preexisting illnesses, allowing premiums to be set at a level which would not raise costs for others. Therefore any increase in premiums which does occur will not be the result of this legislation but of how each State chooses to regulate its individual insurance market. Second, the legislation gives States considerable flexibility in how they address the requirements of the bill. This will allow States to devise strategies which fit their individual situations.

In the past several years, many States have taken significant steps to reform their health care systems, and they are to be commended for these efforts. For example, my home State of Arizona was one of the first to use managed care to improve the efficiency of publicly funded health care, and has passed legislation which encourages the use of Medical Savings Accounts. There are certain reforms, however, which only the Federal Government can make. These reforms fall in that category, and it is our responsibility to make them.

FUNDING MEDICARE FRAUD AND ABUSE CONTROL

Mr. DOMENICI. Mr. President, earlier today we adopted an amendment, now that we have had a chance to review, we find creates a concern.

In effect, in our proper and correct effort to address fraud and abuse in the Medicare Program, we converted spending that previously had been subject to appropriations into entitlement funding.

Because of the consent agreement it is too late to fix this problem.

I had an amendment, however, that would have corrected the problem.

My amendment would have provided a different funding mechanism for the Medicare fraud and abuse control program. Instead of funding this program by creating a very large new entitlement program, my amendment would have provided a different funding mechanism.

The issue is not whether we should fund the Medicare fraud and abuse control program, but how we should fund this program.

I strongly support the Medicare fraud and abuse control program, but I am troubled by the fact that the bill in its current form would create $1.5 billion in new mandatory spending for the administrative expenses for three agencies.

Congress already addressed this issue on the funding mechanism for the Continuing Disability Reviews [CDR's]. As part of the debt limit, we provided for funding for CDR's by providing a mechanism to give these programs additional funding through the appropriations process. My amendment would have essentially taken the same approach as we did with CDR's.

Mr. President, Medicare fraud and abuse control is currently funded through discretionary spending. Discretionary spending is the funding we provide annually for programs through the appropriations process.

My amendment would have replaced the unprecedented new entitlement spending for enforcement in this bill with a mechanism that would have provided an automatic upward adjustment for Medicare fraud and abuse control spending in the appropriations process.

The Medicare Fraud and Abuse Control allowance proposed in this amendment would have provided an automatic upward adjustment in the discretionary spending caps to make sure additional funding for the Inspector General of the Department of Health and Human Services, the FBI, and HCFA is not curtailed by budget limits.

However, under my amendment Congress would still have been required to annually review and fund these programs.

I want to emphasize two important points, Mr. President. First, this amendment would have done exactly what we did for increasing funding for continuing disability reviews in the debt limit bill.

Second, the policy effects for Medicare fraud and abuse control are exactly the same as in the current bill. The increased funding for fraud and abuse control would have still occurred, and the savings would still have resulted.

Mr. President, we will never gain control of Federal spending unless we gain control of entitlement spending. My amendment would have kept us from heading down the slippery slope of creating new entitlements for administrative expenses.

I hope that laying down this concern now, conferees on this bill will attempt to correct his problem before we take final action.

I ask unanimous consent that a copy of the amendment I would have offered be printed in the RECORD.

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

At the appropriate place, insert the following:

SEC. . MEDICARE FRAUD AND ABUSE.

(a) ADJUSTMENT TO DISCRETIONARY SPENDING LIMITS.—Section 251(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding the following new subparagraph:

''(I) Health care fraud and abuse control.—

''(i) Whenever a bill or joint resolution making appropriations for fiscal year 1997, 1998, 1999, 2000, 2001, or 2002 is enacted that specifies an amount for health care fraud and abuse control under the heading 'Health Care Fraud and Abuse Control' for the Office of the Inspector General of the Department of Health and Human Services, under the heading 'Health Care Fraud and Abuse Control' for the Federal Bureau of Investigations, or under the heading 'Health Care Fraud and Abuse Control' for the Health Care Financing Administration, the adjustments for that fiscal year shall be the additional new budget authority in that Act for such health care fraud and abuse control for that fiscal year and the additional outlays flowing from such amounts, but shall not exceed—

''(I) with respect to fiscal year 1997,

''(aa) $14,000,000 in additional budget authority and $13,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $8,000,000 in additional new budget authority and $6,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $18,000,000 in additional new budget authority and $29,000,000 in additional outlays for the Health Care Financing Administration;

''(II) with respect to fiscal year 1998,

''(aa) $29,000,000 in additional budget authority and $28,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $17,000,000 in additional new budget authority and $15,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $78,000,000 in additional new budget authority and $89,000,000 in additional outlays for the Health Care Financing Administration;

''(III) with respect to fiscal year 1999,

''(aa) $41,000,000 in additional budget authority and $40,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $27,000,000 in additional new budget authority and $24,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $143,000,000 in additional new budget authority and $154,000,000 in additional outlays for the Health Care Financing Administration;

''(IV) with respect to fiscal year 2000,

''(aa) $54,000,000 in additional budget authority and $53,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $37,000,000 in additional new budget authority and $34,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $213,000,000 in additional new budget authority and $224,000,000 in additional outlays for the Health Care Financing Administration;

''(V) with respect to fiscal year 2001,

''(aa) $70,000,000 in additional budget authority and $68,000,000 billion in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $49,000,000 in additional new budget authority and $58,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $263,000,000 in additional new budget authority and $274,000,000 in additional outlays for the Health Care Financing Administration; and,

''(VI) with respect to fiscal year 2002,

''(aa) $88,000,000 in additional budget authority and $86,000,000 in additional outlays for the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $62,000,000 in additional outlays for the Federal Bureau of Investigations; and,

''(cc) $283,000,000 in additional new budget authority and $294,000,000 in additional outlays for the Health Care Financing Administration.

''(ii) As used in this subparagraph—

''(I) the term 'health care fraud and abuse control' means the administration and operation of the health care fraud and abuse control program including the following activities—

''(aa) prosecuting health care matters (through criminal, civil, and administrative proceedings);

''(bb) investigations;

''(cc) financial and performance audits of health care programs and operations;

''(dd) inspections and other evaluations; and

''(ee) provider and consumer education regarding compliance with the health care fraud and abuse program;

''(II) the term 'additional new budget authority' means new budget authority provided for a fiscal year for health care fraud and abuse control under the heading 'Health Care Fraud and Abuse Control' for—

''(aa) the Office of the Inspector General of the Department of Health and Human Services in excess of $53,000,000;

''(bb) the Federal Bureau of Investigations in excess of $39,000,000; and,

''(cc) the Health Care Financing Administration in excess of $407,000,000; and

''(III) the term 'additional outlays' means outlays flowing from the amounts specified for health care fraud and abuse control under the heading 'Health Care Fraud and Abuse Control', including outlays in that fiscal year flowing from amounts specified in Acts enacted for prior fiscal years (but not before 1997), in excess of—

''(aa) $56,000,000 in a fiscal year for health care fraud and abuse control by the Office of the Inspector General of the Department of Health and Human Services;

''(bb) $38,000,000 in a fiscal year for health care fraud and abuse control by the Federal Bureau of Investigation; and

''(cc) $396,000,000 in a fiscal year for health care fraud and abuse control by the Health Care Financing Administration.''

(b) BUDGET ALLOCATION ADJUSTMENT BY BUDGET COMMITTEE—Section 606 of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding the following new subsection:

''(f) HEALTH CARE FRAUD AND ABUSE ADJUSTMENT.—

''(1) IN GENERAL.—

''(A) When the Committee on Appropriations reports an appropriations measure for fiscal year 1997, 1998, 1999, 2000, 2001, or 2002 that specifies an amount for health care fraud and abuse control under the heading 'Health Care Fraud and Abuse Control'' for the Office of the Inspector General of the Department of Health and Human Services, the Federal Bureau of Investigations, or the Health Care Financing Administration, or when a conference committee submits a conference report thereon, the Chairman of the Committee on the Budget of the Senate or House of Representatives (whichever is appropriate) shall make the adjustments referred to in subparagraph (C) to reflect the additional new budget authority for health care fraud and abuse control provided in that measure or conference report and the additional outlays flowing from such amounts for health care fraud and abuse control.

''(B) the adjustments referred to in this subparagraph consist of adjustments to—

''(i) the discretionary spending limits for that fiscal year as set forth in the most recently adopted concurrent resolution on the budget;

''(ii) the allocations to the Committees on Appropriations of the Senate and the House of Representatives for that fiscal year under sections 302(a) and 602(a); and

''(iii) the appropriate budgetary aggregates for that fiscal year in the most recently adopted concurrent resolution on the budget.

''(C) The adjustments under this paragraph for any fiscal year shall not exceed the levels set forth in section 251(b)(2)(I) of the Balanced Budget and Emergency Deficit Control Act of 1985 for that fiscal year. The adjusted discretionary spending limits, allocations, and aggregates under this paragraph shall be considered the appropriate limits, allocations, and aggregates for purposes of congressional enforcement of this Act and concurrent budget resolutions under this Act.

''(2) REPORTING REVISED SUBALLOCATIONS.—Following the adjustments made under paragraph (1), the Committees on Appropriations of the Senate and the House of Representatives may report appropriately revised suballocations pursuant to sections 302(b) and 602(b) of this Act to carry out this subsection.

''(3) DEFINITIONS.—As used in this section, the terms 'health care fraud and abuse control', 'additional new budget authority', and 'additional outlays' shall have the same meanings as provided in section 251(b)(2)(I)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(c) CONTROL OF MANDATORY SPENDING.—Notwithstanding section 502(b) of this Act, funding for medicare fraud and abuse control provided by this Act shall only be available to the extent provided for in advance by appropriations Acts.

Mr. HARKIN. Mr. President, I am pleased to support and serve as a cosponsor of the Health Insurance Reform Act of 1995. Senators KASSEBAUM and KENNEDY have worked together in a bipartisan manner to craft legislation that every Senator should support because it will help millions of American families. As a member of the Labor and Human Resources Committee, I was proud to join in unanimous support for the bill in committee.

This is not perfect legislation. It does not fix many of the flaws in the current health care system. But it represents an important step toward reforming health care and injecting some fairness and common sense into the system.

While supportive of comprehensive health care reform in the last Congress I also offered a down payment that would have provided for insurance reform, enhanced tax deductibility of health insurance costs for the self-employed, and increased efforts to crack down on fraud, waste, and abuse in health care—all provisions contained in the bill the Senate is considering today.

Millions of Americans would benefit from the insurance reform provisions in S. 1028. Provisions that would gradually raise the percentage of health insurance costs that the self-employed can deduct from 30 percent to 80 percent over the next 10 years would provide greater equity with larger businesses. And, I am pleased that the bill includes provisions to increase funds for the inspector general to combat Medicare fraud and establish tougher sanctions for committing fraud.

Mr. President, Americans should not be denied health care coverage for changing jobs, getting sick or having a preexisting medical condition. And if someone loses their job, they shouldn't have to lose their health insurance, too. This legislation is designed to respond to those concerns.

The Health Insurance Reform Act will provide American families with more security and choices. It will offer some welcome relief for American families worried about losing their health insurance. It will help prevent people from losing their health insurance when they become sick. And it will limit preexisting conditions. These are all fundamental, necessary reforms.

I want to thank both Senators KASSEBAUM and KENNEDY for working with all the members of the committee to strengthen the bill. I am particularly grateful for their help in making sure that the legislation prohibits group and individual health plans from establishing eligibility, continuation, or enrollment requirements based on genetic information. I offered an amendment on this issue during committee consideration of S. 1028 and am pleased it is included in the bill.

I am also grateful for their help in ensuring that States are given appropriate flexibility. The legislation takes into account the progress already made by States like Iowa which just implemented additional and very significant insurance reforms on April 1 of this year. S. 1028 would allow States to preserve laws such as high risk pools that help small groups and individuals purchase insurance.

The provisions in the legislation related to preexisting conditions are important and add some common sense to the current health insurance market. The bill limits the ability of insurers to impose exclusions for preexisting conditions. Under the legislation, no such exclusion can last for more than 12 months. Once someone has been covered for 12 months, no new exclusions can be imposed as long as there is no gap in coverage—even if someone changes jobs, loses their job, or changes insurance companies.

The bill also requires insurers to sell and renew group health policies for all employees who want coverage for their employees. It guarantees renewability of individual policies.

It prohibits insurers from denying insurance to those moving from group coverage to individual coverage. It prohibits group health plans from excluding any employee based on health status.

The preexisting condition provisions will help real people who have already experienced an illness and want to switch insurers or change jobs.

For example, just last week a father from Iowa City called my office about his daughter who has a chronic health condition and will graduate from college this spring. He was worried that when she graduates and is no longer covered under his health insurance policy she will not be able to find insurance coverage for her chronic health condition.

Because the Health Insurance Reform Act would require insurers to credit prior insurance coverage, his daughter can move to another health insurance plan without being denied coverage for her preexisting condition.

The portability provisions in the bill will help with so-called job lock. Workers who want to change jobs for higher wages or advance their careers often have to pass up opportunities because it might mean losing health coverage. The portability provisions contained in

this legislation would benefit at least 25 million Americans annually according to the General Accounting Office. And, these provisions will provide greater security for the millions of Americans currently covered under group health plans.

I've heard from Iowans who have had to pass up new job offers or forego starting their own small business because they or someone in their family has a preexisting condition. Workers with a sick child are forced to pass up career opportunities because their new insurance may not cover a preexisting condition for 6 months or more. These families have played by the rules and have been continuously insured—they deserve to know that if they pay their insurance premiums for years, they cannot be denied coverage or be subjected to a new exclusion for a preexisting condition because they change jobs. The Health Insurance Reform Act would allow people to switch jobs without worrying about denied coverage for preexisting conditions.

Many States, including Iowa, have already enacted standards for insurance carriers. In fact, legislation passed in Iowa is more comprehensive in many respects and includes provisions that help make insurance more affordable for small groups and individuals. But, Federal legislation is necessary because States are prevented from regulating self-funded health plans—the type of plans that cover the majority of Iowans. This legislation will also provide a national floor and a guaranteed level of protection for all Americans.

I support this bill and urge my colleagues to not offer amendments that will weaken it. We should keep this bill free of the objectionable provisions that were included in the House bill—provisions which will surely prompt President Clinton to veto the bill, and that will ultimately deny long-needed assistance to millions of middle-class American families.

ORGAN DONATION INSERT CARD ACT

Mr. DORGAN. Mr. President, first and foremost, I would like to thank the distinguished managers on both sides for agreeing to include this critical provision in the Health Insurance Reform Act.

The Senate's passage of the Organ Donation Insert Card Act is particularly timely. Next week is National Organ and Tissue Donor Awareness Week, and the need for organ and tissue donors is more crucial than ever. Right now, the national waiting list for an organ transplant has topped 45,000 people, and a new name is added to the list every 18 minutes.

The Organ Donation Insert Card amendment represents a simple, cost-effective way for the Federal Government to help save the lives of those who are waiting for an organ transplant. The amendment will provide millions of Americans with organ and tissue donor information with their income tax refund checks in 1997. This one-time insert will give taxpayers the opportunity to learn more about this important subject and to fill out cards to become donors.

Each year, we miss thousands of opportunities for organ transplantation because of a hesitancy among next-of-kin to authorize donation when they do not know their loved ones wishes. Of the 20,000 deaths each year that fulfill the medical criteria for becoming organ donors, only about one-fourth actually become donors.

As a result, eight people die every day while waiting for a transplant. At least some of these deaths could be prevented through the information campaign authorized by the Organ Donation Insert Card Act.

I understand that authorizing donation is a difficult decision for a grieving family to make, and their task is made much harder when they do not know their loved one's wishes. For that reason, I would like to take a moment to acknowledge a few of the families I have heard from who authorized donation.

Gary and Bobbie Schroeder say they did not give a lot of thought to organ transplantation. I suspect that is true for many of us.

But on November 26, 1989, their 21-year-old son Jeff was in a fatal car accident. Gary wrote to me,

> Jeff was a 4th year pre-med college student in Southern California, when he and his roommate, returning from playing in a college basketball tournament, ran into wet and slippery roads and had a single car accident. Jeff sustained a head injury, even though wearing his seat belt, causing brain death. * * *

Jeff was on life support, but tests showed absence of brain activity, and he was declared brain dead 4 days later.

We were then given the opportunity of making a decision that would give some purpose to a tragic situation. * * * Donating Jeff's organs gave us the opportunity to start the healing process. * * *

Jeff was a giver in life, always helping others; we know he would want to continue helping others, even in death.

Jeff's organs helped sustain life to four other individuals, by giving his heart, liver, and kidneys. He helped give hope and extended life to the recipients and their families. Our decision to give has been a step toward healthy grieving, and we would make the same decision again.''

Patrick Pins, a high school Social Studies teacher in Mandan, ND, also knows firsthand the difficult decision that families face when a loved one dies. In 1992, his wife Barbara was attending a family reunion with her family when she developed a severe migraine, nausea, and neck pain. Although she was rushed to the hospital, she had suffered severe brain trauma and died within 24 hours of arriving at the hospital.

While only a machine kept Barbara's body alive, Patrick and the couple's three children struggled with their grief and talked and prayed. Ultimately, they decided to donate Barbara's organs.

Today, like the Schroeders, Patrick says that confronted with the same decision again, ''I'd do the very same thing.''

Throughout her life, Barbara's family and friends say the popular Head Start teacher constantly gave of herself and taught the children in her care and the people around her important lessons. Through the donation of her organs, she has been able to do the same even in death.

As I have worked for the enactment of this bill, I have also been motivated by the many families who have shared with me their stories of agonizing months spent waiting for a suitable organ and of the joy of receiving a chance to live. I think it would be appropriate to share some of those stories to remind us all that there are names and faces behind the statistics.

Donna Grendahl is a Minnesota mom whose son, ROBBy, received a heart transplant in 1986. In her letter to me, Donna wrote:

> My son received the gift of a new heart in transplant surgery 9 years ago. * * * Now 9 years later, he is a 24-year-old college graduate. He teaches American history/civics and coaches hockey and baseball at the high school level. * * *
>
> Thanks to the availability of a donor, he has been able to enjoy the gift of his second chance at life to the fullest.

Bonnie Simonet, a wife and mother and a double-lung transplant recipient, told me: ''I suffered for 10 years with a disease to my lungs. . . .

> Oxygen kept me alive, but my lips and fingernails were blue. I was on oxygen 24 hours a day, and I was only 47-years young, which I consider too young to die. I had a life left to live. . . .
>
> When my doctor suggested a lung transplant, it seemed so drastic, but I wanted to live. I went through a week of evaluation, many tests and had to get approval from my insurance company. When this was set in motion, I was put on the waiting list for a double lung transplant. . . .
>
> On August 4, 1994, after waiting on the list for 9 months, I was called. . .. I was in surgery 6 hours and came out a new person with a 2nd chance at life and a new attitude about what is important.

Janet Johnston's 19-month-old grandson, Colton, is alive today because he received a new liver. According to Janet,

> My grandson, Colton, went through his first surgery at a month and a half old, which didn't take care of his problem. He was put on a list in January for a liver transplant. We waited six long months, always worried if he was going to live long enough before a liver became available. On July 16th we got our gift.
>
> We are pleased to support your proposed ''Organ Donation Insert Card Act. Please continue to work hard. There are people who do benefit and have happy endings.

Finally, Gary Rux, a heart transplant recipient shares his story:

> I recently received a copy of your proposed legislation for an ''Organ Donor Insert Card.'' I want you to know that I support this legislation with all of my new heart. . . .
>
> I have firsthand knowledge of what it is like to spend over 2 years dying, not knowing for sure if I would be around to provide

for my family. In spite of the time I spent waiting for a heart, I ask that you offer no sympathy to me. I am one of the lucky ones. . . . There are many, however, who are not so lucky. It is they who need and deserve our sympathy. Fortunately for them, you are in a position to do more than simply offer sympathy. I thank you on behalf of the many individuals who are waiting, and dying, at this very moment. Bear in mind as you promote this legislation that some of these individuals who are dying are just children. I believe they deserve a chance, and with your and our support, perhaps they can have that chance.

Fortunately, these stories all have happy endings and they are heartwarming to hear, but we must also remember the many families who do not have a happy ending. In my view, the most common tragedy of organ transplantation is not the patient who receives a transplant and dies, but the patient who has to wait too long, dying before a suitable organ can be found.

But today, the Senate has taken a step to prevent some of these needless deaths.

In closing, I want to thank the many organizations and supporters who have endorsed this bill and that worked tirelessly for its enactment. I also want to mention my Senate colleagues who have cosponsored the bill, Senators BRADLEY, COCHRAN, DEWINE, FRIST, HELMS, INOUYE, BOB KERREY, JOHN KERRY, LEAHY, LEVIN, MOSELEY-BRAUN, MURKOWSKI, ROBB, AND SIMPSON.

Finally, I want to again thank the managers, Senators KASSEBAUM and KENNEDY, for accepting this amendment, and I look forward to working with them to retain it in conference.

Mr. KYL. Mr. President, the U.S. Congress has begun the debate on legislation that will affect the way millions of Americans get their health insurance. Both the House and the Senate bills are intended to address a serious concern among millions of working Americans who currently have employer provided health insurance: the threat of losing private health insurance when they lose or change jobs or, try to obtain coverage when they have a preexisting medical condition.

The Kennedy-Kassebaum bill contains some useful provisions and addresses some important problems in the health insurance market. However, I believe these problems are more effectively addressed in the health insurance reform plan passed on March 27 in the House of Representatives—and reportedly contained in the Finance Committee amendment.

I believe the Kennedy-Kassebaum bill could be improved and expanded by incorporating important provisions in the House bill—and in the proposed Finance Committee amendment. These provisions more successfully address the health care problems faced by millions of Americans, such as:

The Problem: An ambitious worker who wants to pursue a career opportunity, but can't change jobs because his son has cancer, and wouldn't be covered by a new employer's insurance.

The Solution: The House bill guarantees that anyone with employer provided insurance can move to another job with employer provided insurance without losing coverage for a preexisting condition.

The Problem: A worker is laid off, and can't get coverage for a preexisting condition in the individual market.

The Solution: The House bill includes group-to-individual portability, so that when you leave a job that provided coverage for a chronic condition, you cannot be denied coverage in the individual market.

The Problem: An uninsured entrepreneur who can't afford insurance as a self-employed person today.

The Solution: The House bill allows the self-employed to deduct 50 percent of their premiums from their taxes. Increasing deductibility makes health insurance more affordable for self-employed individuals. The Finance Committee amendment may increase the deduction to 80 percent.

The Problem: An uninsured person, out of work, who can't afford a costly individual policy because it is loaded down with State mandated benefits.

The Solution: The House bill includes medical savings accounts, so that an individual can buy a high-deductible policy, with a much lower, more affordable premium.

Mr. President, MSA's offer the ultimate in portability and affordability, and I want to further address this critical issue later in my remarks.

The Problem: A small business employee, whose employer can't afford to purchase insurance for his five employees, because one of them has a chronic illness.

The Solution: The House bill allows small businesses to group together to purchase health insurance.

By grouping together, they can share risk and spread administrative costs over a larger group, lowering premiums for everyone.

These ERISA regulated arrangements would be exempted from state mandated benefits and pooling prohibitions that can drive up the cost of care.

The Problem: The federal tax code often discourages citizens from providing for their own health care needs.

The Solution: The House bill provides for tax deductibility for long-term care insurance premiums and expenses and, tax free use of accelerated life-insurance benefits for health expenses.

The Problem: Fear of frivolous lawsuits and outrageous recoveries forces many doctors to practice costly ''defensive medicine.''

The Solution: The House bill reforms medical malpractice claims. Patients who are injured as a result of malpractice deserve to be fully compensated.

But in today's system, an enormous amount of money that should be dedicated to health care spending goes instead to lawyers—sometimes as much as 40 percent to 50 percent.

The Problem: Fraud, waste, abuse and administrative inefficiency cost the health care system billions per year in wasted resources.

The Solution: Tougher penalties for waste, fraud, and abuse along with administrative simplification through electronic billing and uniform forms.

II. Mr. President, during this debate I plan to support the proposed Finance Committee Amendment. The provisions in this amendment will increase portability, tax equity, and affordability.

Mr. President, it is my understanding that the following provisions will be included in the Finance Committee Amendment to the Kennedy-Kassebaum Health Care Reform Act: an increase in the self-employed health care tax deduction to 50 percent or higher; medical savings accounts providing for deposits of $2,000 for individuals and $4,000 for families; deductibility for long-term care premiums and expenses; and, tax-free treatment of accelerated death benefits for the terminally ill.

Mr. President, assuming these provisions are included in the committee's amendment, it would not be my intention to offer any amendments; further, I would not object to a unanimous consent (UC) agreement.

However, in the event that any of the above provisions are not included in the amendment, I will offer and support amendments to replace these provisions.

III. The importance of MSAs. MSAs are one feature of the House bill—and reportedly the Finance Committee Amendment—that will increase the portability, availability, and affordability of health insurance. MSA are a simple, low cost alternative to traditional health care insurance for the millions of Americans who cannot afford today's health insurance options or, who are not happy with available insurance options.

Here is how an MSA can work: The employer purchases a high-deductible health insurance policy and places an amount of money equal to the employees' deductible in a special savings account called a medical savings account. The money in the MSA, tax-free, to cover most medical costs. The individual keeps what is not used after one year, collects interest, and the balance rolls over into the next year, when the employer makes additional contributions to the account.

In addition to covering basic medical services, these funds can be used to cover services not covered by health insurance, such as elective surgery and long-term care. Money accumulated in an MSA can only be withdrawn for medical expenses as established by the Internal Revenue Code. For MSAs to receive the same tax treatment as employer-provided health benefits plans, a high-deductible plan would have to be combined with the MSA. A high-deductible plan would have a deductible of at least $1,500 in the case of an individual, and $3,000 for a family. Individuals—including the self-employed—could make tax-deductible contributions: up to $2,000 if single, $4,000 if married. The inside build-up would be tax-free. The amounts could be withdrawn from the MSA tax- and penalty-free if used for medical purposes. Employer contributions to an MSA would

not be taxable to the employee on whose behalf the contribution is being made.

While Congress has been considering MSAs, many companies have gone ahead on their own and have developed highly successful MSAs or MSA-type programs. A March 1995 study by the Evergreen Freedom Foundation analyzed the experience of 1037 companies nation-wide who had implemented MSAs. For instance, in 1994, the Valley Surgical Group Health Plan of Phoenix implemented an MSA plan for its 14 employees. According to the Evergreen Report, annual employer costs were reduced by $400 per employee in the first year alone. Mr. President, here is why MSAs will work:

1. Parity in tax treatment: MSAs grant high-deductible health plans—paired with an MSA—comparable tax treatment to that of other forms of employment-based group health plans, and allow people to claim the deduction even if they do not otherwise itemize taxes.

2. Positive incentives: MSAs provide Americans the incentives to purchase health care more carefully by letting them keep what they don't spend.

The current unlimited exclusion for employer-based health care encourages unnecessary spending.

3. Major medical protection: MSAs insure that the necessary coverage will be there in the event of an illness or accident.

4. The ultimate in portability: MSAs provide for real portability. Unlike other forms of employer-based health plans, medical savings in the MSA can be taken from job to job.

5. More choices for consumers: The MSAs empower people to make their own health care decisions.

Funds in the MSA may be spent, on qualified medical expenses that may not be covered under high-deductible plan (e.g., prescription drugs, durable medical equipment, etc * * *).

6. MSAs Help meet long term care needs: MSAs will help people who want to protect themselves against future long-term care needs.

MSA funds can be used to purchase long-term care insurance or services.

7. States are moving toward MSAs: Arizona is one of 15 states that have already passed laws granting favorable tax treatment to MSAs.

The failure to establish federal tax rules regarding MSAs will inhibit innovations that many states have decided is good health policy.

Mr. President, in spite of the overwhelming evidence that MSAs are a viable health insurance alternative with wide appeal, there are still a few who say MSAs favor only the healthy and wealthy. This is inaccurate. While MSAs will be attractive for the healthy, they will be equally attractive for the sick. The reason: The MSA gives individuals the ultimate freedom to choose their health care providers, thereby allowing individuals to seek out the best health care services that meet their budget.

The accusation that MSAs will work only for the wealthy is also inaccurate. According to a 1996 analysis by the Joint Committee on Taxation, middle-income Americans will choose MSAs. According to the Joint Committee, one million Americans are expected to sign up for MSAs. An estimated 650,000 people who earn between $40,000 and $75,000 a year would chose MSAs., 120,000 with incomes between $30,000 and $40,000 would choose MSAs.

MSAs could lower overall health care costs. Voluntarily uninsured workers might receive an incentive to obtain health insurance as a result of MSAs. Younger, healthier workers who don't purchase health insurance because they believe they will never get sick, would now have an incentive to be covered against major illnesses as a result of MSAs. This would increase the number of healthy people in the insurance pool and would lower overall health costs.

Are supporters of MSAs out of the mainstream? No. As part of the Kennedy/Kassebaum bill, the Labor Committee passed a ''Sense of the Committee'' resolution that said:

> It is the sense of the Committee that the establishment of medical savings accounts . . . be encouraged as part of any health insurance reform legislation passed by the Senate.

Also in the Kennedy/Kassebaum bill, there is a provision that allows Medicare risk HMOs to offer medical savings accounts.

The Democratic support MSAs. In 1994, all the Democrats on Ways and Means voted to include MSAs in the Clinton plan. In 1994, Representative Gephardt included them in his Democratic Leadership bill. In 1992, Senator JOHN BREAUX introduced a bipartisan MSA bill. Senators TOM DASCHLE, SAM NUNN, Alan Dickson, RICHARD SHELBY, David Boren co-sponsored the legislation. In 1994, Senator PAUL SIMON was a cosponsor of MSA legislation.

Mr. President, MSAs are one of the keys to portability, affordability, and choice of health insurance for millions of Americans. I believe the Senate must pass MSAs.

The PRESIDING OFFICER. The question is on agreeing to the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading, was read the third time.

The PRESIDING OFFICER. Under the previous order, the clerk will report H.R. 3103.

The legislative clerk read as follows:

> A bill (H.R. 3103) to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage, and for other purposes.

The PRESIDING OFFICER. By previous order, all after the enacting clause is stricken and the text of S. 1028, as amended, is inserted in lieu thereof and the bill is deemed read a third time.

Under the previous order, the vote on final passage will occur on Tuesday, April 23, at a time to be determined by the majority leader.

MORNING BUSINESS

Mr. ABRAHAM. Mr. President, I ask that there now be a period for the transaction of routine morning business, with Senators permitted to speak for up to 5 minutes each.

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

CONGRESS MUST STOP JUNK GUN VIOLENCE

Mrs. BOXER. Mr. President, in 1968, Senator Robert Kennedy was assassinated in California by an assailant carrying a junk gun. That terrible event convinced Congress that something had to be done about the dramatic increase in gun violence. Specifically, Congress concluded that it had to act to stem the proliferation of these junk guns, or as they are also known, Saturday night specials.

Later that year, Congress passed the Gun Control Act of 1968, which barred the importation of junk guns. The guns affected by the import ban had several things in common: They were cheap. They were poorly constructed, and they lacked important safety devices.

Shortly after the passage of the Gun Control Act, unintended consequences began to emerge. Many new companies were formed to manufacture junk guns domestically. Protected from foreign competition and given a virtual monopoly over the U.S. market, the domestic production of junk guns skyrocketed. In fact, all of the companies that produce today's criminals' favorite junk guns were founded after 1968.

In 1972, Congress tried to end the double standard that allows the domestic manufacture of junk guns. Sixty eight Senators—including BOB DOLE and STROM THURMOND—voted to close the loophole permanently. Unfortunately, despite its more than two to one support in the Senate, that bill was killed in a House committee.

Along with my cosponsors, JOHN CHAFEE and BILL BRADLEY, I have introduced legislation, S. 1654, that is closely modeled after that 1972 bill.

The principle of that bill that passed the Senate so overwhelmingly nearly 25 years ago and the bill I have introduced is simple: if a gun is such a great threat to public safety that its importation is banned, then its domestic manufacture should also be prohibited. Its point of origin is irrelevant.

By every measure, the problem of gun violence has grown worse since passage of the Gun Control Act. This indisputable fact was most recently demonstrated in the release last week of a study by the Children's Defense