—rural citizens will subsidize the health costs of their urban and suburban cousins, places where medical costs are not only higher, but so is utilization. In addition, age banding is unnecessarily restrictive. States have the option of setting up a community rate for the entire state.

It limits choice. It would allow states or the D.O.L. to determine, base on unstated definitions, that there is insufficient competition in certain rural areas so they are not required to even offer more than one plan to their employees. That one plan must always be the HIPC, and the HIPC must always include the FEHBP. This amounts to a potential back-door single-payor system for rural areas.

Cost-shifting. It cuts into projected Medicare expenditures, which will hurt many rural hospitals, and because it shifts billions in Medicaid costs to private insurers, cost-shifting will take place. Net result: a massive, unintended cost-shift that will fuel insurance costs of fee-for-service plans—the primary insurance vehicle for rural communities.

Taxes. The new tax on plans with fast growing health premiums will hit fee-for-service plans hardest, especially those in rural areas, for reasons already noted in previous paragraph.

Association Plans. About 1 in 3 farmers and very-small rural small businesses have their health insurance through "association plans", which pool businesses or individuals in a form of voluntary cooperative. These plans are more likely to have begun to negotiate PPO and cost-savings with providers. However, these plans are essentially made ineffective by making them a part of a community rated pool, and not part of an experienced rated pool, despite the fact that many of these plans have more than 500, and some more than 5,000, individuals enrolled. Solutions: allow large association plans to be experienced rated, but require an annual open enrollment for members. The long-range impact of weaker private sector pooling arrangements is to eventually force very small businesses, and the self-employed into the state or federal-directed HIPCs—which may be the insurance of last resort for the poor.

Subsidies. Subsidies do not clearly distinguish the realities of farm income, in which it is true that farmers have relatively high "gross income" but "low net income". Careful consideration should be made for agricultural producers, especially young farmers, because "gross incomes" may not be the best determination.

Health Board. It gives enormous power to several new agencies, especially the National Health Board, but it does not include provisions that would guarantee rural representation on those boards. Health care is not necessarily better, or worse in rural America, but it is different. The composition of any agency with important health powers should include stronger rural representation.

Medical Savings Account. It does not include Medical Savings Accounts. Farmers would benefit from MSAs, and have been pioneers in the use of the MSA concept by blending high deductible plans with personally-funded tax deferral savings vehicles. MSAs are a proven "concept", the Mitchell Plan does not acknowledge their value in any way at all.

There are many positive enhancements to the recruiting of health professionals to rural areas and grants for demonstration projects, but on balance is not a plan we can embrace.

Mr. President, I am not going to read the 150-some organizations from rural America who have signed this letter. I ask unanimous consent to have the letter printed in the RECORD at this point.

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

AUGUST 12, 1994.

Hon. CHARLES GRASSLEY,
U.S. Senate, Hart Senate Office Building, Washington, DC.

DEAR SENATOR GRASSLEY: On behalf of more than 100 farm and rural organizations we would like to voice our concern with the Health Care Reform Proposal offered by Senator Mitchell, as presently written.

We have spoken forcefully in favor of 100 percent tax deduction for the self employed and against an employer mandate * * * and against mandatory alliance.

We cannot support any plan that: 1. Does not achieve a 100 percent deduction. 2. Lays out the foundation for an Employer Mandate. 3. Sets up "required" participation in purchasing alliances, a "de-facto" Mandatory Alliance.

But there are other rural concerns that require bi-partisan attention.

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Cost of insurance may rise. Farmers traditionally buy plans with high deductibles. The Mitchell Plan limits this option. Community rating pools are broadly defined so that—in many instances—rural citizens will subsidize the health costs of their urban and suburban cousins, places where medical costs are not only higher, but so is utilization. In addition, age banding is unnecessarily restrictive. States have the option of setting up a community rate for the entire state.

It limits choice. It would allow states or the D.O.L. to determine, based on unstated definitions, that there is insufficient competition in certain rural areas so they are not required to even offer more than one plan to their employees. That one plan must always be the HIPC, and the HIPC must always include the FEHBP. This amounts to a potential back-door single-payor system for rural areas.

Cost-shifting. It cuts into projected Medicare expenditures, which will hurt many rural hospitals, and because it shifts billions in Medical costs to private insurers, cost-shifting will take place. Net result: a massive, unintended cost-shift that will fuel insurance costs of fee-for-service plans—the primary insurance vehicle for rural communities.

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There are many positive enhancements to the recruiting of health professionals to rural areas and grants for demonstration projects, but on balance is not a plan we can embrace.

Sincerely,

American Agri-Women; American Dry Pea and Lentil Association; American Sod Producers Association; Communicating for Agriculture; farm Health Care Coalition; Farmers Health Alliance; International Apple Institute; National Association of Wheat Growers; National Barley Growers Association; National Cattlemen's Association; National Contract Poultry Growers Association; National Cotton Council; National Cotton Council of America; and the National Council of Agricultural Employers.

National Council of Farmer Cooperatives; National Christmas Tree Association; National Christmas Tree Nursery; National Grange; National Milk Producers Federation; National Pork Producers Council; United Agribusiness League; United Egg Producers; United Fresh Fruit & Vegetable Association; Women Involved in Farm Economics; Agricultural Council of Arkansas; Agricultural Producers; Alabama Contract Poultry Growers Association; AZ Cotton Growers Association; and the Arkansas Association of Wheat Growers.

Arkansas Contract Poultry Growers Association; California Association of Wheat Growers; CA Cotton Ginners Association; CA

Cotton Growers Association; California Farm Bureau Federation; California Grape & Tree Fruit League; Colorado Association of Wheat Growers; Florida Contract Poultry Growers Association; Florida Fruit & Vegetable Association; Florida Nurserymen & Growers Association; Georgia Contract Poultry Growers Association; Idaho Grain Producers Association; and the Idaho Onion Growers Association.

Illinois Cattlemen's Association; Kansas Association of Wheat Growers; Kentucky Contract Poultry Growers Association; Kentucky Small Grain Growers Association; LA Cotton Association; LA Cotton Producers Association; Louisiana Contract Poultry Growers Association; LA Ginners Association; LA Independent Cotton Warehouse Association; Delmarva Contract Poultry Growers Association; Minnesota Association of Wheat Growers; Mississippi Contract Poultry Growers Association; and the Mississippi Delta Council.

Montana Grain Growers Association; Nebraska Wheat Growers Association; New England Apple Council; New Mexico Wheat Growers Association; North Carolina Apple Growers Association; North Carolina Small Grain Growers; North Carolina SweetPotato Commission; North Dakota Grain Growers Association; North Dakota Stockmen; Ohio Contract Poultry Growers Association; Oklahoma Contract Poultry Growers Association; and the Oklahoma Wheat Growers Association.

Plains Cotton Growers Association; South Carolina Contract Poultry Growers Association; South Dakota Wheat Incorporated; Southern Cotton Growers Association; Southeastern Cotton Ginners Association; Tennessee Contract Poultry Growers Association; Texas Cattle Feeders Association; Avian Cooperative of Texas; Texas Citrus & Vegetable Association; Texas Wheat Producers Association; South Texas Cotton & Grain Association; and the Rolling Plains Cotton Growers.

Virginia Agricultural Growers Association; Virginia Contract Poultry Growers Association; Virginia Small Grain Growers Association; Washington Association of Wheat Growers; Washington Cattlemen's Association; Washington Growers Clearinghouse Association; Washington Growers League; Washington State Horticultural Association; Washington Women for the Survival of Agriculture; Western Growers Association; and the Western Pistachio Association.

Wisconsin Christmas Tree Producers Association; Wyoming Wheat Growers Association; Curtice Burns Foods/Pro-Fac Cooperative; Dovex Fruit Company; Eastgate Farms, Inc.; El Vista Orchards, Inc.; Florida Citrus Mutual; Forrence Orchards, Inc.; Grainger Farms, Inc.; Grower-Shipper Vegetable Association of Central California; Hood River Grower-Shipper Association; and the Johnny Appleseed of Washington/CRO Fruit Company.

Knouse Fruitlands, Inc.; Lyman Orchards Country; Newman Ranch Company; Nyssa-Nampa Beet Growers Association; Princeton Nurseries; Rocky Mountain Apple Products Company; Torrey Farms, Inc.; Valley Growers Cooperative; Ventura County Agricultural Association; Wasco County Fruit & Produce League; and the Yakima Valley Growers-Shippers Association.

Mr. GRASSLEY. The letter was initiated by the Farm Bureau but signed by 150 organizations.

I will yield the floor in just a minute. But the purpose of reading from that letter is, under a massive 1,400-page bill like this, making these changes, I am asking our colleagues to be cognizant that we already have problems in rural America under the status quo. If we make the massive changes like those in this 1,400-page bill we are going to have terrible consequences for the delivery of health care in rural America. The Daschle amendment legitimately is taking care of a lot of those problems. But the point I want to make is, and it is not the intention of Senator MITCHELL or any of the people working closely with him, but it is just a fact of life—when you have a massive rewrite of legislation like this, some of the good you want to accomplish for the Nation as a whole has negative consequences in rural America. I do not think that the things that are in the Daschle amendment and other amendments that will be offered for rural America are going to make up the difference.

We want to be prepared, to make sure that we take care of those. I hope we have, in the process, corrected some of those things that are in the original Mitchell bill, the underlying piece of legislation, so those negative impacts will not exist for rural America.

Tomorrow on this side of the aisle we look forward to considerable discussion. Many of my colleagues want to speak on the impact of this legislation on rural America. I do not think too many of my colleagues will disagree with what Senator DASCHLE is trying to accomplish in his amendment. But we want to go through some provisions in the underlying legislation to point out where we feel that it has a very negative impact upon the delivery of health care in rural America.

One of those would be what Senator HARKIN has already mentioned. Self-employed people, farmers, et cetera, are not going to have equity under this legislation. We have to have 100 percent tax deductibility for the self-employed.

The impact of Medicare cuts is further going to increase the number of rural hospitals going out business, above the 330 that Senator REID just recently referred to. There are other things in this underlying legislation that is negative to rural America.

So I yield the floor and look forward to the debate tomorrow.

Mr. BINGAMAN. Mr. President, I rise in support of the amendment pending before the Senate. I worked with my distinguished colleagues from the Senate Finance Committee, Senators DASCHLE, ROCKEFELLER, BAUCUS, and my distinguished colleague on the Labor and Human Resources Committee, Senator HARKIN on this package, and I am pleased that we are discussing health care in rural America tonight.

This package of amendments is straightforward, aimed at helping to develop a health care infrastructure and improve the health care delivery system in our five States—New Mexico, South Dakota, West Virginia, Montana, and Iowa—and throughout rural America. I urge my colleagues to support this package.

Mr. President, there are many features of the majority leader's bill that would significantly improve the standard of health care for rural Americans. We have moved closer to really taking seriously the health needs of farmers, ranchers, small business owners, their families, and their employees. This is an important accomplishment.

I. RURAL FEATURES OF HEALTH REFORM BILL

The majority leaders's bill will, contrary to some assertions, make it easier for all small businesses to buy health insurance, whether those businesses are located in the inner city of Chicago or the rural towns of Mora County, NM.

A. INSURANCE REFORM RULES

This is because the proposal limits the ability of insurance companies to discriminate against Americans with preexisting conditions. Many small businesses in rural areas would be protected from escalating costs and arbitrary charges.

B. WORK FORCE: MORE RURAL PROVIDERS

The bill will increase the number of primary health care providers, which will significantly ease burdens on doctors, nurse practitioners and other health care providers in States like New Mexico. By increasing the number of health care providers nationally, the bill will make health care for rural Americans more accessible and more affordable.

Last week, Senator BAUCUS told us that urban America has 2½ times as many doctors per 100,000 people as rural areas. By offering tax credits to doctors and other providers who practice in rural areas, we can ensure both continuing excellence in specialty care and improved access to primary care.

C. TELEMEDICINE

The bill before us today also provides grants for telemedicine, or high-technology networks between rural health care providers and specialists. Many believe these cutting-edge programs are among the most efficient and promising developments in rural medicine.

D. COMMUNITY HEALTH ADVISERS

I am particularly pleased that the majority leader's bill contains a provision I authored in the Labor and Human Resources Committee health reform bill. This provision authorizes a new community health adviser program as part of the Public Health Service's priority National Initiatives on Health Promotion and Disease Prevention.

Through this initiative, the Public Health Service will assist States, local governments, and nonprofit organizations in establishing and maintaining vital community health adviser programs.

The advisers are specially trained local community residents who deliver preventive health information to their communities, in homes and larger groups. They help encourage access to critical primary and preventive care; in particular, this program would be aimed at helping to achieve the Healthy People 2000 goals. These programs can play an important role in reducing overall health care costs.

Community health advisers and the provision in Senator MITCHELL's bill are widely supported by public and women's health organizations, including the American Public Health Association; Children's Defense Fund; the National Breast Cancer Coalition; the New Mexico Public Health Association; the National Women's Health Network; and dozens of other national organizations.

E. ASSISTANT SECRETARY FOR RURAL HEALTH

Finally, this bill takes a step toward acknowledging the health care needs of rural Americans by creating a permanent position of Assistant Secretary for Rural Health within the Department of Health and Human Services.

II. TWO AMENDMENTS

Mr. President, the majority leader's bill is a beginning to improved rural health. But there are also some real opportunities to strengthen this legislation and make it even more responsive to the needs of rural Americans. I would like to briefly describe two of the provisions contained in the amendment pending before the Senate.

B. RURAL RESIDENTS ON BOARDS

First, we believe it is critical that rural residents be included on any board or commission authorized under this bill. Rural residents, rather than rural experts or rural representatives must be specifically included in all board membership lists to ensure that rural people assume a fair and proper role in all issues of governance.

C. RURAL FRONTIER AREAS

Second, we need to make sure that in the very definition of "rural," we do not exclude the people who most depend on us. A provision of title IV (section 4111(d)(2)(B)(i)) gives States the authority to designate medical assistance facilities in frontier areas.

Under the current criteria of this section, States can only designate these special facilities if the entire county has fewer than six residents per square mile. This disadvantages Western States.

Many of our counties are larger than some States in the east. In addition, they encompass both urban and very remote areas. As the bill stands, these counties would be disqualified even though many of their residents live in areas far more remote than eastern rural counties.

We propose that an equivalent unit of local government or subcounty unit designated by the Governor or chief officer of the State be an acceptable criterion for designating the medical assistance facilities.

Only by making this change can we actually conform to the true intent of the provision: To improve medical services in rural America.

Mr. President, these are all vital provisions. They are essential to building the health care infrastructure and networks that are desperately needed in rural America. I urge my colleagues to support this package of amendments and to continue to work with us to improve the quality of life for all of our rural constituents.

HEALTH CARE REFORM

Mr. HATCH. Mr. President, both yesterday and today, our colleague from North Dakota, Senator DORGAN, spoke in this Chamber about spiraling medical costs in the hospital and drug sectors. He pointed to specific drugs and compared the prices of those drugs in other countries with their prices here.

He did not mention that all of those drugs have cheaper, generic counterparts. Nor did he mention that Congress specifically passed legislation—legislation that I sponsored—to accelerate the entry of generic drugs to the market as a cost-saving alternative to branded drugs.

I think it would be useful for my colleagues to look at some relevant facts, starting with the latest figures from the Bureau of Labor Statistics [BLS].

According to the BLS, drug prices, at the producer level, rose 2.8 percent during the 12-month period that ended in July 1994. That increase can hardly be characterized as skyrocketing. If NASA's rockets rose at that rate, we would have never reached the Moon.

In fact, this 2.8-percent increase is a new low, the lowest in 20 years. That is a trend this Congress should encourage, not discourage.

Drug prices have fallen steadily since 1989, when the rate of increase was 9.5 percent. I simply do not think this could be characterized as relentless inflation. On the contrary, I think it shows that drug inflation is under control.

And this is a very important point. Because it is the result not of anything the Government has done, but because the market is working.

In a June 1994 report, "How Health Care Reform Affects Pharmaceutical Research and Development," the Congressional Budget Office stated:

> The market is changing. On the supply side, sales of generic drugs are increasing. On the demand side, buyers exercise more market power to reduce the profits of the pharmaceutical companies. * * * in view of the increasing competition within the pharmaceutical market, drug prices could easily decrease regardless of the Administration's proposal.

This competition—which some of my colleagues seem to ignore—is also controlling the introductory prices of new drugs. The Boston Consulting Group looked at the prices of new drugs approved and launched during 1991 and 1992 and found they were, on average, 14 percent lower than the market leader in their category.

I recently saw a cartoon in the Wall Street Journal. It showed a receptionist telling a visitor: "Can you come back tomorrow? Mr. Ferguson is in deep denial today."

I think some of my colleagues must be in deep denial, Mr. President.

Marketplace reform is for real.

The figures show it.

The experts confirm it.

Instead of denying this competition, as I have said, I think we ought to encourage it.

Nor can we deny the fact that there are people, especially among the elderly, who are forced to make desperate choices between medicine and other necessities.

There are the people we need to help, the elderly poor, not millionaires and billionaires who would be eligible for the new Medicare drug benefit in the Mitchell bill.

No matter how much Congress tries to regulate drug prices, there will be some patients who cannot afford them. And the more we talk about artificially controlling prices, the more we hurt drug research. Seven out of 10 drugs lose money for the manufacturer.

What we should be doing is targeting efforts on those who need assistance. Then, we can help those who need help the most, and we can do it without hurting drug research and without discouraging the market forces which are working.

The PRESIDING OFFICER. The Senator from West Virginia [Mr. ROCKEFELLER] is recognized.

Mr. ROCKEFELLER. Mr. President, I want to echo the concerns of Senator REID, the Senator from Nevada, about what the Senator from Iowa said. I have always thought of the Senator from Iowa as being sort of a quintessential westerner in the farm sense, and I have told him so. So that is not unnecessary flattery. He is very independent. It is my understanding that Senators from Iowa do not usually get reelected to second terms but this Senator has, Senator GRASSLEY. I think it is because he has an independent streak. I think when he feels about something deeply, as he does about rural health care and rural matters, it comes through. I think it comes through partly because if you shake his hand it is usually pretty rough, because he owns a farm. His son runs it for him but he is there to help on weekends if it is needed.

So this Senator, the junior Senator from West Virginia—very junior Senator from West Virginia—wanted to add his praise of the remarks the Senator from Iowa has made.

Mr. DASCHLE. Will the Senator yield?

Mr. ROCKEFELLER. Of course.

Mr. DASCHLE. I appreciate very much the comments made by the distinguished Senator from Iowa. I have had the good fortune to work with him on both Agriculture and Finance. He and I had the opportunity to work with the distinguished Senator from West Virginia on rural health issues during the ongoing consideration of health in general over the last several months.

As is always the case, he is an extraordinary student of the issues relating to rural health and is a tremendous partner. I associate myself with the remarks made by the distinguished Senator from West Virginia. He is absolutely correct, he has been someone that I hope we can continue to work with on many of these issues mutually.

I thank the Senator for yielding.

Mr. ROCKEFELLER. I thank my friend from South Dakota.

Mr. President, I rise with a great deal of passion, interest, and fervor and good feeling because we are discussing something which I think is at the core of what we need to do, and that is to try to be helpful to rural America—which the distinguished Presiding Officer also represents—in any way we can in terms of health care. My colleague Senator DASCHLE, Senator BAUCUS, Senator REID, and Senator HARKIN and I have offered a number of amendments that I think are very important.

It is late in the evening. Not many people are here, but that does not make any difference because our work here is significant.

From this Senator's point of view, Mr. President, Senator MITCHELL's bill already offers substantial hope for rural America. It contains important provisions to make very sure that the promise of health care is more than just an empty promise. That is very much on the minds of people who live in rural parts of this country.

Nationally, 25 percent of all Americans live in a rural area. In West Virginia, that figure is 64 percent. We are 77 percent forest, so the fact we are 64 percent rural should not be surprising. In addition, all or part of 43 of our 55 counties in West Virginia are designated as "medically underserved"—a seriously bad designation.

I should say, Mr. President, that my senior colleague, Senator BYRD, is not a fan of charts and neither is his junior colleague. In the nearly 10 years that this Senator has been in the Senate, I have never used a chart or a graphic entity on the floor of the Senate because I do not have a good feeling about them. But on this matter of rural health care in America, I feel strongly enough that I have broken my habit this one time, hopefully.

One can see very easily, if I simply describe that all of the yellow that one sees on this map are areas that have enough doctors and all of the red, which is obviously the great majority of the map, are areas that do not have enough doctors. I will explain more of what I mean by enough doctors. These are basically underserved areas.

Senator MITCHELL comes from Maine. There is just a very small, little area here. Look at California. People think of California always as being—I do—as being urban with sort of rural intervals. Of course, that is not true and this proves it. Ninety percent of California is underserved.

Look at Arizona, almost entirely, 95 percent underserved; New Mexico, 98 percent underserved. My own State is right here. You can see there are just very few areas which are yellow which means that they are adequately served medically. Look down to Florida. I would have thought Florida would be substantially served for many reasons—its climate, its population, its way of life. But entirely to the contrary. It is hurting medically in terms of health care professionals and opportunities to get health care.

Indeed, if you look at North Dakota, South Dakota, more toward the west than toward the east, but then look at Louisiana, it is really quite distressing; Mississippi; Hawaii, even with its universal health care plan, has substantial service problems. So they must be doing a remarkable job to overcome that.

This map leads me to want to know more. I find this a distressing map. All the red—is not enough health care. It is the great majority of our country and it also describes, I think, that a lot of our country is rural. It certainly describes that my State of West Virginia is not alone.

More than half a million Americans live in a county, Mr. President, that does not have a single doctor, and 34 million Americans live in areas with a thoroughly insufficient supply of physicians, or other health care providers. That all adds up to a situation that makes it extremely difficult for the rural areas, which the Presiding Officer, myself, the Senator from South Dakota, and others represent, to get health care in any form, much less when they need it and where they need it.

Less access to primary and preventive care means more costly and serious illness that have to be treated later. I will give you an example in my own case.

My wife and I and our four children have a farm right on the West Virginia border in the Allegheny Mountains in a beautiful county called Pocahontas County.

And in the northern part of the county, we had, I can remember, a number of years ago when our children were still young a Dr. and Dr. Jones, a couple. They were two wonderful young physicians who graduated from West Virginia University and decided to come and live in that extremely rural area. The county where we live is one of the largest counties east of the Mississippi, Mr. President, and has only 6,000 people, which, of course, my family and I love because of the solitude and the beauty of the West Virginia hills.

But Dr. and Dr. Jones, husband and wife, came there with the full idealism, the full expectation of being able to make it. They both were family physicians. They both happened to love railroads, and we have some old logging railroads that still exist from earlier days. I suspect they do in the Presiding Officer's State also.

They made the best of it for about 3 or 4 years, but then they just could not hang on, could not get the payments, could not meet their own bills, and they were forced to leave. So there we are with a building and with a doctor who visits from time to time and, basically, without health care in an enormous county, which in itself is a vast area of wilderness.

Most of us realize that an insurance card is, in fact, meaningless unless there are doctors and hospitals and nurses and physician assistants who are actually available in an area to provide health care services. They have to be there or be close by. People understand that.

In many parts of West Virginia, access to health care is simply wishful thinking. The problems of rural health residents in buying insurance are similar to the problems of small business owners, because so many of them are self-employed or employees of very small firms or, in many cases, not employed at all.

Rural Americans generally have to pay insurance premiums that are higher than nonrural Americans because they are buying small-group or individual policies which are generally 35 to 40 percent more expensive than what larger companies can pay for the same product.

It is not fair. It is part of what is wrong with our health insurance system. But it is a fact in rural America.

Rural families are subject to the most abusive kinds of insurance underwriting practices because they are purchasers of small-group insurance policies.

What I mean by that basically is that they are more or less helpless as they face the insurance company. Many rural residents are not familiar with terms like "lifetime limits," "preexisting condition." I would think that many rural residents, as many urban residents, would not know that if you are a young woman, get married and get pregnant and you do not have health insurance, you cannot buy health insurance. By the act of becoming pregnant, being pregnant, that itself constitutes a preexisting condition, and therefore you cannot get health insurance.

Most people do not know that. Rural people are more likely to be subject to that kind of underwriting practice. They wind up having their policies canceled the minute that they or a family member has a serious medical condition. Most of them do not know that that is going to happen because they would tend to trust the insurance policy, because in America, if something is institutional, you tend to trust it.

Well, sometimes that trust is not well placed. So a family member has a serious medical condition. No more health insurance. Or they might get to keep the health insurance but their premiums would rise very sharply in order for them to keep health insurance. Just because they are farmers. Just because they are loggers. Just because they are coal miners. Just because they are older, or just because they have something called a preexisting condition. And thus it is in rural America.

Rural residents will gain significant health benefits under Majority Leader MITCHELL's bill because they are so disadvantaged under the current system. Very stringent insurance reforms; the availability of purchasing cooperatives—something which is understood by farming families—the targeted subsidies to purchase private health insurance, all of these are ways that the majority leader's bill will substantially benefit rural Americans. I am very happy about that, and I am very excited about that. That is important and significant news.

Before describing the exact provisions that I have worked on and authored in this amendment, I would like to just take a moment to emphasize that while an insurance card alone does not guarantee the actual delivery of health services, it is one of the single, most important things that we can do to try to encourage doctors and other health providers to move to a rural and underserved area, because if a physician or other provider understands that people have insurance, they are going to understand that they are going to be reimbursed, that life financially is going to be different.

The proportion of people without insurance is higher in rural areas than in urban areas. Without a stable source of reimbursement that can only come with an insurance card, many doctors and nurse practitioners and physicians' assistants and others cannot sustain a viable practice in a rural area. My example of Dr. Jones and Dr. Jones that I talked about a moment ago applies here. If the vast majority of their patients are uninsured, a health practice is simply not sustainable—a fact of life, and a very painful one in rural America.

Mr. President, the amendment we are offering, and that the distinguished Senator from South Dakota, TOM DASCHLE, is leading, offers several important provisions to make health care a reality for millions of Americans across this country. So I want to take a moment to describe a couple of these provisions.

Especially important to me is the provision to provide improved funding for the National Health Services Corps. This is something about which I care deeply. VISTA, which is similar to the National Health Service Corps, changed my whole life. I did in social work what physicians and other providers will be doing in the National Health Service Corps. I know that if you get a young American in their mid twenties studying medicine, or in my case trying to learn more about their country and having the rudiments of social work in my head, when those folks get to the rural places or to the urban places, inner-city areas, they are going to be challenged. They will see things that they have never seen before. They are going to understand the importance of their presence to the people in that area.

When I went to West Virginia as a VISTA volunteer, I had no intention of staying in West Virginia as a VISTA volunteer because all of my training had been in Japan and China and Asian affairs. I had worked in the Peace Corps and State Department and had lived in Japan for a number of years. VISTA just turned my life upside down because it put me in contact with real people in rural areas where there were real needs and where I thought I could make a real difference.

If you are young and in your mid twenties or mid thirties and your life is before you, this is exciting. It is extremely exciting. So under this amendment, we will move towards restoring pre-1980 award levels in the National Health Service Corps. At that time 3,000 to 7,000 scholarship awards were made on an annual basis. So imagine that, physicians, in return for payment of part of their medical school years, spreading out, 3,000 to 7,000, all across America in rural and inner-city areas.

A very good friend of mine did that in eastern Kentucky, and it changed his life. It just totally changed his life. Eastern Kentucky is like southern West Virginia. He went there, practiced medicine there, fell in love with the place, with the opportunity, could not leave and has had a remarkable career—a fellow named Harvey Sloan.

The amendment Senator DASCHLE and I have proposed would provide sufficient funding to place at least one doctor, nurse practitioner, or physician assistant in every single county in America that is currently designated a shortage area. In every one of those red areas, in every county in California, in every county in North Dakota, South Dakota, Montana, Wyoming, in every one of them, there would at least be one health care provider. That seems to me very reasonable, a very exciting prospect. And it can be done and is done under the amendment that Senator DASCHLE, myself, and others are offering.

Now, last year, Mr. President, there were 2,492 primary care shortage areas.

That is a big chunk of this country. A health professional shortage area is an area that does not have at least 1 primary care provider for every 3,500 residents. That is what is reflected on this map; there is not 1 physician or nurse practitioner or physician's assistant or other health provider for every 3,500 residents. That is pretty slim coverage.

If we want to do the ideal—which, of course, I would—but we cannot because of the finances, the ideal percentage is 1 doctor for every 2,000 people. That is what it ought to be. That is what this country ought to have. We do not. It is a mystery that we do not. We continue not to. But, nevertheless, that is the fact.

The National Health Service Corps Program has been extremely successful in providing essential services in remote areas, which are very familiar to the Presiding Officer, and rural areas, and, again let me repeat, in inner cities.

I am a member of the board of the Children's Health Fund. It was started actually in New York City by a wonderful pediatrician, a physician by the name of Dr. Irwin Redliner. The Children's Health Fund's purpose is to put pediatricians in areas of the country where they are not.

So in New York City, which is surrounded within 10 blocks by doctors of every variety, there is an enormous shortage of physicians, a shortage in New York City, not to speak of upstate New York.

The National Health Service Corps would place health care providers in rural areas and in the inner-city areas. It is so popular as a concept, and well thought of, in fact, that Senator DOLE and Senator PACKWOOD in their summary also list a provision to fully fund the National Health Service Corps Program. That is what we intend to do. That is what they said they intend to do.

A total, Mr. President, of 43.5 million people in America live in medically underserved areas. Last year, the National Health Service Corps had only 1,200 providers in the field providing care to only about 1.2 million of those 43.5 million people who need their help. So you can see the disparity between availability and need.

The corps received over 4,000 applications last year, Mr. President, to fill awards for 406 slots. So do not tell me that medical students are not ready to do that, that idealism is dead in America.

This demonstrates the tremendous interest by medical students, by nursing students, by physician's assistants

to have their training paid for in return for making a commitment to practice in an underserved area, urban or rural, after completing their training. I cannot think of a better deal for those young students, and for America.

For many students, especially minority students, and low-income students, this is the only way that they can afford to go to medical school or to go to nursing school—a major factor to bear in mind.

I constantly get calls from West Virginia clinics and hospitals who are desperate to find a physician or other health care provider. In 1986, Mr. President, 26 corps doctors were placed in West Virginia. That was 8 years ago. In 1987, 28 came to West Virginia. In 1988, 5 came to West Virginia. Since then, between one and three physicians or other providers have been placed in West Virginia on an annual basis. I am appalled. I am appalled at our willingness to so ignore underserved areas of America. Needless to say, the need for these folks has not declined.

Funding in our amendment will give all underserved areas, rural and urban, a tremendous boost. In fact, I want to note that of the 43.5 million people that live in designated medically underserved areas, 50 percent are urban residents. The funding for the corps in this amendment will help millions of people from Appalachia, Montana, Colorado, South Dakota, Massachusetts, Chicago, and Los Angeles.

Mr. President, a lifeline in many, many rural counties in West Virginia and rural areas across the country are something called local health centers, rural health centers. Some of them are designated federally qualified health centers. Some are rural health clinics. Some are just primary care clinics. While the names and the designations may vary, their missions are all exactly the same, and their importance is all exactly equal.

I have probably visited all, certainly most, of our clinics in West Virginia. I am always not just impressed but in many ways overcome by their dedication, by their commitment—the doctors, the nurses, the administrators, the physician's assistants who staff these clinics. They are not big hospitals. They are small places. One place I am thinking of in a small county in West Virginia is in a grocery store that closed down in a shopping center. But it is comfortable. People are familiar with it. There it is. I am so proud of what they do. I cannot say that strongly enough. They are performing miracles every day with very meager resources and without notice from the rest of the world.

The majority leader's proposal establishes several special accounts to help rural providers improve, expand, and reorganize themselves, to deliver services efficiently and to deliver them effectively.

One account provides funding for network development and expansion into shortage areas, including recruitment and training, upgrading equipment purchasing, and as Senator HARKIN mentioned, telemedicine systems.

A second account provides grants and loans for capital needs. And a third account provides funding for supplemental or enabling services, such as transportation services, home visiting, case management, and outreach.

Our amendment would expand the list of providers eligible to apply for funding from these accounts to include rural health clinics. That is my point.

Under the majority leader's proposal, federally qualified health centers, or FQHC's, are automatically eligible for funding opportunities. But rural health clinics with the same mission, same miracles, the same people, and the same need, are not eligible, except if they are part of something called a consortium.

Mr. President, I support the notion of various rural providers banding together to promote integration and coordination of services. But I do not think the participation of rural health clinics should be restricted.

Under this amendment, rural health clinics would be able to qualify and compete for funds in each of the separate accounts, without being a part of a larger consortium. For profit, rural health clinics would be eligible to apply only for capital funding for loans. Nonprofit rural health clinics could compete for funding under all three separate accounts.

In my own State of West Virginia, the majority of clinics and centers are already designated federally qualified health centers. West Virginia has about 38 of them, and about 14 rural health clinics. My point is that the rural health clinics do the same work, serve the same people, and have the same needs, and provide the same miracles as the federally qualified health centers.

Of those 14 rural health clinics, a few are in the process of qualifying as a federally qualified health center. But a few are not. And they cannot. The reasons they are not designated federally qualified health clinics has nothing to do with the quality of the service they provide or the qualifications of the people providing those services. A few clinics cannot qualify because they do not meet the very specific criteria required of a Federal qualified health clinic. I am not quarreling with the criteria, but I do want to make sure that all essential rural providers in West Virginia have equal access to all of the available funding sources in Senator MITCHELL's bill.

For example, the Belington Community Medical Services Association, in Belington, WV, a very small community, often flooded, cannot qualify for FQHC status because one full-time physician is not a permanent staff member. That is part of the FQHC criteria. The Belington clinic is run by a physician assistant named Tom Harward, and physician coverage is provided on a rotating basis. That is the best they can do, Mr. President. And they do it well. But they do not have a permanent physician on staff and, therefore, the Belington clinic cannot nor will they ever receive FQHC status. I think you understand that is not fair.

I do not think that fact alone should disqualify the Belington clinic, along with other rural health clinics across this country who are in a similar situation, who cannot meet the criteria for reasons which they cannot overcome, from applying for all available funding to help clinics in underserved areas.

Tom Harward, who runs the Belington clinic, was honored several years ago by his professional association as the Outstanding Physician Assistant of the Year. At that time, Tom described his typical week. This is what his week is.

He sees 20 to 30 patients a day and makes house calls 2 days a week. That still happens in places like West Virginia, and I expect South Dakota and Colorado. I, frankly, do not know when he would find the time to even fill out an application for new rural health funding. But if he can find the time, I want to make sure that he is not automatically disqualified because his clinic is something called a rural health clinic as opposed to a federally qualified health clinic.

Another example is the Children's Health Care Clinic in Pineville, WV, in the southern part of the State. They cannot qualify for federally qualified status because they only serve children. They only serve children. Yes. Therefore, they do not qualify. One of the criteria for federally qualified status is that they must provide a full range of services to people of all ages, not just pediatric services.

Again, we are not talking about a quality problem but rather a criteria issue. Children's Health Care Clinic in Pineville, WV, should also be able to compete for any and all funds made available under the majority leader's bill. I intend to fight to make sure that it happens.

A final provision would clarify that the current set-aside for nurse practitioners for National Health Service Corps funding includes physician assistants—the same Tom Harward I have just been talking about. I think it was a drafting oversight. I think it was nothing more than that. The current National Health Service Corps program already includes a 10 percent set-aside for nurse practitioners, nurse midwives, and physician assistants. The majority leader's bill increases the set-aside to 20 percent, and my provision

merely clarifies that physician assistants are included in the corps set-aside, as they are under current law.

So, Mr. President, Senator MITCHELL's bill would go a long way to assure financial and physical access to health services for rural residents that are on my mind very much, as I speak. I see faces and I see families, as I speak. Our amendment—mine, Senator DASCHLE's, and others'—builds on some very important improvements that the majority leader already proposed. Taken altogether, I believe rural residents will gain real health security from health care reform. There will still be challenges. There will still be bumps in the road. There always are in places like West Virginia. But I believe that, on the whole, I can tell the majority of my constituents that the legislation we are considering will make a real difference in their lives. I have no other reason for being here. That is what I am hired on to do by my people of West Virginia—to try to make a difference in their lives. I believe this bill and this amendment will do that. For rural doctors and rural hospitals, this bill, frankly, is a long-awaited relief package that will provide them with additional resources and stable financing.

Mr. President, I look forward to the adoption of this amendment by my colleagues.

I thank my patient colleague from South Dakota and the distinguished Presiding Officer, and I yield the floor.

The PRESIDING OFFICER. The Chair recognizes the Senator from South Dakota [Mr. DASCHLE].

Mr. DASCHLE. Mr. President, let me commend the distinguished Senator from West Virginia for an extraordinarily complete explanation of our amendment.

I think it is appropriate that as we begin this debate we have a better understanding of why it is necessary to introduce this amendment, and how it addresses the critical shortage of rural health providers that the Senator from West Virginia so ably depicted on his chart.

I commend him. He has been an extraordinary partner in this whole effort and, as a cosponsor, has been a real leader over the years in rural health care reform. It has been my privilege to work side by side with him for virtually as long as I have been here, and I cannot think of a greater privilege I have had in the Senate.

I commend him for his statement and appreciate very much his contribution to this effort.

Mr. President, I ask unanimous consent that Senators WOFFORD and LEAHY be added to the list of cosponsors, which includes Senators BAUCUS, HARKIN, ROCKEFELLER, and REID.

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

Mr. DASCHLE. Mr. President, the Senator from West Virginia, as I indicated, has described our amendment very well. He, too, publicly commended our majority leader for including in his bill a substantial set of rural health provisions.

Senator MITCHELL has listened to the concerns that many of us have expressed about how rural areas would be affected by changes being proposed in our health care system. The bill he introduced, as the Senator from West Virginia has indicated, truly reflects his commitment to ensuring that rural health reform does not pass by rural communities.

The amendments that we are proposing tonight build upon the solid base that the majority leader's bill establishes for rural America.

From the very beginning of this debate, many of us have insisted that we would not vote for a bill that did not include substantial recognition of the need for improvements to rural health care access. I do not think anyone who has cosponsored this amendment is prepared to back off that determination. We are not going to abandon that principle now.

Thankfully, efforts to enhance access to rural health care have always had strong bipartisan support, as the statement from the Senator from Iowa indicated this evening.

Earlier this year I cochaired a bipartisan working group that recommended a series of rural provisions that should be included in health reform. I am very pleased that many of the suggestions we recommended were included in the Senate Finance Committee bill and now in the legislation Senator MITCHELL has presented to us.

Our efforts have been for a good cause. Indeed, both Republican and Democratic health reform bills frankly have included similar strong rural provisions. It gives me hope that the majority of Senators on both sides of the aisle share our insistence that health reform benefit rural and urban areas alike.

We have come together on this issue in the past, and I am hopeful that we can be united again on this debate. Let the same bipartisan spirit of cooperation prevail as we consider this set of amendments.

We all want to make health care reform a guaranteed winner for rural people.

The amendments that we are proposing tonight would encourage doctors, nurse practitioners, and physician assistants to practice in rural underserved areas, to ensure that financial and other assistance is available to help rural facilities adjust to the changing health care environment, and to assist rural providers in forming their own health care networks.

Among the provisions we are proposing, including some the Senator from West Virginia described so ably tonight, is a proposal to increase funding for the National Health Service Corps, one of the most important, respected workforce programs in the country today.

This program was nearly eliminated in the 1980's despite the fact that many rural communities are completely dependent upon corps doctors as their only source of physician care. While the program has been slowly built back up over the last couple of years, rural America badly needs more of these providers.

Another amendment we are proposing would provide Medicare bonus payments to nurse practitioners and physician assistants who practice in rural areas. This incentive money will help rural America attract and retain these important practitioners.

Another series of provisions included in this amendment would ensure that clinics in rural areas are eligible for loans and grants that can help them upgrade their services, form networks with other providers, and help better serve rural areas.

Finally, to help rural communities determine how to develop their own health care plans, we have established 10 demonstrations projects for the development of rural-based managed care.

Simply put, rural America's most significant problem is that we do not have enough providers. We see that in rural Colorado. We see it in rural Idaho. We see it in rural South Dakota. We have attempted to address that problem through a number of different provisions in our amendment.

Why do we need these provisions, some may ask. Does not universal coverage solve the problems facing rural America? It is true that if we move closer to universal coverage we could enhance access to care in rural America.

The problem we have is that guaranteed health insurance in rural America is defined differently than it is in urban America. In my home State of South Dakota, 145,000 residents had no health insurance at some point in 1993.

We must ensure rural residents have the same opportunities as urban dwellers to buy the range of insurance plans that will be required under the Mitchell bill.

Because we know that, compared to their urban counterparts, rural residents are less likely to be insured and tend to be older, sicker, and poorer with higher rates of uneconomic and chronic ailments and disability. This will remain so in spite of the fact that rural Americans may have improved coverage under the Mitchell bill.

Universal coverage is the most important building block to ensuring health security in rural America. But providing health coverage is not and cannot be the whole solution for what ails rural America today.

In far too many rural areas a health insurance card does little good because

there are simply no providers to care for patients. Increasing the supply of primary care practitioners and attracting them to rural communities is by far the biggest challenge facing us today.

This is a serious issue in South Dakota and in many States throughout the Midwest and West. South Dakota currently ranks 47th in the country in terms of physician-to-population ratio with 1 primary care doctor for about every 1,500 people. In fact, 16 counties in my State have no hospital at all. Equally important is increasing the number of nonphysician providers practicing in these rural areas and enhancing their ability to practice independently.

More recently, we have seen a new problem. The increased competition for primary care physicians and nonphysician providers from urban-managed care plans is complicating life in rural America today. Rural areas are seeing a drain of primary care physicians from rural to urban areas, where employment packages offered by HMO's provide a shorter, more predictable work schedule and a much higher guaranteed income.

In other words we exacerbate the problem of a shortage of practitioners by encouraging doctors to leave underserved areas to go to those areas where there is no shortage.

We try to address that problem, Mr. President, with a number of the provisions to encourage providers, both doctors and other health care practitioners, to move to rural areas, and stay there, once they are there.

Coordinating care in rural areas is another major challenge. While urban residents can join a number of health care plans and have available to them a network of primary care doctors, specialists, nursing homes, and home health care providers, we have very limited access to integrated networks that can help patients manage their care.

These arrangements rarely exist in our part of the country. Managed care plans have been hesitant to enter rural health care markets and few rural providers have formed no networks at all.

So we need to do everything we can to encourage providers to cooperate and form integrated service delivery networks.

We should not wait for an urban-based HMO to set up shop in rural America. We can form our own community health plans and networks. All the providers need are the proper incentives.

In sum, this package of amendments makes the statement that rural America should no longer be asked to settle for less health care than their urban counterparts. What better message can we send as we debate health reform?

I certainly hope that, as we debate this amendment over the next day, Mr. President, we appreciate fully the unique set of circumstances that we have in rural America today; that we understand, we also have a unique responsibility to be sensitive to those circumstances. We simply cannot allow health reform to pass rural America by.

This amendment is a concerted effort on the part of a number of Senators from different States, all with the same appreciation of the need to respond more effectively to rural health care needs, recognizing very well how much the majority leader has already done in his bill to address many of the concerns we have expressed to him.

So I am hopeful, Mr. President, that before the end of the day tomorrow, perhaps, we can have a good debate and a good discussion about these needs and about ways to respond more effectively to these needs. This is our best effort to do so in a concerted and very sincere way.

I also ask unanimous consent, Mr. President, that the junior Senator from Colorado, Senator BEN NIGHTHORSE CAMPBELL, be added as a cosponsor to this amendment.

The PRESIDING OFFICER (Mr. AKAKA). Without objection, it is so ordered.

Mr. DASCHLE. Mr. President, the distinguished Senator from Idaho has shown remarkable patience tonight. So while I have a much longer statement and full explanation of what our amendment would do, I would like to elaborate more tomorrow on each of the provisions. We got a good start tonight from the Senator from West Virginia, so there is no need to further delay this evening.

I am aware that a number of housekeeping chores are required, and I will do that and then yield the floor to the distinguished Senator from Idaho.

MORNING BUSINESS

SENATOR CAROL MOSELEY-BRAUN REMEMBERS CECIL PARTEE

Ms. MOSELEY-BRAUN. Mr. President, many of the actions I have taken in my life have been heralded as firsts. But, people like Cecil Partee were firsts before I was even born and made my way possible. Mr. Partee was an example to me—an example of how to be an excellent legislator, an example of how to use the political system to make people's lives better, and an example of how to reach goals and hold on to dreams.

Cecil Partee believed in the Dream of America, and he proved, time and time again, that excellence and merit and hard work could overcome the odds and barriers he faced as an American of African descent. He was always a gentleman, and personified the dignity and class that are borne of struggle and achievement.

When I first ran for the general assembly, Cecil Partee was one of the first to become a friend and resource. Sometimes I would go down to his office just to sit and talk with him, and learn from his intelligence, his patience, and his experience. He was a mentor to me, and to countless others who saw public service as a noble calling.

Mr. Partee was born in Arkansas in 1921. He attended Tennessee State University for his undergraduate degree and then chose to pursue a career in law. The University of Arkansas would not accept him, however. They did not admit African-Americans at the time. The university agreed to pay his way to a northern law school. He chose Northwestern University Law School in Evanston. We can be thankful he came to Illinois and even more thankful that he stayed.

He passed the Illinois bar in 1947, but was not allowed to attend the congratulatory dinner with the other new lawyers, because the hotel where the dinner was held did not allow African-Americans. A year later Mr. Partee started his public career as an assistant state's attorney. In 1956, he was first elected to the Illinois House of Representatives.

Mr. Partee went on to serve for 10 years in the Illinois House of Representatives and for 10 years in the Illinois Senate. He was the first African-American to be president of the Senate, a post he held from 1971–73 and 1975–77.

He had a reputation as an astute and able legislator who fought to make the lives of ordinary citizens better. He worked to eradicate discrimination in the public and private sectors. He wanted to make sure that people could get good jobs and decent homes, whatever their race or nationality. He worked to ensure that consumers were treated fairly under the law. Most importantly, he worked to bring people together, and to eliminate barriers to real communication. He was a warrior in the battle to make the American dream a reality for all.

In 1989, Mr. Partee was named state's attorney. He took over the position from Mayor Daley, and served in that capacity for a year. He also served as city treasurer in Chicago for three terms.

The people of Illinois owe a great debt to Cecil Partee. He spent many of his years serving us, leading us, and making our lives better. His legacy is inspiring and tangible.

Partee's wife and their two children and two grandchildren have much to be proud of and much to miss. He was a good man, a pioneer, and a great politician. I will miss him. We will all miss him.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. DASCHLE. Mr. President, I ask unanimous consent that the Senate proceed to executive session to consider the following nominations: Calendar Order No. 1121, Ricardo Martinez, to be Administrator of the National Highway Traffic Safety Administration; Calendar Order No. 1122, Dharmendra K. Sharma, to be Administrator of Research and Special Programs Administration, Department of Transportation; Calendar Order No. 1124, Harold J. Creel, Jr., to be a Federal Maritime Commissioner; Calendar Order No. 1125, Delmond J.H. Won, to be a Federal Maritime Commissioner; Calendar Order No. 1127, Alexander Williams, Jr., to be a U.S. district judge; Calendar Order No. 1128, Charles Redding Pitt, to be a U.S. attorney; Calendar Order No. 1129, Larry Reed Mattox, to be a U.S. Marshal; Calendar Order No. 1130, Walter Baker Edmisten, to be a U.S. Marshal; Calendar Order No. 1131, Thomas Joseph Maroney, to be a U.S. attorney; and all nominations placed on the Secretary's desk in the Coast Guard.

I further ask unanimous consent that the nominees be confirmed en bloc; that any statements appear in the RECORD as if read; that upon confirmation, the motions to reconsider be laid upon the table en bloc; that the President be immediately notified of the Senate's actions; and that the Senate return to legislative session.

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

The nominations considered and confirmed en bloc are as follows:

DEPARTMENT OF TRANSPORTATION

Ricardo Martinez, of Louisiana, to be Administrator of the National Highway Traffic Safety Administration.

Dharmendra K. Sharma, of California, to be Administrator of the Research and Special Programs Administration, Department of Transportation.

FEDERAL MARITIME COMMISSION

Harold Jennings Creel, Jr., of Virginia, to be a Federal Maritime Commissioner for the term expiring June 30, 1999.

Delmond J. H. Won, of Hawaii, to be a Federal Maritime Commissioner for the term expiring June 30, 1997.

THE JUDICIARY

Alexander Williams, Jr., of Maryland, to be United States District Judge for the District of Maryland.

DEPARTMENT OF JUSTICE

Charles Redding Pitt, of Alabama, to be United States Attorney for the Middle District of Alabama for the term of four years.

Larry Reed Mattox, of Virginia, to be United States Marshal for the Western District of Virginia for the term of four years.

Walter Baker Edmisten, of North Carolina, to be United States Marshal for the Western District of North Carolina for the term of four years.

Thomas Joseph Maroney, of New York, to be United States Attorney for the Northern District of New York for the term of four years.

NOMINATIONS PLACED ON THE SECRETARY'S DESK

IN THE COAST GUARD

Coast Guard nominations beginning Roger K. Wiebusch, and ending Robert W. Montfort, which nominations were received by the Senate and appeared in the Congressional Record of May 17, 1994.

Coast Guard nomination of Kay L. Hickman, which was received by the Senate and appeared in the Congressional Record of May 17, 1994.

Coast Guard nominations beginning Mark L. Everett, and ending Euill W. Long, III, which nominations were received by the Senate and appeared in the Congressional Record of July 27, 1994.

STATEMENT ON THE NOMINATION OF RICARDO MARTINEZ

Mr. HOLLINGS. Mr. President, I urge my colleagues to support the nomination of Ricardo Martinez to be Administrator of the National Highway Traffic Safety Administration [NHTSA]. His nomination was unanimously approved by the Committee on Commerce, Science, and Transportation at its executive session on August 11, 1994.

NHTSA was established to reduce the number of deaths, injuries, and economic losses resulting from traffic accidents on the Nation's highways. Armed with that mission, the agency plays a vital role in reducing health care costs, by promoting safety of cars and light trucks.

If confirmed as Administrator, Dr. Martinez will bring a fresh perspective to the agency with his extensive medical background in trauma services and injury control and prevention. The nominee is currently serving as a consultant to Secretary of Transportation Peña on health issues. Prior to this, he most recently served as associate professor of surgery and emergency medicine at Emory University school of medicine. From 1985 to 1993, Dr. Martinez served in various positions at Stanford University, including associate director of trauma service at the university's hospital, and clinical assistant professor in the Department of surgery at the school of medicine. In addition, Dr. Martinez has written extensively on medical issues, and his works have been published in numerous medical journals, magazines, and books.

At his confirmation hearing on April 21, 1994, Dr. Martinez stressed his commitment to injury prevention, and the need to reinvigorate NHTSA to prepare it for the challenges of the next century. He also acknowledged NHTSA's role with respect to consumer education, as well as the important mandate the agency has to set CAFE [Corporate Average Fuel Economy] standards, and to analyze and disseminate data concerning fuel economy issues.

This nominee deserves our support, and I urge my colleagues to join me in approving Dr. Ricardo Martinez to be NHTSA Administrator.

STATEMENT ON THE NOMINATION OF DHARMENDRA K. SHARMA

Mr. HOLLINGS. Mr. President, I am pleased that the Senate is considering the nomination of Dharmendra K. Sharma to be Administrator of the Research and Special Programs Administration [RSPA] of the U.S. Department of Transportation [DOT]. At its executive session on August 11, 1994, the Committee on Commerce, Science, and Transportation unanimously ordered this nomination reported favorably.

The position of Administrator of RSPA is a critical one. RSPA is responsible for hazardous materials transportation and pipeline safety, transportation emergency preparedness, safety training, multimodal transportation research and development activities, and the collection and dissemination of air carrier economic data. Two of the more significant offices within RSPA are the Office of Hazardous Materials Safety, which develops and issues regulations for the safe transportation of hazardous materials by all modes, and the Office of Pipeline Safety, which establishes and provides for compliance with standards that assure public safety and environmental protection in the transportation of gas and hazardous liquids by pipeline.

The nominee brings to this position a broad range of technical, research, analytical, and management abilities. He has demonstrated expertise in the fields of energy, science, and technology. For over 10 years Dr. Sharma has served as a Manager with the Electric Power Research Institute [EPRI], and prior to that he worked for the General Electric Co.

This nominee has demonstrated his understanding of the critical issues facing RSPA. He understands the need for greater vigilance over RSPA's pipeline safety program and the need for some form of comprehensive "one-call" legislation so that the number of pipeline accidents may be reduced. In addition, Dr. Sharma's background and expertise will allow him to assist Secretary Peña in the area of transportation technology development, a cornerstone of this Administration's plan for the future.

Mr. President, I am confident that Dharmendra K. Sharma's professional background and experience have prepared him well for the tremendous challenges confronting DOT and our Nation's system of transportation. I welcome this opportunity to recommend Dharmendra K. Sharma's confirmation as RSPA Administrator, and I urge my colleagues to join me in approving this nomination.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous, the Senate will now return to legislative session.

REPORT ON THE CONTINUATION OF THE EMERGENCY RELATIVE TO THE NATIONAL UNION FOR THE TOTAL INDEPENDENCE OF ANGOLA [UNITA]—MESSAGE FROM THE PRESIDENT—PM 139

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Banking, Housing, and Urban Affairs.

To the Congress of the United States:

Section 202(d) of the National Emergencies Act (50 U.S.C. 1622(d)) provides for the automatic termination of a national emergency unless, prior to the anniversary date of its declaration, the President publishes in the Federal Register and transmits to the Congress a notice stating that the emergency is to continue in effect beyond the anniversary date. In accordance with this provision, I have sent the enclosed notice, stating that the emergency declared with respect to the National Union for the Total Independence of Angola ["UNITA"] is to continue in effect beyond September 26, 1994, to the Federal Register for publication.

The circumstances that led to the declaration on September 26, 1993, of a national emergency have not been resolved. The actions and policies of UNITA pose a continuing unusual and extraordinary threat to the foreign policy of the United States. United Nations Security Council Resolution 864 (1993) continues to oblige all Member States to maintain sanctions. Discontinuation of the sanctions would have a prejudicial effect on the Angolan peace process. For these reasons, I have determined that it is necessary to maintain in force the broad authorities necessary to apply economic pressure to UNITA to reduce its ability to pursue its aggressive policies of territorial acquisition.

WILLIAM J. CLINTON.

THE WHITE HOUSE, *August 17, 1994.*

REPORT ON BELARUS AND UZBEKISTAN RELATIVE TO THE GENERALIZED SYSTEM OF PREFERENCES—MESSAGE FROM THE PRESIDENT—PM 140

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Finance.

To the Congress of the United States:

I am writing to inform you of my intent to add Belarus and Uzbekistan to the list of beneficiary developing countries under the Generalized System of Preferences [GSP]. The GSP program offers duty-free access to the U.S. market and is authorized by the Trade Act of 1974.

I have carefully considered the criteria identified in sections 501 and 502 of the Trade Act of 1974. In light of these criteria, and particularly the level of development and initiation of economic reforms in Belarus and Uzbekistan, I have determined that it is appropriate to extend GSP benefits to these two countries.

This notice is submitted in accordance with section 502(a)(1) of the Trade Act of 1974.

WILLIAM J. CLINTON.

THE WHITE HOUSE, *August 17, 1994.*

MESSAGES FROM THE HOUSE

At 3:59 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 3508. An act to provide for tribal self-governance, and for other purposes.

H.R. 4709. An act to make certain technical corrections, and for other purposes.

H.R. 4867. An act to authorize appropriations for high-speed rail transportation, and for other purposes.

H.R. 4868. An act to amend the Railroad Unemployment Insurance Act to reduce the waiting period for benefits payable under that Act, and for other purposes.

H.R. 4884. An act to authorize noncompetitive, career or career-conditional appointments for employees of the Criminal Justice Information Services of the Federal Bureau of Investigation who do not relocate to Clarksburg, West Virginia.

The message also announced that the House agrees to the amendment of the Senate to the bill (H.R. 1305) to make boundary adjustments and other miscellaneous changes to authorities and programs of the National Park Service, with an amendment, in which it requests the concurrence of the Senate.

The message further announced that the House agrees to the amendments of the Senate to the bill (H.R. 2947) to extend for an additional 2 years the authorization of the Black Revolutionary War Patriots Foundation to establish a memorial.

The message also announced that the House disagrees to the amendments of the Senate to the bill (H.R. 4624) making appropriations for the Departments of Veterans Affairs and Housing and Urban Development, and for sundry independent agencies, boards, commissions, corporations, and offices for the fiscal year ending September 30, 1995, and for other purposes, and agrees to the conference asked by the Senate on the disagreeing votes of the two houses thereon; and appoints Mr. STOKES, Mr. MOLLOHAN, Mr. CHAPMAN, Ms. KAPTUR, Mr. TORRES, Mr. THORNTON, Mr. OBEY, Mr. LEWIS of California, Mr. DELAY, Mr. GALLO, and Mr. MCDADE as the managers of the conference on the part of the House.

At 7:14 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 2182) to authorize appropriations for fiscal year 1995 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 285. Concurrent resolution directing the Secretary of the Senate to make technical corrections in the enrollment of S. 2182.

ENROLLED BILLS SIGNED

At 8:13 p.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the Speaker has signed the following enrolled bills:

H.R. 2815. An act to designate a portion of the Farmington River in Connecticut as a component of the National Wild and Scenic Rivers System.

H.R. 4812. An act to direct the Administrator of General Services to acquire by transfer the Old U.S. Mint in San Francisco, California, and for other purposes.

MEASURES REFERRED

The following bill was read the first and second time by unanimous consent and referred indicated:

H.R. 4907. An act to reform the concept of baseline budgeting; referred jointly, pursuant to the order of August 4, 1977, to the Committee on the Budget, and to the Committee on Governmental Affairs.

H.R. 4709. An act to make certain technical corrections, and for other purposes; to the Committee on Indian Affairs.

H.R. 4868. An act to amend the Railroad Unemployment Insurance Act to reduce the waiting period for benefits payable under that Act, and for other purposes; to the Committee on Labor and Human Resources.

H.R. 4884. An act to authorize noncompetitive, career or career-conditional appointments for employees of the Criminal Justice Information Services of the Federal Bureau of Investigation who do not relocate to Clarksburg, West Virginia; to the Committee on Governmental Affairs.

ENROLLED BILL AND JOINT RESOLUTIONS PRESENTED

The Secretary of the Senate reported that on August 17, 1994, she had presented to the President of the United States, the following enrolled bill and joint resolutions:

S. 2099. An act to establish the Northern Great Plains Rural Development Commission, and for other purposes.

S.J. Res. 153, Joint resolution to designate the week beginning on November 20, 1994 and ending on November 26, 1994, as "National Family Caregivers Week."

S.J. Res. 196. Joint resolution designating September 16, 1994, as "National POW/MIA Recognition Day" and authorizing display of the National League of Families POW/MIA flag.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–3223. A communication from the Secretary of Defense, transmitting, pursuant to law, the report of the Joint Military Net Assessment for calendar year 1994; to the Committee on Armed Services.

EC–3224. A communication from the Acting Chairman of the Nuclear Regulatory Commission, transmitting, pursuant to law, the report on the nondisclosure of Safeguards Information for the period April 1, 1994 through June 30, 1994; to the Committee on Environment and Public Works.

EC–3225. A communication from the Secretary of Housing and Urban Development, transmitting, pursuant to law, the report of the Federal Housing Administration for fiscal year 1993; to the Committee on Governmental Affairs.

EC–3226. A communication from the Assistant Attorney General (Office of Legislative Affairs), transmitting, pursuant to law, the report of the Office for Victims of Crime for fiscal year 1992; to the Committee on the Judiciary.

EC–3227. A communication from the Secretary of Education, transmitting, pursuant to law, the report of final regulations—Strengthening Institutions Program; to the Committee on Labor and Human Resources.

EC–3228. A communication from the Secretary of Education, transmitting, pursuant to law, the report of final regulations—State Independent Living Services Program and Centers for Independent Living Program; to the Committee on Labor and Human Resources.

EC–3229. A communication from the Director of the Congressional Budget Office, transmitting, pursuant to law, the sequestration update report for fiscal year 1995; referred jointly, pursuant to the order of August 4, 1977, to the Committee on the Budget, and to the Committee on Governmental Affairs.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–617. A joint resolution adopted by the Legislature of the State of California; to the Committee on Commerce, Science, and Transportation.

"JOINT RESOLUTION 40

"Whereas, The United States Passenger Services Act allows only United States-flagged ships to sail between United States ports, while foreign-flagged vessels are permitted to sail between California ports only as part of a longer journey; and

"Whereas, Historically, United States-flagged cruise lines were prohibited from offering gambling on board their vessels, while foreign-flagged vessels have always had gambling on board their vessels; and

"Whereas, The United States-flagged cruise industry has had difficulty in competing with foreign-flagged cruise lines; and

"Whereas, In order to level the playing field, in 1992 Congress amended the federal Johnson Act to allow United States cruise ships to offer gambling; and

"Whereas, Congress left the right to regulate or prohibit gambling on voyages or segments of voyages that are intrastate to the individual states, and

"Whereas, California's efforts to prohibit gambling cruises to nowhere have had the effect of prohibiting gambling on cruise ships traveling between California's ports, even as part of a longer journey; and

"Whereas. Cruise ships are declining to visit California ports, citing a ban on cruise ship gambling; now, therefore, be it

"*Resolved, by the Assembly and the Senate of the State of California jointly*, That tourism is an important and vital industry to California, and that passengers disembarking from cruise ships in California ports add significantly to our economic base; and be it further

"*Resolved*, That California memorializes Congress to amend the Johnson Act to remove California's authority to regulate gambling on cruise ships traveling to foreign ports or on segments of voyages going to another state or country; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, and to each Senator and Representative from California in the Congress of the United States."

POM–618. A joint resolution adopted by the Legislature of the State of California; to the Committee on Environment and Public Works.

"JOINT RESOLUTION 52

"Whereas, Providing the American people with safe and wholesome drinking water has long been an important national objective; and

"Whereas, State and local water suppliers have attained this national objective by developing water systems that provide some of the safest drinking water in the world; and

"Whereas, The water suppliers of this country have worked with state and federal officials to ensure this safe water at a reasonable cost; and

"Whereas, Water treatment techniques applied in this country have eradicated waterborne organisms that have historically resulted in widespread disease and death; and

"Whereas, Federal legislation and legislation enacted by many states aims to ensure that the quality of drinking water remains at a level that will protect the public health and safety from the threats posed by contaminants, both naturally occurring and those introduced by human activity, with particular legislative emphasis on significantly reducing public exposure to substances that may cause cancer of birth defects; and

"Whereas, The federal Safe Drinking Water Act (42 U.S.C. 300f et seq.) is the foundation for this nation's drinking water protection, including an aggressive federal regulatory program administered in most states by the United States Environmental Protection Agency (EPA) and, in states that have qualified for "primacy," by state regulatory agencies; and

"Whereas, The technical ability to detect and monitor the presence of substances in drinking water has, in some cases, outstripped scientific understanding of the impact of those substances on public health and safety; and

"Whereas, On at least one occasion, in commenting on proposed federal regulations regarding radon in drinking water, the EPA's own Science Advisory Board criticized the regulatory principles that the EPA has relied on in promulgating regulatory requirements, questioning whether those requirements will significantly improve the public health; and

"Whereas, Increasing regulatory requirements and concomitant costs threaten to make water a very expensive commodity, with the potential to place a significant financial burden on many Californians; and

"Whereas, The use of financial resources to promulgate and enforce water quality regulations, some of which may be of minimal protective value, occurs at a time when the people of this country, particularly those in California are having difficulty providing funding for many government programs and for needed improvements in our public infrastructure; and

"Whereas, National and state water organizations, associations of public health officials, the National Governors Association, and the National Association of State Legislatures, have proposed amendments to the federal Safe Drinking Water Act that will both maintain a program to protect the public health and minimize some of the negative regulatory impacts on the water systems and the water consumers of this country: Now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly* That the Legislature of the State of California respectfully memorializes the President and Congress of the United States, when the federal Safe Drinking Water Act is reauthorized, to adopt amendments to that act that will preserve the federal requirements that ensure the protection of the public health and safety but will reduce the regulatory burden on drinking water providers and, in turn, reduce the financial burden on the citizens of this nation; and

"*Resolved*, That the Legislature respectfully memorializes the President and Congress to adopt amendments to the federal Safe Drinking Water Act recommended by various state and national water organizations, associations of public health officials, and the National Governors Association, that do all of the following:

"(a) Revise present law that requires the EPA to establish water quality standards for 83 specified contaminants and requires the EPA to establish standards every three years thereafter for 25 additional contaminants, to, instead, require standards to be established in addition to the original list of 83 contaminants only when it is determined that a substance present in drinking water poses a potential public health risk.

"(b) Require the EPA to revise the list of regulated substances or the standards applicable to those substances if new scientific findings indicate that a regulated substance does not pose a threat to the public health or safety or does not require as stringent a standard.

"(c) Revise monitoring requirements so that the frequency of routine testing and reporting is reduced to a minimum when a

public water system demonstrates that a substance is not, and has not historically been, present in its water supply.

"(d) Replace existing public notification requirements that may cause undue public concern with more flexible rules that allow for adjusting the content of a public notice to the degree of health risk present.

"(e) Recognize that, while some substances that pose a health hazard, such as radon, may be present in water, remediation efforts should be more heavily focused on the medium that poses the greatest risk of exposure, such as indoor air in the case of radon exposure, where those remedial efforts are more likely to provide the greatest public health benefits; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, to each Senator and Representative from California in the Congress of the United States, and to the Administrator of the Environmental Protection Agency."

POM-619. A joint resolution adopted by the Legislature of the State of California; to the Committee on Environment and Public Works.

"JOINT RESOLUTION 51

"Whereas, The Metropolitan Water District of Southern California, Upper San Gabriel Valley Municipal Water District, Three Valleys Municipal Water District, San Gabriel Valley Municipal Water District, and the Main San Gabriel Basin Watermaster jointly studied conjunctive use as a means to control the migration of groundwater contamination in the Main San Gabriel Groundwater Basin; and

"Whereas, The Federal Environmental Protection Agency published the Baldwin Park Operable Unit Feasibility Study Report and Proposed Plan; and

"Whereas, The feasibility study includes an analysis of four project design alternatives to remedy contaminated groundwater in the Main San Gabriel Groundwater Basin, with two of the four project design alternatives incorporating the elements of conjunctive use; and

"Whereas, The Federal Environmental Protection Agency selected an alternative in the Proposed Plan that did not incorporate conjunctive use as the plan's preferred remedy; and

"Whereas, The Region IX Administrator of the Environmental Protection Agency is scheduled to sign the Record of Decision (ROD) for the Baldwin Park Operable Unit Cleanup Project in late March or early April; and

"Whereas, Following the signing of the ROD, negotiations to compel the responsible parties to design and construct the selected remedy will begin; and

"Whereas, The Board of Directors of the Metropolitan Water District of Southern California has committed financial support for a Baldwin Park Operable Unit Cleanup Project that incorporates conjunctive use; and

"Whereas, Public Law 102-575 authorizes 25 percent cost sharing from the Bureau of Reclamation for a Baldwin Park Operable Unit Cleanup Project that incorporated conjunctive use; and

"Whereas, The combined funding provided by the Metropolitan Water District of Southern California and the federal Bureau of Reclamation could potentially provide cost savings for the responsible parties; and

"Whereas, The Metropolitan Water District of Southern California and the Main San Gabriel Basin Watermaster, the court-appointed entity having the responsibility for managing the Main San Gabriel Groundwater Basin, are working to develop the Conjunctive Use and Basin Cleanup Agreement to govern the operation and management of conjunctive use in the Main San Gabriel Groundwater Basin; and

"Whereas, The incorporation of conjunctive use into the remedial design would accomplish the objectives of controlling the migration of groundwater contaminants and maximizing contaminant removal; and

"Whereas, The California Legislature concludes that the incorporation of conjunctive use into the remedial design would provide broad benefits to the Main San Gabriel Groundwater Basin and the affected region that are superior to those that would be realized by the alternative selected by the federal Environmental Protection Agency in the Proposed Plan; and

"Whereas, The California Legislature believes that the incorporation of conjunctive use into the remedial design would be the preferred means by which to remove significant contamination and to augment the region's water supply: Now therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the Administrator of the Environmental Protection Agency to incorporate conjunctive use into the remedial design for the purpose of remedying groundwater contamination in the Main San Gabriel Groundwater Basin; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, to each Senator and Representative from California in the Congress of the United States, and to the Administrator of the Environmental Protection Agency."

POM-620. A joint resolution adopted by the Legislature of the State of California; to the Committee on Finance.

"JOINT RESOLUTION 1

"Whereas, The closing of Norton Air Force Base in March of 1994 will result in the loss of more than 4,000 jobs in the San Bernardino area; and

"Whereas, The site of Norton Air Force Base is ideally suited for the location of a foreign trade zone center and the existing base airport and surrounding facilities could be easily adapted to accommodate a foreign trade zone; and

"Whereas, Foreign trade zones are designated sites licensed by the Foreign Trade Zones Board under the United States Department of Commerce that permit domestic transactions involving foreign products to take place as if those transactions were conducted outside United States Customs territory, thus offsetting trade advantages available to foreign producers who export in competition with United States producers; and

"Whereas, Foreign trade zones facilitate and expedite international trade, assist in state and local economic development efforts, and create new employment opportunities; and

"Whereas, A foreign trade zone center at Norton Air Force Base, in addition to the Lockheed Corporation facility and a proposed Department of Defense Finance Accounting Center, would serve as anchor tenants employing nearly 10,000 people: Now, therefore, be it

"*Resolved by the Assembly and the Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and the Congress of the United States and the Foreign Trade Zone Board under the United States Department of Commerce to designate the airport located at Norton Air Force Base in San Bernardino County as a foreign trade zone center; and be it further

Resolved, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, the Secretary of Commerce, the Chairman of the Foreign Trade Zone Board, the Speaker of the House of Representatives, and each Senator and Representative from California in the Congress of the United States."

POM-621. A joint resolution adopted by the Legislature of the State of California; to the Committee on Finance.

"ASSEMBLY JOINT RESOLUTION 69

"Whereas, the lingering recession has hit California families hard through the loss of jobs and deflation of the housing market; and

"Whereas, many Californians have had sizable amounts of money invested in their homes; and

"Whereas, many Californians have suffered from deep depreciation in the value of their homes and are being forced, by circumstances, to sell their homes for a loss; and

"Whereas, the Internal Revenue Code treats nonreinvested profits from the sale of a home as capital gain; and

"Whereas, the same tax code makes no comparable allowance for those who realize a capital loss on the sale of a home: Now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and Congress of the United States to provide tax relief to homeowners caught in the largest housing market depression in many years by providing for the recognition of a capital loss on the sale of a principal residence; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, and to each Senator and Representative from California in the Congress of the United States."

POM-622. A joint resolution adopted by the Legislature of the State of California; to the Committee on Finance.

"ASSEMBLY JOINT RESOLUTION 70

"Whereas, the federal income tax burden during the past four decades has increased by more than 300 percent as a share of family income; and

"Whereas, measuring average after-tax per capita income, families with children are the lowest income group in America, with average after-tax income below that of elderly households, single persons, and couples without children; and

"Whereas wage stagnation and an ever-increasing tax burden has forced a growing number of families to rely on two wage earners to make ends meet; and

"Whereas, in 1948, a family of four at the median family income level paid just 2 percent of its income to the federal government in taxes; and

"Whereas, in 1989, that same family paid nearly 24 percent of its income to the federal government in taxes; and

"Whereas, the personal exemption for children was intended to help offset the costs of raising a child; and

"Whereas, in 1948, the personal exemption was six hundred dollars ($600), or roughly 20 percent of the median income for two-parent families, and for a family of four shielded 80 percent of personal income from taxation; and

"Whereas, to have the same value to families today as it did in 1948, the personal exemption would have to be raised from two thousand three hundred fifty dollars ($2,350) to eight thousand dollars ($8,000) and continue to be indexed to inflation; and

"Whereas, the effect of this ever-shrinking exemption penalizes the most vulnerable members of our society, our children; and

"Whereas, our children are the most likely members of our society to live in poverty, in part because their parents are not able to keep enough of their wages after taxes to properly feed, clothe, and shelter their children; and

"Whereas, in 1948, as much as 80 percent of personal income was exempt from federal income taxation, and this relatively low level of taxation helped to fuel the growth of the strongest economy in the world; and

"Whereas, our economy would be strengthened by returning substantial tax dollars to our citizens; and

"Whereas, American families are struggling to make ends meet; and

"Whereas, the fact that an increasing number of our children grow up in single-parent households makes it all the more imperative that we relieve the tax burden on their parents: Now therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and the Congress of the United States to reduce the tax burden on children and families by restoring the inflation-eroded value of the personal exemption by increasing that exemption from two thousand three hundred fifty dollars ($2,350) to eight thousand dollars ($8,000), and continuing to index the exemption to inflation; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, the Speaker of the House of Representatives, and each Senator and Representative from California in the Congress of the United States."

POM-623. A joint resolution adopted by the Legislature of the State of California; to the Committee on Foreign Relations.

POM-624. A joint resolution adopted by the Legislature of the State of California; to the Committee on Foreign Relations.

"ASSEMBLY JOINT RESOLUTION 75

"Whereas, the President of the United States and the President of Mexico signed an agreement on August 14, 1993, entitled 'Agreement Between the United States of American and United Mexican States in Cooperation for the Protection and Improvement of the Environment in the Border Area'; and

"Whereas, the Board of Supervisors of Imperial County and the Mexican State of Baja California Norte, on December 14, 1993, entered into a memorandum of understanding concerning environmental matters; and

"Whereas, the recent approval of the North American Free Trade Agreement (NAFTA) strengthens the economic and environmental ties between Mexico and the United States; and

"Whereas, the New River, which originates in Mexico and flows northward across the international boundary into California's Imperial County, is the most contaminated river in the United States, and is aesthetically repulsive to the residents of, and visitors to, Imperial County; and

"Whereas, the Governor, on October 6, 1993, documented the health and public safety dangers associated with the unregulated discharges into the New River in a state of emergency proclamation; and

"Whereas, due to the international nature of this problem, it is the obligation if the United States, on behalf of the residents of the State of California and Imperial County, to implement adequate measures to correct the contamination of the New River caused by discharges within the Republic of Mexico; and

"Whereas, the contamination of the New River is caused by uncontrolled discharges of raw and inadequately treated sewage, highly toxic industrial, chemical solid and geothermal waste and seepage from major garbage dumps slaughter houses, and industrial refuse within or near the City of Mexicali into the New River; and

"Whereas, the contaminated waters of the New River flow into the Salton Sea, which discharges are incompatible with the ecological, recreational, and other beneficial uses associated with the Salton Sea; and

"Whereas, Federal, state, and local public officials have documented the clear and present danger that the contaminated New River presents to residents of, and visitors to, Imperial County; and

"Whereas, immediate action to clean up the New River is essential for the health and safety of the public: Now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California jointly*, That the Legislature of the State of California respectfully memorializes the President and the Congress of the United States to implement measures in cooperation with the Republic of Mexico and state and local public officials, to correct the contamination of the New River caused by discharges within the Republic of Mexico; and be it further

"*Resolved*. That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, the Speaker of the House of Representatives, each Senator and Representative from California in the Congress of the United States, the Secretary of the Interior, the Administrator of the Environmental Protection Agency, and the Governor of California."

POM-625. A joint resolution adopted by the Legislature of the State of California; to the Committee on the Judiciary.

"ASSEMBLY JOINT RESOLUTION 77

"Whereas, the prison system in California is seriously overcrowded and is currently operating at 180 percent capacity; and

"Whereas, approximately 16,000 or 15 percent of all prison inmates who are imprisoned in California are undocumented aliens who have been convicted of felony offenses under state law; and

"Whereas, the cost of imprisonment in California is twenty-two thousand dollars ($22,000) per prison inmate per year, which totals approximately three hundred fifty million dollars ($350,000,000) per year to imprison undocumented alien criminal offenders; and

"Whereas, the federal government is responsible for immigration policy and should bear the cost of imprisonment for undocumented alien criminal offenders; and

"Whereas, the Congress of the United States is considering the construction of 10 new regional federal prisons as part of the Omnibus Crime Bill: Now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and the Congress of the United States to immediately enact legislation to construct new federal prisons and to transfer undocumented alien criminal offenders who are presently imprisoned in state prisons to the new federal facilities as a first priority in order to relieve California and other states from the financial burden of imprisoning dangerous convicted criminals who have entered the country illegally; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, the Attorney General of the United States, the Speaker of the House of Representatives, and each Senator and Representative from California in the Congress of the United States."

POM-626. A joint resolution adopted by the Legislature of the State of California; to the Committee on the Judiciary.

"ASSEMBLY JOINT RESOLUTION 84

"Whereas, the Armenians, among us, have contributed to the progress and betterment of life through agriculture, commerce, teaching, the professions, churches, and community and worldwide organizations; and

"Whereas, the United States of America has repeatedly gone on record in support of human rights around the world; and

"Whereas, it is well documented that approximately 1,500,000 Armenians were massacred in Turkey during the years 1915 to 1918, although this genocide has been consistently denied by the Turkish government; and

"Whereas, by their own resolute Christian faith and will to survive and live again, and the generosity of many in the United States of America resulting in relief operations, a fraction of the survivors were rescued and subsequently immigrated to this country; and

"Whereas, the Armenians in some other countries must continue to endure daily acts of oppression, such as denial of their basic human rights, confiscation of their churches and schools, and punishment for speaking their native language openly; and

"Whereas, April 24, 1915, is the date historians have marked as the beginning of the massacre and consequently this day should be a day of reflection by all Armenians and other Americans; now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and the Congress of the United States to designate April 24 as 'National Day of Remembrance' and requests the President of the United States to issue a proclamation calling upon the people of the United States to observe that day as a day of remembrance for all the victims of genocide, especially those of Armenian ancestry who succumbed to the genocide perpetrated in 1915, and in whose memory this date is commemorated by all Armenians and their friends throughout the world; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to

the President and Vice President of the United States, to the Speaker of the House of Representatives, and to each Senator and Representative from California in the Congress of the United States."

POM-627. A joint resolution adopted by the Legislature of the State of California; to the Committee on the Judiciary.

"ASSEMBLY JOINT RESOLUTION 78

"Whereas, Congress has proposed to create the 'Public Safety Partnership and Community Policing Act of 1993,' establishing a program of grants and assistance to the states for a period of six years for the hiring and rehiring of additional career law enforcement officers; and

"Whereas, the purpose of this program is to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and to otherwise enhance public safety; and

"Whereas, the ability of state and local law enforcement agencies to qualify for these grants is dependent on their ability to provide matching funds; and

"Whereas, these nonfederal matching funds must provide 25 percent of costs of the program, project, or activity provided under a grant; and

"Whereas, for a grant for a period exceeding one year for hiring or rehiring career law enforcement officers, the federal share shall decrease from year to year for up to five years when state or local grant recipients shall be required to fully fund the program, project, or activity provided under a grant; and

"Whereas, the State of California has been experiencing a severe, persistent, and continuing recession that has resulted in four successive years of contraction of the state and local budgets; and

"Whereas, as a result of the recession, most California law enforcement agencies have seen a reduction in their budgets; and

"Whereas, declining revenues will make it impossible for many California law enforcement agencies to meet the matching funds requirement contained within the proposed 'Public Safety Partnership and Community Policing Act of 1993' without impacting existing programs; and

"Whereas, those California communities suffering the most severe budget shortfalls are experiencing the greatest impact of crime and would benefit most from access to the federal grant program; now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and the Congress of the United States to include in the 'Public Safety Partnership and Community Policing Act of 1993' an exemption for California law enforcement agencies from meeting the matching funds requirement; and be it further

"*Resolved*, That if no exemption for California law enforcement agencies is forthcoming, the President and the Congress should give the Attorney General broad authority to waive the matching funds requirement; and be it further

"*Resolved*, That local officials should also be permitted to use the funds in the most flexible manner so that they may be applied to the most pressing local needs, which include using the funds to keep existing police officers on the streets longer, for improved communications technology, and for necessary equipment; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, and to each Senator and Representative from California in the Congress of the United States."

POM-628. A joint resolution adopted by the Legislature of the State of California; to the Committee on the Judiciary.

"JOINT RESOLUTION 46

"Whereas, An estimated 18,000 illegal aliens who are convicted felons are being housed and fed in California's state prisons, five times more than any other state, have cost California taxpayers more than one billion dollars in the last five years, and will cost a projected $375 million during the 1994-1995 fiscal year; and

"Whereas, California's prisons are overcrowded at 180 percent of capacity; and

"Whereas, California's current inmate population is over 120,000 inmates as of March 1994, which is nearly double the system's design capacity; and

"Whereas, The state prison population is projected to grow to at least 141,000 by 1997-1998; and

"Whereas, California is suffering from a severe fiscal crisis; and

"Whereas, The United States Congress is making trade agreements with other countries: Now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and the Congress of the United States to negotiate with countries to whom the United States gives foreign aid or with whom the United States enters into trade agreements, for an agreement to require that nationals convicted of felonies in the United States, when they have entered the United States illegally, serve their prison sentences in their country of origin and that the term of each sentence to be served in a country of origin shall be comparable to the sentence imposed in the state within the United States wherein the crime occurred; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, and to each Senator and Representative from California in the Congress of the United States."

POM-629. A joint resolution adopted by the Legislature of the State of California; to the Committee on the Judiciary.

"JOINT RESOLUTION 81

"Whereas, United States Senator Dianne Feinstein (D-California) has introduced a bill (S. 1522) which would direct the United States Sentencing Commission to promulgate guidelines or amend existing guidelines to provide sentencing enhancements of not less than three offense levels for hate crimes; and

"Whereas, United States Congressman Charles E. Schumer (D-New York) has introduced a bill (H.R. 1152) which would direct the United States Sentencing Commission to promulgate guidelines or amend existing guidelines to provide sentencing enhancements of not less than three offense levels for hate crimes; and

"Whereas, Those two bills combine to make up the 'Hate Crimes Sentencing Enhancement Act of 1994'; and

"Whereas, The Sacramento area has witnessed and is still recovering from a series of racially motivated violent incidents, including the firebombings of the local National Association for the Advancement of Colored People headquarters, the Japanese-American Citizens League headquarters, the office of the Department of Fair Employment and Housing, the home of City Councilman Jimmie Yee, and the B'Nai Israel Synagogue; and

"Whereas, California is a multiracial, multicultural state which expects to have a majority of communities of color by the year 2010; and

"Whereas, The Legislature has demonstrated repeated dedication to the abolition of hate crimes by passing major pieces of hate crimes legislation that have come before them: Now, therefore, be it

"*Resolved, by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and the Congress of the United States to swiftly pass and sign into law the "Hate Crimes Sentencing Enhancement Act of 1994"; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and the Vice President of the United States, to the Speaker of the House of Representatives, and to each Senator and Representative from California in the Congress of the United States."

POM-630. A joint resolution adopted by the Legislature of the State of California; to the Committee on the Judiciary.

"JOINT RESOLUTION 60

"Whereas, Persons who lawfully reside in the United States, whether they be American citizens, immigrants, or persons working or studying in the United States on a visa, have traditionally been assured their spouses and children could also lawfully reside in the United States; and

"Whereas, Family unity has always been a cornerstone of American immigration policy; and

"Whereas, The spouses and children of persons who have become permanent residents, through the amnesty provisions of the Federal Immigration Reform and Control Act of 1986 (IRCA) do not enjoy the same derivative rights; and

"Whereas, The result is that the spouses and children of many of the nearly 1.5 million persons in California who have become permanent residents of the United States are subject to deportation as undocumented persons even though their spouses or parents may lawfully reside and work in the United States; and

"Whereas, The federal Immigration and Naturalization Service has deported or has begun procedures to deport the spouses and children of persons who have in good faith secured amnesty under the laws of the United States; and

"Whereas, It is a waste of taxpayer funds to commence deportation proceedings, resulting in costly litigation, when virtually all of the children and spouses of persons granted amnesty under IRCA will eventually become lawful permanent residents through petitions filed by their spouses or parents within a few years; and

"Whereas, The two separate amnesty provisions of IRCA were available to applicants for the period of May 5, 1987, to November 30, 1988, inclusive, and thus, the persons and families affected are necessarily limited in number; and

"Whereas, It would not be in the sense of fairplay and justice to destroy families; and

"Whereas, It is nonsensical for American society to grant amnesty to parents and

leave their children subject to deportation: Now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the State of California respectfully memorializes the President and Congress of the United States to do all of the following:

(1) Review the actions of the Immigration and Naturalization Service with respect to deportation procedures for the children and spouses of permanent residents who were under the amnesty provisions of IRCA and (2) amend Section 301 of the Immigration Act of 1990 to ensure that the spouses and children of permanent residents who are legalized under the amnesty provisions of IRCA are afforded family unity protection; and be it further

"*Resolved*, That the President is strongly urged to issue an executive order that will direct the Immigration and Naturalization Service to cease any deportation actions that it may be taking against the spouses and children of permanent residents until the effective date of the amendments to Section 301 of the Immigration Act of 1990 described above; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, and to each Senator and Representative from California in the Congress of the United States."

POM-631. A joint resolution adopted by the Legislature of the State of California; to the Committee on Labor and Human Resources.

"ASSEMBLY JOINT RESOLUTION 80

"Whereas, it is estimated that one of every nine women in the United States will develop breast cancer, with more than 36,000 women in their 40s dying each year from this disease; and

"Whereas, there were 175,000 new cases of breast cancer diagnosed and 44,500 breast cancer deaths reported in 1991; and

"Whereas, the five-year relative survival rate in women whose breast cancer is detected early when the disease is localized is over 90 percent, while the five-year relative survival rate drops to 18 percent when the disease is not detected early; and

"Whereas, breast cancer is a critical health concern for women, not only because it threatens life itself, but also because of its impact on the self-image and quality of life of women; and

"Whereas, women are more likely than men to have no health insurance because they are concentrated in small businesses and low-wage, part-time, or temporary work and their health needs and the illnesses that are more prevalent in women, such as breast cancer, have historically been ignored in clinical research: Now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Legislature of the state of California memorializes the President and the Congress of the United States to include the provision for mammograms and other women's health care needs as an integral part of any nationwide health care benefit reform package; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and the Vice President of the United States, to the Speaker of the House of Representatives, and each Senator and Representative from California in the Congress of the United States."

POM-632. A joint resolution adopted by the Legislature of the State of California; to the Committee on Labor and Human Resources.

"ASSEMBLY JOINT RESOLUTION 44

"Whereas, today, over 37 million Americans and over 6 million Californians lack health insurance, constituting a public crisis that adversely impacts the quality of our health as well as our economy; and

"Whereas, title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) has brought relief to approximately one million Americans every year who face the loss of group health insurance through termination of employment, the death of a spouse, or other qualifying event; and

"Whereas, the Consolidated Omnibus Budget Reconciliation Act of 1985 requires employers to offer, at the employee's expense, the continuation of group health insurance at group rates, to enrollees and their eligible dependents whose group coverage would otherwise end due to termination of employment, death of a spouse, or other qualifying event; and

"Whereas, the terminated employee, the spouse of a deceased employee, or other dependent, may continue coverage for 18 to 36 months after a change in work or family status; and

"Whereas, the rate for coverage is not to exceed 102 percent of the applicable premium charged for that employee's coverage for the applicable period preceding that employee's termination of employment; and

"Whereas, a gap exists in this continuation coverage, to wit, terminated employees or dependents of employees cannot continue their COBRA coverage beyond 36 months; and

"Whereas, Americans between the ages of 50 and 64 who lose group health insurance often have difficulty replacing it with affordable insurance and are disproportionately affected by this gap in COBRA coverage; Now, therefore, be it

"*Resolved by the Assembly and Senate of the State of California, jointly*, That the Congress and President of the United States are respectfully memorialized to extend the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) to enable individuals 50 years of age or older to continue participating in their employer provided group health plan after a qualifying event until the qualified beneficiary or beneficiary's spouse has attained the age to qualify for Medicare, or a beneficiary's dependent minor has reached the legal age of adulthood; and be it further

"*Resolved*, Consistent with existing law, continuation coverage shall provide for health care benefits at a rate not to exceed 102 percent of the premium charged for that employee's coverage for the applicable period preceding that employee's termination of employment or change in work status without medical qualification or exclusions for preexisting medical conditions; and be it further

"*Resolved*, That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives, to each Senator and Representative from California in the Congress of the United States, to the Majority Leader of the United States Senate, and to the United States Secretary of Health and Human Services."

POM-633. A resolution adopted by Board of County Commissioners, Okaloosa County, Florida relative to Federal mandates; to the Committee on Governmental Affairs.

REPORTS OF COMMITTEES

The following report of committees were submitted on August 16, 1994:

By Mr. INOUYE, from the Committee on Indian Affairs, with an amendment:

H.R. 734: A bill to amend the Act entitled "An Act to provide for the extension of certain Federal benefits, services, and assistance to the Pascua Yaqui Indians of Arizona, and for other purposes." (Rept. No. 103-338).

The following report of committees were submitted on August 17, 1994:

By Mr. INOUYE, from the Committee on Indian Affairs, with an amendment in the nature of a substitute:

S. 2329. A bill to settle certain Indian land claims within the State of Connecticut, and for other purposes (Rept. No. 103-339).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. ROTH:

S. 2400. A bill to establish the Northern Yukon-Arctic International Wildlife Refuge, and for other purposes; to the Committee on Environment and Public Works.

By Mr. DECONCINI:

S. 2401. A bill to establish the National Commission on Major League Baseball, and for other purposes; to the Committee on Commerce, Science, and Transportation.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. ROTH:

S. 2400. A bill to establish the Northern Yukon-Arctic International Wildlife Refuge, and for other purposes; to the Committee on Environment and Public Works.

NORTHERN YUKON-ARCTIC INTERNATIONAL WILDLIFE REFUGE ACT

• Mr. ROTH. Mr. President, I address our needs as well as our opportunities for international cooperation to protect our world's circumpolar region.

During my years in the Congress I have expressed my sincere ideology concerning mankind's responsibility to the environment. Simply stated, it is that man is bound to serve nature through an environmental ethic. Mankind has the responsibility to pass on a life-giving, life-sustaining environment to future generations. Our natural and cultural heritage rank high among our most priceless and irreplaceable possessions. To lose any of these possessions would be a loss to all of mankind.

It is often exhibited that all ecosystems—from Alaska to Africa, South America to Saudi Arabia—are inextricably connected. Not only can destruction in one small area bruise the conscience of man, but it can affect the fragile ecological balance of a tiny world appear more vulnerable with

each passing day. Perhaps this environmental transcendentalism is nowhere more apparent than in the circumpolar region which serves as a sink for global pollution. It gathers the wastes and fallout from all that surrounds it, and we all know the tragic consequences befalling the fragile ecosystem and biosphere. The wind, water, fish, fowl, caribou, and other animals and plants know no political boundaries. Whether the pollution that threatens their pristine and fragile environment comes from the Soviet Union, Brazil, Eastern Europe, or the United States is of little consequence—especially when the contamination begins to affect the native peoples who depend on the ecosystem.

Likewise, the contamination of this precious international resource poses a threat to the Arctic region as scientific laboratory for comparisons of the Earth's health. As someone recently put it: "if the Arctic systems fail, the health and the understanding of the health of the entire planet fails." It is for those and other reasons that I commend proposals that encourage international cooperation to protect the precious Arctic area. The Finnish and Pisces initiatives and the Beringia Cooperative Agreement are very important steps in this process. Likewise, I'm proud to announce my own piece of legislation, that I am introducing today.

Mr. President, today I am introducing legislation to establish a Northern Yukon-Arctic International Wildlife Refuge. Its purpose is to bring these two great nations together in historic cooperation to permanently protect the last complete Arctic ecosystem in North America, North America's serrengethi, to fulfill our responsibility as stewards of our land, its resources and the life that depends on it.

This effort will protect all shared wild bird resources native to North America that are in an unconfined state and that are protected under the Migratory Bird Treaty Act. Likewise, it protects wetlands, marine mammals—including seals, walruses, whales, and polar bears; and it maintains our commitment to the principles of caribou management as prescribed under the Porcupine Management Agreement. And it provides for continued protection of marine and anadromous fish species that inhabit the coastal waters of the Beaufort Sea. Finally, it reaffirms the commitments we made to the residents of these lands, to continue to provide them with the opportunity for subsistence uses for the resources of these lands.

Each of these objectives is worthy, and this bill is an important step toward caring for our stewardship in the entire Arctic National Wildlife Refuge as it is currently administered under the National Wildlife Refuge Administration Act. However, most important is that this bill demonstrates the willing spirit and many opportunities nations can take advantage of toward the objective of protecting our environment. It is a first step—an important first step. But it is my hope that it serves as an example of what nations can do with shared objectives, a spirit of cooperation, and little bit of effort.

It is also my hope that we can build on this effort to actively pursue arctic agreements that lead to an arctic refuge protection plan. Such a plan should include international protection for shared lands and waters, cultural and historical sites, and management of fish, birds and wildlife, as well as international cooperative efforts to control the sources of pollutants that affect this fragile environment. The legislation that I am introducing today should be one of the building blocks for this effort.●

By Mr. DECONCINI:

S. 2401. A bill to establish the National Commission on Major League Baseball, and for other purposes; to the Committee on Commerce, Science, and Transportation.

NATIONAL COMMISSION ON MAJOR LEAGUE BASEBALL ACT OF 1994

Mr. DECONCINI. Mr. President, I know that we all are very much consumed on the health care. The debate has been going on for some time.

There is something that is really, really important that people are missing in this country, and that is baseball. I want to talk about it for a moment.

Today I am introducing legislation that would establish a five-member, National Commission on Major League Baseball. The purpose of this Commission is very simple. This panel will do for baseball, and the baseball fans of America, what baseball has been unable to do for itself—that is keep the focus on the game and not on the lawyers, and more importantly make the game accountable to the millions of Americans who call themselves baseball fans.

This Commission will have oversight and regulatory control over major league baseball. In particular, the Commission will have the ability to investigate many areas of major league baseball, including expansion, ticket prices, stadium financing, television revenues, and marketing and merchandising. Most importantly, however, is the Commission's power to conduct binding arbitration in the event of a labor impasse. Given that we are currently in the eighth work stoppage in the past 22 seasons, it is unfortunate, but obvious, that baseball cannot put its own house in order. The need for this authority has never been more clear than it is today.

Once again, the players and the owners have betrayed the American public and put their own self-interests above those of the fans. To the average fan, salary caps and labor negotiations do not matter. The average fan feels no sympathy for either the multimillion-dollar players or the multimillion-dollar owners. All the average fan wants to do is enjoy baseball. This Commission is intended to give them that opportunity.

While developing this Commission, I envisioned a panel which could act as an impartial commissioner of the national pastime. Unfortunately, baseball does not have a commissioner at this time despite the repeated promises to appoint one. With all due respect to Mr. Selig—I know him, he is a fine man, and a very good businessman—this game needs a strong, impartial leader who can be guided not solely by the interests of the players or the owners, but by the best interests of the game. Accordingly, this must involve the views of the fans.

Under the legislation, the President will select three individuals from the millions who proudly call themselves baseball fans to serve on the Commission. This Commission may not resolve the myriad of problems which plague the game, but it will give the fans a much needed voice in the debate. Additionally, the Commission will have a member chosen from among the players and a member chosen from among the owners. The panel will have the power to hold hearings and to obtain all relevant documents and other evidence in order to make their review as comprehensive as possible. If the parties will not unilaterally disclose their positions then this legislation will compel them to do so. The distrust and secrecy between the players and the owners has made reaching a compromise all the more difficult. If we are to address these issues and the concerns of the respective parties, it can only be done through complete disclosure. This Commission has the power to make certain that reality and not rhetoric is the basis for any discussion of these issues.

Many people might wonder why, or if, Government should involve itself in this matter. But the Government is already involved and has, in effect, created a baseball monopoly. Baseball is special and receives special treatment through the antitrust immunity.

This exemption allows baseball to operate as one large entity which operates free of the threat of competition, despite the fact that competition is the hallmark of American free enterprise. In other instances where we create a monopoly, such as utilities, no one questions the Government's authority to regulate the industry. In essence we grant the monopoly, but we do so with the understanding that this rare exception has conditions, one of which is the Government's right to regulate.

And the players are just as much at fault. They could settle this but, no, they have three or four agents that

hold out and really do not care about the fans.

Many will argue that we should simply repeal the exemption. Frankly, that day may be coming, but at this point I think the larger issue is whether or not the game can police itself—I have not seen much recently to suggest that it can. Proponents of the exemption cite the unique place of baseball in American society. This raises the obvious question of how many times will the game which claims to be uniquely American walk away from the American public? My legislation is a compromise between the two positions which lets the exemption remain for the time being, but subjects the monopoly to regulation. Furthermore, my bill requires the Commission to study the need for the anti-trust exemption and the effects of its possible repeal and report to Congress on their findings within 3 years. This study will allow Congress to better understand the consequences of continuing or repealing the anti-trust exemption. That decision, when and if it is made, should be an informed one, and the Commission will help in that regard.

Critics will argue that this Commission is ill conceived, that it places complex issues in the hands of those who lack the knowledge or understanding to resolve them. To those critics, I suggest that what this situation desperately needs is a little perspective and a good dose of reality. Who better to provide it than the very people who fill the coffers of the players and owners by going to the games, by purchasing the merchandise, by supporting the advertisers who pay the enormous television contracts? One thing is clear, the current system has failed and it is time for new ideas.

It is true that baseball is a uniquely American game. But with that special place in American culture comes a responsibility to the American public. The select few who constitute the ownership and players of major league baseball must preserve the game for the enjoyment of all fans. When the games stopped last week, fans were enjoying perhaps the finest season in many years. Matt Williams, Ken Griffey, Jr., and Frank Thomas were all chasing Roger Maris's home run record. Houston Astro Jeff Bagwell might have become the first triple crown winner since 1967. On the field the game was living up to its proud tradition. But now this fine season has been taken away and replaced with sound bites of lawyers from both sides who always find a new way to say, "we've made no progress." The baseball fans of America are the most loyal and dedicated in all of sports, they deserve better. They deserve a chance to watch the game they love—this Commission will give them that chance.

Mr. President, I compliment the Senator from Ohio here, who has tried to bring public attention to this in a different way, by lifting the exemption. I have not been a supporter of that because I am not convinced that it is going to solve the problem. I have given it a lot of thought, and I came to the conclusion that we need to regulate this monopoly, not just open it up by taking the exemption away. Critics will argue that the commission is ill-conceived and places complex issues in the hands of those who lack the knowledge or understanding to resolve them. To those critics, I suggest that what the situation desperately needs is a little perspective and a good dose of reality.

Who better to provide it than the very people who fill the coffers of the players and the owners by going to the game, by purchasing the merchandise, by supporting the advertisers who pay the enormous television contracts?

You know who that is: the baseball fans.

One thing is clear, the current system has failed, it is broken, it is not working.

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

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

S. 2401

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 "National Commission on Major League Baseball Act of 1994".

SEC. 2. ESTABLISHMENT.

There is hereby established the National Commission on Major League Baseball (hereafter in this Act referred to as the "Commission").

SEC. 3. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of five members, all of whom shall be appointed by the President. The President shall appoint—

(1) one member after consultation with the Major League Baseball Players Association;

(2) one member after consultation with the owners of Major League Baseball; and

(3) three members (after consultations with baseball fan organizations and the informal solicitation of recommendations from the general public), one of whom the President shall designate as Chairman of the Commission.

(b) TERM.—Members of the Commission shall be appointed for a six year term. No individual may serve as a member for more than one term.

(c) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but the Commission may provide for the taking of testimony and the reception of evidence at meetings at which there are present not less than three members of the Commission.

(d) APPOINTMENT DATE.—The first appointments made under subsection (a) shall be made within 60 days after the date of enactment of this Act.

(e) FIRST MEETING.—The first meeting of the Commission shall be called by the Chairman and shall be held within 90 days after the date of enactment of this Act.

(f) PUBLIC MEETINGS.—All Commission meetings shall be open to the public.

(g) VACANCY.—If any member of the Commission is unable to serve a full term or becomes unqualified to serve in such position, a new member shall be appointed to serve the remainder of such term of office, within 45 days of the vacancy, in the same manner in which the original appointment was made.

SEC. 4. DUTIES OF THE COMMISSION.

The duties of the Commission are to oversee and regulate any aspect of Major League Baseball, where, in the opinion of the Commission, it is in the best interests of baseball to intervene, including but not limited to the—

(1) conduct of binding arbitration in the event of a labor impasse;

(2) setting of ticket prices;

(3) expansion and relocation of franchises;

(4) financing of any stadium;

(5) regulation of television revenues;

(6) regulation of marketing and merchandising revenues; and

(7) revenue sharing disputes among the owners of Major League Baseball.

SEC. 5. POWERS OF THE COMMISSION.

(a) HEARINGS AND MEETINGS.—The Commission or, on authorization of the Commission, a panel of at least three members of the Commission, may hold such hearings, sit and act at such time and places, take such testimony, and receive such evidence, as the Commission considers appropriate.

(b) OBTAINING DATA.—The Commission may secure directly from any Federal department, agency, or court information and assistance necessary to enable it to carry out this Act. Upon request of the Chairman of the Commission, the head of such agency or department shall furnish such information or assistance to the Commission. In addition, the Commission may request any relevant information from any appropriate parties with an interest in Major League Baseball.

(c) SUBPOENA POWER.—

(1) ISSUANCE.—The Commission may issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation by the Commission. The attendance of witnesses and the production of evidence may be required from any place within a judicial district at any designated place of hearing within the judicial district.

(2) ENFORCEMENT.—If a person issued a subpoena under paragraph (1) refuses to obey the subpoena or is guilty of contumacy, any court of the United States within the judicial district within which the hearing is conducted or within the judicial district within which the person is found or resides or transacts business may (upon application by the Commission) order the person to appear before the Commission to produce evidence or to give testimony relating to the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt of the court.

(3) MANNER OF SERVICE.—A subpoena of the Commission shall be served in the manner provided for subpoenas issued by a United States district court under the Federal Rules of Civil Procedure for the United States district courts.

(4) PLACE OF SERVICE.—All process of any court to which application may be made under this section may be served in the judicial district in which the person required to be served resides or may be found.

(d) FACILITIES AND SUPPORT SERVICES.—The Administrator of General Services shall provide to the Commission on a reimbursable basis such facilities and support services as the Commission may request. Upon

request of the Commission, the head of a Federal department or agency may make any of the facilities and services of such agency available to the Commission to assist the Commission in carrying out its duties under this Act.

(e) EXPENDITURES AND CONTRACTS.—The Commission or, on authorization of the Commission, a member of the Commission may make expenditures and enter into contracts for the procurement of such supplies, services, and property as the Commission or member considers appropriate for the purposes of carrying out the duties of the Commission. Such expenditures and contracts may be made only to such extent or in such amounts as are provided in appropriations Acts.

(f) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal departments and agencies of the United States.

SEC. 6. COMPENSATION OF THE COMMISSION.

(a) PAY.—Each member of the Commission shall be a full-time Federal employee and shall be paid at an annual rate of basic pay payable for level II of the Executive Schedule under section 5313 of title 5, United States Code.

(b) TRAVEL.—Members of the Commission shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in the performance of their duties.

SEC. 7. STAFF OF COMMISSION; EXPERTS AND CONSULTANTS.

(a) STAFF.—

(1) APPOINTMENT.—The Chairman of the Commission may appoint and terminate no more than ten staff personnel to enable the Commission to perform its duties.

(2) COMPENSATION.—The Chairman of the Commission may fix the compensation of personnel without regard to the provisions of chapter 51 and subchapter II of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(b) EXPERTS AND CONSULTANTS.—The Commission may procure temporary and intermittent services of experts and consultants under section 3109(b) of title 5, United States Code.

SEC. 8. REPORT TO CONGRESS.

No later than three years after the date of the enactment of this Act, the Commission shall submit a report to the Congress on the need for continuing the antitrust exemption for Major League Baseball and the possible effects resulting from the elimination of such exemption.

SEC. 9. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated $1,500,000 to carry out this Act.

SEC. 10. EFFECTIVE DATE.

This Act shall take effect on the date of enactment.

Mr. METZENBAUM. Mr. President, I rise to applaud Senator DECONCINI for proposing legislation to deal with the horrible problems that result from the Major League Baseball's exemption from our Nation's competition laws. As a consequence, today, baseball is not operating. Baseball games are not being played in the major lesion. Because baseball functions as an unregulated cartel, fans throughout the country have suffered as the season came to a crushing halt.

Senator HATCH and I have introduced a bill that will limit baseball's exemption from the competition laws. We hope for speedy passage of that bill, and we hope that it will convince the players to end their strike and management to sit down and negotiate, without imposing any one-sided conditions on the players.

I prefer this free market solution, as opposed to regulation.

However, I applaud my colleague for his effort to remedy the inequities in baseball, and I agree with him that we should not stand for an unregulated cartel.

I hope to work with my friend from Arizona to combine our legislative efforts in the hopes of letting the season continue for the benefit of all fans.

There is no secret about it that the situation that presently exists, where the owners are in a position to impose, on their own, conditions on the baseball players, has brought baseball to this condition in this country. That is not what the fans want, not what the country wants, and I do not think it is good for baseball or for the country. I think perhaps Senators DECONCINI, HATCH, and I, and others, who have a strong interest in the subject will be able to move forward and bring our some legislative resolution of the issue. Hopefully, the parties themselves will be able to resolve the issue and get baseball back on the field rather than in the U.S. Senate.

ADDITIONAL COSPONSORS

S. 1887

At the request of Mr. BAUCUS, the names of the Senator from North Dakota [Mr. DORGAN], the Senator from California [Mrs. FEINSTEIN], the Senator from Connecticut [Mr. DODD], and the Senator from Maine [Mr. COHEN] were added as cosponsors of S. 1887, a bill to amend title 23, United States Code, to provide for the designation of the National Highway System, and for other purposes.

S. 2255

At the request of Mr. GORTON, the name of the Senator from Mississippi [Mr. LOTT] was added as a cosponsor of S. 2255, a bill to amend the Budget Enforcement Act of 1990 to establish a new budget point of order against any amendment, bill, or conference report that directs increased revenues from additional taxation of Social Security or Railroad Retirement benefits to a fund other than the Social Security trust fund or the Social Security Equivalent Benefit Account.

S. 2257

At the request of Mr. DURENBERGER, the name of the Senator from Indiana [Mr. LUGAR] was added as a cosponsor of S. 2257, a bill to amend the Public Works and Economic Development Act of 1965 to reauthorize economic development programs, and for other purposes.

At the request of Mr. BAUCUS, the name of the Senator from Arkansas [Mr. BUMPERS] was added as a cosponsor of S. 2257, supra.

S. 2286

At the request of Mr. LUGAR, the name of the Senator from Maine [Mr. COHEN] was added as a cosponsor of S. 2286, a bill to amend title 23, United States Code, to provide for the use of certain highway funds for improvements to railway-highway crossings.

S. 2330

At the request of Mr. ROCKEFELLER, the name of the Senator from Hawaii [Mr. INOUYE] was added as a cosponsor of S. 2330, a bill to amend title 38, United States Code, to provide that undiagnosed illnesses constitute diseases for purposes of entitlement of veterans to disability compensation for service-connected diseases, and for other purposes.

SENATE JOINT RESOLUTION 214

At the request of Mr. BINGAMAN, the name of the Senator from North Dakota [Mr. CONRAD] was added as a cosponsor of Senate Joint Resolution 214, a joint resolution designating August 9, 1994, as "Smokey Bear's 50th Anniversary."

SENATE CONCURRENT RESOLUTION 66

At the request of Ms. MIKULSKI, the name of the Senator from Arizona [Mr. DECONCINI] was added as a cosponsor of Senate Concurrent Resolution 66, a concurrent resolution to recognize and encourage the convening of a National Silver Haired Congress.

SENATE CONCURRENT RESOLUTION 73

At the request of Mrs. FEINSTEIN, the names of the Senator from Mississippi [Mr. COCHRAN] and the Senator from South Dakota [Mr. DASCHLE] were added as cosponsors of Senate Concurrent Resolution 73, a concurrent resolution expressing the sense of the Congress with respect to the announcement of the Japanese Food Agency that it does not intend to fulfill its commitment to purchase 75,000 metric tons of United States rice.

AMENDMENTS SUBMITTED

THE HEALTH SECURITY ACT OF 1994

NICKLES (AND OTHERS) AMENDMENT NO. 2563

Mr. NICKLES (for himself, Mr. MOYNIHAN, Mr. PACKWOOD, Mr. CRAIG, Mr. COATS, Mr. GREGG, Mr. D'AMATO, Mr. GRASSLEY, Mr. DASCHLE, Mr. STEVENS, Mr. DURENBERGER, Mr. SHELBY, Mr. MACK, Mr. GORTON, Mr. ROTH, Mr. LOTT, Mr. BURNS, Mr. EXON, Mr. MURKOWSKI, Mr. SMITH, Mr. THURMOND, Mr. SPECTER, Mr. WOFFORD, and Mr. COVERDELL) proposed an amendment to amendment No. 2560 proposed by Mr.

MITCHELL to the bill (S. 2351) to achieve universal health insurance coverage, and for other purposes; as follows:

On page 145, strike lines 1 through 5.

DASCHLE (AND OTHERS) AMENDMENT NO. 2564

Mr. DASCHLE (for himself, Mr. HARKIN, Mr. ROCKEFELLER, Mr. BAUCUS, Mr. REID, Mr. LEAHY, Mr. WOFFORD, and Mr. CAMPBELL) proposed an amendment to amendment No. 2560 proposed by Mr. MITCHELL to the bill S. 2351, supra; as follows:

On page 112, line 6, insert "including residents of rural areas" before the period.

On page 215, line 10, strike "(c)" and insert "(d)".

On page 215, between lines 9 and 10, insert the following new subsection:

(c) TRANSFER OF DUTIES.—Effective January 1, 1996, the functions, powers, duties, and authority that were carried out in accordance with Federal law by the Office of Rural Health Policy in the Department of Health and Human Services are transferred to the Office of the Assistant Secretary for Rural Health in the Department of Health and Human Services.

On page 612, line 24, insert before the period the following: ", at least one of whom resides in a rural area".

On page 613, line 9, insert before the period the following: ", at least one of whom resides in a rural area".

On page 647, strike lines 25 and 26, and insert the following:

"For purposes of carrying out section 3341, there are authorized to be appropriated $15,000,000 for each of the fiscal years 1997 through 2001.".

On page 664, line 10, strike "or health professional shortage areas" and insert "area, health professional shortage area, or other rural underserved area (as designated by the Governor)".

On page 651, between lines 9 and 10, add the following new paragraph:

(3) SUBPART F.—For the purpose of providing funds under subpart F, there are authorized to be appropriated $10,000,000 for each of the fiscal years 1996 through 2000.

On page 652, line 18, strike "and".

On page 652, between lines 18 and 19, insert the following new paragraph:

"(7) rural health clinics, except that for-profit rural health clinics shall only be eligible for direct loans and grants under subpart C; and".

On page 652, line 19, strike "(7)" and insert "(8)".

On page 653, after line 23, add the following new subsection:

(f) PURPOSES AND CONDITIONS.—Grants shall be made under this part for the purposes and subject to all of the conditions under which eligible entities otherwise receive funding to provide health services to medically underserved populations under the Public Health Service Act. The Secretary shall prescribe comparable purposes and conditions for eligible entities not receiving funding under the Public Health Service Act, including conditions with respect to the availability of services in the area served (as provided for in section 330(e)(3)(A) of such Act), and conformance of fee and payment schedules with prevailing rates (as provided for in section 330(e)(3)(F) of such Act). With respect to federally qualified health centers, such comparable purposes and conditions shall include conditions concerning sliding fee scales under section 1128B(b)(3)(D) of the Social Security Act and waivers of deductibles under section 1833(d) of such Act.

On page 672, line 1, strike the subsection heading and insert "FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS".

On page 673, line 3, insert "and rural health clinics" after "Act)".

On page 675, between lines 16 and 17, add the following new subpart:

Subpart F—Rural-Based Managed Care Grants

SEC. 3467. RURAL-BASED MANAGED CARE GRANTS.

(a) IN GENERAL.—The Secretary shall award grants for the development and operation of rural-based managed care networks that integrate the medicare population of the area served.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an applicant organization shall—

(1) prepare and submit to the Secretary an application, at such time, in such manner and containing such information as the Secretary may require;

(2) be based or provide services in rural or rural underserved areas; and

(3) be currently operating or in the process of establishing a provider network serving the nonmedicare population .

(c) USE OF FUNDS.—Funds provided under a grant under this section may be used—

(1) for the development and implementation of rural-based managed care networks;

(2) for data and information systems, including telecommunications;

(3) for meeting solvency requirements for a risk-bearing entity under the medicare program under title XVIII of the Social Security Act;

(4) for the recruitment of health care providers; or

(5) for enabling services, including transportation and translation.

(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to—

(1) applicants that will use amounts received under the grant to develop and operate rural-based managed care networks that would serve at least one rural underserved area; and

(2) applicants that involve local residents and providers in the planning and development of the rural-based managed network.

(e) DEFINITIONS.—As used in this section

(1) RURAL AREA.—The term "rural area" means a rural area as described in section 1886(d)(2)(D) of the Social Security Act.

(2) UNDERSERVED RURAL AREA.—The term "underserved rural area" means a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e) or an area designated as underserved by the Governor of a State taking into account—

(A) financial and geographic access to health plans by residents of such area; and

(B) the availability, adequacy, and quality of qualified providers and health care facilities in such area.

(f) STUDY.—The Secretary shall study different risk-bearing approaches for rural managed care and payment methodologies that differ from or modify the medicare average area per capita cost payment methodology.

Beginning on page 675, strike line 24 and all that follows through line 4 on page 676, and insert the following: "priated $314,000,000 for fiscal year 1996, $285,000,000 for fiscal year 1997, $365,000,000 for fiscal year 1998, $382,000,000 for fiscal year 1999, $386,000,000 for fiscal year 2000, $91,500,000 for fiscal year 2001, $53,350,000 for fiscal year 2002, $38,100,000 for fiscal year 2003, and $38,100,000 for fiscal year 2004, of which $2,000,000 shall be made available in each of the fiscal years 1996 through 2000 to carry out section 338L of the Public Health Service Act.".

On page 676, line 10, strike "NURSES" and insert "ADVANCED PRACTICE NURSES AND PHYSICIAN ASSISTANTS".

On page 676, line 20, strike "nurse anesthetists" and insert "nurse anesthetists or physician assistants".

On page 676, lines 21 and 22, strike "nurse anesthetists" and insert "nurse anesthetists or physician assistants".

On page 677, between lines 13 and 14, add the following new parts:

PART 4—ANTITRUST SAFE HARBORS FOR RURAL HEALTH PROVIDERS

SEC. 3491. ANTITRUST SAFE HARBORS FOR RURAL HEALTH PROVIDERS.

(a) IN GENERAL.—The Attorney General, in consultation with the Commissioner of the Federal Trade Commission, shall clarify existing and future policy guidelines, with respect to safe harbors, by providing additional illustrative examples with respect to the conduct of activities relating to the provision of health care services in rural areas.

(b) DISSEMINATION OF INFORMATION.—The Attorney General, in consultation with the Commissioner of the Federal Trade Commission and the Assistant Secretary for Rural Health, shall develop methods for the dissemination of the guidelines established under subsection (a) to rural health care providers.

PART 5—EMERGENCY MEDICAL SYSTEMS

SEC. 3495. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d-51 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

"(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

"(b) APPLICATION AND PLAN.—

"(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

"(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

"(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

"(B) demonstrate that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

"(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

"(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State

would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

"(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

"(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

"(G) demonstrate that the State, in utilizing the grant proceeds, will—

"(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received; and

"(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

"(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan; and

"(I) contain such other information as the Secretary may determine appropriate.

"(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

"(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

"(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

"(d) STATE ADMINISTRATION AND USE OF GRANT.—

"(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

"(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

"(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

"(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

"(f) REPORTS.—

"(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

"(A) a description of the manner in which the grant proceeds were utilized;

"(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

"(C) such other information as the Secretary may require.

"(2) TERMINATION OF FUNDINGS.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

"(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for fiscal year 1995, and such sums as may be necessary for each for fiscal years 1996 and 1997.".

Beginning on page 718, strike line 23 and all that follows through line 5 on page 719, and insert the following new paragraph:

"(8) with respect to the National Health Service Corps program referred to in section 3471, $314,000,000 for fiscal year 1996, $285,000,000 for fiscal year 1997, $365,000,000 for fiscal year 1998, $382,000,000 for fiscal year 1999, $386,000,000 for fiscal year 2000, $91,500,000 for fiscal year 2001, $53,350,000 for fiscal year 2002, $38,100,000 for fiscal year 2003, and $38,100,000 for fiscal year 2004, of which $2,000,000 shall be made available in each of the fiscal years 1996 through 2000 to carry out section 338L of the Public Health Service Act;".

On page 720, line 22, strike "; and" and insert a semicolon.

On page 720, between lines 22 and 23, insert the following new paragraph:

"(14) with respect to the development of rural telemedicine under section 3341, $15,000,000 for each of the fiscal years 1997 through 2001; and".

On page 720, line 23, strike "(14)" and insert "(15)".

On page 725, strike lines 7 through 11, and insert the following:

"(6) in subsection (l), by striking paragraph (1) and inserting the following new paragraph:

" '(1) IN GENERAL.—The Secretary shall use amounts made available under section 3471 of the Health Security Act to carry out this section in each of the fiscal years 1996 through 2000.' ".

On page 777, line 18, strike "and medical assistance facilities".

On page 780, line 3, insert "In the case of payment under this subsection to medical assistance facilities, the lesser-of-cost-or charges provisions under subsection (j) are not applicable." after "services.".

Beginning on page 808, strike line 16 and all that follows through page 809, line 4, and insert the following:

(2) by inserting "described in paragraph (2) and services furnished by a physician assistant, nurse practitioner, or a clinical nurse specialist described in such paragraph that would by physicians' services if furnished by a physician" after "physicians' services",

(3) by inserting "physician assistant, nurse practitioner, or a clinical nurse specialist" after "physician",

(4) by striking "10 percent" and inserting "the applicable percent", and

(5) by adding at the end the following new paragraph:

"(2)(A) The applicable percent referred to in paragraph (1) is—

"(i) in the case of physicians' services that are primary care services, a percent determined by the Secretary that may not be less than 10 percent and may not exceed 20 percent,

"(ii) in the case of services furnished by a physician assistant, nurse practitioner, or a clinical nurse specialist described in such paragraph that would be physicians' services that are primary care services if a physician furnished the services, a percent to be determined by the Secretary that is equal to the percent determined in clause (i) and determined so that the total amount of such payments under this clause and clause (i) is equal to the amount that would have been paid under clause (i) if the applicable percent for such clause was equal to 20 percent, and

"(iii) in the case of physicians' services other than primary care services furnished in a health professional shortage area located in a rural area (as defined in section 1886(d)(2)(D)), 10 percent.

On page 873, line 20, insert "urban and rural" after "representative of the".

On page 874, line 1, insert ", at least one of whom resides in a rural area" before the first period.

On page 874, line 4, insert ", at least one of whom resides in a rural area" before the first period.

On page 1390, line 22, insert "and that at least one member of the Commission is a resident of a rural area" before the period at the end.

GRASSLEY AMENDMENTS NOS. 2565–2567

(Ordered to lie on the table.)

Mr. GRASSLEY submitted three amendments intended to be proposed by him to amendment No. 2560 proposed by Mr. MITCHELL to the bill S. 2351, supra; as follows:

AMENDMENT NO. 2565

On page 263, between lines 15 and 16, insert the following new section:

SEC. . LIMITATION ON FULL-TIME EQUIVALENT POSITIONS.

Nothing in this Act, or an amendment made by this Act, shall be construed as permitting the total number of full-time equivalent positions in all agencies to exceed the limitations contained in section 5 of the Federal Workforce Restructuring Act of 1994.

AMENDMENT NO. 2566

On page 817, strike lines 14 through 24, and insert the following:

(a) COVERAGE IN OUTPATIENT SETTINGS; DIRECT PAYMENTS TO NURSE PRACTITIONERS.—

(1) IN GENERAL.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2))K)) is amended—

(A) in clause (i)—

(i) by striking "or" at the end of subclause (II); and

(ii) by inserting "or (IV) in an outpatient setting as defined by the Secretary" following "shortage area,"; and

(B) in clause (ii)—

(i) by striking "in a skilled" and inserting "in (I) a skilled"; and

(ii) by inserting ", or (II) in an outpatient setting (as defined by the Secretary)," after "(as defined in section 1919(a))".

(2) DIRECT PAYMENTS TO NURSE PRACTITIONERS IN OUTPATIENT SETTINGS.—(A) Section 1833(r)(1) (42 U.S.C. 1395l(r)(1)) is amended by

inserting "or for services described in section 1861(s)(2)(K)(ii)(II) (relating to nurse practitioner services in outpatient settings)," after "rural area),".

(B) Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking "clauses (i), (ii), or (iv)" and inserting "clauses (i), (ii)(I), or (iv)".

On page 820, line 4, strike "(a)(2)" and insert "(a)(1)(B)".

AMENDMENT NO. 2567

On page 1226, beginning with line 4, strike all through page 1227, line 13.

On page 1227, line 14, strike "(B)" and insert "(A)".

On page 1227, line 19, strike "(C)" and insert "(B)".

Mr. GRASSLEY. Mr. President, I want to speak and have it placed in the proper place in the RECORD—so it does not interfere with the debate on rural health care—a discussion of three amendments that I am going to offer later on in this bill's debate, and I want to send those amendments to the desk for file.

I am going to offer these amendments at such time as the managers of the bill see fit. In the meantime I want to have them on record so people will know what I am thinking about doing. I do not want to play any games with anybody. There is no reason to keep these amendments secret.

One of the amendments deals with one of the subject matters that is going to be involved with the Daschle amendment anyway.

The first amendment would ensure that the effects of the Mitchell bill would not supersede the provisions of another law that was passed earlier this year, Public Law 103-226. That law established ceilings for the numbers of Federal workers over the next 6 years.

Based on an amendment that Senator PHIL GRAMM and I offered, the ceilings are set forth in the Federal Workforce Restructuring Act of 1994. Section 5 of the act is entitled "Reduction of Federal Full-Time Equivalent Positions." The ceilings are set for fiscal year 1994 through fiscal year 1999.

The purpose of the amendment originally offered by Senator GRAMM and myself was to put teeth in the administration's program to reinvent Government. I am a strong believer in the reinventing Government program. I support the efforts of the Vice President and have indicated that many times here on the floor.

The Congress is also on record strongly supporting the program, because the Senate voted 82 to 14 in support of the Gramm-Grassley amendment.

The amendment that I intend to offer to the Mitchell bill would preserve what Congress did earlier this year. It would say that the Mitchell bill would have to be consistent with section 5 of Public Law 103-226. In other words, the Mitchell bill could not add to the overall full-time equivalents, or what we call FTE's, established in law.

This amendment is relevant, I believe. The short answer of why is that is there is a great fear on our side of the aisle that the Mitchell bill would lead to new, flourishing bureaucracies, even though the author denies this. So my amendment is a way to keep the author of the legislation consistent with what this Senate previously had done, not to increase the number of employees. If there are not going to be bureaucracies, there will not be bureaucracies. I want to make it clear that my intention is not to call into question the author's assertion. Rather, my intention is to ensure that the statutory ceilings are protected.

As our side has analyzed the Mitchell bill, it would create 50 new Federal bureaucracies. They would include, among others, a National Health Benefit Board and a National Health Care Cost and Coverage Commission. It would also give hundreds of new powers to the Secretary of HHS as well as the Secretary of Labor.

The point is that, if you have new bureaucracies, then new bureaucrats would have to do this new work. Presumably, they could be shifted from elsewhere within the Federal work force. Such a zero-sum shift would be acceptable from the standpoint of protection of the limits of employment under current law as long as the overall totals established in the law are not breached.

However, when I say acceptable, I want to make it clear I am talking about from the standpoint of protecting current law. I am not accepting the motion that all these bureaucracies are either wise or needed.

The second amendment that I am filling is also a portion of the amendment that is before this body. It deals with the direct Medicare reimbursement to nurse practitioners providing services in outpatient settings. I first introduced this legislation in November 1991. I was successful in adding this legislation to the Senate version of H.R. 11 in 1992, which was eventually vetoed by President Bush.

I offered this amendment again in the Senate Finance Committee's version of OBRA fiscal year 1993. And I was successful in adding this legislation to the Finance Committee's health reform bill. Senator MITCHELL has included this legislation in his bill. But it appears that some drafting errors make it necessary to refine it. I think that is what Senator DASCHLE is trying to accomplish, because it would not in original bill permit direct reimbursement of these providers. The amendment I file separately would also deal with that issue.

Finally, Mr. President, my third amendment that I want to present to the Senate for consideration over the next few days would do two things: It would strike what is a de facto employer mandate on the self-employed as well as the resulting tax penalty for noncompliance. This is in section 7203 of the Mitchell bill.

Mr. President, I want to make sure my colleagues are made aware of my intentions to offer these amendments to the Mitchell bill, and I would urge their cooperation and support.

As I indicated, Mr. President, I want these amendments placed or filed or sent to the desk merely for printing in the RECORD and for everybody's consideration over the next few days.

NOTICES OF HEARINGS

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. LEAHY. Mr. President, I would like to announce that the Senate Committee on Agriculture, Nutrition, and Forestry Subcommittee on Agricultural Research Conservation, Forestry, and General Legislation and the House Agriculture Subcommittee on Environment, Credit and Rural Development will hold a joint field hearing concerning the future of the Conservation Reserve Program. The hearing will be held on Thursday, September 1, 1994, at 9:30 a.m. in Aberdeen, SD, at the Ramkota Inn. Senator TOM DASCHLE will preside.

For further information, please contact Tom Buis at 224-2321.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. AKAKA. Mr. President, I would like to announce that an oversight hearing has been scheduled before the Subcommittee on Mineral Resources Development and Production.

The hearing will take place on Thursday, September 22, 1994, beginning at 9:30 a.m. in room SD-366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of the hearing is to receive testimony on the question of immigration in the Commonwealth of the Northern Mariana Islands.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, anyone wishing to submit a written statement is welcome to do so by sending two copies to the Committee on Energy and Natural Resources, 304 Dirksen Senate Building, Washington, DC 20510.

For further information regarding the hearing, please contact Dionne Thompson of the subcommittee staff at (202) 224-5925.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON THE JUDICIARY

Mr. DASCHLE. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on Wednesday, August 17, 1994, at 2 p.m., in room 226, Senate Dirksen Office Building, to hold a hearing on the

nominations of William Bryson to be U.S. circuit judge for the Federal circuit, Salvador Casellas to be U.S. district judge for the District of Puerto Rico, Daniel Dominguez to be U.S. district judge for the District of Puerto Rico, and Sarah Vance to be U.S. district judge for the Eastern District of Louisiana.

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

ADDITIONAL STATEMENTS

HOMICIDES BY GUNSHOT IN NEW YORK CITY

• Mr. MOYNIHAN. Mr. President, I rise today to announce to my Senate colleagues, as has been my custom each week during this session of the 103d Congress, that during the last week, 18 people were killed by gunshot in New York City, bringing the 1994 total to 621.•

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. The Chair recognizes the Senator from Idaho [Mr. KEMPTHORNE].

Mr. KEMPTHORNE. Thank you very much, Mr. President.

May I also acknowledge and thank for his courtesy the Senator from South Dakota, who is always a gentleman in all floor debate I have ever seen. I appreciate that.

I often read comments from Idahoans here on the Senate floor, because they reflect down-to-earth common sense. This is such a case. I am going to share with you three quotes from Idahoans relating to this current health care debate:

> I do not believe that we have a crisis in the health care system. We have a good system, it just needs to be amended, says Missy Hunsucker of Boise.

Dr. Andrew McRoberts of Pocatello says:

> What I fear now is they're going to rush something through with very little thought or planning and when it's done they're going to say, 'Oh, my God, what did we do'

And Jim Guthrie, a small business owner in McCammon says,

> When you look at what the government is doing with some of the other things they've got their hand in, it's scary. I think something needs to be done, but I don't think this is it.

These are comments from hard-working, thoughtful and practical Idahoans. Real people, not policy wonks or "inside-the-beltway" analysts. These are the thoughts of the people whose lives will be impacted by the decisions we make in Congress. I hope we keep their comments in mind when we examine the whole question of health care reform.

The mail, faxes, and phone calls that come into my State offices and to my Washington office are almost unanimous in opposition to government-run health care and the Clinton-Mitchell bill. These are not part of any organized campaign, they are honest comments from concerned Americans.

There is no dispute that our country's health care system is the best in the world. Americans enjoy the best physicians, the best hospitals, and the best research facilities. There are changes that need to be made, but not a complete overhaul in our health care delivery system.

Is the Clinton-Mitchell plan, all 14-hundred-plus pages, the way to go? I do not think so. Veteran Senators tell me this is one of the most complex pieces of legislation they have ever seen. And what compounds the problem is the fact that we are now working on the third version of the bill—a bill that has not had the benefit of a complete committee markup and review, and a bill that frankly, not many people totally understand. The non-partisan Congressional Budget Office says this bill will cost more than $1.1 trillion over 8 years. In 1998 alone, it would cost nearly $104 billion, making it the third largest program in the budget.

My personal preference is to have Congress do what Idahoans tell me they would do: Implement local innovations and ideas, reform elements of the system, and let the private sector work.

When I first looked at the Clinton-Mitchell bill, one of the first phrases I saw was, "A participating State shall." A version of that phrase is repeated at least 85 times in the bill. What does that mean? Does it mean a State can opt out of the program? Far from it.

Under the Clinton-Mitchell bill, States would have to choose one of three options: Comply with the bill entirely, including the mountains of new rules and regulations; become a single-payer socialized medicine State; or let the Federal Government totally control health care in the State. None of these are attractive options.

State governments should not be forced to comply with the overly restrictive nature of this bill when they are doing a lot on their own, right now—and without Federal intervention.

The State of Idaho is not immune to the problems in health care. While Idahoans pay less for care than others, costs are going up and there are not enough doctors. That is making health care more difficult to get than in the past. Mr. President, 84 percent of Idahoans have health care coverage, but there are still more than 100,000 without coverage. Of those with coverage, 15 percent still do not have access to a primary care physician. That is because in a State with a large land mass and a small population, doctors tend to live in population centers, not in small, remote towns.

The Clinton-Mitchell bill makes provisions for rural communities. But that does not go far enough to meet the needs of a lot of towns in Idaho.

There are communities like Warren or Atlanta, ID—I could name dozens—that have no doctors or health care facilities. They are truly western frontier towns. They may be 25 miles or 100 miles from the nearest doctor, often isolated in the mountains and accessible by, at best, a gravel road. In the winter, they are lucky if that road is even plowed. They do not fit within the definitions of the Clinton-Mitchell health care bill for rural communities. We need to acknowledge these towns and their conditions and make allowances for them.

How important is a hospital to small town Idaho? It is often the difference between life and death, and is critical if there is an accident or sudden illness. Larry Lee, chief financial officer at Harms Memorial Hospital in American Falls is scared of the Clinton-Mitchell plan. He says isolated hospitals without cost efficiencies found in more urban areas are at risk. He says his greatest fear is that, "this small hospital will cease to exist—everything will be centered around the large hospitals with no consideration given to distance. Everything will be based on cost." In Emmett, a farming community northwest of Boise, the emergency room at Walter Knox Hospital treated 4,292 patients last year. That is roughly equal to the population of the town, and about one-third of the total number of people living in the entire county. The community can ill afford to lose its immediate care. There are other advantages of a hometown hospital beyond the medical needs of the community. An economic impact report presented to the local officials found that the hospital attracted three physicians to the valley, employs 92 people, and contributes more than $2 million annually to the economy. The report also stressed the importance of indirect revenues from related medical and service industries. So you can see that if small towns like Emmett, ID, lose their hospitals, they lose much more than health care—their economic health is also jeopardized. I do not want any part of a plan that causes rural hospitals and doctors to close their doors and abandon small towns. I doubt very much whether my colleagues do either.

Will the farmer in Idaho benefit from the Clinton-Mitchell plan? I mentioned that Idaho does not have enough health care providers. While the Clinton-Mitchell bill contains funding for outreach into rural underserved areas, it also creates disincentives to practice there. One example of such a disincentive may be the 25-percent tax for noncompetitive areas. The tax on so-called

high cost plans is to be paid, partially, by physicians.

Rural doctors already face low reimbursement rates—the additional burden may force some into more urban areas where there is a larger patient base and reimbursements are higher.

The 25-percent premium tax on high-cost plans is such a disincentive. My staff has prepared an analysis. This is how it works.

Your insurance policy will be taxed if your WAP is greater than the WARP. That is, if your Weighted Average Premium is greater than the Weighted Average Reference Premium. This is from the Clinton-Mitchell bill. The WARP is figured out this way: You take the total of all U.S. health care payments and subtract from that the Medicare beneficiaries, Supplemental Security Income recipients, worker's compensation, automobile or other liability insurance. To that amount you add the projected expenditures for underinsured and uninsured people and increase that amount by the estimated percentage reflecting the proportion of premiums required for administration and State premium taxes. Decrease that amount by a percentage that reflects the estimated average percentage to total amount payable for items and services covered under the standard benefits package that will be payments in the form of cost sharing under a certified standard benefit plan with a high-cost option. Then, divide that amount by your community rating area difference—which is actually the percentage of difference in health care expenditures, in rates of uninsurance and underinsurance and in the proportion of expenditures for services provided by academic health centers.

Sound simple? Not at all.

It will require an army of Washington bureaucrats to figure all this out, and this is just one small section of the Mitchell bill. The bill is a jobs bill for bureaucrats.

There are other complexities of this provision. The fact that you will not know when you buy insurance if your policy is going to be taxed. The fact that your doctor might very well be getting a bill for half of the tax at the end of the year. We all know who ends up paying this tax. Individuals and small businesses.

Is it so important that we enact this type of legislation and cause such disruption in the lives of many Americans? Isn't there a better way to improve health care? I think there is, and it is being done by the States and private sector already.

The Idaho legislature adopted health care reforms the last two sessions.

These are State, not Federal solutions.

Idaho has enacted legislation which guarantees access to health insurance, regardless of preexisting conditions or current health status.

At the same time, the legislature created true portability of insurance by allowing the insured to transfer coverage from one plan to another without a loss of coverage.

Administrative simplification was next on the list. Idaho now requires insurance companies to use a uniform claim form to reduce administrative costs and simplify the insurance process for the patient, the doctor, and the insurance companies.

Finally, the lawmakers took a step toward increasing the affordability of insurance by establishing Medical Savings Accounts. Contributions to these accounts are tax deductible from State income tax and may be used tax-free for medical expenses.

Idaho State Senator Dean Cameron says lawmakers recognized the need to do something, and he added, "We've accomplished everything they (the Federal Government) are trying to accomplish."

The private sector has also acted on its own. Moscow, Idaho, and Pullman, WA, are towns only 8 miles apart. They face a rural health care delivery problem, and they are doing something about it. Pullman Memorial Hospital and Gritman Medical Center have formed an alliance to keep costs down, improve care, and keep doctors and services available to the Palouse region.

The physician hospital organization, called a PHO, is voluntary—not mandated. Gritman's administrator, Robert Colvin, says, "We think we're doing this ahead of the curve, before it's do or die." This arrangement should be able to reduce costs and improve service by reducing the amount of duplicated services. Again, this is something these two communities, their hospitals, and doctors decided to do. The Federal Government did not tell them to do it.

I might add with no small amount of pride that I was an orderly at Gritman Medical Center when I was a student at the University of Idaho.

Because of the actions taken by the Idaho legislature, and innovations by private-sector health care providers, health care insurance and coverage in the State will be more affordable and accessible to many people. This was done without increasing taxes or more bureaucracy. The U.S. Congress could learn a lot from the Idaho State legislature.

Instead, the Senate is now debating a piece of legislation which will increase our taxes and dramatically increase the health care bureaucracy. Early reports indicate the Clinton-Mitchell bill will impose 17 new taxes and create 25 new bureaucratic regimes.

Over 90 percent of all employers in Idaho are small businesses. They employ almost two-thirds of the State's workers. People who currently receive their insurance through their employer, a small business, would be forced to change their current health plan. The business would be required to purchase a plan through the proposed Health Insurance Purchasing Cooperative, and the plan would have to provide the standard benefits package. Even if the worker preferred the old plan, he or she could easily be stuck paying for a plan that contains unneeded items or does not provide benefits that fit the worker.

Employees would suffer, and so would employers. Businesses would be negatively impacted by the Clinton-Mitchell plan. We are all aware of the serious impact the so called employer mandates will have on small business. Under this bill, there is little doubt that the mandate would likely be enacted. Willard Wood was in the restaurant business in Idaho for 58 years before retiring. He's managed both large and small restaurants, and he says employer mandates could be lethal to mom-and-pop businesses. "If health care reform goes through and the employer has to pay for all the employees, it will mean the loss of thousands of small businesses. I am talking about where the owners are working long hours just to make a living." After 58 years in business, I think Mr. Wood could be considered an expert in the field.

Chris Nye, who manages a business in Pocatello, says if employer mandates are forced onto his business, he will have to change his hiring practices because he won't be able to hire part-time help.

With examples like that, I can foresee where this bill will only serve to increase welfare rolls and lengthen unemployment lines because this health care bill will put people out of work.

Even before the mandates kick in, this bill is bad for a number of businesses—the small companies that have chosen to self-insure. They have taken the time and often the investment to carefully study their insurance needs and options and have decided that self-insuring provides them with the most efficient and most cost-effective way of providing coverage for their employees. Under the Clinton-Mitchell proposal, this would no longer be an option. The businesses would either have to buy insurance through those purchasing cooperatives I mentioned earlier or not provide insurance for their workers. I doubt we want to create a situation where a company is discouraged from providing coverage for its employees.

So how do we help small businesses across this country? What areas of reform are important to address right now?

There are insurance market reforms, providing portability, so a person can take insurance with them even between jobs.

Such reforms would also do away with limitations on insurance caused by preexisting conditions.

Antitrust reform is needed to allow hospitals and doctors to communicate and cooperate to provide the best care for a community.

St. Alphonsus Regional Medical Center and St. Luke's Regional Medical Center in Boise are only about 3 miles apart. Boiseans are truly fortunate to have two such fine facilities in their community. There have been times when people in Boise have wondered why each hospital provides the same specialized treatment or service. Would it not make sense to combine efforts? Normally, yes. But current antitrust laws make cooperation difficult. However, the hospitals have decided to push the edge of those laws and have combined their diabetes treatment centers. In doing so, the hospitals decided that several factors are more important than possibly risking violation of antitrust.

Both hospitals have diabetes centers. Both centers lose money or barely break even. So instead of passing the losses on to their patients in the cost of other services, the hospitals have combined efforts to improve delivery and cut costs. In the end, the community wins with a better quality of service in a facility that does not run the risk of closing down because it is losing money. It is a small step with two small programs, but could lead to more. Administrators at both hospitals say it could mark the beginning of more cooperative efforts. But they are nervous that the cooperation could run afoul of antitrust provisions. Enactment of antitrust reforms could remove the hurdles and provide incentive for the two hospitals to work together, not against each other, for the good of the community. Antitrust reform is not included in the Clinton-Mitchell bill.

One hundred-percent deductibility of health care premiums would give farmers, ranchers, and small business owners the same kind of advantages large corporations get. If you want to help rural and frontier areas, this would go a long way.

Congress should enact medical malpractice insurance reform. Bob Seeheusen, executive director of the Idaho Medical Association, says the current Clinton-Mitchell bill would preempt State laws on medical malpractice. In Idaho's case, he says this would undo what the State has already accomplished, and would likely push malpractice premiums up in price. It is unfortunate that even hospital equipment manufacturers need to buy malpractice insurance. Hospital administrators tell me that is what increases the cost of equipment, and the cost of care. If a hospital or doctor has to pay more for equipment, the cost is passed to the patient.

We need to enact anti-fraud and abuse control provisions; and administrative simplification. Nurses spend too much time filling out forms, taking away from the time they would like to spend with the patients.

I introduced a health care reform bill earlier this year that contained these reforms. I do not claim total authorship of the measure—I was able to take these items that are common to a variety of health care bills that had been introduced, and put them in one bill. I believed then, and I believe now, that there are reforms that most of us agree on and put in one bill and enact immediately and begin the reform of health care in America. Those should be put in a bill and enacted now so we can get started on the real reform Americans want.

Finally, it seems appropriate to remind everyone of the old adage, "Haste makes waste." It may seem trite, but it fits. With issues as detailed and complex as health care, it is vital that we not proceed too rapidly. We should not pass any piece of health-related legislation until we are sure we fully understand the consequences of our actions. Otherwise, we may find that we create more problems than we solve.

Larry Lee at Harms Memorial Hospital in American Falls has an interesting suggestion. He believes that before Congress jumps into something that is unproven, we should authorize pilot programs and test these theories. He says the health care reform proposals should go through the same kind of scrutiny, testing, retesting, and sampling that drugs undergo by the Food and Drug Administration.

There are many aspects of health care reform that I have not talked about today. They will be discussed by my colleagues on both sides of the aisle. But I look forward to that exchange. Only through extensive and thorough debate of the issues will we be able to unravel all the questions facing us, and only then will we hope to be able to pass legislation that Americans say they want and need.

The Clinton-Mitchell bill is not the right prescription for Idaho. Health care is too important an issue to pursue in this manner.

We would be wise to follow the advice of Missy Hunsacker, Dr. Andrew McRoberts, and Jim Guthrie when they say Congress should not move toward a hasty, big-government solution to our Nation's health care.

Mr. President, that completes my remarks. I thank you for your courtesy and the courtesy of all who have remained here this evening. I yield the floor.

ORDERS FOR TOMORROW

Mr. DASCHLE. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand adjourned until 9:30 a.m., Thursday, August 18; that when the Senate reconvenes on that day, the Journal of proceedings be deemed to have been approved to date, the call of the calendar be waived, and no motions or resolutions over under the rule; that the morning hour be deemed to have expired; that the time for the two leaders be reserved for their use later in the day; that there then be a period for morning business, not to extend beyond 10 a.m., with Senators permitted to speak therein for up to 5 minutes, with Senator HATCH recognized to speak for up to 10 minutes; and that at 10 o'clock, the Senate resume consideration of S. 2351, the Health Security Act.

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

ADJOURNMENT UNTIL TOMORROW AT 9:30 A.M.

The PRESIDING OFFICER. Under the previous order, the Senate now stands adjourned until 9:30 a.m., Thursday, August 18.

Thereupon, the Senate, at 9:29 p.m., adjourned until Thursday, August 18, 1994, at 9:30 a.m.

CONFIRMATIONS

Executive nominations confirmed by the Senate August 17, 1994:

DEPARTMENT OF TRANSPORTATION

RICARDO MARTINEZ, OF LOUISIANA, TO BE ADMINISTRATOR OF THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION.

DHARMENDRA K. SHARMA, OF CALIFORNIA, TO BE ADMINISTRATOR OF THE RESEARCH AND SPECIAL PROGRAMS ADMINISTRATION, DEPARTMENT OF TRANSPORTATION.

FEDERAL MARITIME COMMISSION

HAROLD JENNINGS CREEL, JR., OF VIRGINIA, TO BE A FEDERAL MARITIME COMMISSIONER FOR THE TERM EXPIRING JUNE 30, 1999.

DELMOND J.H. WON, OF HAWAII, TO BE A FEDERAL MARITIME COMMISSIONER FOR THE TERM EXPIRING JUNE 30, 1997.

THE ABOVE NOMINATIONS WERE APPROVED SUBJECT TO THE NOMINEES' COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

THE JUDICIARY

ALEXANDER WILLIAMS, JR., OF MARYLAND, TO BE U.S. DISTRICT JUDGE FOR THE DISTRICT OF MARYLAND.

DEPARTMENT OF JUSTICE

CHARLES REDDING PITT, OF ALABAMA, TO BE U.S. ATTORNEY FOR THE MIDDLE DISTRICT OF ALABAMA FOR THE TERM OF 4 YEARS.

LARRY REED MATTOX, OF VIRGINIA, TO BE U.S. MARSHAL FOR THE WESTERN DISTRICT OF VIRGINIA FOR THE TERM OF 4 YEARS.

WALTER BAKER EDMISTEN, OF NORTH CAROLINA, TO BE U.S. MARSHAL FOR THE WESTERN DISTRICT OF NORTH CAROLINA FOR THE TERM OF 4 YEARS.

THOMAS JOSEPH MARONEY, OF NEW YORK, TO BE U.S. ATTORNEY FOR THE NORTHERN DISTRICT OF NEW YORK FOR THE TERM OF 4 YEARS.

COAST GUARD

COAST GUARD NOMINATIONS BEGINNING ROGER K. WIEBUSCH, AND ENDING ROBERT W. MONTFORT. (SEE EXECUTIVE JOURNAL PROCEEDINGS OF MAY 17, 1994, FOR COMPLETE LIST.)

COAST GUARD NOMINATION OF KAY L. HICKMAN.

COAST GUARD NOMINATIONS BEGINNING MARK L. EVERETT, AND ENDING EUILL W. LONG III. (SEE EXECUTIVE JOURNAL PROCEEDINGS OF JULY 27, 1994, FOR COMPLETE LIST.)