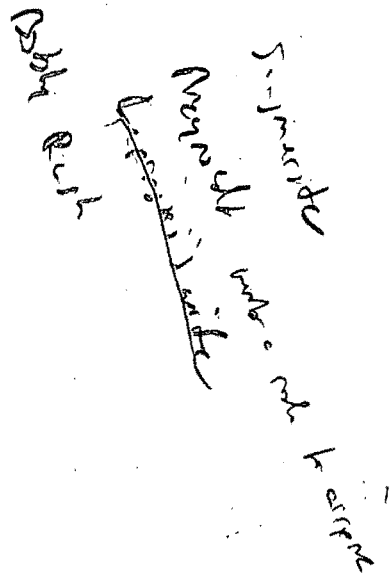
Rec'd 6/10/93

Note to: Chris Jennings
From: Karen Davenport
Subject: Senator Kerrey's remarks on health reform

As Mrs. Clinton requested, I am enclosing copies of Senator Kerrey's floor statements on health reform. I have flagged sections where he addresses responsibility for personal health or cost control. Unfortunately, I have not found any remarks where he discusses the Heritage Foundation plan. However, in these statements he also criticizes the status quo -- another "message" issue in his discussion with Mrs. Clinton.

If I can provide any other information, please let me know.



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Kerrey: American People Must Take Responsibility in Health Care<

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OMAHA, Neb. (AP) People will have to take responsibility for controlling costs and paying for health care if changes in the system are to work, Sen. Bob Kerrey, D-Neb., said Friday.

Whatever the eventual details of President Clinton's proposals, people will have to change, Kerrey said at a news conference.

In distributing health-care costs, the plan must bear the total economy in mind, he said. ``This thing has to contribute to the creation of jobs in America,'' Kerrey said.

The senator explained some of his views on health care in an address to the National Medical Information Networking Conference, which was meeting at the hotel.

Controlling costs will require Americans to examine their lives and see what they can do to cut costs, Kerrey said.

``That may mean I've got to stop smoking. That may mean I've got to pay attention to my diet,'' he said.

The health-care system should primarily prevent illness and promote good health, and treating people who are sick should be important but secondary, Kerrey said.

``The measure of success should be, `Are we getting healthier?''' he said.

Kerrey said he would fight to make health care a fundamental right for all Americans. That right would bring the responsibility to pay for the care and to participate in controlling costs, Kerrey said.

People with more money should be required to pay more for their health care, but all Americans must accept the responsibility to make a payment, Kerrey said. People should not have to be destitute before getting assistance, he said.

Addressing the theme of the conference, Kerrey said computer and communication technology must be harnessed to provide information in ways that improve education and health care.

``Technology is sitting there waiting for us to take it in our hands and use it for good,'' he said. ``Are we going to apply human values to this and use it for good?''

Regulation and spending need to be revamped to allow development of communication networks that give health-care professionals the information they need to serve patients, even if they are in remote areas such as parts of western Nebraska, he said.

``Perhaps I'm going to be able to make contact in my own home with my physician,'' Kerrey said.

Trade Act of 1974 to Czechoslovakia and Hungary; to the Committee on Finance.

By Mr. GORTON (for himself and Mr. WALLOP):

S. 1469. A bill regarding the extension of most-favored-nation treatment to the products of the People's Republic of China, and for other purposes; to the Committee on Finance.

By Mr. HATCH:

S. 1470. A bill to alleviate burdens imposed upon educational agencies and institutions by the Family Educational Rights and Privacy Act of 1974 with respect to the maintenance of records by campus law enforcement units; to the Committee on Labor and Human Resources.

By Mr. ADAMS (for himself, Mr. KENNEDY, Mr. DODD, Mr. HARKIN and Mr. DECONCINI):

S. 1471. A bill to amend the Older Americans Act of 1965 to establish an elder rights program, and for other purposes; to the Committee on Labor and Human Resources.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. DOLE (for himself, Mr. METZENBAUM, Mr. PELL, Mr. HELMS, Mr. PRESSLER, Mr. NICKLES, and Mr. D'AMATO):

S. Res. 153. A resolution to express the Senate's support for democratization in Yugoslavia; considered and agreed to.

By Mr. DODD (for himself, Mr. LIEBERMAN and Mr. LAUTENBERG):

S. Con. Res. 52. Concurrent resolution condemning resurgent anti-Semitism and ethnic intolerance in Romania; to the Committee on Foreign Relations.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. KERREY:

S. 1446. A bill to provide for an equitable and universal national health care program administered by the States, and for other purposes; to the Committee on Finance.

HEALTH USA ACT OF 1991

Mr. KERREY. Mr. President, on behalf of the people of the State of Nebraska, who guided this bill's development, I am pleased to introduce the Health USA Act of 1991.

Health USA comprehensively reforms the way our Nation finances health care. It controls soaring health care costs; extends coverage to every American; provides long-term care for our elderly; and unties health care coverage from employment, so that concerns over health benefits do not lock Americans out of productive jobs. And because Health USA budgets health care expenditures, reduces administrative costs, improves health care management, and encourages prevention, it achieves its goal without America spending a single penny more for health care.

In fact, under Health USA, the majority of America's families will pay less for health care than they do now. The average family in Nebraska will get better health coverage and save about $500. Over the next 5 years, Health USA will save America over $150 billion in health care expenditures—over $150 billion we can use to increase American productivity, competitiveness, and living standards.

Health USA is more than a health care reform. It is an essential building block for a strategy of economic expansion and opportunity. It is an equally essential building block for a humanitarian strategy. And in both economic and humanitarian terms, I believe it will improve life in America—for the Nation as a whole, for businesses, for families and individuals. It will lead us to take better care of our own health, better care of our children, and better care of our work force.

Health USA is not the Canadian model of health care, or the British model, or the German model. It is an American model. It builds on the best of American health care while it eliminates the worst. It maintains our high-quality, private-sector-based system of delivering care; but it replaces our system of financing, so that all Americans can be covered at less cost. Health USA preserves our freedom to choose among private doctors, hospitals, and health plans; but it eliminates excessive paperwork and administrative costs. It builds on America's advanced systems for managing care; but it gives greater incentive to invest in prevention, and reduces interference with the clinical decisions of health professionals. It keeps our current health system's high quality; but it encourages even more diversity in the marketplace by rewarding good outcomes, encouraging healthy lifestyles, and placing a premium on simplicity.

Health USA's financing is based upon two important American principles. The first is personal responsibility to do and pay what you can. The second is that the best public decisions are those made in the full sunlight of citizen visibility. Not only must all Americans pay something for their health care, but no able American can expect to be subsidized for long. The second principle ensures we will known how and why every one of our health care dollars is spent.

Mr. President, before I explain what Health USA does and why it is needed, I want to say a few words about how this bill was developed. Health USA is a proposal by, for, and about Nebraskans. Its goals and its approach are the product of over 100 meetings, across 2½ years, with over a thousands Nebraskans, in dozens of towns. Its philosophy reflects input from Omaha to Ogallala. Its substance incorporates suggestions from Nebraska's farmers and doctors; insurance executives and policyholders; medical school faculty and parents; hospital administrators and hospital patients; Democrats and Republicans; young and old.

The goal of this process has been to spark a dialog among Nebraskans over what kind of health care financing system we want. Until there is informed consensus among the people in our States, there can be no informed progress here in Washington. And on such an important issue, I thought it better for Nebraska to put its fingerprints on the Nation that the other way around.

If it works in Nebraska, I believe it will work for the Nation. And I am convinced Health USA will work in Nebraska. It will work for Nebraska's businesses and their employees, 75 percent of whom work in firms with fewer than 100 employees, by giving them affordable coverage, predictable costs, and certainty of payment. Health USA will work for Nebraska's rural areas, for its steers medical personnel and facilities to rural areas, and provides targeted tax relief to small employers, like farms and suppliers, who are the backbone of our rural economy. Health USA will work for Nebraska's inner-city neighborhoods, like North Omaha, for it eliminates the financial barriers to prenatal care, immunizations, cancer screening, and other preventive procedures that can save lives and strengthen families. And Health USA will work for small towns and suburbs from the banks of the Missouri to the Nebraska sandhills, for it controls the explosion in health insurance rates that is lowering take-home pay and raising anxieties.

Since this bill came from the people of my State, I have told them I will not push it here in Washington in the usual ways until they feel comfortable with it. I will not actively seek cosponsors. Nor will I ask Washington's interest groups to come to my office with proposed modifications that might garner their support. Rather, my plan is to keep working with the people of Nebraska—to hear their reactions and consider their modifications—until I am confident Nebraskans understand and endorse the details of this proposal. For this is an unfinished policy: A progress report on a dialog that will continue for some time until the moment of reform arrives.

But Mr. President, make no mistake about it, the moment of reform will arrive. Indeed, in my judgment, it is already long overdue.

This morninig we read in the Washington Post an article that described the potential increased cost for the Medicaid program.

It is now estimated by the Secretary of the Department of Health and Human Services [DHHS] that we will spend $200 billion by the year 2000 for Medicaid, a huge increase over the $72 billion we currently spend. That is more than we currently spend on Medicare, Mr. President. And, as I have examined Medicaid, it is altogether too obvious to me why the costs of that program are growing so rapidly. The sad and tragic reason, Mr. President, is because increasing numbers of working Americans who are turning to a welfare program to obtain health care

services, because it is the only available way for them to take care of their families.

Mr. President, when I talk about the need for reform, I am not talking about the way we deliver health care in America. Our delivery system—the quality of our personnel; the effectiveness of our hospitals; the sophistication of our technology—these are the envy of the world. Our system of delivering health care has enhanced the value of life for millions of Americans, including myself.

But our system of financing health care is a different story, Mr. President. Our system of financing health care is a train wreck in progress. Instead of excessive speed, the culprit here is excessive cost. Our method of financing health care is simply out of control. It is fragmented, cumbersome, inefficient, bureaucratic, limited in accountability, and it has given us the most out-of-control health costs in the world. In 1970, our Nation spent approximately 7 percent of our gross national product [GNP] on health care. By 1990, it was over 12 percent—over $650 billion. Sometime this decade, quite possibly by 1995, health care spending will surpass 15 percent of GNP or over a trillion dollars. Mr. President, in 1970, we spent $40 billion on health care.

And if the national costs are not sufficient to alarm us, we only need to look at the cost to business. And if the increase in the cost of business, particularly to small business, is not sufficient to alarm you, look at the cost to the individuals and track the increases in health care costs to increases in the number of Americans turning to Medicaid for health coverage, track that increase in health care costs to our Nation's dismal infant mortality rate, track that increase in health care costs to low American productivity, Mr. President, and I believe you will have a sufficient amount of urgency to allow us collectively to overcome our resistance to change. For U.S. businesses, health costs have nearly quadrupled as a percent of prayroll since the 1960's, and grown from less than 10 percent of businesses' pretax profits to over half of those profits today.

These increases are simply unsustainable. They conjure up the image of some malignancy, relentlessly feeding off the body of its host. Our system of financing medical care is already doing harm to those it is meant to heal, as its growing cost eats away at worker paychecks, retiree savings, public budget, entrepreneurial initiatives, and U.S. competitiveness. It is hurting our Nation. It is hurting our businesses. And it is hurting our people, who are increasingly driven into the rolls of Medicaid, the ranks of the underinsured, or the wrenching anxiety of wondering how long their coverage will be affordable and how much they can depend on it when illness strikes.

For the nation, for business, for individuals—these cost increases are simply unsustainable. How can our nation invest enough in schools and roads and other improvements to make our economy more productive when rising health care costs devour 25 percent of each year's gains in GNP? How can our businesses compete when health costs here are 127 percent higher than Japan's and 91 percent higher than Germany's? How can our workers compete when millions of them are blocked from taking more productive jobs due to considerations about their health insurance?

And how can our entrepreneurs prosper in this kind of environment? Before I entered public life I started and operated some restaurants and health clubs. For small business owners like myself, these runaway health care costs can mean a choice between continuing to provide our employees with health care coverage, or continuing to provide them with jobs. Increasingly, we cannot afford to do both. And that is simply an unacceptable choice.

It is even becoming an unacceptable choice for those who have energetically opposed reform. The Wall Street Journal recently reported that when the late Chairman of the Republican National Committee, Lee Atwater, was diagnosed as having a brain tumor, the RNC's insurance carrier told the Party to drop Mr. Atwater's coverage, or else it would triple the RNC's rates. The RNC did what hundreds of other less well-connected businesses have had to do. They cared about Mr. Atwater, and so they continued his coverage but changed insurance companies. But the new firm's premiums were higher, and now the new Party Chair, who is opposed to the reform I am proposing, laments that some of their younger, less well-to-do staffers cannot afford coverage. Well, they are not alone.

The status quo is unacceptable. The status quo means we will watch our Nation's health care costs soar, and will agonize as coverage correspondingly decreases. Businesses will pass along rising costs in the form of higher deductibles, higher copayments, reduced coverage, or by simply dropping health care benefits altogether. Politicians will pass along higher health care costs in the form of cutbacks in Medicare benefits and restrictions on Medicaid eligibility. Hospitals will pass along rising costs by passing along patients—literally, by telling patients without insurance that they must take their illness or their child's injury or their pregnancy to some other hospital that can afford to provide charity care.

As a result, fewer Americans will have health care coverage. Already, over 33 million lack any coverage; about as many are underinsured. One in six Americans reports their coverage has been reduced over the past 2 years. Millions who are insured live with a gnawing anxiety their coverage may disappear when they need it most. And when coverage evaporates, too many Americans forego tests or treatment that could lead to better health and lower treatment costs. Our system of financing health care puts very little premium on prevention. As a result, we have too many infants in neonatal intensive care units at thousands of dollars a day who might be home if their mothers had access to inexpensive prenatal care. We have too many women with breast cancer who might have had a chance to live longer if they had been able to afford a mammogram.

Medicaid, a program originally created for the poor, is now the source of health care for 27 million Americans. We read this week of Dick Darman's SWAT team that he dispatched to find out why so many Americans are getting health care through their local welfare office. The answer is obvious to all of us who are elected to serve the people: rising costs are driving more and more Americans away from work and into the waiting arms of a Medicaid case worker.

Increasing health care costs have decreased health care coverage. And decreasing health care coverage have increased costs. It is a vicious, deadly, unnecessary circle. It diminishes the productivity of our people. It haunts families. It kills children. It shrinks our future.

Mr. President, I belive at the center of that circle is a third problem with our system of financing health care—a problem that links the rising costs and the diminishing levels of coverage. That third problem is the employment-based nature of our health care system. This is the real explanation for the train wreck. This is where the trains collide.

An employment-based system of financing health care requires hundreds of thousands of firms and insurers each to become experts on health care, to make decisions about benefit packages, to evaluate risk, to worry about costs and utilization, to process forms.

It means that the more than 20 million Americans who start a new job each year must wonder about whether their new firm offers health benefits and must wonder, as well, what will happen if their firm does not make it and they find themselves unemployed.

It means that the millions of Americans with pre-existing medical conditions must worry that no new firm or insurer will ever cover them, so they're locked into their job forever.

It means that new employees who get coverage must wade through stacks of forms and often risk weeks of no coverage while they wait for the new policy to take effect. It means that mothers on welfare often have an incentive to reject opportunities to work because it may mean losing the meager coverage she and her children receive under Medicaid.

Above all, an employment-based system of financing health care means we cannot control health care costs. It dilutes the incentives for any employer, insurer, or State to invest in prevention. It precludes our ability to decide how much of our national income we want to spend on health care, and it locks us into a two-tier system of care; one system for the employed and another for the poor, that guarantees degrading and inadequate care for some and cost shifting, risk skimming, and health care inflation for the rest.

Mr. President, in testimony given on June 18 at the House Committee on Government Operations, Dr. Katherine Swartz, a senior research associate at the Urban Institute, provided a very concise explanation of the perils of linking health care eligibility with employment. I recommend it to my colleagues who are struggling with this question and, Mr. President, I ask unanimous consent to include Dr. Swartz' statements at the conclusion of my remarks.

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

Mr. KERREY. The three primary goals of Health USA are worth repeating, Mr. President. Cost control is the first, so we can free up billions of dollars for more productive purposes. The second is universal access, because such access is fair and essential to control health care costs. The third is to uncouple health care coverage from employment, to end job-lock, and increase the productivity of our workers and our economy.

Mr. President, I will not take up any more of the Senate's time explaining more of the details of how Health USA will work, the full details are in the bill itself.

Mr. President, the proposal's most fundamental feature is this. It finances the basic health care of all Americans and pays for that coverage with public funds which will replace most of our current health care insurance premiums and out-of-pocket health care expenses. This should not be seen as simply a new spending program. Indeed, as I have said, most Americans will pay less. It replaces health insurance premiums with payments to Federal and State health trust funds. It also replaces Medicare, Medicaid, and health programs for military personnel and civil servants.

But, Mr. President, Health USA is definitely not a free ride. The cost control mechanisms of Health USA are real, and they put upon the American people not only a new opportunity but a serious obligation to get involved in the discussion of how we are going to spend our resources and how we are going to allocate them. Politicians will not be provided with an incentive simply to say "yes" to every new request because people will see directly that every new request will add costs to their system, and every new cost will mean increased payments from them; payments, unfortunately, that are currently all too often disconnected from the American people.

It will increase costs on some businesses and individuals. But it will also decrease costs on many businesses and most individuals. It will highlight the responsibility each of us has to take care of our own health. It will require us to adjust to a new way of paying for health care, one that channels more health care spending through an institution—Government—about which we have well-founded reservations. But for most Americans this new way of paying will mean they pay less. And over time, it will be much less than what it will be if we continue with our current system of financing health care.

Health USA constitutes a declaration that the preferred way to control America's cost of health care is to do so directly. Direct budgeting allows Health USA to retain the best of our system while rejecting the worst. It rejects continued reliance on employment-based health benefits because such an approach cannot do enough to control costs. At the same time, it rejects the Canadian model of reform which would abolish private health insurance because that approach leaves too little room for competition, consumer choice, or creative and cost-saving management of care.

Let me briefly answer the key questions about the program I have heard from across Nebraska. The one that I hear the most often is how does this proposal control costs? I must say that I have heard of many proposals that assert they control health care costs. Usually the language is shaded just slightly. It will say this proposal has "mechanisms to control cost" or, it will "control costs of health care better."

Mr. President, Health USA will control costs because we will have the obligation to budget our health care spending. And every American can ask us if we are running for the Senate, can ask us if we are a candidate for the House of Representatives, can ask us if we are a candidate for President, or Governor, or for State legislatures: How much do you want to spend on health care? And we will be obligated to answer that question. Because we are obligated to answer the question we have the means to control health care costs.

There are several other ways that health care costs will be controlled under Health USA. There will be negotiated fee schedules and expenditure targets established for physicians. Hospitals will have budgets for patient care services. A process will be developed for capital budgets. Individuals will have cost-sharing obligations. Medical effectiveness research and the development of practice guidelines will be strongly supported. Administrative procedures will be simplified. And we will also stand at the plate and hit the ball of malpractice insurance, which must be addressed if we are going to get health care costs under control.

Mr. President, the second question is, Who is covered? Under Health USA, all Americans are covered for a comprehensive package of services including preventive and long-term care. Families and individuals will pay a $100 deductible, a small amount for each office visit, up to 20 percent of the cost of each procedure but no out-of-pocket expenses on preventive care, and in no case will a family face more than $2,000 a year for out-of-pocket costs.

The third question I hear is, How will Americans obtain their health care? Health care will continue to be provided as it is now, primarily through private hospitals, private physicians, and private health professionals who are affiliated with private health plans, such as fee-for-service programs, managed care programs, or health maintenance organizations [HMO's]. In each State, a wide variety of such plans will be operated by insurance companies, existing HMO's, or other private, public, or nonprofit organizations. Families and individuals will choose the plan from which they want to obtain their coverage. No plan may discriminate against any applicant for any reason. Every year there will be an open enrollment period when people may switch to a new plan.

The fourth question is, Who will administer the plan? A National Health Commission will be created and each year it will recommend to Congress the level of health care spending required to fund the federally prescribed package of benefits. Funds will be distributed to State health programs on a capitated basis, that is, so much per person, with adjustments for the factors of each State's population that most affect health care spending such as age, sex, geographic dispersion of the State's population, and other factors.

Each State will be required to fund a portion of the basic benefits package, and may also decide to offer additional benefits if they are willing to finance them. The State program will then pay each of the health plans approved in that State a set amount for each person they have enrolled, with that amount again adjusted for the age, sex, and other relevant risk factors of the plan's enrollees. Each State will have separate accounts for acute and long-term care services and for investment in capital, education, and prevention.

The fifth question is, How will health plans operate and compete? It will be a market competition, but under changed rules. Insurers in other health plans will no longer be able to compete by skimming the healthiest and least expensive people, since no plan can reject any applicant. Plans will not compete on a promise to pay.

That promise will have been predetermined. Rather, plans will compete for enrollees on the basis of service and quality. Plans that boast the best record of health outcomes, the best service, and the best amenities will attract more enrollees and thus more money from the State. At the same time, these plans will be forced to control utilization, administrative costs, and marketing expenses in order to stay within their budgets and maximize their profit margin. Any plan that overrestricts the utilization or scrimps on quality will drive its subscribers to a competing plan. Every plan will have a direct financial interest in finding ways to keep its subscribers healthy. This healthy and health-producing tension will provide the competitive environment in which insurers and other health plans operate.

The sixth question is, how will providers be paid? Under Health USA, as I noted above, there will be separate systems of negotiated fee schedules and binding expenditure targets for physicians, and budgets for hospitals. These will enable us to control health care costs directly, decisively, and they will do much more. They will enable us to improve the work environment for health professionals who increasingly hear their clinical decisions questioned by a new industry of third-party cost managers whose mission is to slash utilization. Health USA moves us away from a reliance on these invisible scrutinizers, and instead trusts health professionals to make the best decisions about quality and utilization within their overall fee schedules and budgets. For citizens, the cost control provisions offer both an opportunity and an obligation to participate in a decision about how much our Nation should spend on health care.

Mr. President, America's annual health care spending will no longer be a shocking number handed to us by a DHHS statistician at the year's end. Rather, it will be a number we democratically decide before the year begins. Candidates for office will be asked that level of spending and services they propose and voters will be able to see if the budget matches the promise, something we simply cannot do now.

The seventh question is, what will Health USA do to improve the availability of health care in rural America and in other medically underserved areas? The proposal establishes a resource development fund which States may use to provide financial incentives to providers in rural areas or to develop alternative ways of providing service in such areas. The proposal will also encourage the training of health professionals to these areas through the National Health Service Corps program, and through the use of a resource based relative value scale which will support the many family and general practitioners who are often the mainstay of physician care in difficult-to-serve areas. The proposal will also support other health professionals, including nurses, physician assistants, and others, who are crucial to the delivery of quality care in all areas, particularly rural areas.

The eighth question is, how will all this be financed? I have proposed one package of revenues in order to form the basis for discussion. The financing package starts by shifting over all Federal revenues currently devoted to medicare, medicaid, CHAMPUS, and civil service health benefits. It then adds revenues from a number of sources, the largest of which is a new 5-percent payroll tax of which 4 percent is paid by employers and 1 percent is paid by employees. This source is supplemented by an expansion of the wage base for the FICA payroll tax; a new top bracket and rate for nonwage income on the personal income tax; an increase in the corporate income tax; an increase in excise taxes; and States will be required to provide about 13 percent for the first year's cost of the program. They will meet the obligation by using the revenues they currently use to finance their share of Medicaid, supplemented by other sources.

States face the same problem that we do with Medicaid, but they face that problem with a slightly different set of circumstances. They cannot pay for their growing costs of Medicaid with the sale of bonds. For States, Mr. President, the growing costs of Medicaid must be paid for directly with tax dollars. Medicaid, Mr. President, is taking a larger and larger bite out of State budgets and diverting funds available for other important State functions.

Finally, Mr. President, one of the questions that comes most often is, does this mean that we are going to have more and bigger Government? I am prepared to argue—although I will not argue at length this morning—based upon experience with the current health care system and based upon what I believe we can have with Health USA, that we will get less Government that we will have with the status quo. More important, Mr. President, we have the opportunity to make sure that it is better Government; that we have Government do those things that it can do well and make sure it does not do those things that it cannot do well. We have the opportunity to make sure that we not only have less Government, but that we have good Government.

What does this all add up to, Mr. President? That is a difficult question to answer. Estimating the impact of this kind of program is a mammoth task, and few groups in Amnerica are equipped to undertake it. One group so equipped is Lewin/ICF, one of the Nation's premier health care consulting firms. I contracted with Lewin/ICF to estimate the cost and distributional implications of my plan.

Lewin/ICF estimates, in all, if fully implemented in 1991, this proposal would drive national health expenditures down from an estimated $651.6 billion to around $640 billion, a savings of over $11 billion. We would save $11.2 billion in administrative costs by budgeting health care, and I inject again for emphasis, Mr. President, this is not a free lunch.

In order to get this $11 billion in saving, there needs to be real cost control mechanisms. The American people will have, as I said, not just an opportunity, but an obligation, to do something that is seriously needed for the economic health of the United States of America as we increasingly try to compete with other nations on this Earth. We would save $21.5 billion through better management of care. And the combined $32.7 billion in savings would enable us to expand coverage to all Americans, which will cost about $15 billion, and extend an additional $6 billion of long-term care to the elderly and disabled Americans.

After saving America $11 billion in 1991, the savings would grow over time. In 1992, the savings would be $20.1 billion; by 1995, the annual savings would be over $55 billion, Mr. President. In all, from 1991 to 1995, our Nation would save a little over $158.5 billion in national health costs compared to the way we now finance health care and over $700 billion during this decade.

I say again, Mr. President, that if we wanted to, we could save more than that. This gives us the opportunity to decide how much we will spend and how much we want to save. It would give us, again, the obligation to do so. No longer will we be able to say it is this person who is causing the problem, and have that person point the finger down the line at the next, and that person point the finger down the line at the next, before it comes all the way around the circle back to us.

By having our national health care spending flow through our Government, we can make it flow in a much more efficient, equitable, predictable, and accountable way. For that reason, Mr. President, Americans will spend less.

The analysis of Lewin/ICF also tells us what the impact will be on America's average family. In general, families who earn $50,000 or less will spend about the same or less on health care. The average family with an income of between $15,000 and $20,000 will save about $1,000 in the first year. Average families with incomes between $20,000 and $40,000 will save about $500. In all, an estimated 50.2 percent of all American families will pay less under the first year of Health USA than they would under our current system of financing health care.

Finally, Mr. President, the analysis shows that businesses that currently insure their employees will pay less on average. Total savings to such firms

will exceed $3 billion annually, an average savings of $77 per employee. Further, these firms will no longer have to bear the cost of analyzing and administering health care plans. They will no longer have to bear the uncertainty of health care cost increases that currently hampers business planning. And the many firms who face a staggering burden from the cost of health benefits for their retirees will now have that burden eased.

Mr. President, I do not mean to suggest that everyone will benefit. In certain parts of our economy, Health USA will unleash winds of creative disruption. Most firms who have not been insuring their workers will pay more, but, Mr. President, they should. Most health insurers will operate in a marketplace with different rules, but they must. And Americans everywhere will be forced to confront hard questions about our Nation's health care spending. Mr. President, that is a question we literally cannot afford to ignore any longer.

To those firms and individuals who have experienced this creative disruption, I will say what President Bush said when he asked us to give him fast-track authority on his trade negotiations. We now compete in an international marketplace and if we are going to try to lower the barriers of trade for business, we must try to lower the barriers for workers so they will not be penalized when they need to learn the new skills required by new technology, when they move from one job to another as a consequence of those jobs. We must lower the barrier for human beings, Mr. President, by providing them a right, access to health care, unrestricted by the locus of their employment.

I will say to those who experience this creative disruption, to look beyond the immediate disruption, to take a long-term view. Put the long-term national interest ahead of your own short-term interests. That is precisely what Health USA is all about, the national interest. It is about much more than how we pay doctors and hospitals. Fundamentally, it is about the kind of nation and future we want. It is about the kind of lives we want for ourselves, for our parents and for our children. I think Health USA will improve our lives and our Nation and I want to conclude my remarks by talking about three ways it will do that.

First, Health USA will change the life of every Member of Congress, every Governor, every State legislator, everyone who ever runs for President, and make each of us more responsive. Right now, we have all the wrong incentives as health policymakers. When we vote on health care policy, we make decisions only about the poor, or the disabled, or the elderly; we have little fear that our decisions will govern the way we, our spouses, or our children consume health care. When budgets get tight, we cut Medicaid and Medicare, and tell our voters that we have saved them money. In fact, as we know full well, we have simply shifted the health costs of the elderly and poor and disabled onto paying consumers in less visible ways.

Health USA stops that shell game. When we make decisions about what services to cover, we will be making decisions about our own families. We will be making decisions about all of our constituents, whether they make $20,000 or $20 million. When we are pushed by taxpayers to reduce costs, there will be no more hidden cost shifts. We will have to go to all our voters and ask what services they want and what they are willing to pay. Our constituents will press us hard to find new ways to reduce national health costs. And we may suddenly see them develop new interest in seat belts, air bags, bicycle helments, nutrition, alcoholism programs, violence prevention, basic medical research, and other efforts that can reduce health spending as they improve our lives.

Second, Health USA will change the way we function as workers and business owners. It will simply get health care out of business' way. Firms won't have to become health care experts in order to evaluate the plans they offer or negotiate with insurers. They will not have to get into fire-fights with their workers over cuts in health benefits. They will not have to worry about whether their premium costs will go up 10 percent or 100 percent next year. They will not have to worry about whether they will lose their coverage if they bring on a worker who happens to have a history of heart trouble. They will not have to fear that their contract obligations to retirees are going to wreck their balance sheet. They can spend more time inventing, investing, and producing.

America's workers will also be freed to strive to the limits of their ability. No worker will be dissuaded from going back to acquire new skills because he would lose his health coverage. No worker will be blocked from taking a better job because the health benefits are inferior or because a preexisting medical condition would preclude a change in insurers. And while workers may never welcome changes in technology or trade that could threaten their jobs, at least they will not have to live in fear that such job displacement could leave their families exposed to medical indigency. In short, I genuinely see an economy that will feel different. It will feel more flexible. It will feel less anxious. It will feel more productive. Above all, it will be more prosperous.

Finally, Health USA will change the way we think about our health and our lives. The way we finance health care is not the biggest determinant of our health or longevity; other things are: our behavior, our genes, our jobs, even luck. These do the most to measure our days and negotiate our contract with mortality. Yet the way we pay for our health care makes a difference.

It makes a difference if a young woman can get prenatal care from any obstetrician in town. It may not guarantee she will stay healthier during those 9 months, but it makes a difference.

It makes a difference if the only barrier between a child and his measles or polio vaccination is the trip to the doctor's office. It may not guarantee a healthier life, but it makes a difference.

It makes a difference if a factory closing does not wipe out a community's health care coverage along with their jobs. It cannot make such closings painless, but it makes a difference.

It makes a difference if older Americans do not have to fear that going into a mursing home might use up their children's life savings. It may not make aging easier; but it makes a difference.

It makes a difference if people understand that if their fellow citizens smoke cigarettes or consume excessive alcohol, then health costs will be higher and their taxes will go up. It may not guarantee society will change its values and rules; but it makes a difference.

"It makes a difference." Mr. President, how often in this Chamber can we say that with confidence? How often can we be sure that our efforts will improve the day to day lives of the vast majority of Americans? How often can we be certain that our actions will produce a better nation? Mr. President, on this proposal, I am very certain.

I am certain that if we do not fundamentally change our method of financing health care the trains will collide and the vast majority of our people will be caught in the middle. I am certain that if we don't adopt comprehensive reforms Americans will be increasingly dissatisfied with a health care system that costs them more and covers their needs less. I am certain that we can do better. I am certain America has arrived at a moment of challenge, and that Americans have the foresight and courage to rise to that challenge. I am certain that the people of Nebraska have helped me formulate a plan that can save us money, cover more Americans, improve our health, and make this a more productive nation. And I am certain, Mr. President, that the time to adopt it is at hand.

Mr. President, in my own life I had a moment when the Nation responded to my health care needs and, as a consequence of that response, I am personally aware of the change that it can make in your life to know with certainty that health care will be there for the rest of your life. In my case, my eligibility for health care occurred as a consequence of being disabled in the war in Vietnam.

Regardless of how the eligibility occurred, the eligibility is there, and it frees me, Mr. President, through the ups and downs in my life. It frees me, Mr. President, because I know that health care will be there.

I am not suggesting that the Government operate hospitals and hire the doctors as they do in my case. I know that such care sometimes is not as high quality as Americans want. I know that at times in that kind of care there are lines we have to wait in in order to get care. I am not suggesting that kind of care.

But, Mr. President and Members of this Senate, it works for me and it has liberated me and enabled me to live a life without fear that I will be denied health care when I need it the most. It is a generous Nation that responded to provide me with that care. It has not, Mr. President, produced a life of dependency upon my Government. Instead, it has produced a life of gratitude, of sincere gratefulness to a Nation that extended itself to help me when I needed it the most and when I was least likely to say thank you.

Not only do I stand and say thank you today, Mr. President, but I stand and say today let us do that for all Americans. Let us not make it a free lunch. Let us not make it so that we are disconnected from the responsibility to pay. But let us do it in a manner that liberates all of us from the fear of having health care not be there when we need it the most.

Mr. President, I ask unanimous consent that the text of the bill, the testimony of Dr. Swartz, the cost containment overview and a statement that outlines the overview of cost containment provisions be printed in the RECORD.

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

S. 1446

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health USA Act of 1991".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS AND PROGRAM GOALS.

(a) FINDINGS.—The Congress finds that—

(1) health care spending in the United States has grown at a rate that substantially exceeds the rise in the Nation's gross national product (GNP), and more specifically that—

(A) between 1965 and 1989, national health spending doubled, increasing from 5.9 to 11.6 percent of the GNP;

(B) national spending on health care has been increasing at a greater rate than the general cost-of-living index and the growth in the GNP for a number of years;

(C) in 1989, spending on health care was $604,000,000,000, an amount which exceeded the proportion of the GNP spent on health care by every other industrialized nation;

(D) the Nation's high relative expenditure on health care diminishes American incomes, productivity, and competitiveness in global trade;

(E) administrative, marketing, and liability costs are among those components of health care costs that have grown the fastest; and

(F) cost-shifting, the rising cost of insurance premiums, and declining coverage are leaving more Americans without access or without adequate access to important health services;

(2) a growing number of Americans are uninsured or inadequately insured to meet their health care needs, and more specifically that—

(A) all Americans have a right to at least a basic level of health care services that are continuously available and determined to be cost-effective;

(B) at least 33,000,000 Americans currently lack access to basic health services at any point in time; and

(C) it is estimated that during any 2-year period, approximately 25 percent of the non-elderly population of this Nation has neither health insurance nor public health care coverage for some period of time, and that an additional 13 percent of all Americans are underinsured for health care; and

(3) the growing costs of health care, coupled with declining access to services, represent a growing national problem, and more specifically that—

(A) despite growing expenditures on health care, health status indicators in the United States lag well behind those of other industrialized nations;

(B) studies indicate that persons who are uninsured or underinsured are less likely to receive adequate health care services;

(C) studies also find that insufficient access to health care services has a negative impact on health status and also increases health care expenditures in the longer term;

(D) the Nation's current system of financing health care is complex, confusing and frustrating to many Americans, including physicians and other providers of health care; and

(E) national expenditures on health care cannot continue to expand faster than inflation and the rate of national economic growth without endangering the country's domestic standard of living and international economic competitiveness.

(b) PROGRAM GOALS.—It is the policy of the Congress that the financing of the health care system of this Nation should reflect the following goals:

(1) The financing system should contain adequate measures to control health care costs and expenditures with emphasis placed on the provision of appropriate and effective services.

(2) Administration of health care financing and methods of paying for health care services should be simplified and made more efficient.

(3) Access to an adequate level of effective and efficient health care services, including long-term care services, should be provided to all United States citizens and permanent residents to promote the health of the American people.

(4) To facilitate equitable access and meet cost control objectives, coverage should be provided in 1 universal health care financing program.

(5) To ensure universal and uninterrupted coverage of the population and to free employers from the administrative burden of providing coverage, health care coverage should be separated from employment.

(6) The population and professional providers should have the freedom of choice among a range of health care plans.

(7) To meet the broad health care needs of the population, it is necessary to establish an adequate system of financing comprehensive health care services that emphasizes the delivery of quality preventive, diagnostic, treatment, rehabilitative, and long-term care services.

(8) To improve the balance within the delivery system, greater emphasis should be given to primary and preventive care services.

(9) To further assure adequate access to health care services, the system should provide incentives for physicians and other health care professionals to locate and practice in rural and other medically underserved areas.

(10) To ensure that coverage is universal and that costs are equitably distributed, the financial burden for the program should be shared progressively, based on ability to pay.

(11) Revenues, from specifically dedicated and general taxes, should be sufficient to fund the Federal share of the program, including adequate reserves.

(12) The incidence and cost of professional liability, as they affect access to health care services and health care costs, should be addressed.

(13) Flexibility and responsiveness should be encouraged among State programs and local providers of health care services to provide quality, effective, and adequate care that recognizes local variations in medical needs and preferences.

development—the B-2 bomber, the advanced technology fighter, SDI, the next generation tank, and the Army's light helicopter. A single buying agency woud be best able to efficiently transfer these technological advances because there would be no need to work around procedures at each military department that currently limit the use of such innovations.

Mr. President, I commend the Congressional Research Service for recognizing the merits of the single defense buying agency. I intend again to introduce a new bill that would streamline DOD's acquisition system into a single agency. This approach is supported over and over by studies and real world events. As the CRS report noted, the success of Operation Desert Storm demonstrates the importance of unity of command and the need for reforming the defense acquisition system to reflect this principle.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. GRAHAM). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KERRY. 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 chair advises the Senator that the time for morning business has expired.

EXTENSION OF MORNING BUSINESS

Mr. KERREY. Mr. President, I ask unanimous consent that the period for morning business be extended and that Senators be allowed to speak as in morning business for such time as needed.

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

HEALTH CARE

Mr. KERREY. Mr. President, yesterday the Democratic leadership introduced comprehensive health care legislation. It is obvious to me and I think practically everyone in this body would share the observation that some comprehensive solution is much needed and it is long overdue. I also point out that it is exceedingly controversial health care.

The distinguished occupant of the Chair yesterday introduced legislation that will, I think, address a serious problem, and that problem is the problem of growing cost of Medicaid as well as the increase in difficulty that working people have in being able to get access to health care.

There is a variety of proposals. The Democratic proposal, the proposal introduced by the leadership is comprehensive and thus it stakes out a piece of territory, and thus it demonstrates a willingness to confront the status quo and say we simply cannot allow the status quo to go on.

I appreciate earlier the distinguished Republican leader came forward and commented and in praising the Democratic leadership pointed out some differences of opinion, pointed out some aras where he believes that there is philosophical disagreements. Indeed, I think there may be philosophical disagreements throughout.

Thus, I would like to focus a bit this afternoon on the philosophy of health care which I think is terribly important because I think what we are about to do is much more than just solve or hopefully solve a domestic problem.

As I said, Mr. President, this is much needed and overdue because of rising costs at the national level, rising costs at the business level, and rising costs at the individual level. All of these rising costs are squeezing American families and businesses. They are decreasing the capacity of both individuals and businesses to maintain competitive stature in the marketplace.

In addition to that, as he spoke well of yesterday, rising costs are also forcing too many Americans onto the thin ice of medical indigency. It is also needed and overdue because of a more vexing change than just the change associated with rising costs. Although the necessity of solving this problem and its close companions decreasing access is urgent, we should not view this as just another domestic problem to be solved by legislative action.

The larger and more important context for this debate is the need to adjust to a changed competitive environment. The larger context is the same one which guided our debate of the President's request for fast-track authority to negotiate trade agreements.

American workers have been competing in an international marketplace for at least the past 20 years. As communications technology has improved and as the move of jobs offshore has increase in the 1980's, the risk to American jobs has been the object of much of our attention. The impulse to protect our markets and to shelter our industries is a powerful and understandable impulse.

Mr. President, I believe it is a mistake for us to yield to this impulse because the United States has an obligation to lead the world toward freer trade. However, it is an even greater mistake if we conclude that treatics alone, that treaties all by themselves, will make us competitive. Our public and private institutions simply cannot hunker down around the status quo if we expect to do well in this dramatically changed world.

Thus, for me health care reform is one of several changes we need in order to give American workers a more level playing field in an international workplace. The enormous change in the competitive environment of the American worker necessitates fundamental changes in our public and private institutions of health care. To those who will be adversely affected by this change, and there will be some—perhaps the insurance industry will be adversely effected by needed change, perhaps there will be some providers that will be adversely affected by needed change—we must do the same thing that we did during the debate about the extension of fast-track authority for the President: Look to the future and understand that there may be some short-term changes that will produce some short-term pain but that long-term what we are trying to do is say to an American worker, increase your skills, think about what you need in order to raise your standard of living, and do not worry that if what you need causes you to increase your skills that you are going to lose health care as a result of going back to school. Do not sit and worry that technology is going to come into the marketplace and perhaps displace you and your job, that that displacement will cause you to lose health care.

We need to be thinking that way, Mr. President. Think about American workers up against German workers, American workers up against Canadian workers, American workers up against Japanese workers, and American workers up against every worker of every country in the world, except for South Africa, and think about what those workers need so that they can raise their skill level, so they can raise their standard of living and will not be penalized as a consequence of their action.

We cannot afford to avoid difficult institutional changes just because there may be some short-term pain. President Bush, who demonstrated he was willing to forge ahead on trade negotiations to reduce trade barriers, has been unwilling to reduce barriers faced by working American families. He has been unwilling to face institutional opposition that may indeed be adversely affected if we do the right thing with health care.

If we are to do this right, we simply cannot afford to be intimidated by our political supporters. Just as many of us Democrats took the long view in voting to give the President fast-track authority for trade negotiations, the President must take the long view with health care.

If we are to do this right, we must look into the future to see Americans not just at risk to rapidly rising health care costs, but also at risk to rapidly increasing worldwide competition. Only inside this context is it possible to see the need for health care benefits which are attached to being an American rather than attached to the place of work.

Mr. President, here is where I believe philosophy is important, and I believe simplicity is important, if we want to have a health care system

that not only enables us to provide our workers with a level playing field but itself becomes simple as a consequence.

Mr. President, as a consequence I believe it is important for us to argue whether or not we believe that a universal right to health care in America should be a fundamental principle of our health care proposals. I believe it should be.

I believe that the case for a universal right to health care is in the first instance an economic case. Since our industrial competitors allow workers to move from job to job, or from job to temporary unemployment, without fear of losing health care benefits, their workers are not penalized if they attempt to increase their job skills.

The definition of a universal right is that everyone qualifies for it. We should not stigmatize the poor, and we do not need to create a special interest group when the right is universal.

A universal right is not an absolute right. There are limits. Thus, the fear that we will break the bank by establishing a universal right to health care should be no greater than our fear of breaking the bank's windows by creating a right to free speech. Moreover, Mr. President, the fear and I hear it all the time, all the time, from those who oppose establishing this right, the fear that limitations will produce destructive rationing I believe is almost the exclusive property of those whose income and/or status enable them to avoid the rationing with which a majority of Americans are already quite familiar.

A universal right allows us to simplify our system. The most rapidly growing area in most providers' offices is the space used for data processing or bill collecting. If we established a nondifferentiated right with a budgeted, negotiated fee schedule method of financing, there would be no more Americans employed to answer questions about eligibility or questions about how payment is going to be achieved. By creating a certainty to access we also create a certainty in payment.

A universal right to health care also allows us to consider much needed welfare reform. Anyone familiar with the details of our Medicaid Program will tell you that breaking the cycle of poverty must begin with health care reform.

Mr. President, as good as the Democratic leadership proposal is, and I believe it is a good proposal, it does not establish a right to health care as a fundamental principle. It attempts to solve some of the most serious problems Americans face, and as such gives us a very solid foundation upon which to begin our debate. However, I hope we use this opportunity to see health care in a larger context than just a domestic issue. I hope we use this opportunity to require the kind of institutional change that a rapidly changing workplace demands.

Mr. President, I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, what is the parliamentary situation? What is the pending business?

The PRESIDING OFFICER. Pursuant to the unanimous-consent agreement offered by the Senator from Nebraska we are in an extended period of morning business.

Mr. BAUCUS. I thank the Chair.

Mr. KERREY. The majority leader just asked me to do something here. Could I get the distinguished Senator from Montana to yield just for a few minutes?

Mr. BAUCUS. Yes.

DEFENSE PRODUCTION ACT AMENDMENTS

Mr. KERRY. Mr. President, I ask that the Chair lay before the Senate a message from the House of Representatives on H.R. 991, the Defense Production Act.

The PRESIDING OFFICER laid before the Senate the following message from the House of Representatives:

Resolved, That the House disagree to the amendment of the Senate to the bill (H.R. 991) entitled "An Act to extend the expiration date of the Defense Production Act of 1950, and for other purposes", and ask a conference with the Senate on the disagreeing votes of the two Houses thereon.

Ordered, That the following Members be the managers of the conference on the part of the House:

From the Committee on Banking, Finance and Urban Affairs, for consideration of the House bill, and title I of the Senate amendment, and modifications committed to conference: Mr. Gonzalez, Mr. LaFalce, Ms. Oakar, Mr. Vento, Mr. Carper, Mr. Wylie, Mr. Ridge, and Mr. Paxon.

From the Committee on Banking, Finance and Urban Affairs, for consideration of title II of the Senate amendment, and modifications committed to conference: Mr. Gonzalez, Mr. Annunzio, Mr. Neal of North Carolina, Ms. Oakar, Mr. Schumer, Mr. Carper, Mr. Wylie, Mr. Leach, Mr. McCollum, and Mrs. Roukema.

From the Committee on Energy and Commerce, for consideration of section 8 of the House bill, and sections 203-206 of the Senate amendment, and modifications committed to conference: Mr. Dingell, Mr. Markey, Mrs. Collins of Illinois, Mr. Lent, and Mr. Rinaldo.

From the Committee on the Judiciary, for consideration of section 5 of the House bill, and section 104 of the Senate amendment, and modifications committed to conference: Mr. Brooks, Mr. Edwards of California, and Mr. Fish.

From the Committee on Ways and Means, for consideration of sections 202-204 of the Senate amendment, and modifications committed to conference: Mr. Rostenkowski, Mr. Gibbons, Mr. Jenkins, Mr. Archer, and Mr. Crane.

Mr. KERREY. Mr. President, I move that the Senate insist on its amendment to the House bill, agree to the request for a conference with the House on the disagreeing votes of the two Houses, and that the Chair be authorized to appoint conferees on behalf of the Senate.

The motion was agreed to, and the Presiding Officer appointed Mr. RIEGLE, Mr. SARBANES, Mr. DIXON, Mr. GARN, and Mr. D'AMATO conferees on the part of the Senate.

Mr. KERREY. I thank the Chair, and I thank the distinguished Senator from Montana.

Mr. WARNER. Mr. President, there is no objection on the minority side.

The PRESIDING OFFICER. The Senator from Montana.

THE CLEAN WATER BILL

Mr. BAUCUS. Mr. President, Last month, I introduced, with Senator CHAFEE and other members of the Environment Committee, legislation to expand and strengthen the Clean Water Act.

In a statement in the Senate shortly after introducing the clean water bill, I highlighted one of the major themes of the legislation—pollution prevention. For many years we have focused our efforts on treating whatever pollutants we generated before dumping them into the water. But further progress toward our goal of fishable and swimmable waters demands that we expand our efforts to reduce the amounts of pollutants we create in the first place.

Today I want to describe two other central goals of our clean water bill—better water quality science and tougher controls over toxic pollutants.

The water pollution control issues we will face in the coming years will be increasingly complex and challenging. If we are to address these issues successfully, we must assure that the water programs operate on a solid scientific foundation.

A critical first step in this effort is to improve our water quality research program. The present research program is badly underfunded. Further, if does not provide the information we need about the effect of poilutants on aquatic systems and on human health.

In addition, our research efforts are not fully effective in stimulating advances in pollution prevention and control technology. Improving the state-of-the art for water pollution prevention and control is critical if we are to advance the cause of water quality protection.

Another element of improved water quality science is better monitoring of our rivers, lakes and coastal waters. We cannot operate effective water quality programs if we lack data on the extent of pollution problems and the effectiveness of our response.

Today, information concerning water quality conditions is very sketchy. For instance, we only assess about 30 percent of our river miles.

Furthermore, we need better indicators of the cumulative effect of toxic pollutants. And, we need better methods to measure the pollution associat-

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HEALTH CARE: A HUMANITARIAN ISSUE

Mr. KERREY. I thank the Chair.

Mr. President, my comments connect rather well with the observation of the distinguished Senator from Louisiana on what has happened to working Americans in the 1980's. The decline they have experienced in earning power and their increased tax burden is well documented. I think it is important for our colleagues to pay close attention to the remarks the Senator from Louisiana just made.

I rise today to talk about health care as an issue that I think is closely associated with the decline in the standard of living and the difficulties that working-class Americans are having in purchasing the things that they need. I believe from my experience in Nebraska that health care is perhaps the most important issue that is facing the people of this country.

I believe, first of all, that health care and its availability is a humanitarian issue. It is an issue that is of great importance to all of us who are concerned about the humanitarian nature of the United States of America.

We simply have people who are not getting well because they do not have access to health care. We have people who are not taking their children to see the doctor because they do not have the means to pay for the doctor. We have older Americans who are similarly wondering whether or not they are going to become medically indigent merely because they do not have the capacity to provide that care for themselves.

Health care is an important humanitarian issue. It is an important factor as people try to move up the ladder of economic opportunity that the United States of America has always offered to its people. Yet it can, and in many instances, has become a significant barrier.

When this body debated the Welfare Reform Act 2 years ago, it was a central piece of that effort that we try to provide transitional health care benefits to people as they try to move off of welfare. We know that fear of loss health benefits can be an enormous barrier, particularly for working mothers as they try to get back into the workplace and to move off welfare.

So it is a solid, humanitarian issue, Mr. President. But in addition to being a humanitarian issue, it is also an issue of American productivity. We are now devoting approximately 12 percent of our gross national product each year for health care. That percentage is not declining. It is going up.

Some predict that close to 15 percent of our gross national product will go to health care by the year of 2000 and instead of the $650 billion which we expect to spend in 1990, we will be spending close to a trillion dollars by the year 2000. Yet, unless substantial changes are made, more Americans will be denied access to health care services than are today.

Something needs to be done. We have all seen the macronumbers. We have heard from business and labor

about the need for fundamental reform. We all understand, it seems to me, there is a crisis in health care and something needs to be done. I rise today to offer a few suggestions that I think would be helpful.

Between June 1 and 3, the Senator from South Dakota, Senator TOM DASCHLE, and I held a series of rural health care hearings in South Dakota and Nebraska. These hearings were authorized by the distinguished Senator from North Dakota, Senator BURDICK, of the Appropriations Committee, and Senator BENTSEN of the Senate Finance Committee.

What Senator DASCHLE and I heard at the microlevel, from doctors, businesses, providers of all kinds, and patients, was that Americans are facing excessive paperwork and redtape, excessive Government regulation, fear of malpractice claims, insufficient Medicare and Medicaid reimbursement, rising business costs and decreased coverage to employees. We even heard of a hospital that, as an employer, is finding itself faced with the need to decrease the amount of coverage provided to the people who work at the hospital to help the hospital make ends meet. We heard of preexisting medical conditions, that not only make it difficult for people to move from one job to the next, but make it impossible for people to find the coverage they need. As a consequence, disturbing numbers of people are finding themselves simply without the resources to meet their health care needs, forced to declare bankruptcy, forced to quit work, forced to go on to welfare. All of these consequences, it seems to me, are in direct conflict with other values we hold as a nation, and all in order to get the care they need for their children.

We also heard stories of how our system is set up to discourage the primary and preventive care services that research has told us is the lowest cost and most beneficial care we can provide to our people. We found examples of this in rural Nebraska, as I suspect exist in all rural parts of our Nation and too many nonrural areas as well. Many of these difficulties revolve around the availability of physicians and other primary care providers. In the decade of the 1980's, the National Health Service Corps was decimated. So that today, in the United States of America, we find underserved rural areas competing with underserved urban areas for approximately 100 National Health Service Corps physicians. That is about two per State, and I urge my colleagues, Mr. President, to observe that this is woefully inadequate to be able to serve underserved areas of this country.

I do not expect any health care system to be complaint free. I have been in hospitals enough as a patient as a consequence of being injured in the war in Vietnam to know you are always going to have complaints. It can never be perfect. The patient is always going to have problems, always going to have difficulties. I do not expect it to be complaint free. But the things I heard during our recent rural health hearings go far beyond ordinary complaints. These are symptoms of the serious problems with our Nation's health care system that I believe we must address.

I ask unanimous consent to include in the RECORD several different statements made over the course of the hearings from a variety of Nebraskans.

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

STATEMENT OF KAROL OSTERLOH

Mrs. OSTERLOH. My name is Karol Osterloh and I'm here to ask you to provide health care to all in memory of our children. I'm speaking to you in memory of my daughter Pam, her twin sons, and all who have suffered and/or died as a direct result of the present American health care system. The purpose is not merely for a grade in my English class, but to raise the awareness of my brothers and sisters so we may unite, change the system and prevent the tragic reoccurence. God grant me the serenity to accept what I can't change, the courage to change what I can and the wisdom to know the difference. Pam's Prayer.

The power of the people can and will change our health care system that is failing miserably to care for our women, children, elderly and poor. Prevention is much

more economical and humane than the expensive high-tech procedures that are employed to rescue those put into danger by lack of care. Prenatal care may be provided for as little as $400 to prevent low-birth-weight infants which will cost the U.S. health care system from $14,000 to $30,000. The 11,000 low birth weight babies born each year in the U.S. and the cost of each of these infants may reach a cost of $40,000. The 1987 death rate of American infants is 10.2 per 1000 live births compared to Japan's five per 1,000 live births in 1986. If the U.S. could match the Japanese rate, the 20,000 children saved would contribute $2.6 billion in Federal income taxes in their lifetime. Programs designed and maintained to aid the needy are falling far short. The ones who need help are not being reached and others just don't meet the restrictive requirements. For every one dollar Reaganomic's budget cut from the health care programs, the defense dollar increase by $4.15. The strength of our nation lies not only in the strength of its military defense, but in the health and well being of its women, children and all citizens. Does not our destiny rest in the hands of our offspring?

The Closest Thing to Heaven is a Child, sung by the Oakridge Boys tells the story. Our cradles are empty or too often occupied by weak, small inferior babies as compared to other nations. Some 40,000 American infants each year do not live to celebrate their first birthday. In 1986, 38 million Americans had no form of health insurance coverage and 36 percent of them were children, as stated by A National Health Program is Necessary. Without insurance, women seeking prenatal care are denied access to such care unless they can meet the payments demanded of them up front by the greedy medical profession and the greedy clinics. Medicine is big business operated on a grand scale with one goal in mind, Profit. According to a Children's Defense Fund report, babies of mothers who received late or no prenatal care are three times more likely to die in infancy than babies whose mothers receive early prenatal care. Reaganomics on women has brought this about as a direct result of Federal Health-care budget cuts. The Federal government cut programs and proclaimed a declining infant mortality rate, but it is misleading. The death of 11.3 per 1000 is not a result of better prenatal care or prevention, but to higher tech intervention in hospitals. The Children's Defense Fund notes that the death rate climbed in eleven states between 1981 and 1982. Mortality rates are as high as 59.5 per 1000 live births. This is higher than Guyana, Panama, Tobago, and other poorer nations. Washington, D.C. loses more nonwhite infants than Cuba or Jamaica. Also no or late prenatal care results in endangering the mother's life. This sad fact has brought the predicament of pregnant women home to me in the death of my 25 year old pregnant daughter. Pam was a vital, energetic, and positive person. Behind every cloud she saw the silver lining. She always seemed to be an adult, for even as a small child she visited the older people on our block, She was ambitious, working every summer during her high school years. Pam and Marvin Breeze, fell in love, married, and were a trucking driving team for five years. She always wanted to see the country and she saw it through the windshield as they trucked coast to coast. We worried about her on the highway all those hours, but Breeze and Pam won several safe driving awards. The miles took their toll on the truck and the maintenance bills climbed faster than the revenue. Thus, they dreamt and saved for a new eighteen wheeler.

In December of 1989 a brand new 1990 Peterbuild rolled off the assembly line with their name on it. A dream come true. Yes, it took every cent they could muster up, but it will soon return a good revenue. Pam also found out she was expecting their first child. Breeze will now wheel the eighteen wheeler and I'll have my daughter close, as they bought a little house just across the street from me. Having Pam home and the added blessing of another grandchild on the way was an answer to my prayer. Pam is my middle child with two older sisters and two younger brothers. Connie and Shelley are married with two and three children, respectfully. They are busy with their own little tribes, just as they should be. Scott and Brad, Pam's brothers, also have lives and interests as all young men. That left Pam and I as she had no children to occupy her time and Breeze was on the road a lot. Pam would pop in for a few minutes nearly every day or give me a jingle on the land line. The only cloud on the horizon was the new trucking concern that had leased the truck failed to keep Breeze rolling. He would be laid over for two or three weeks at a time, yet the truck payments were rolling around. Shelley had a baby the same year as Pam became pregnant and she told Pam how very much she liked the woman doctor.

On January 10th Pam had her first visit with the doctor. At this time it was revealed that unlike Shelley, Pam had no insurance. Apparently the fee for prenatal care would have to be paid up front before Pam's next visit. Pam made the appointment for February 28 extending it to the very end of the month thinking, of course, that by this time the new truck would easily have returned the $800 she needed. It didn't happen. March, Pam tried again and made another

appointment. At this time she had $400, half the fee. The door once again was slammed in her face. Pam was poor, white and proud. She thought she could handle it all by herself, and God forgive me, I thought she could, too. I thought I was doing the right thing by raising my kids to be independent and not interfere. Pam landed a couple of part time jobs, but the money she earned always had another destination. Pam painted furniture for the baby's clothes, removed paneling and painted, converted their office into a nursey. She called me to come see how nice it looked. I had to smile to myself as I watched her prepare her nest. Sometimes Pam would complain a little about getting up a lot at night and her feet began to swell. She had a little cold and her sister Connie, who at this time was pregnant and also seeing the lady doctor, had a cold as well. Pam wouldn't take anything for her cold fearing it may harm her baby. Connie and Pam went shopping and Connie told her what the doctor had told her to use for her cold and so Pam did the same. Tho doctor would see Connie, for she had insurance. Pam also stopped eating salt hoping this would prevent the swelling. The swelling kept getting worse and everyone was becoming concerned. Shelley told the doctor when she treated Shelley's son's broken finger that she is really worried about her little sister, she is really swelling up and becoming numb on one side. The doctor said, when you are large, pregnant and lay on one side all night, this may happen. This doctor's visit took place on March 19, 1990. Pam told me she didn't feel well and was sometimes sick to her stomach. She still had a little cold. Pam's words will echo forever in my mind, "As old as I am, when I'm sick, I want my Mom."

One night Pam popped in for a moment to show me her hair. She had put a rinse on and it turned a bit orange. Pam's crowning glory is her pretty, thick long blond hair. She was good at cutting hair and after high school attended beauty school. She thought if she fixed her hair she'd feel better. I always feel the same thing, it just makes a woman feel better. On this visit Pam said the doctor would not return her calls and since Pam wanted to see only this woman doctor, I suggested she tell them it is an emergency. You need fluid pills, I told Pam. I had previously suggested Pam call our old family doctor and explain her predicament; seven months pregnant, her physician would not see her, and ask him for a prescription for fluid pills. This is the last time I saw my daughter alive. We chatted on the phone the last time on Friday, April 6th and Pam told me she had the money and an appointment with the doctor on April 9th. I asked why she didn't see her on Friday and Pam replied, she isn't in. Why don't you see her Saturday then, I inquired. Again Pam replied, "She isn't in but I'll see her Monday."

Sunday, April 8th, after Pam did not return Connie and my phone calls, Connie and I went to check on her. We found our Sunshine lying on the floor, dead and no chance to save her or the twins she carried. The doctor Pam had not been able to see was contacted on the day of Pam's death by the investigating officer. He obtained her unlisted phone number and here is what she told him, "I have had no messages from Pam." Connie and Shelley had both expressed their concern for Pam's welfare to this very doctor. Pam's phone bill listed four calls from Pam's to the doctor's office from April 3 through the 6th, at which time Pam managed to make an appointment. Some doctors claim the high cost of medical treatment is caused by the high cost of malpractice insurance. It looks to me as though the medical profession's incompetency and neglect of their patients is a very real contributing factor. Insurance companies say the high settlements they are required to pay out are the reason for the high rates. They have gone so far as to print guidelines for doctors to follow so as to prevent claims. Insurance companies instructing the medical profession on how to conduct their business? Are the doctors so lax in their care that it has come down to the responsibility of the insurance companies? No one expects the medical profession to work without compensation but how much is enough? Why not the sliding rule to include people such as Pam, who just don't have the means, at the time, to meet the high costs of medical care? I have three daughters and all three went to the same clinic and the same woman doctor for prenatal care, and Pam is the only one denied prenatal care after her initial visit. She is also the only one not covered with insurance. The doctor claims she has nothing to do with the front office policy on admitting patients, yet another M.D. working for the same clinic says he makes sure his patients get in for their prenatal visits, regardless of ability to pay or insurance. He also said because of Pam's weight and the fact that she is a smoker, she was a high-risk.

JUNE 8, 1990.

Senator BOB KERREY,
Regional Office, Scottsbluff, NE.

DEAR SENATOR KERREY: We are writing with deep concern of the medical situation in the panhandle. For the past six months we have had a critical care child and these

are some of the situations in which we have encountered during her illness.

In February our daughter Molly spent nine days in Omaha's Children's Hospital and the insurance company reimbursed these doctors in full, however when we returned to Scottsbluff and had to hospitalize her again Blue Cross/Blue Shield would only reimburse our pediatrician for approximately half of his charges. After further inquiry, we were told that Dr. Baisch's charges were over normal and customary charges for Scottsbluff. We feel very strongly that we are being penalized by Blue Cross/Blue Shield for living in a rural area and having a child who demands the need for a specialized pediatrician.

To begin with the lack of qualified pediatricians in the panhandle is frightening. To compensate for this shortage the physicians are allowing their nursing staffs to call in prescriptions without even seeing the patient and charging for this phone call a fee ranging from $10-$14 It is quite disturbing when you can't get your sick child into the doctor's office because the doctor is to busy and full responsibility of the child's well being is placed in the hands of the nursing staff. When a child is sick they need to be examined by their doctor, this way the doctor not only hears but sees the symptoms thus, eliminating guessing over the phone and at the same time adding that reassuring feeling to the parents and patient.

We would also like you to know that the elderly are not the only victims of unfair medical reimbursement. Insurance companies are automatically throwing out large portions of our claims stating that they are in excess of, "usual customary or maximum benefit amounts", their normal and customary charges however are not based on what we have to pay for medical services in the Scottsbluff area. We pay the same premiums as do the rest of the people on the State of Nebraska's insurance plan but end up paying hundreds of dollars out of our pocket because physicians in our area charge more.

We have enclosed a copy of a letter and the 200 signatures of the concerned parents. These signatures represent only a small percentage of parents that are deeply concerned with the pediatrician situation in our area.

Thank you for your time and consideration into these matters.

Sincerely Yours,

BRAD AND MICHELE GOERKE.

SIDNEY, NE, *June 30, 1990.*

Senator ROBERT KERREY,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR KERREY: I am writing you to follow up on our conversation of June 3rd in Scottsbluff regarding two issues in particular, CLIA 88 (Clinical Laboratory Improvement Act in 1988) and the over regulation of rural hospitals and physicians.

CLIA 88 has to be the most intrusive, most meddlesome, most irritating, most inflationary, poorly conceived, and most unnecessary piece of legislation that has been developed in a long time. This legislative bill started out to solve a problem with Pap Smear Mills with poor quality control. Most Nebraska physicians did not use these services since we like to know the Pathologist who is reviewing our Pap Smears and use him as a consultant in problem areas. How this bill was expanded to include all Physician Office Laboratories, I will never know. However, it has the potential of disrupting the office practices of nearly all primary care physicians and the cost of the regulations, as now drafted, are astronomical ($2,000.00 for a license and $750.00 to $1,000.00 for proficiency testing, none of which will be covered by Medicare). Virtually all physicians use hospital or clinical laboratories to verify results of the office laboratory many times per month. In our office we cross check results with Metro Laboratory in St. Louis, one of the largest and best equipped clinical laboratories in the country. Even with their "state of the art" technology I still find results that do not fit clinically and on retesting are not confirmed. Testing an unknown specimen from time to time does not guarantee any more accurate results than we are currently providing but it sure does increase the busy work and the cost. The cost figures I cited above are the outside costs only and do not include the "in-house" costs for reagents and nurses' time for running the unknowns. We do controls on our computerized machine daily and reprogram the procedure if the control doesn't check out satisfactorily.

The categories of Laboratories listed in the current regs are ridiculous. There are only 3 levels of laboratories, the waivered lab, the Level I, and the Level II. If the regulation is necessary, which I don't believe it is, then there ought to be at least a dozen levels of laboratories with only those reference laboratories, the ones who sell laboratory services to other labs, hospitals, clinics, and physicians, should be required to have an on site Pathologist. There are not anywhere near enough Laboratory Technologists to fill the vacancies on hospital and reference laboratory staffs now, let alone be available for every physician's office. I used to employ a laboratory technologist in my office and found that she couldn't drink coffee alone—she had to take one of the

office nurses with her, which created a real personnel shortage. The current equipment which we have in our office can be operated by any intelligent high school girl, although it is operated by our registered nurses. If the Secretary wants to check the companies who manufacture the equipment, he can do so without CLIA 88. At least half of the capability of our equipment will be shut off by the current regs because the procedures are on the laundry list of Level II laboratories requiring a registered technologist and a pathologist on site.

The disruption that this law will create is unbelievable and will interfere with the care of most of the patients of primary care and rural physicians. It is my feeling that this mess should be repealed and that the Pap Smear problem be solved in an intelligent manner without disrupting the entire practice of medicine as CLIA 88 promises to do as presently drafted. Is it possible to forestall this whole mess by an emergency bill? The Medical profession and the patients we serve would be in your debt if this could be accomplished. Office laboratory service is the most cost effective service available.

The second matter we discussed briefly was that of the possibility of exempting rural hospitals and rural physicians from a lot of the current Medicare regulations. As you are aware, most of the regulations are drafted with the 200 bed hospital and the urban physician group practice in mind. Unfortunately the fiscal intermediaries treat all hospitals and all physicians alike, which make the regulations excessively burdensome for small hospitals (most Nebraska hospitals are 50 beds or less) and for small medical practices of 1-5 physicians. The constant flow of new regulations or new interpretations of old regulations results in monthly letters or small booklets with the accompanying threats of Federal Sanctions, fines, or imprisonment which Federal regs seem to have to include. This paper blizzard is too much to keep up with even if you make an honest effort to do so and these rules constantly get in the way of caring for patients and for getting paid for the services you render in good faith. The Medicare problem is further compounded by the abitrary division of physicians into those who accept assignment and those who do not. Many of us refuse to accept assignment on the principle that we provide services to patients and expect payment from the person who receives the service regardless of the type of insurance he may or may not have. This is the principle of free enterprise and we happen to think that this is what has made this country great. All physicians accept assignment on persons with demonstrated need and Medicare requires us to accept assignment for all laboratory services we provide. The reimbursement for laboratory services is based on the lowest cost that laboratory services can be obtained from large laboratories on a "batch" testing basis (the cost per test if you do 30, 40, or 100 tests all at the same time). Office laboratory services are provided for the most part on a "stat" basis, the provision of the service at the time it is needed in the care of a particular patient. We seldom do more than 1 or 2 tests of the same type at any one time and frequently will do only one test of a particular kind (plus a control) in a given day. The current tactic in the Medicare program is to portray physicians who do not accept assignment on all patients as second class citizens and money grubbing practitioners and most of the EOB's (Explanation of Benefits) sent to patients of physicians not accepting assignments have a statement telling the patient that he could have saved "X" number of dollars had he done to one who accepts assignment. They also publish a list of the "favored" so that their practices can be promoted at the expense of the "other guys". Those of us whose practices have large numbers of Medicare patients (older and mostly rural physicians) would be unable to shift the Medicare shortfall to non Medicare patients if we accepted assignment.

As I presented in Scottsbluff, the real problem facing rural Americans is a shortage of qualified physicians who will choose to practice in the over regulated, under reimbursed areas and this spells real danger for the next generation. It is also a concern for me. Who will care for me after I retire? Will I have to leave rural Nebraska, which I dearly love, in order to get the Medical care which I may need some day? This is a real and frightening possibility. Rural practiced might be able to compete for physicians if incentives could be offered—namely decreased regulation and increased reimbursement in Federally funded programs.

We in rural Nebraska are looking to you for help, not just for ourselves but for the patients we have served so long, so well, and so faithfully this last many years. The exodus of rural physicians from rural Nebraska is creating a crisis of access to necessary health services and threatens the survival of all our small rural hospitals since the hospital cannot function without a medical staff of physicians.

Thank you so much for your continuing interest in these very important matters. If I can be of service to you at any time, please don't hesitate to call on me. Thank you for coming to Western Nebraska to see first hand the problem we face. We hope to see

and talk with you in the future as our Senator.

Sincerely,

C.J. CORNELIUS, Jr., MD.

STATEMENT OF TERRY NULL

Mrs. NULL. Thank you. Terry Null, 2202 Avenue O, Scottsbluff.

I would like to address that twofold issue as a patient's perspective on health care for rural Nebraska.

The first being the care that is received. The second being the filing and collecting under insurance.

I am Terry Null, and I have multiple sclerosis. I was diagnosed 19 years ago. My particular type of MS is a chronic progressive disease. I depend upon Home Health through Regional West Medical Center not only for my care but for insurance filing with costs being reimbursed through insurances.

I require skilled nursing care and physical therapy weekly. Home Health shines in these two departments, and I receive excellent care. The area that I am most concerned about is attendant care. Certified nursing attendants required so many hours of training which is provided by the hospital, and those attendants are paid minimum wage. After training and some working experience these attendants find it more lucrative to go out and work privately on their own.

Therefore, we are understaffed at our hospital. There are not enough attendants to care for individuals. I do require daily attendant care, and I am not receiving it. I cannot get out of bed, toilet, bathe, and dress myself without assistance. Without attendant care, I have been forced to give up so many things I enjoy and love doing.

The main focus on home health care now is either childrenn or the elderly. I am neither so I fall into a gap. I depend on the Handi-Bus service for transportation providing I go between the hours of 8 a.m. and 4 p.m. and not on weekends.

Having a catastrophic disease is a big financial burden. I cannot afford to privately pay for attendant care or transportation. I need a lift van and cannot afford one. I cannot depend upon my husband because of his physical limitations, and he works out of town. I feel that I am too young to go to a nursing home, yet I am not well enough to live independently by myself.

I am not only speaking for myself but for other handicapped individuals. We fall into the gap. What can we do about it? How can we change it? How can we make the system work for us?

The second issue I would like to address is the filing of insurances. This is a monthly task. This is difficult and timely and filing with Medicare is literally a paper battle. I do the best I can and have to employ an individual from Home Health that does nothing but Medicare filing. She has to call on me at my home several times a month for proper filing, and I am only one individual receiving care from them.

Home Health Medicare tells me they are my secondary insurance carrier. My primary insurance carrier is covered through my husband's employer. I first file my Home Health care costs with my primary carrier, and under the policy I am allowed so many visits per calendar year. This insurance covers 80 percent and Medicare covers 20.

My primary carrier rarely correctly processes my claim. I have constant written correspondence, requests, and long distance phone calls to straighten out proper payment. The Home Health clerk does the same thing. Then we have to follow up with payment verifications in the billing department.

In turn Medicare is then filed. The barrage of paper with Medicare is overwhelming. On my lap I have a folder of pending paper work that I am waiting to hear on. Medicare paid on my first claim of June 1989. In May of 1990 Medicare is backlogged 12 months in processing claims.

I filed an equipment claim for a wheelchair purchased in November of 1988 with Medicare twice because Medicare said those papers were lost. The third filing was sent registered mail. Medicare denied payment. The claim was resubmitted, and Medicare requested additional forms. This claim is still pending upon filing of Medicare.

I never know where my claims might go. It might be Iowa, Texas, Kansas City, or Minneapolis. I also find Medicare denying every first claim. Why is this so? Why does a patient have to file, refile, resubmit every claim with Medicare? Think of the hours of manpower logged to this process. It is most difficult for me to keep up with this paper battle. I simply do not know what some handicapped people do for their coverage, and I cannot fathom our senior citizens doing this kind of paper work, and people must give up and like me go ahead and privately pay the balance.

We need to make some revisions on Medicare payment when certain aids or equipment is needed. I find it hard to believe that a shower bench or a chair or grab bars around the toilet are not covered by insurance, because they are not considered necessary but cosmetic.

I feel like I have a good perspective on this situation, and I feel that I can speak not only for myself but for a lot of other handicapped individuals. We need to be con-

cerned about the care we receive or the care we do not receive simply because we fall into the cracks. How do we correct this? What do we do for those of us that need attendant care? We that need equipment or transportation. We cannot privately pay for it on our own, yet we have insurance, and it is not being covered.

We are being bogged down with paper work, and yet we cannot collect. It is a burden financially with those of us with chronic progressive disease; however, let us not forget that we are members of families. We have spouses and children. We have to provide homes, children to raise and educate, and provide all the basic necessities of everyday living. When we have a financial burden of this kind, why it is such a problem that we take away from our families our basic or individual needs. What are the answers and how do we fix it? I thank you for your attention to my concerns, and I hope that together we can find some answers.

STATEMENT OF DR. RICHARD RAYMOND, FORMER PRESIDENT, NEBRASKA MEDICAL ASSOCIATION

Dr. RAYMOND. Thank you, Senator. My name is Dick Raymond. Not only am I immediate past President of the Nebraska Medical Association and speaking here on their behalf, but I have also been in family practice in O'Neill, Nebraska for 17 years. I may be able to connect with Senator Daschle more than the other speakers as I'm just 40 miles from the border. I spend a lot of weekends at Francis Case Lake.

Several of the speakers have already touched on some of the subjects I wanted to bring up, and that as Kate mentioned, is the Canadian experience of paying rural physicians more. Dr. Wright mentioned the number of towns looking for physicians. I would like to point out just a little bit, though, to give you a sense of urgency to the problem, not only have 19 counties lost physicians in the last three years and 19 counties currently have no physicians, but 24 doctors have left rural Nebraska in the last 10 months. O'Neill, community I have practiced in for 17 years, one year ago had five physicians. As of today, they have one. We set up two satellite clinics, Kate, many years ago, perhaps one of the first ones in Nebraska. And they are both now closed because there is no one to staff them.

Dr. Waldman and the dean from Creighton University did a study for the Medical Association, or with us, a year or two ago to try to determine why the applicant pool is declining, and they found 67 percent of freshmen and sophomore medical students were advised by their family physician not to go into medicine. That's the amount of disgruntlement that is out there with current policy.

The reasons I would like to underscore why physicians are no longer staying in rural Nebraska or going to rural Nebraska is many factors. A lot of it is just the bureaucracy and regulations of the MAAC's, PRO's HCFA, liability. Another major reason disproportionate high percentage of Medicare Medicaid patients what we have in rural areas, that that's an elderly population there are so any rules that Medicare makes effects us perhaps two times more than an urban physician. Many of our residents of rural Nebraska are self-employed, particularly farmers and ranchers, and have no insurance so payment is more difficult for them.

When a student graduates from medical school with a hundred thousand dollar indebtedness, he looks at how he is going to pay off—he or she looks at how he is going to pay off that indebtedness and they look to the other specialties that may reimburse them at higher than family practice. If they do go into family practice, they look at where they can make the most money to service that debt, and that is in the urban areas, as has been mentioned many times today because of the disparity which I would like to talk about a little later.

Currently for those in the audience who do not know, there are 237 geographical payment areas in the United States. That's 237 areas that have different payment schedules for the same procedure, and of those 237 payment areas, rural Nebraska is number 236, next from the bottom. I don't know how anybody practices in rural Nebraska. Medicare is the only insurance company that I know of that has a uniform premium throughout the United States. Every Medicare patient pays the same premium regardless of where they live but the reimbursement is based on where they live, not on their needs or on their wealth. In Nebraska 32 rural physicians participate in Medicare. Therefore, our patients have to pay more out of pocket to see the physician because Medicare reimbursement to the patient is second lowest in the nation. Therefore, our senior citizens are being tapped twice. It is socialized medicine. They are supporting health care in Miami and Los Angeles and New York City and it's just not fair. The only explanation I have for it is there are more votes in those populated areas.

There are 237 categories we are told through the Medical Association and HCFA is based on 1973 charge data which is not available for Nebraska. We have tried for

years to get a hold of that charge data and it cannot be found. In 1973 I did not practice medicine but I was still punished by the fee schedule of 1973, and at that time health care was cheaper in rural areas and health care was less adequate in rural areas also. Rural physicians now at rural hospitals are expected to deliver the same quality care as they get in the cities and to deliver that quality of care costs a lot more money than it used to but we cannot raise our fees to compensate for that. Our costs include higher skilled personnel such as nurses, lab techs, X-Ray techs and quite often takes more money to hire them in rural Nebraska than it would if you live in an urban area. We have no group purchasing of supplies with a one or two man clinic. The equipment will be underutilized and we have one or two doctors using one X-Ray machine and doesn't get used as much if you have a ten doctor group using that X-Ray machine and takes longer to pay it off.

Insurance is often higher for physicians in rural Nebraska because in rural Nebraska we do obstetrics. If I lived in the city, I may not do obstetrics, I could lower my malpractice premium. I have no choice in a small town.

Office space is not cheaper in rural Nebraska. In fact, in rural Nebraska you either rent from the only person that owns the clinic or you take out a mortgage and build your own clinic. You do not have a choice of where you practice. Continiuing education costs more money because you have to take a day off to come and testify at meetings like this. You don't get continuing education, you cannot drop across town for a two-hour course and gas costs more. The Texas Medical Association has done an in-depth study of cost differences between rural and urban practices and they reported to PPRC, Physician Payment Review Committee, about that and found tht rural costs are 15 to 30 percent higher for rural practice of medicine than urban.

American Medical Association also did studies that coincided well with Texas Medical Association studies that showed rural physicians having more patient contact with older, sicker patients, working longer hours with less cross coverage and they also found that in rural areas the average family physician, 60 percent of his patients are Medicare, where as in urban areas that 30 percent are Medicare.

The Physician Payment Reform had promise to solve this problem. However, Section 4001 of HR 3299 states that, quote, Beginning in 1992, the relative value for each physician's service is based on the sum of three components, general practice expenses, malpractice expenses and physician work. The general practice expense component is defined the same way as the practice expense component was defined for earlier years, except that malpractice expenses are now excluded.

It goes on to define that each urban and each rural area within each state as those areas are defined for payment purposes now will be used in prospective payment system.

We have tried to contact the PPRC to testify and we have not obtained any satisfaction with them. Curently PPRC is investigating the GPCI, Geographical Practice Cost Index factor. This uses 1980 census data for labor, input prices and assumes one national price on supplies and equipment.

They have three current options the PPRC is considering recommending to Congress in July. One would maintain the current 237 areas as they are. One would go statewide which would be a help but they say they cannot do that because of states like California, the large metropolitan areas of L.A. versus the rural areas. So the one they currently put in this book as their one they will probably recommend will actually add areas. Call it the Metropolitan Statistical Areas slash Rural. There will now be 365 geographical payment areas. Nrebraska, if you go statewide, will be paid at a ratio of 0.90 which would be second lowest in the country. Senator Daschle, South Dakota, incidently, would be 0.91, they would be a step above us now. In they go MSA slash Rural, which is most likely, and that uses the current Hospital PPS system, Omaha will receive payment of 0.93, Lincoln will receive 0.91 and all the remainder of Nebraska will receive 0.88.

Rural South Dakota will receive 0.89, there will be a five percent differential between rural Nebraska and Omaha, and back to my main point, as long as there is a five percent differential, why won't that young doctor stay in Omaha where he does not have to take as much emergency call at night, has more contact with other professionals and can get continuing education easier and has a better social life. For five percent difference, he will stay in Omaha. He will not come out to the rural areas. We need help in getting rid of that disparity in Medicare reimbursement because it affects us in rural areas even more than it affects the doctors in the city because we see a larger percentage of Medicare patients. The Nebraska Medical Association's House of Delegates has gone unanimous vote twice to be in favor of a one-tier payment system for Nebraska. Omaha and Lincoln doctors do realize what's fair and what they need to do for rural Nebraska. We need your help. Thank you for allowing me to testify.

Senator KERREY. Thank you. The thing at the end, the House of Delegates voted unanimously because of the fact that Lin-

coln and Omaha doctors will take a vote on this reimbursement and are willing to do it principally because, as you say, it's unfair. It's a significant thing. There is an awful lot of people that say, that may be unfair but if I have to give up something in order to get fairness, I may not be willing to do it. It's a very strong example, I think, of how unfair the current system is in that House of Delegates vote. And we will try and set up through Senator Exon's office, a meeting with the Nebraska Medical Association at HCFA.

Dr. RAYMOND. We have traveled to Washington, D.C. and have representatives of Finance Committee to set up, also representatives of HCFA and your office and Senator Exon's office, and that's why I ran for this job two years ago, to try to maintain access to rural health care, try and solve this one problem.

Senator KERREY. Make any progress?

Dr. RAYMOND. I got into Senator Exon's office and I met your health aide.

STATEMENT OF DR. LESLIE SCHLAKE

Dr. SCHLAKE. Senators, first of all, I would like to express appreciation for being invited here. I have been sending letters to Washington for a long time and I didn't know if anybody is listening. I'm glad there is somebody there.

You have heard over and over again, I'm sure, from much of the practicing rural physicians their interpretation of the cause of hard times in rural medicine. I would just like to point out I'm not here to complain about my income. My partner and I have generous incomes. I do, however, wish to point out that my partner and I work 80 hours a week in order to generate that income and make a living. I don't want rural health care issues to be minimized as simply a bunch of whinning physicians wanting more money. What we're really demanding is a little bit of respect, a little less paperwork and an improvement in our lifestyles. As Dr. Raymond read—already brought up how many physicians have already left the area, I don't think there is much prospect of them coming back and being replaced in the near future. There has to be a reason for this. Some of it is certainly monetary, and, I think, the Congress owes it to rural physicians to at least pay them an adequate wage. They need to realize that in giving us an adequate wage, it doesn't mean we are going to get rich.

What I would like to do is have reimbursement levels that are fair and competitive so that I can attract another physician to my community and in so doing I can cut my 80 hours a week down to 60 hours a week. 60 hours a week I can participate in the rest of the life of the community.

Right now I'm not involved in anything, not rotary, not sports, not school events not even the upbringing of my children. I think that is the heart of the rural health care dilemma. We don't have a life there. Physicians are placed at an economic disadvantage. They make up for that by spending more hours working. Soon they are burned out, disgruntled and they opt for the city where they make a good living and have a personal life. The result, rural areas go shortchanged.

Another dilemma facing rural physicians is the excessive paperwork brought on by HCFA and PRO's. And I agree that they have to have some cost containment and have to do that on skilled physicians. However, the current system is inadequate to do either. It generates paperwork whether you are a good physician or a bad physician. They just keeping firing papers at you and they don't know what's going on.

So far the PRO's identified two practicing physicians in the state of Nebraska and singled them out for discipline. That's out of 2,400 physicians. They have harassed every single one of those physicians in the process. They expended millions of dollars in the review process and generate a lot of benefit—or very little benefit for what they have done. Money could be spent better elsewhere. These agencies cannot really tell from their process whether you are doing good or bad, whether you are practicing economically or not. Persistence seems to be total arbitrary, haphazard and I don't think there is any method in the madness.

Unfortunately, these institutions were designed as cost savings but they have not realized any success there either. Rather than concentrating just on physician reimbursement, I think we need to concentrate on broader issues and that is the survivability of our health care system in general. Right now it is threatening to either consume the entire national product or destruct itself due to lack of finances. It's at a crossroads. We need to get an organized system nationwide which can be fair and equitable not only to rural physicians but to urban physicians. We need to talk about a one-tier system in this country with universal health care.

The working class taxpayers are footing the bill right now, either he's paying his taxes and the government is dispensing it or he's paying his insurance premiums and the insurance companies are dispensing it, but in any case, he spends 40 cents of his dollar administering the cost and only 60 cents on medical care. We need to rectify that. If we could utilize the administrative money in actual care of people, there would be plenty for all. The government needs to recognize

that there are limitations as to what the medical system can give to anybody. We are not capable of giving everything to every person. No matter how much we expend on any individual, that individual will eventually die. It's a God given fact that we are born into this world and we are going to die. We need to set realistic goals as to what an individual can expect from health care and then have a one-tier system which is capable of enforcing those limitations.

Right now no such limitations exist. With a haphazard approach to financing medical care, no one can say enough to anyone. In the current system says the physician is in charge of saying no. When the Gramm Rudman hits and there is a decrease in the budget by 10 percent, I do not have the ability to say no to 10 percent of the heart attack victims. I will not be able to say no to a fracture victim and I will not be able to say no to a delivery. I simply have to take care of them.

In closing, bookkeeping techniques in the real world of medicine is impractical and yet that is the system we have. It is grossly unfair and right now is hitting the rural sector harder than it is elsewhere. Our system is becoming bankrupt. We have only HKFA and PRO which cannot address these problems. They have placed the physician against the patient, the patient against the hospital and generated ill feeling. There isn't a day goes by that I do not admit a patient to the hospital that expresses fear of being rejected by Medicare. There is a definite fear in this country of losing all health care. In the rural areas I think this fear is justified, much more so than the urban areas. It is the current system and regulations that brings this fear. You as the leaders of this country need to address that fear. Medical care is a necessity in life and is a commodity which most people feel is a right. You need to do what you can to guarantee that right not only for urban centers but for rural areas and for everyone, rich or poor. We need to set realistic limitations as to what people can expect. Not everybody should receive $200,000 worth of medical care. We need to build a system which this country can afford, setting standards at a level that most people can accept as legitimate. You must build disincentives into the system that not only the physician has to enforce but also the patients themselves. A co-payment system would be a good disincentive. And you really need to consider it in the next Congress. In the meantime, if reimbursement levels could be made a little more fairer, that would certainly help the bird of crisis in the rural areas. With the flight of physicians in these areas there will soon be no hospitals, no physicians, no clinics nor other facilities to worry about except in five years we can come back and establish them at three times the cost.

I'm charging you with the duty to go out and devise a survivable system which guarantees adequate levels of service to everybody, to guarantee reimbursements to physicians and hospitals to guarantee their survival and to do it quickly. If you do that, I'll quit bitching and you won't hear from me again.

If you do not, you will be hearing from me as well as a patient, anyone I can bend an ear on. I believe there is a general fear in rural population of losing health care and they will not be silenced. When the health care goes out of rural America, so does the business and industry, so do the schools. You will see a collapse in rural culture. You have a great responsibility before you. Good luck in seeking a compromise with your colleagues of these problems but you must seek it quickly.

Senator KERREY. Well, we are at the end of the hearing—oh, I'm sorry, one person left, Jim Dietloff, Goldenrod Hills Community Action Council, Wisner, Nebraska.

Mr. KERREY. During the hearings, we heard from a doctor in Broken Bow who argued forcefully for a plan to take care of all Americans in a way that is fair and equitable to both the patients and providers of health care.

We heard a poignant presentation by Mrs. Karol Osterloh who had three daughters who were pregnant at approximately the same time. Two of her daughters had health insurance. The third was the wife of a self-employed businessman and did not have health insurance during her pregnancy. As a consequence this daughter was unable to obtain the basic prenatal care services her sisters received. She suffered complications during her pregnancy and tragically died as a result of complications that could have been prevented or minimized with adequate and timely preventive care.

We heard from rural health care providers, family practitioners who said, instead of being reimbursed $14.80 for an office visit, which is what Medicare says they will be reimbursed, they only give you $8. It is different than if the reimbursement were $1400 for a special procedure. If you are going to chase $800, you can afford to

do it. But when you are chasing $6, it is simply not cost efficient. We are punishing the very physicians and health care professionals we are trying to encourage to come into our rural communities.

We heard from a multiple sclerosis patient in Scottsbluff, NE, who is trying to receive home health care and is simply unable to get it. The family is struggling to provide the quality care she deserves and simply is not able to get the job done.

We heard from an insurance agent who brought us a document that he hoped would remain confidential of a pricing that he had just given a small business for $740 a month for family coverage for health insurance.

We heard from a hospital administrator in Valentine, NE, a small rural community, complaining, on the one hand, about the woefully inadequate reimbursement that rural communities receive from medicare, a terrible condition throughout all of the rural communities we are reimbursing in Nebraska at the lowest rate in the Nation. At the same time, he is concerned about this reimbursement there is the possibility he might lose primary care physicians and may not be able to keep his hospital open. He recently priced his health insurance, and found employees who are paying over one-third of their income for health insurance. It seems to me incomprehensible that we do not reach a conclusion in the face of that kind of evidence that something needs to be changed.

I have a list of recommendations. Many of the recommendations that I have that would help rural communities immediately have already been identified by some of my colleagues. Senator EXON, the senior Senator from Nebraska, has long been an advocate of a proposal by Senator BENTSEN to immediately eliminate the urban-rural hospital payment differential under medicare. It simply must be done. Otherwise, we are not going to be able to have equity and fairness in rural communities and we are not going to have hospitals to provide services. Unless we make that one fundamental change, it is going to be difficult for us to have equity and get the kind of distribution of health care that we need in rural communities.

The State Offices Rural Health Act is also important. Under this act, State offices of rural health such as the one in Nebraska, can receive some additional assistance, some modest amounts of funding to help improve the rural health care delivery system. The Health Objectives 2000 Act that Senator HARKIN has introduced is also an important piece of legislation. Mr. President, again, this legislation enables States to coordinate the establishment of essentially preventive health care objectives and to obtain some Federal assistance in helping them to get that done. The Rural Nursing Incentive Act that Senator DASCHLE of South Dakota has introduced is also a very important effort to provide opportunities for innovation in the delivery of rural health care services. And the revitalization of the National Health Service Corps that Senator KENNEDY has introduced is also very important as I stated earlier.

We simply must revitalize and strengthen the National Health Service Corps. Two physicians per State is simply not enough. It is unfortunate that we find ourselves in fact with rural and urban communities competing for an inadequate supply of physicians in the rural health service corps.

Mr. President, I have reached some other conclusions about what our Nation's health care system ought to provide. I would simply say that I intend later this year to introduce a more detailed proposal.

I would, however, like to share with my colleagues some general principles that might perhaps help them sort out some of the many confusing elements in health care in America. It is not a simple issue. There are a lot of competing influences, a lot of competing elements, and a lot of people out there trying to tell us what ought to be done.

Let me suggest a few principles that I have personally concluded and about

which I feel very strong. We should have one program for all. The complexity of the current competing programs inescapably leads to cost shifting and the kinds of difficulties in providing and receiving proper care that we have heard over and over again from many people.

I find it difficult to go home and say that, as a consequence of being a U.S. Senator, I am better able to decide what health care should be provided the person who is working delivering health care. We ought to have one health care plan for all.

We ought to debate it. I believe health care is a right, but I do not believe it is an absolute right. I do not believe we have the right to have everything we want.

We have put a Federal system in place that was put in place during the the Presidency of a conservative President, Ronald Reagan. In fact, I think that is part of the problem. So I urge all to consider that nationally financed does not necessarily mean that it is federally delivered.

We should restore the relationship between the physician and the patient. We should concentrate on producing a system that poses fewer administrative problems for the provider. I think we must deal with the question of malpractice, and right along with that deal with the question of a true system of isolating those physicians who are not competent.

We should allow innovation in delivering health sciences. We ought to allow innovation at the State level so States can develop and implement approaches that address their very specific and unique needs. We should put a high priority on health care.

We can set up a system where the money flows through approved institutions. I believe the United States of America has been successful in many areas because we have stressed innovation. Now, we need to similarly stress innovation in health care.

Mr. President, I think we should place greater emphasis on preventive care—making sure that we are putting our dollars early on in young children, making sure that we are putting dollars in the areas where we are apt to prevent much more expensive health care as a consequence of individuals being negligent toward themselves.

Finally, as I referenced earlier, I think health care should be a right to all Americans, but I do not believe it is an unlimited right. It is a relative right. It will be constrained by our own judgments, both objective and subjective—judgments about what ought to be included and what we ought to be paying for, not just a debate on what we are going to pay for people with lower incomes.

It ought not to be just a debate on what we are going to pay providers under Medicare and Medicaid. That should not be the debate. The debate should be what we are going to provide for all of us.

We should not be sitting here arguing on the floor of the Senate how much are we going to cut veterans benefits next year. We should be talking about what our health care is going to be—about what the Members of Congress health care benefits are going to be in the next fiscal year.

We very simply have no mechanism at the moment to even begin that kind of debate.

I close by urging my colleagues to see health care again not just as a humanitarian issue, but as an issue of American productivity. It is an issue where people who are concerned about the welfare of Americans can come together with people who are concerned about the competitive status of America, and reach a common solution.

We cannot continue delivering health care and financing health care in the way we are doing it right now. There are too many Americans who are not covered, and the costs continue to rise as well.

I appreciate and thank the distinguished President pro tempore, also the chairman of the Appropriations Committee, for authorizing the hearings that Senator DASCHLE and I had in June. It was a very informative hearing for me. It gave me increased enthusiasm to make change.

There will be losers in this proposition. There will be people who will have to give up some things. There may be some people that are in business that will not like what we are proposing. There may be Members in this body who will get less coverage as a consequence of bringing all people in. There may be losers, Mr. President, but I think the United States of America will be the overall winner if we can come to grip with this problem, both as I said for humanitarian reasons consistent with the overall values that this country has, but also for economic reasons as well.

So I thank the Chair for the time. I

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Pay-as-you-go

Senate

THURSDAY, JUNE 25, 1992

(Legislative day of Tuesday, June 16, 1992)

FEDERAL HOUSING ENTERPRISES REGULATORY ACT

The Senate continued with the consideration of the bill.

Mr. KERREY. Mr. President, I rise to speak in support of the Byrd substitute to the Nickles amendment. The debate about this constitutional amendment, the need to amend our Constitution to generate a balanced budget, has been an informative debate. It has allowed us to examine our deficit. It has allowed us to open up and see what our problem is. I come this evening, Mr. President, to discuss what I believe is a solution to our deficit.

One of the problems that we have with deficit reduction, Mr. President, is we very often look for someone to blame. In looking for someone to blame, we divide, and then find it difficult to reach a solution. Democrats will rise and blame the President; the President will blame the Congress; Republicans will blame Democrats; and Democrats will blame Republicans. We will issue our press releases. We will all attempt to achieve a majority vote in the next election, satisfying the voters that we indeed are not the problem; it is the other person who is the problem.

Mr. President, the case for deficit reduction has been adequately made both by proponents of the balanced budget amendment—and I should declare that I am not one of those proponents—both by proponents of the balanced budget amendment and by opponents of the balanced budget amendment.

It is worthy to note, Mr. President, as the Senator from Missouri [Mr. DANFORTH] did earlier, that the debate does tend to divide into two camps: One camp that wants to talk about balancing the budget and reducing the deficit, and the other, indeed, wants to do something about it. The latter camp is much smaller than the first.

I recall in 1990 when we went through the agonizing process of trying to reduce the deficit and producing the 1990 budget deficit agreement that there was a great deal of consternation. Said rather paradoxically, people themselves say: We want politicians who tell us the truth and who do the right thing, in spite of what they said before.

The President of the United States, reversing himself on a previously held position of not supporting the tax increases, found himself being pounded by public opinion for, in my judgment, doing the right thing, coming to the Congress and saying that we are going to take action.

The 1990 deficit agreement did work, Mr. President, and it worked because we both reduced spending and turned to the tax side and produced the largest reduction in the deficit in the history of this country. It was precisely because we were required to vote for spending cuts and because we were required to go to the American people and say, if you want programs, you are going to have to pay for them.

Mr. President, the problem is not the President. The problem is not the Congress. The problem is that we have not leveled with the American people about what it is that we are doing with U.S. Government spending. We are going to spend $1.5 trillion this year, Mr. President, and of that $1.5 trillion, we are only going to pay for about $1.1 trillion ourselves. The balance, about $400 billion, we will fund with debt, selling bonds. And for those of you who are, for some reason, watching in your homes today on your television—I do not know why, but if you are watching, you have to consider, when we write those checks, whether it is salaries for the military, civil service, for anything, for Medicare, for Social Security, understand that when you get one of those checks, 25 percent of that check—indeed, if you lay Social Security aside, 30 percent of that check—is provided as a consequence of our willingness to sell bonds.

President Reagan, once in the 1980's, said that, in truth, bond sales and taxes were identical, that there really was not any difference. There is a well-known businessman from Nebras-

ka Warren Buffett, who said if that is the case, why not do a bond sale for all of it? Why not sell $1.5 trillion of bonds and eliminate taxes altogether?

Mr. President, we have a contract with the American people which says essentially that we are going to give you $1.5 trillion of spending, but we are only going to require you to pay for $1.1 trillion of it. Mr. President, it is that contract which is causing the economic difficulties that this Nation faces, and it is that contract which has us gridlocked over whether or not to amend our Constitution.

Those who are advocating amendment of the Constitution remind me in many ways of a group of people who say we know what we are doing is wrong, it is bad, we know we ought to stop, but we cannot stop what we are doing so we will pass a law making what we are doing legal. I think anybody who examined our budget, examined our cash flow understands what we need to do, and that is, to begin with, Mr. President, we need to tell the American people the truth.

I come here this evening, Mr. President, to talk about one issue. I believe, if we address one issue, the issue of health care, directly and honestly and apply to the financing of health care the values that every single one of us apply outside of Government, this issue of the deficit will rapidly fade and move behind us. It will not be easy, Mr. President, but I believe it is the right thing to do.

Those who have come here both for and against the balance budget amendment, who have talked about the budget—I have done a fair amount myself—have correctly said deficit reduction would allow us to reduce long-term interest rates, to stimulate economic growth in the American economy, to raise the economic standards of the American people.

The distinguished Senator from Illinois has talked about the diminished standard of living that will occur to Americans in the year 2000 unless we do something with the deficit today. There is no question that the deficit impairs and slows economic growth today, and there is no question, Mr. President, that it impairs our economic growth in the future. We are buying things today, we are issuing IOU's for roughly 30 percent of those expenditures, and we are passing those IOU's, those chits on to the future.

Mr. President, the problem that we face with spending can be seen most dramatically in health care. In the area of health care, most of us are very much like the character played by Richard Dreyfuss in the movie, "Tin Men," where he goes in to the Cadillac salesman, and he sits down with the Cadillac salesman, and he says: "I would like to buy a Cadillac." And the salesman said, "What would you like?" He said, "I want a brand new Cadillac, and I want everything on it." And he puts everything on it. He comes up with a price, and he says, "Well, sir, what do you want to pay for it?" And Mr. Dreyfuss in the movie says, "Well, the truth of the matter is I don't want to pay anything for it."

That is the dilemma we face, Mr. President. We do want the Cadillac, but if you ask us how much we want to pay for it, the truth is we probably do not want to pay anything for it. If you ask me about health care, I would like to have the vitality I had at 17, not the way I am at 48. If I have any pain, I would like it to be gone almost immediately. If I am sick, I want to be well tomorrow. If I am in the hospital and I hit the buzzer for a nurse, I want the nurse there in 3 minutes, not 30 minutes. Those are the requirements for me, Mr. President. For my 17-year-old son and my 15-year-old daughter, I have even more serious requirements. Lord help the provider that does not provide the care I want for those two young people.

We find ourselves requiring a great deal, Mr. President, in the area of health care. Regrettably, at times, we find ourselves, not the other guy, not the other person, but ourselves unwilling to pay the bills when the bills come due.

Mr. President, those who have examined the budget—and I would like to reference some statistics here this evening—have made it clear that it is the gross cost of health care in our budget that has created the likelihood that our deficits are going to continue in the $200 billion range for the foreseeable future.

Health entitlements are driving the deficit, Mr. President. Between 1993 and 1997, 85 percent of the growth in entitlement programs is predicted to come form Medicare and Medicaid alone. Health entitlements will soon surpass Social Security as the single largest component of mandatory spending, according to the Office of Management and Budget. In fact, Federal health outlays are growing rapidly by all measures as a percentage of all Federal outlays and as a percentage of all outlays but Social Security and as a percentage, as well, of our gross national product.

According to the Director of the Office of Management and Budget, Mr. Dick Darman, these increases are unsustainable. Mr. Darman is quite correct. Deficit financing of health care, Mr. President, is perhaps one of

the hidden secrets of our transaction with the American people.

Of all the things I want to communicate this evening to those who are listening in their homes and those who read this RECORD and those who, for some reason, are in their office and do not have the television on mute, we have a contract where we are deficit financing our current health care expenditures. This year we will sell bonds, we will acquire 69 billion dollars worth of additional debt to pay doctor and hospital bills. Health programs are also, Mr. President, growing faster than other components of the Federal budget. Between 1980 and 1990, Medicare increased at an annual average rate of 12.2 percent. Between 1980 and 1990, Medicaid increased at an average annual rate of 11.4 percent. In 1991, however, Medicaid had an annual increase of 18.8 percent, and it is estimated for 27.8 percent in 1992.

Mr. President, one of the givens of our health care financing is that the Federal Government finances Medicaid differently than the States do. All of us who have been Governors, all of us who have listened and watched, as the distinguished occupant of the chair has been involved with State government, understand what the growing cost of Medicaid is doing to our States.

Again, Mr. President, if we have an increase in Medicaid or Medicare at the Federal level, it is not a serious problem for us. We do not find debates on the floor of the Senate that have us saying we have to cut aid to education, that we have to cut aid for research, that we are going to have to reduce our investment in space, that we are going to have to reduce our military defenses because of rising health care costs. No, Mr. President, there is a wall of silence around the increases in Medicaid and Medicare. We merely sell bonds.

We acquire additional debt, but for a State it is much different. It is no accident that States are on the cutting edge of health care reform. We have 12 States that have come to the Federal Government asking for waivers dealing with Medicaid. States have the option of going to other parts of their budget and cutting—vital investment in education, vital investment in transportation, vital investment in law enforcement, prisons, economic development, and natural resources. States must cut in other areas as their Medicaid costs increase while we in Congress face no similar situation.

Health care programs as a percentage of the Federal budget, Medicaid, Medicare and other health care programs accounted for 7 percent of the Federal budget in 1970. In 1990 they have grown to 13½ percent and CBO predicts they will reach 22 percent in 4 more years, by 1997; and the year 2000, 28 percent of our entire Federal budget.

Health care costs will continue to increase rapidly on their own because of the aging population, because of advancement in technology, current medical care inflation, and current tax policy which are affecting health care. Health care increases will not slow without substantial reform at the Federal level.

State health care spending also, as I indicated earlier, is showing substantial increase. And there are two big components at the State level that must be paid for in the current year. Not only are there increases for Medicaid, but typically State governments are large employers of people and thus they also face a large increase on a year-to-year basis to fund health insurance premiums for their employees.

Again I say to the people of the U.S. of America, this transaction is an honest one. They have an investment in expenditures for health care. They pay for it in the current year. But we in the Federal Government at the Federal national level have no similar transaction.

Mr. President, I have come here tonight not to argue that the health care reform can reduce and eliminate our Federal deficit, but that it will require the American people coming to us in Congress and saying we want it to be done.

First and foremost we must have the American people behind the idea, the principle of a pay-as-you-go system for health care, a system that says essentially if you want a benefit, whether it is for the Veterans Administration, the Army, the Air Force, the Navy, the Marine Corps, the Federal agencies that are set up, the Federal employee health program, Medicare, Medicaid, we must pay for it in the current year. That transaction alone will produce $69 billion worth of deficit reduction; that transaction alone, if we merely say it is morally wrong, and it is, for us to borrow money to pay the doctor, or those bills, with no expectation and anticipation of repaying those bills. We do not expect to repay that debt. We are borrowing it. So we do not have to lay out a lot of money for it.

A second great concern that I have is we have no real cost cotnrol at the Federal level. We have a regulatory control cost mechanism, a top down cost-control mechanism. We have rapidly increasing costs at the Federal level for Medicare and Medicaid. Un-

fortunately that is all we control. We merely reduce a massive cost share over to the private sector that causes premiums to go up.

We have to have a mechanism so that we, as a people, control the rising costs of health care. We know that our gross national product can exceed 100 percent. That is a given. Our health care expenditures today are 13.5 percent of the GNP, heading to 18 percent by the end of this decade. And we are extracting larger and larger pieces of our gross national product.

We have an obligation, an economic obligation, for promoting economic growth and prosperity in the other areas of our economy to control the rising cost of health care.

Third, the concern that I have is we have no incentives in our current financial arrangement to try to prevent illness, sickness, and disease, in the first place.

Essentially we say as you get sick we will pay for the bill; as soon as you find yourself needing hospitalization, we will pay the bill; need to get the Medicare, we will pay the bill. But you get immunization, you have to get in a special line to get that bill. If you want to do any preventive case, you have to come and prove somehow that it is going to produce a positive goal.

We are the only industrial Nation that does not have continuous health care for our children; the only nation on Earth that does not say when a woman gets pregnant, we will make sure she has the kind of education, the kind of advice, nutritional and health assistance that is needed to make sure that baby is not born with low birth weight, and other kinds of problems. We are the only industrial nation that does not have it. It adds not only an enormous cost to our health care burden but it also adds enormous costs as a result of lack of economic capacity.

Mr. President, and again those of you who are watching this evening, I would like to show you something here tonight that I think is not very well understood. That is where we are spending our money. What is the total expenditure? We might hear a lot from people who are not advocates of comprehensive reform of health care, who say we cannot have the Federal Government at all in health care, who say do not have big Government response, or a big tax response.

What I will show this evening will reveal the Federal Government involvement, current involvement, not as a consequence of special interest, but as a consequence of special needs of the American people. This has come as a result of what the American people themselves say they want. I would like to describe this evening the total expenditure for health care, and show the revenues that come in, we are getting in the current year, and how we are financing our health care system so, again, the American people can understand where it is we are coming up short.

Mr. President, in this year, 1992, we will spend $131 billion for Medicare, we will spend $72 billion for Medicaid, and a $20 billion increase, I might point out, again without much debate about how we are going to get money to finance it.

There are 21 billion dollars' worth of expenditures to the National Institutes of Health, the Centers for Disease Control, other Federal agencies, put out for community health sciences, vital community clinics, both Republicans and Democrates as well as executive branch.

We have $14.4 billion in the expenditures being made in the Army, Air Force, Navy, Marine Corps health care system. I, myself took advantage of that.

I went on a trip to Russia with the distinguished Senator from New Jersey [Mr. BRADLEY] and the distinguished Representative from Iowa, Congressman JIM LEACH. Coming back we were in an automobile accident in Vilnius, Lithuania. I received a traumatic cut to my leg, and I went to the hospital. I did not think it was very adequate health care. I was flown to a hospital in Germany, and I found some of my friends who think I am radical in the area of health care say, you did not like that Communist health care system?

I said no, that is not true. I went to a socialist health system in Germany and got my health care through a competent, well-trained Army physician who provided first-class health care.

I am not advocating that we provide health care in that way. I want the American people to understand we have $14.4 billion being spent through our Department of Defense providing high-quality health care for those young men and women who have raised their hands and sworn to uphold the Constitution of the United States of America and go in harm's way if necessary to defend our liberty.

We also spent $10.5 billion in a program called the Federal Employee Health Program providing health care for you and me and Members of Congress and other employees who retire. There are those now in the ranks of retirement using the Federal Employee Health Program, a generous, pro-

gram, comprehensive program, I might point out, that all of us enjoy, which cost $10.5 billion a year.

We also spend $13.7 million in the Veterans' Administration.

Again, I very often am amused when I hear people talk about these top down essentially controlled proposals. It is rare to hear the same individual condemning that kind of proposal, suggesting that we ought to abolish the Veterans' Administration.

In addition there are indirect expenses: $41 billion in tax expenditures for employees' health benefits, employer-paid health insurance benefit of approximately $24 billion. We expend on behalf of the American people—the American people receive through their Federal Government—$328 billion of medical care expenditures.

So you say, Mr. President, are we paying for it? Are we asking the American people to come up with $328 billion so we can say we are current? And the answer is, regrettably, no, we are not.

Again, I say the problem is not that somebody in the Republican Party or somebody in the Democratic Party or somebody in the White House or somebody in the Congress is at fault. We have a contract with the American people; we are giving the American people something for nothing.

Mr. President, with 328 billion dollars' worth of benefits, we are taking in only $105 billion of tax premiums through the Medicare system. The balance of that, $223 billion, if you assume with Social Security now off budget, that we are financing 31 percent of the balance of our expenditures with bonds, with debt; we are only paying for $154 billion in the current year. The balance is $69 billion we are giving to the American people, and we are not telling them that we are financing it with that.

Again, for emphasis, I know the issue of comprehensive health care reform is very controversial and complicated, and we are all concerned about the quality and potential deterioration of quality. Perhaps we cannot get reform this year. If we cannot, Mr. President, at the very least, we should stop this kind of financing transaction and say to the American people that we will pay-as-you-go, as we do our retirement programs for Social Security. A pay-as-you-go system just for health care would reduce our fiscal deficit by $69 billion.

Mr. President, this next little visual aid here shows how these expenditures are distributed. I indicated earlier I wanted to make sure the American people could see that roughly half is going for Medicare, and a quarter for Medicaid. We have a quarter of this, an awful lot of money, which typically is not thought of, going to the Federal Employee Health Benefit Program, VA, Department of Defense, and other Federal agencies.

The Federal Government is putting out $323 billion, Mr. President, of an $800 billion bill. $136 billion is going out to State and local government. Between the two, we have over $460 billion, with $200 billion out of pocket. Mr. President, most of these expenditures right now are being funneled through our taxpayer system. For those who say we do not want to have a big Government response, we have that now. It is incoherent, inconsistent, and it is grounded on the immoral principle that says we are not going to pay for what we receive.

Mr. President, this represents visually the financing transaction, and I am leaning into this as hard as I can, not only for my colleagues, but for my good citizens of the State of Nebraska who wonder how we end up with the deficit that we have right now. We are trying to figure out what we can do about it. They have heard a lot of debate, but, Mr. President, that is the biggest part of the problem. That little black slice is $69 billion—$69 billion, Mr. President. I have heard people come to the floor and say what are we going to do about this? Can we maybe set aside the B-2 bomber, or not fund SDI, or shut down a few agencies of Government? This is a $69 billion slice. If we will only say, as I think we should, that on the issue of health care we will bring in the various items that we budget for health care—we do not need to consolidate the agencies—and we will just have a single budget for health care. If it is 323, then we ought to go to the American people and get the revenue. If you say I do not want to get $69 billion from additional taxes, let us reduce the expenditures and close the gap and say we are only going to have those things we pay for in the current year.

It is dishonest to say to the American people that somehow you are getting the health care that you deserve, because we are getting today from our Federal Government 69 billion dollars' worth of health care that our kids are paying for. I figure it ought to be the other way around. I am supposed to pay for the health care of my children. They are indeed paying for my health care, Mr. President. I think that is wrong.

These charts have been brought to the floor by other people that have

shown the deficit and what is going to happen to it. The most relevant problem we are going to have is we are going to get a little fool's gold here with the deficit that is going to reduce in the next few years. The pressure will be off, because it will go down. It ought to be big enough to satisfy anybody's need for developing the required requisite sense of urgency to go to the American people and say we have to do something. It is going to go down over the next few years, and then it is going to be right back up again. There is urgency to act today.

The baseline for health care expenditures is $830 million today. The sooner we act, the cheaper the solution is going to be.

All of us have been watching the events in Eastern Europe and trying to give advice and trying to figure out what we ought to do to help the Russians, the people of the Ukraine and of Czechoslovakia. An article in the New York Times said Sunday that a group of people in from the United States decided they would go to the investment bankers and people that have been involved in doing leveraged buyouts and other transactions here in the United States and go to Czechoslovakia, and they have been providing financial services and advice to the people of Czechoslovakia. The finance minister, Vaclav Klaus, correctly says that, "Whatever you do, do it quickly, because the longer you delay, the more expensive the problem is going to get." In no other area do we find that case being made better, as with health care. Every single year, we wait, and this problem gets worse.

Mr. President, this is what happens to our deficit, if we convert to a pay-as-you-go system. Again, I understand that there is great debate and differences of opinion about what ought to occur with comprehensive health care reform. I am going to show what would happen if we budgeted health care, in addition to a pay-as-you-go system. Say we cannot reach agreement—which is likely, that we will reach an impasse and fail to get an agreement—we should agree again for emphasis—and I say to the American people watching tonight, particularly those of you in Nebraska, make sure you say that we are going to have a pay-as-you-go system, because if we did that, one single item—the deficit—would go down in a rather dramatic fashion.

I do not consider $130 billion in 1996 to be terribly acceptable, but it is a dramatic reduction in the deficit, Mr. President. And it must be done. No defense cuts are going to get the job done. No cuts in the Federal programs are going to get the job done. It is the entitlement programs, Medicare and Medicaid, that are driving this deficit, and unless we come and say that we are going to pay for it in the current year, we are not going to get it done.

So I appeal to the American people, I appeal to those of us who understand that we have an obligation to our children, to say that on this line item, on these expenditures, we will pay for it on a current basis.

Mr. President, the distinguished occupant of the chair has a health care proposal that he and the Senator from South Dakota [Mr. DASCHLE] introduced that is very similar to mine, so I am preaching in many ways to the choir when I say that the second big piece we have to face is the need to put in place in this country some mechanism to control costs, and there is debate on what it ought to be. It may be that we have something entirely different than the one I have introduced. I suspect it is going to be somewhat different. I notice there is not enough enthusiasm, partly because I have been very specific on how I pay for it, but partly because there are genuine philosophical differences. One thing I believe is that we must have the capacity to honestly control costs and to feel confidence that those costs will be controlled.

Mr. President, the growth in health care expenditures is in excess of 11 percent this year, and if it continues at a double digit pace, Mr. President, in 1995 we will be spending over $1 trillion for health care. We will be pulling almost 2 percent of our GNP just on the increased cost of health care.

It is like an animal, like a cow or cattle which is penned up. If they break down the fence, as health care has, it begins to graze in other pastures and eat other things. That is what health care is doing, squeezing out other investment, not only on the private side, but on the public side as well, and we must have a mechanism to control costs. The proposal I have introduced allows health care expenditures to grow at 8½ percent a year, which is a fair amount, Mr. President.

I correct myself. Allowing yourself inflation of 8.2 percent will reduce the deficit in year 2000 to $66 billion. I would agree to reduce it even further than that; 8.2 inflation is a rather substantial number. It is double the cost-of-living increase. Were we to control it at a rate of 5 percent we would be in balance by the year 1997.

We do not have to have the kind of rationing and bitter sort of choices that very often is advertised whenever

proponents of budgeted health care reform come to the floor; 8.2 percent inflation growth is more than practically any other line of our budget. That is a lot of money—I am willing to put it in—that will reduce the budget deficit to $66 billion and continue the deficit going down in the outyears.

We must do health care cost containment if we are serious about deficit reduction. I say this not just to my colleagues in the Senate. I say this again to the American people who are trying to figure out what ought to be done. We are the problem.

I cited earlier our desire to have a Cadillac and wish not to pay anything for it. We have to pay for it. And unless we do health care cost containment, I believe it is going to be difficult for us and I believe it would be impossible for us to reduce our deficit and restore the kind of economic growth not only the American people want but I believe every Member of this Senate and Congress and the President himself would like to get.

It will not be easy, Mr. President. Asking the people to pay the full price for something is never easy. They have gotten use to getting 30 percent of it free. They have gotten use to getting 30 percent of health care expenditures from the Federal Government, essentially asking their kids to pay for it.

It is going to perhaps come as a rude surprise and shock to learn that we have a hole that size. I hope that the people of the United States of America say that we will accept responsibility and plug in that hole and we are prepared to do it, either by tax increases or spending cuts. Let us have a debate how we are going to do it, but let us do it in order to restore the confidence of the American people and to move the Nation in the direction of economic prosperity.

Mr. President, I would like to cite some additional things that I believe are connected to reduced cost of health care, comprehensive health care reform, that will accrue as a benefit if we reform and provide comprehensive health care to all of our people, particularly if we break the link between employment and eligibility, particularly if we get our costs under control.

Corporation after corporation after corporation, small and large, will tell you that one of the problems they have with increasing the number of people who are working for the company is the imbedded cost of each employee. Imbedded cost sounds like a horrible thing to have. They are principally health care costs and retirement costs. Those two costs are providing restrictions for our companies to expand their work force base. We find ourselves essentially with 5 percent more of our GNP than Germany. We find ourselves essentially 5 percent in the area of employment care on growth.

We believe imbedded cost with employment and employment health care cost reform will enable us to create economic opportunity to getting that cost under control.

I indicated earlier the devastating nature of not being able at the State level to essentially cover the increases through bond sales as we do at the Federal level. We are seeing State after State cut vital growing-oriented investment as a result of increased cost of their own employees and increased cost of Medicaid.

All experienced people in our States described the terrifying nature of getting locked into a job, not being able to move from that job if they lose the employment or if they consider that they need to increase their training and increase their skill. The marketplace is brutal, Mr. President. If you do not have the skills that you need to earn the living that you desire, estimates by the U.S. Department of Labor indicate that 40 million Americans in our workplace are undertrained for the income that they would like to have. If you lose your health care when you leave your job it is a barrier to do the right thing, a barrier to get that education and job training.

We are the only industrialized Nation that has health care for its people and every job training we put in place, whether public or private, must deal with this barrier or otherwise I think they will struggle to be successful.

There are 31 million Americans next year who will go to a welfare office to prove that they are poor enough to be eligible to have their health care benefits paid through the Medicaid system. There are 15 million Americans who work full time and earn less than $10,200 a year, who typically find themselves without health care benefits.

When health care costs were $3 a month as they were in 1970 it was not a big problem, but in 1992 where the average cost of health care for a family of four can be $500 a month—and in New York State it is almost $11,000 for Blue Cross/Blue Shield for a family—you have to wonder how an individual with average means stays in the workplace.

We have an incentive today in a Nation that talks about free enterprise and the marketplace. We have incen-

tive in place, because of the way we finance health care, people quit work to go on welfare, Mr. President. It is a terrible thing to have in place. I tell you if we do not do anything other, we need to reform the system to take the Medicaid system and change it so it does not become a place where Americans have to go in order to get their health care.

Finally, Mr. President, I have to say that the more I look at health care the more I see it as an idea that is much larger than just health care itself. The truth is I do not think we really want health care. Most of us want health. We prefer not to need health care. Health care need comes only as a consequence of being unhealthy. We prefer to stay healthy.

The idea of health care is connected to many other things. The distinguished Senator from Rhode Island came to the floor and gave a brilliant, articulate speech talking about the price of handguns. He had a controversial amendment that confiscated handguns as a proposal. I support the solution he is an advocate of. He is correct saying it is $4 billion in health care expenditures, because of the trauma resulting in handgun injuries.

Mr. President, as to most of those unreimbursable expenditures, most people going in emergency rooms get the expenditure.

We have $60 billion, Mr. President, of direct health care expenditures in the United States of America that are there, because people smoke cigarettes. I say smoke them if you have them. I do not want to subsidize the behavior.

We have $15 billion worth of expenditures directly attributable to the fact of alcohol abuse.

Health care expenditures that come as a consequence of trauma on our highways, health care expenditures coming as a result of damage to the individuals themselves, with alcohol abuse, we do not have a financing system that allows us to make sure that we take political action that will provide an environment where people have incentive to take care of themselves.

The idea of health care is connected to the quality of our homes. Housing is a health care issue. Transportation is a health care issue. It is $15 million estimated worth of expenditure in southern California simply as a consequence of the quality of their air.

Mr. President, health care is much bigger than just a hospital and the doctor.

I believe as we look to reform our health care financing system, not only do we need to be honest in the way we finance it and say that if we have Medicare, Medicaid, VA, and Federal employees health benefits at least we in Congress ought to be able to say if we are going to get health care benefits, we are going to pay for it all. We do not, Mr. President. We finance 30 percent of it with bond sales.

It is immoral and irresponsible. Not only do we need to change the way we finance health care we need to do it so that we can deal with the growing problem of our deficit, directly and straightforwardly.

Mr. President, we have to reform our financing system of health care so we can begin again to think about how do we create health in this country. We have one of the highest infant mortality rates in the world. If you live in Harlem and happen to be black in Harlem and live to the ripe old age of 48 that is your life expectancy. Health care is much bigger than just how am I going to get taken care of when I get sick.

Mr. President, I intend, as we roll through this deficit reduction debate, to say over and over and over that there is a way, a simple way, for us to deal with the deficit. It is at least simple mathematics; it is not easy in the details. You cannot get something for nothing and we are giving the American people. I say to every person who is watching tonight, we are giving you something for nothing and we have to stop it.

And unless we have a contract with the American people that says that we are going to change that we will never solve the rest of it. No constitutional amendment will get the job done. No statutory change will get the job done. We have to step to the line and say we are Americans and we are going to pay our bills. We ask every nation on Earth to whom we give credit to pay us back. We have to pay our bills, too, Mr. President. The American people must pay the bills, or this deficit of ours will not disappear.

Mr. President, I thank my colleagues for their indulgence, and I yield the floor.

that, as of 1993, all new television sets (with screens 33 cm or larger, i.e., 96% of new television sets) be manufactured with built-in closed-captioning circuitry. A similar law should require that eventually all new television sets be manufactured with built-in time-channel lock circuitry—and for a similar reason. Market forces alone will not make this technology available to more than a fraction of households with children and will exclude poor families, the ones who suffer the most from violence. If we can make television technology available that will benefit 24 million deaf and hard-of-hearing Americans, surely we can do no less for the benefit of 50 million American children.

Unless they are provided with information, parents are ill-equipped to judge which programs to place off-limits. As a final recommendation, television programs should be accompanied by a violence rating so parents can gauge how violent a program is without having to watch it. Such a rating system should be quantitative and preferably numerical, leaving aesthetic and social judgments to viewers. Exactly how the scale ought to be quantified is less important than that it be applied consistently. Such a rating system would enjoy broad popular support: In a national poll, 71% of adult Americans favor the establishment of a violence rating system for television programs.

It should be noted that none of these recommendations impinges on issues of freedom of speech.

I do not pretend to be an expert on television. I probably watch far less than most Americans and my viewing runs heavily to sports, news and special programs like "The Civil War" series on PBS last year. I do not have children at home watching cartoons anymore, but I worried for years when my children were younger, and I am sure many parents face this problem with anxiety today.

But I think it is time we in America look at this issue seriously. I believe the great majority of parents want to do what is best for their children.

I am not talking about violating any first amendment rights. I am not advocating censorship—or limiting adults' rights to watch whatever they choose—or broadcasters' rights to broadcast.

I do think parents should be able to protect small children from being influenced by violence before they even know what they are seeing, or can tell the difference between fantasy and reality.

I also think corporate executives should pay attention to what they are sponsoring, and consider whether they want to associate their firms and their products with some of the things on the air. I believe that the chief executive officers of companies that advertise should do more than ask for rating points. They have a responsibility to our society to review programs they are sponsoring with their advertising dollars.

If we are ever going to make a difference in the lives of our young people, I believe it has to come in the lives of individual children.

As James Agee said in "Let Us Now Praise Famous Men:

In every child who is born, under no matter what circumstances, and of no matter what parents, the potentiality of the human race is born again, and in him, too, once more, and of each of us, our terrific responsibility toward human life, toward the utmost idea of goodness, and of the horror of terror, and of God.

TRIBUTE TO SENATOR ALAN DIXON

Mr. CONRAD. Mr. President, I rise today to pay tribute to the distinguished senior Senator from Illinois, ALAN DIXON, and wish him well in his future endeavors.

During the 6 years I have worked with ALAN, I have found him to be one of the friendliest, one of the most outgoing of my colleagues. Whenever I have had the occasion to see ALAN he invariably has had a smile of greeting and a word of encouragement or concern for me. And ALAN has the same beaming greeting for everyone. He genuinely enjoys his work for the people most important to him—the people of Illinois.

ALAN has been dedicated to helping his State. His 30 years of service in State and local government before coming to the Senate left him intimately aware of the needs and concerns of people throughout Illinois, and not once has he forgotten their interests when legislation came before the Senate. And he has been especially careful to represent the interests of the little guy, to help average Americans when their interests conflicted with the wealthy or powerful. He is tireless in taking their case to me and to our other colleagues—both in person and through impassioned speeches on the Senate floor.

Mr. President, I am honored to have worked with ALAN on several issues. The ones I most vividly recall are those on which we agreed most strongly. ALAN was an early, loud, and persistent critic of the Resolution Trust Corporation's handling of the S&L crisis. He fought hard against the confirmation of Timothy Ryan to head the Office of Thrift Supervision, arguing that we needed better and more experienced leadership to protect American taxpayers from the ever-growing cost of the cleanup. And he followed this effort with legislation to overhaul the regulation of the FDIC to help prevent the need for a similar taxpayer-financed bailout of the banking industry. On another issue, ALAN was a strong proponent of saving costs by bringing American troops home from overseas and forcing our allies to pay their fair share of their own defense. He strongly opposed the construction of a new base at Crotone, Italy, and he secured approval of a 50,000-person cut in our European troop strength during consideration of the fiscal year 1991 defense authorization.

Mr. President, I will miss ALAN DIXON, and the Senate will miss ALAN DIXON. I wish him well wherever he may go next.

THE NATIONAL HIGH BLOOD PRESSURE EDUCATION PROGRAM—20 YEARS OF SUCCESS

Mr. KENNEDY. Mr. President, this month marks the 20th anniversary of one of the Nation's most successful health initiatives, the National High Blood Pressure Education Program.

High blood pressure poses a major threat to the country's health. It is the leading cause of stroke and a major contributor to heat disease and kidney failure. The National High Blood Pressure Education Program was established to increase patient, professional, and public awareness of the dangers of hypertension and the ways to prevent and treat the disease. The program is a coalition of 44 public and private health organizations coordinated by the National Heart, Lung and blood Institute.

Since its beginning in 1972, the program has had unprecedented success. It plays an extremely important role in providing information to the public in an understandable form. It does so by translating the latest findings into practicable education materials for the public, and by providing prevention and treatment guidelines for physicians and other health professionals.

In the 20 years since the program was formed, the number of persons aware of the relationship between high blood pressure and stroke and heart disease has increased from 24 to 90 percent; one of every two patients with high blood pressure is controlling it today, whereas fewer than one in eight was doing so before the program began. The death rate from heart disease has dropped by 45 percent and the death rate from stroke has dropped by 57 percent in the last two decades.

The National High Blood Pressure Education Program is an exemplary public and professional education campaign for preventive health. It has earned well-deserved bipartisan support in Congress and across the country, and I commend all those involved in the program for the outstanding success they have achieved.

THE FISCAL YEAR 1993 LABOR/HHS/EDUCATION APPROPRIATIONS BILL CONFERENCE AGREEMENT

Mr. KERREY. Mr. President, I began this statement 3 weeks ago as an expression of my support for the fiscal year 1993 Labor-HHS-Education appropriations bill. As the Senate completes action on the conference agreement on the fiscal year 1993 Labor-HHS-Education bill, this has grown into a larger effort to describe other more fundamental changes that need to be made in the area of human services.

Let me begin with the Labor-HHS-Education bill. This bill contains funding for many high priority health and education programs that will be of great benefit to many Americans. This spending will save and enrich lives of the most vulnerable Americans. Like

few other things we do, there are lives at stake with this effort.

Unfortunately, the urgency to act is too often not felt as strongly as the desire to score political points. Thus, the loudest voices in the chamber have been talking/preaching about abortion, homosexuality, seatbelts, and drug addicts. My own view is that when a person falls into the water and appears to be drowning, we should act to save them. Instead, some are content to argue the morality of something happening away from this most obvious and dire scene.

Mr. President, the sounds of drowning Americans are all around us. One child in four lives in poverty. Ten percent of our people need food stamps to supplement their income. Desperation and lack of hope spread deep in American today.

These problems are daunting, but the direction we need to move in is clear. I know we need more economic growth. I understand a lack of investment has caused much of the difficulty. I know we can't just throw money at the poor; still I hear the voices crying and feel we must move. Let me suggest two areas in particular where dramatic action is needed.

The first is the need to control the growing budget deficit. Central to that effort is the enactment of comprehensive health care reform with strict cost control provisions to address the rapid growth in health care entitlement sending in the Medicare and Medicaid programs. Control over health care spending is critical if we are ever to have the opportunity to meet our nation's economic and job creation needs. It is critical if we want to address the priority needs of children, health care, education and other important areas.

Control of health costs will be central to any effort to control entitlement spending and cut the deficit. Between 1993 and 1997, 85 percent of the growth in entitlement programs will be in Medicare and Medicaid alone. The health entitlements will, in fact, soon surpass Social Security as the single largest component of mandatory spending, according to the Office of Management and Budget.

Medicare, Medicaid and other health programs accounted for 7 percent of Federal spending in 1970. In 1990, these programs were 13.5 percent of the budget. By 1997, CBO predicts these programs will reach 22 percent of the budget. States are seeing similar rapid increases in Medicaid costs, the program for which they share financing with the Federal Government. My home State of Nebraska is facing a $25.1 million budgetary shortfall this year—a large part caused directly by skyrocketing Medicaid costs.

Perhaps the most tragic fact of this spending is that our children are financing today's health care spending. Of the $330 billion or so the direct and tax expenditures of the Federal Government going to health care programs in 1992, nearly $70 billion is being deficit financed. In other words, we are borrowing $70 billion from our children to pay for today's health care bills. If the bondholders insist on 7 percent interest payments, we will be adding $5 billion to every annual budget in the future, $50 per year per taxpayer.

Too many of our citizens believe the tradeoff for increased domestic spending is decreased defense spending. This mistaken belief is reinforced by several good amendments on the Labor-HHS appropriations bill which attempted to do just that.

However, the real culprit is the increasing demands imposed by the health care programs. At the state and Federal level the rapidly rising cost of health care is leaving less and less room for spending for other important programs. It means less is available for educational programs to help developmentally disabled children get a good start in life; for childhood immunization programs; for important rural health programs; and for educational scholarships, loans and grants for students.

There are three steps we must take to get health entitlement spending under control. We must establish: First, a health care system that covers all Americans for at least a basic level of health services; second, move to a single budgeted health care system with strong cost-control mechanisms that eliminates the possibility of the cost shifting that reeks havoc in our current system; and third, finance this system on a pay as you go basis—rather than deficit financing health care services as we currently do.

Taking these three steps will help control our staggering budget deficits and adequately address the range of health and social needs faced by our Nation today.

There are those in the Administration who would have the American people believe that a budgeted health care system is the first step in the creation of a huge medical bureaucracy that will ration every aspect of American medicine.

Secretay Sullivan has made claims that the proposals put forth by Democrats would involve massive new government intervention in the medical marketplace and would lead eventually to a complete takeover of health care financing and delivery.

They do not acknowledge that we already have a huge medical bureaucracy micromanaging our health care system. And that this system includes plenty of massive government intervention.

They do not acknowledge that we already have a rationed health care system—rationed on the worst possible grounds, from a health perspective, on ability to pay.

The Administration has given little thought to how a budgeted health system could actually reduce the need for micromanagement of health care that has been the trademark of the Reagan-Bush approach that has led to nonstop increases in health care costs and nonstop declines in coverage for Americans.

More and more Americans are recognizing the need for a budgeted health care system with firm cost controls. The American College of Physicians recently called for a universal system of care with a national health care budget and expenditures managed within that budget through a system of negotiated fee schedules. Others have echoed similar concerns and solutions.

My health care reform proposal, the Health USA Act, carefully distinguishes between how a health system is financed and how services are delivered—a crucial distinction. By establishing a budget, it delineates the exact and limited role government will play and then leaves the rest to the private sector. It recognizes that government should not be used to micromanage health care administration and delivery and sets up a structure whereby that is avoided.

The second area where fundamental change is needed is in reorganizing agencies of the Federal Government to help meet the needs of families at the local level. We cannot achieve successful budget control without better management at the Federal level, and our communities cannot provide services to their people without improved delivery of those services. Children and families are eligible for about 125 Federal programs administered by 12 different agencies. This kind of fragmentation prevents us from focusing our resources where they are needed most and, more importantly, prevents us from helping the people who need it most.

Infant health programs offer an excellent example of the problems with this fragmentation among agencies, programs, requirements and criteria, as well as the benefit of reorganization and coordination of Federal agencies.

North Omaha has long been plagued with an infant mortality rate well above the National and State average. In 1989, a variety of health, medical, and social service professionals representing State, local and nonprofit agencies in the Omaha area came together to address this problem. Working cooperatively, and with the funds from the Public Health Service, they established a one stop shopping prenatal program.

This program, called FirstStep, pulled together the resources of the State of Nebraska, Douglas County, the U.S. Departments of Health and Human Services, Labor, Transportation and Agriculture, and nonprofit agencies such as the American Cancer Society, to coordinate Medicaid, WIC, drug and alcohol counseling, immunizations, food stamps, transportation, and job training into one coordinated effort with the goal of getting these children off to a good start in life.

It's not enough to merely support a smaller Federal Government. This program illustrates the need to fight for a

real consolidation of a myriad of Federal programs. The benefits of coordinating should be enough to motivate us to overcome the difficulty involved in solving a specific problem given the fragmentation among agencies, programs, requirements and criteria.

Mr. President, to summarize our dilemma, unless we first enact cost controls on health care in the context of comprehensive health care reform, we will face three choices: cut much needed investments in economic growth as well as spending on those most needy; enlarge our borrowing by increased deficit financing; or cut too deeply or rapidly into America's defenses. Second, unless we radically alter the shape of the Federal Government we will be throwing good money after bad.

Even with this quandary, there is an overpowering need to act. The fiscal year 1993 Labor/HHS appropriations bill includes funding for many programs of great importance in Nebraska, which allows us to begin to set priorities to meet pressing economic and human needs.

In the area of rural health, the bill includes funding for the important programs of the Health Resources and Services Administration which include health education and training programs, allied health professions training programs, the National Health service Corps, and other critical programs. It also provides funding for rural initiatives, such as the Rural Hospital Transition Grant and the Rural Health Outreach Grant Programs that continue to be so beneficial to rural Nebraska.

Mr. President, as you know, the Administration proposed to eliminate all health professions training funding, except for a few programs specifically targeted to minority students. This is an incredibly shortsighted policy given the health manpower shortage faced by chronically underserved areas of both rural and urban America.

The programs of the Nurse Education Act are very important to Nebraska. Several of the provisions in this act directly benefit Nebraska. For example, the traineeship program provides funds to nursing graduate students so they can continue their educations and prepare to teach tomorrow's nursing students. Educational loans under the program provide loans to programs, such as the Accelerated Nursing Program which often prepares nontraditional nursing students for careers in nursing.

Other health professions training programs are important to Nebraska universities and health manpower. These include scholarship and loan programs; assistance for disadvantaged or minority students; and preventive, family, general internal medicine and other residency programs.

The Rural Health Outreach Grant Program has been very important in meeting the challenges of rural health care. Two rural Nebraska health coalitions have been awarded Federal funds through this program. Blue Valley Community Action in Fairbury received funds for programs for prenatal outreach and post partum in-home services by a coalition of medical, health, and social service agencies. This program targets the most vulnerable members of our society—mothers and children who might otherwise not receive needed care. Similarly, Panhandle Community Services in Gering, NE uses these funds to deliver mental health and primary care services in rural areas targeting pregnant women, children, and the elderly.

Since 1989, 28 rural hospitals in Nebraska have benefited from the Rural Hospital Transition Grant Program. These funds have been used to help these hospitals continue to serve rural residents by enhancing their ability to recruit health professionals and provide important preventive and primary care services. Additional hospitals plan to apply for these grants this year.

The University of Nebraska has used Federal funds from the Health Resources and Services Administration [HRSA] to develop an interdisciplinary training program. This program trains health professionals for work in rural or other underserved areas. They are currently working hard to expand this program to allied health professionals in Chadron and Kearney. Model programs, such as this, are crucial to our understanding of the ability to provide rural residents with access to quality health care services.

The National Health Service Corps [NHSC] is another example of a rural health program that is very important to rural Nebraska. It is critical that Congress continue to enhance this program that was so drastically reduced during the 1980's.

There are many other programs funded under this bill that provide invaluable services to Nebraska.

Among these are the block grant programs, including the Maternal and Child Health, Preventive Health Services Block Grant, Social Services Block Grant and Community Services Block Grant Programs; the Community and Migrant Health Centers Program; the Centers for Disease Control's Childhood Immunization Program; and the Head Start Program.

This legislation also provides critical assistance to our country's elementary and secondary schools. At a time when we are seeing a growing interest in strengthening our schools by parents, teachers, and other local leaders, we should ensure that the Federal Government is there to provide resources through programs that work.

Impact aid is a program that deserves special mention. Many Nebraska school districts receive impact aid funds from the Federal Government due to property taxes foregone because of Federal ownership, and for lost revenues from federally connected parents. This is not a special benefit, but rather a fulfillment of a Federal responsibility to these communities. This legislation includes a $20 million decrease from fiscal year 1992 though this amount is far better than the administration's effort to slash this program by more than 30 percent.

This legislation also includes funding for students choosing to pursue postsecondary education. Unfortunately, the current budget constraints have prevented us from appropriating the funds necessary to meet the higher maximum grant award under the Pell Grant Program included in legislation recently passed by Congress. In fact, the maximum per student award amount will fall this coming fiscal year. This raises serious concerns about access to higher education for our Nation's neediest students.

The Child Care Development Block Grant remains an important source of funds to increase the quality affordability, and availability of child care in Nebraska. The funding level in this year's bill is $150 million more than the fiscal year 1992 appropriation, which provides more money for States to enable low-income families to obtain quality care for their children. It also provides funds for the important task of licensing and monitoring these child care centers.

Mr. President, in conclusion, our annual consideration of the Labor-HHS Appropriations bill says something important about what we need to do as Americans. How we handle issues that are either directly or indirectly related to this bill is illustrative of how we provide for the most vulnerable members of our society. How we handle the need for health care reform and structural change in our Government will determine whether we have the resources and the ability to do what we need.

The compassion to help—to answer the cry of those who are drowning—must be joined by a toughness to fight a deficit sapping our strength and Federal bureaucracies that cannot do what we want.

WALTER REED ARMY INSTITUTE OF RESEARCH

Mr. JOHNSTON. Mr. President, I am pleased that the Defense appropriations conference report which passed yesterday included an additional $20 million for the AIDS Research Program conducted by the Walter Reed Army Institute of Research [WRAIR]. The Army's Research Program has been responsible for some of the early testing of a gp160 vaccine, for the treatment of people infected by HIV [human immunodeficiency virus]. The vaccine has been shown safe to administer to humans. In addition, following treatment with the gp160 vaccine, CD4 counts which are a measure of the functioning of the immune system have been shown to be stabilized rather than declining, and the amount of virus in recipients has been stabilized rather than increasing.

These early results of the Army's testing suggest that this vaccine shows

HEALTH CARE REFORM AND THE DEFICIT

Mr. KERREY. Mr. President, last week I came to the floor to talk about the connection between health care reform and this Nation's deficit. This evening, I would like to continue that discussion. In the past, most of us, I believe, have recognized that deficits reduce national savings, that they leave less capital for investment in plants and equipment than otherwise would be necessary, less capital for education and training, and almost everything else that we need to get our economy growing.

The problem of the deficit is that it pulls resources away from needed investment. We have been able to make that argument in a fairly general fashion, and it is compelling for me on the surface.

However, Mr. President, it is always difficult to an audience to make it so compelling that the audience is prepared to actually act. It seems to me that is the gap between what we know in our heads and what we should do and what we are willing to do. The American people are not quite ready to make the leap.

Recently two economists provided some information for a GAO study that was debated or offered in the balanced budget debate. The two economists are Nathan Harris and Charles Skindell, and they have developed a model that enables us to quantify the impact of our fiscal deficit upon per capita income for Americans, essentially the per capita GNP for Americans, what happens if we continue with current policy with no change, what happens if we muddle through and do a few things but do essentially nothing to really reduce the deficit dramatically, what happens if we get the budget balanced in 2001 and what happens if we get the budget in 2-percent surplus in 2001.

The numbers are dramatic. It shows by the year 2020, those who are 48 and have 28 years until 76, which is a painful exercise to go through. We hope we are still alive at 76. We would like to have the people in the year 2020 to say, "Senator KERREY, you were around in 1992. Did you do anything constructive to improve life? Was your service to America truly useful?"

This study shows that whatever the reduction we would like to arrive at that point and answer the question, "Yes." We would like be able to answer that we did something constructive and had a real long-term impact.

The study shows under current policy per capita GNP by the year 2020 would be $23,825. If we can get the budget in balance by the year 2000, we would be able to say to people then that the reason that your per capita portion of GNP is $32,355 or a full third more, that about $9,000 is a consequence of our balancing our budget. We would be able in my judgment to actually say we did something relatively constructive.

The study goes on to show if the budget is in surplus there would be another approximately $800 per capita of GNP.

Mr. President, this is no small matter. Very often we are faced with people who ask us what can we do to get incomes up, how can we reverse the particularly apparent decline in the standard of living for younger Americans? What do we do? How do we reverse this decline of productivity going on since the early 1970's?

Mr. President, here is a hard answer for us, hard in that it is concrete, and hard in that it is difficult for us to face what we indeed need to do in order to get the budget either into balance by the year 2001 or get it into surplus.

Mr. President, last October Congressman LEON PANETTA, the chairman of the House Budget Committee, at the request of the Congressional Budget Office, released a 10-year forecast that showed the Federal deficit after dropping in the mid-1990's begins soaring again. He shows we could be at $400 billion a year by the late 1990's or early 21st century. The single biggest culprit, according to chairman PANETTA, is an exploding Medicare and Medicaid Program; and all of us who look at the budget know that. We see this year, for example, we are silently, in fact, authorizing an increase of about $20 billion in the Medicaid Program alone. I say it is silent, because those of you who are on the Budget Committee, the distinguished occupant of the chair is, have not been involved in debate, because it is an entitlement program; it goes up automatically. More importantly, unlike the States when they face increases in the Medicaid Program they have to pay for it; we do not have to pay for it. We can fund some of it with current tax money and whatever we do not fund with current tax money we will fund with a bond sale with additional deficit financing.

I am going to show as I did last week again the impact of the pay-as-you-go system. Recently, the Office of Management and Budget released a forecast. First, it was to just a few of us here on the Hill. Then they did it to everyone after the figures appeared in a few news stories. This showed that the deficit could approach $600 billion by the year 2005 if the economy performed

modestly and actually exceed $1 trillion if it grows more solidly.

Again, Mr. Darman, the head of the Office of Management and Budget, identifies fiscal health care cost increases as being the No. 1 culprit in the deficit.

So we have Congressman PANETTA showing that our budget deficits could reach $400 billion by the end of the decade and Mr. Darman saying it could be $600 billion by the end of the decade, both of them concluding it is health care cost increases that are driving the deficit. And I would like to show once again the ingredients of how health care is producing deficit financing.

I say this not only to my colleagues here but to the American people. This indeed is a contract between us and you. It is not just us and Congress making this decision. It is our contract with you. We are attempting to represent the people themselves. I am just suggesting there is something going on here that most of us do not know about and that in the knowing of it we have a critical decision to make.

Mr. President, this pie chart again shows the approximate arrangements of the expenditures for health care. I would argue they are larger than most people realize. The charge in the white area there is for Medicare. We spend another $21 billion, $131 billion for Medicare, $21 billion this year for Federal agencies making a variety of expenditures, National Institutes of Health, Centers for Disease Control communities health care programs, block grants back to the States. We spend a surprising $14 billion on the Department of Defense, Army, Air Force, Marine, and Navy.

I got some recent care in Germany myself after being injured in an automobile accident in Vilnius, Lithuania. I had a good orthopedic surgeon, a member of the United States Air Force. He sewed and cleaned me up so I did not get an infection.

There is $14 billion approximately that goes to the Veterans' Administration. We have the Federal Employee Health Benefit Program which not only covers Members of Congress, it covers all Federal employees, active and retired. That is $11 billion, and then the program known as Medicaid is $72 billion.

In addition, we make indirect expenditures through our tax system; that is the tax deduction for people who received health care in the work force, and there is a FICA deduction for businesses that are providing health care.

The total direct and indirect expenditures for health care in this year ending September 30 will be $328 billion; $328 billion, Mr. President, is the amount of expenditures that we are making on behalf of the people. We are making these expenditures on behalf of the American people.

The next question ought to be for those of us who kind of worry about cash flow from time to time, what kind of revenues are we receiving, and where are we getting the money?

Mr. President, we are taking in from Medicare part A, and we are taking in from Medicare part B approximately $105 billion. We have $92 billion that comes from Medicare part A. We have $13 billion coming in from Medicare part B. So $105 billion is all the premiums. Those are tax premiums that we are collecting from the American people. What we are giving the American people is 328 billion dollars' worth of benefits.

So the question is where do we get the rest of it? Sad to say, Mr. President, we are getting some of it in current dollars and some of it we are getting by selling bonds by going deeper into debt. We are getting $154 billion by my calculation from the taxpayers in the current year and going to sell bonds for $69 billion.

The reason I come up with this number, Mr. President, and my colleagues may have some disagreement on this, we have set Social Security off budget. One of the things that needs to be declared is our retirement accounts are really on a pay-as-you-go basis and they are current. I would support some reform of the retirement act, and I talked about that before. But as far as cash flow goes, we have a very large surplus in retirement right now. That is not the cash flow problem. The problem is in health care, where, because we set Social Security off budget, it is fair to say that of every dollar expenditure for anything that we spend at the Federal level 31 cents of it is done with additional debt.

So, Mr. President, I calculate that of that approximately $208 billion that we are looking for that we are funding $69 billion of it with additional debt. We are debt financing 69 billion dollars' worth of our health care expenditures.

Mr. DASCHLE. Mr. President, will the Senator yield?

Mr. KERREY. Of course I yield, and I am glad to yield.

Mr. DASCHLE. Mr. President, I just have had the good fortune to hear the distinguished Senator from Nebraska talk about this issue, and frankly I do not believe that our colleagues fully appreciate the magnitude of what the distinguished Senator is addressing here.

I commend him for it. There is no one in the Senate who has spent more time and has put more effort into understanding this issue and in such eloquent ways and in such easily understood ways and is now able to describe it for his colleagues and for the American people.

This is just another illustration of the Senator's leadership in this regard, and I commend him for it.

What I think I understand the Senator to say is that we are now spending, out of the entire health care budget for this country, 40 percent of all of that money we are spending is spent out of Government revenues. Is that what the Senator is telling us? Roughly, he is saying, $328 billion out of $800 billion is funded through the Government, so 60 percent, as I understand what the Senator is telling us, is spent in the private sector, but 40 percent today is spent out of Government; is that correct?

(Mr. BRYAN assumed the chair.)

Mr. KERREY. That is correct. Actually the $328 billion is what the Federal Government spent. State and local governments spend about $135 billion on top of that, roughly $180 billion private insurance, and the balance is out of pocket; that is correct.

Mr. DASCHLE. So what the Senator is saying is Government already spends more than half of all this country spends on health care; is that a correct statement?

Mr. KERREY. That is correct.

Mr. DASCHLE. Oftentimes, I go home or I talk around the country to various groups who have come to me and said, of all things, I hope you will preserve the private sector's role in our health care system. And I agree that, to the maximum degree possible, we should.

But I do not think people fully appreciate what a limited role that is, given the fact that when we look at the overall financing package, as the distinguished Senator has indicated, that package now constitutes a significant role for Government at the State and local level.

Now the thing I am most surprised at, and I would like the Senator to elaborate on it a little bit, is, as I understand what he said, one out of every 3 cents, or 30 cents out of every dollar that we are committing to the health care system today at the Federal level is borrowed; is that what the Senator is telling us?

Mr. KERREY. Yes. Every dollar that we spend at the Federal level, other than retirement programs, which we have now set off budget, every dollar that we spend, if you are a Federal employee, if you are in agriculture, if you work for the Department of Defense out there building roads, whatever, we are spending—for every dollar we spend, we must sell 31 cents worth of bonds to pay for it. We are deficit financing approximately 30 percent of everything we spend.

Mr. DASCHLE. So, again, going back to your chart because it is so critical that we understand the financing, as we try to begin considering alternatives, financing is a very significant part of it. What I hear the Senator telling us is that approximately, then, 15 percent of our entire health care system would be spent by borrowing, taking from future generations in order to accommodate the tremendous proliferation of costs we have seen over the last several years.

Mr. KERREY. That is correct. And it touches everybody. If you get a tax deduction, understand that is an expenditure, it is indirect, and we have to deficit finance to do that as well. So it is not as if you are able to say we are def-

icit financing for poor people, we are deficit financing for elderly people. Medicare is the only thing we are receiving direct premiums for; everybody is participating in what is essentially a free ride.

Mr. DASCHLE. So in a way you are saying that those children, those who are most detrimentally affected by the current system, mothers who are not getting prenatal care, children who do not have access to primary care, are not only hurt by the fact that they have no access to the system, now we are being told by the distinguished Senator from Nebraska that they are also being hurt very significantly by the fact that they are ultimately paying for a system to which they do not have access.

Mr. KERREY. That is quite right.

Mr. DASCHLE. They are paying a lot, maybe 15 percent, into the current system and they do not have access to it.

Mr. KERREY. That is quite right. We are spending the dollars, as the distinguished Senator from South Dakota knows, because I have heard him talk very eloquently about it, we spend health care dollars in a pyramid fashion; that is to say, almost no incentives at all for prevention. We basically have a system that says when you get sick we will pay the bills, but if you are not sick you are going to have a difficult time getting expenditures; that means prenatal care, well baby care.

Our system of providing continuous health care for children is appallingly inadequate. The consequence of that underfunding is not only do you spend more money later on but you are underfunding, as the Senator quite rightly says, that very group that is going to suffer most because we are deficit financing the current expenditures.

If you think about it, if we say we are going to give $10,000 a year, $9,000 a year, roughly, and these are hard numbers now, one does not have to guess anymore. One thing about our debate today is we no longer have to talk in generalities about what the deficit is doing to us. We can look out in the future and say if we get in balance in the year 2001—and I am going to show how we can do that—we will add another $9,000 of per capita GNP to every single American in the year 2020. Failing to do that, they will have $9,000 less per capita.

The Senator is quite right. The very people we are underfunding today with our health care proposals will be the ones that will have to pay for it 28 years from now.

Mr. DASCHLE. I know the Senator has a presentation and I do not want to interrupt him any further.

But I think the other hidden cost that the Senator has addressed and needs to be emphasized is that if 15 percent of all of the money that we are spending this year is borrowed, when one takes the cumulative costs year after year of the borrowed dollars, that ultimately adds up to a lot more than the 15 percent we are paying now. It could exceed the current cost per year in a very short number of years.

Certainly by the time these young people, who do not have access and who are now paying because we are borrowing, come to the point when they do have some access, the overall cost is going to be far greater simply because we borrow the money and they will then be paying the cumulative interest and that debt will be larger.

Mr. KERREY. That is quite right.

Mr. DASCHLE. I think the Senator is making a very important point and I hope that our colleagues will have the opportunity to listen carefully.

Mr. KERREY. It is one of the reasons I objected in January, not just because I was out on the Presidential campaign trail myself, but when the President introduced his health care proposal, it was essentially additional tax expenditures with no identification of where he was going to get the money. He just wanted to spend some additional money to try to solve the problem.

The proposal of the distinguished Senator from South Dakota takes cost containment head-on, and we have to do that. Unless cost containment is our top priority with health care, we are merely reinforcing all the very bad things that we are currently doing and making them worse. We may provide some additional access but at a considerable cost to taxpayers and particularly the young people who will in the end have to pay the bill.

Mr. President, I am just going to try to in brief form lay out three things that we could do if we as a body would like, as old men and women, to stand out there at sometime in the future and be able to say that indeed we did add to the per capita GNP of young Americans who today are looking in the future, expecting to be working out there in that year. Three things, and they are relatively simple to say and relatively difficult to do.

The first is just to declare that we will take all of our health care expenditures and put them into one account. And that does not mean we shut down the VA. It does not mean we consolidate the VA into some other organization, or the Department of Defense. We can leave all the agencies as they are. We will, simply for budgetary purposes, consider them as one account, including the tax expenditures that we make that I indicated earlier. So now we have one account.

I am arguing the first thing we should do is operate on a pay-as-you-go basis. If we want to provide a benefit, whether it is a benefit to people who are buying private health insurance or people getting their health care through the Veterans' Administration or Medicaid or Medicare, we should raise the money and pay for it, close this $69 billion gap that we have this year that will be larger next year.

The second thing that I propose we do, Mr. President, is agree that the cost increases and cost increases of all of our health care expenditures will not exceed 5 percent a year. Maybe we said it was going to be 4 or 3. I am pegging it at 5 percent. That is still in excess of the rate of inflation. It still exceeds the increase in our gross national product. It should be reasonable for us to fund our program.

The third thing we need to do is to find approximately by my guess—I will fill that blank in—find an additional $15 billion or so of spending reductions in defense and other areas.

We have, acoording to the distinguished Senator from Arkansas [Mr. PRYOR] in talking to him earlier, we have a huge increase in the amount of outside contracting we are doing. We ought to be able to find an additional $10 or $15 billion in reduction.

If we did those three things in fiscal year 1993, here is what would happen, Mr. President. The red line shows the reduction that occurs as a consequence of operating on a pay-as-you-go basis. It is a huge reduction in the deficit in the first year, continuing down in the outer years. The orange line merely accumulates what happens if we operate with a 5-percent increase.

By the year 1997, we have moved the deficit down to $23 billion. It does not take a magician to figure out that a relatively steep reduction in defense and other items in our early years would put us in the position where we would get into surplus.

One of the things that needs to be said at this point, Mr. President, and why I like this approach, is that under the current environment what we are doing is shortchanging the very kinds of investments we need to be making from the Federal level that will promote even more economic growth.

This really shows up at the States, where States cannot deficit finance. States cannot sell bonds, as the distinguished occupant of the chair knows, having been a Governor of the great State of Nevada. We cannot sell bonds, typically at the State level, if we run short.

The State of Nebraska is about $25 million short with Medicaid, and that is about the size of the increase with Medicaid. As I indicated earlier, the Federal Government has a $20 billion increase in Medicaid. I do not recall anyone coming to the floor, saying we have a terrible crisis with Medicaid. The reason it is not a terrible crisis is because we know if we are running a little short, we just sell bonds. For our $20 billion, we will sell approximately $6 billion of bonds to pay the difference.

At the State level, what we see is they have to cut back on higher education; they have to cut back on primary and secondary education; they have to cut back on current investments. All we see is those current investments as domestic discretionary expenditures; they have to cut back

current investments that will produce long-term economic growth.

Health-care cost increases at the Federal level are doing the same thing. Even though we are selling bonds and we mask the impact of it, we are still doing the same thing. What we are rushing to do under the current arrangements, without addressing this cost increase of health care, is that we are cutting back on those very things we need to put our money into to promote additional economic growth and prosperity for our people.

This morning I had the distinction of following President Bush's domestic policy adviser, I believe he is—I do not know what his exact title is—former Secretary of Agriculture, Clayton Yeutter, who is also from the State of Nebraska. As I told the Agriculture people, I was pleased. We are proud that former Secretary Yeutter now is the head of this domestic policy council. As a Democrat, I said, I wish he were still Secretary of Agriculture. But he is over there, and proud of what he is doing.

He came before this group to defend the free trade agreement with Mexico. And as he defended that free trade agreement, which I voted for—fast track; I think it could be good—he said the key part, the key part of making that trade agreement work if it is going to work is to invest in job training for our people. Because, the President's adviser said, there is no question that lower-income Americans will have their jobs destroyed; there will be job displacement as a consequence of this action.

By the way, Mr. President, even if we do not get a free trade agreement, that is happening anyway. We are seeing jobs move offshore as a consequence of being in a global environment. We have at least 40 million of our people—by a recent Department of Labor study—in the work force today who are undertrained. We need to be investing in their training.

It is going to take money. Yes; they will have to make an effort. Yes; they will have to work harder. But, Mr. President, we will have to make an investment in our community colleges, an investment in our private-sector training efforts. We need to get started making the kind of investments in our people that Governor Clinton has been talking about, frankly.

We are not going to be able to do that unless we get this deficit under control, and unless we get the deficit under control in a manner that has us facing head on public enemy No. 1.

Again, for emphasis, we only need to do three things. One, pay-as-you-go health care expenditures. If the American people want to health care benefit, we will collect the tax revenue to pay for it. If they do not want the $65 billion they are getting for nothing right now, let us cut the $69 billion and get current.

The second thing we should do is declare we are going to allow health-care growth not to exceed 5 percent a year. It can be 4 percent; it can be 3 percent. If we decide it is going to be 6 percent then, the third area of action will have to be even larger.

The third area of action is we have a package, a relatively small amount of reductions in defense and other items. Again, the distinguished Senator from Arkansas earlier was talking to me about some contracts that are possible. We can surely find $10 billion to $15 billion worth of expenditures in these areas.

Mr. President, if we do those three things, we will be in surplus by the year 1997.

If we get this surplus, we will add at least $9,000 per capita by the year 2020 for every single American, and we will be able to turn our attention to making investments in education, making investments in job training, making investments in the kinds of things that will increase American productivity and increase our standard of living and give Americans a sense that we can restore the economic health of this country.

The PRESIDING OFFICER. The Senator from South Dakota is recognized.

Mr. DASCHLE. Mr. President, let me again compliment the distinguished Senator from Nebraska for his leadership in this area, and for enlightening all of us, who can learn so much from his study and from his dedication to this issue.

He has served this Senate well. He certainly has been a major contributor to the debate about health care reform and the need to make significant change in the coming months.

I commend the Senator and I appreciate his interest and his leadership on the issue.

Mr. KERREY. Mr. President, I should add my thanks, as well, to the distinguished Senator from South Dakota. He has made a very comprehensive commitment to people. He and Senator WOFFORD campaigned on health care. It was an exciting proposal, one indeed that incorporates the elements that are described here.

I should say for emphasis, to my colleagues who have not, in their own minds, resolved as to what we ought to do with health care—I have. There are some details I am willing to debate. These two things can be done without necessarily reforming in a comprehensive way our health care system. These are just fiscal conditions, fiscal conditions that I believe should be incorporated in comprehensive health care reform.

Indeed, in order to make the 5-percent growth limitation on health care expenditures truly work without having the cost shift that again I heard the distinguished Senator from South Dakota describe very eloquently, one must move to comprehensive health care reform to get the job done. Anyone who has really looked at the numbers of health care growth in America, government and private sector, knows that we cannot continue at this pace. We are going to have to change in a fundamental way the way we are financing health care.

It does not mean the way we deliver health care has to change. We can still have private health care in America. We can still have very high-quality health care in America.

I heard the distinguished Senator from Minnesota [Mr. DURENBERGER] the other day on the floor complimenting, as he should, the Mayo Clinic in Rochester, MN, for being identified as one of the lowest-cost hospitals in America. No one would argue the fact that Mayo is also one of the best hospitals in America, demonstrating that cost control and quality are not mutually exclusive. Indeed, cost control can force us to make sure we are doing accurate and up-front qualitative analyses.

Mr. President, I believe cost reduction, economic growth, and providing an environment where Americans no longer fear they are going to have their health care taken away from them. And I, for the record, want to compliment, as well, the Senator from South Dakota, who has not only been a leader on this issue, but has managed as only he can to pull people that are apparently of different minds together to move toward consensus, Republican and Democrat, as we need to do on behalf of the American people.

Mr. DASCHLE. Mr. President, I thank the distinguished Senator from Nebraska. I appreciate so much the cooperation and all of the effort he has put forth.

He made the point I was going to make tonight, that no one ought to be wedded to a specific proposal. He said there are a set of principles here that should be incorporated in to any reform proposal. I think that really is something we need to concentrate on more. There ought to be a set of principles on which we agree and with which we begin to base a comprehensive health care delivery system in this country.

Obviously, as we try to put those principles together, one of the key questions is, to what degree do those principles address the problems that are besetting this country today with regard to health care?

I have addressed that series of problems in previous remarks, and I will not elaborate, but I think for review, they are important to mention again, to appreciate the magnitude of the problem. It is not just a cost problem; it is not just a problem of access. In my view, it is also a problem with the way we allocate our resources.

The fact that we are misallocating resources is becoming much more clear. And I think, as it becomes clear, we begin to address this series of problems in a much more comprehensive way. We are misallocating resources to administrative costs; we are misallocating resources to expensive health care delivery methods that

could be reallocated to save substantial resources committed now unnecessarily.

Another problem, that I certainly have addressed, and others have, as well, is that we spend far too much on unnecessary care. Some will tell us that that unnecessary care could be as much as 30 percent of all the care delivered today, for a lot of different reasons which we have outlined in the past.

Finally, of course, the hassle factor, the fact that doctors and administrators are spending far too much time filling out forms, dealing with bureaucracy, and not providing health care. Experts have told us that as much as the equivalent of 2 work weeks are spent each month by doctors who have to spend an incredible amount of work and time and effort filling out these bureaucratic, nightmarish forms to a point that they never dreamed possible when they were in medical school.

So we have all of these problems. There is no single bullet with which to solve them. Some would say all we have to do is revise our current health care delivery system, adopt what many people call managed care; managed care will take care of the problem.

There was an interesting article in the paper just in the last couple of days which indicated that, while managed care can contribute, managed care, in and of itself, will not solve the problem. Businesses and corporations of all kinds are coming before the Congress and are reiterating that managed care is not meeting their expectations. So managed care is no silver bullet.

There is no single bullet. There is no easy answer. There is no incremental approach that will softly and gently move us into a new arrangement whereby we could resolve all of the five problems.

But what ought we to consider as a basic core set of principles that can begin creating this comprehensive health care plan? I think there are a number of them. I very briefly want to touch on those principles today. They can be incorporated into any one of a number of different comprehensive health care reform proposals. But I think, for a comprehensive approach to health care reform to be successful, they ought to include in some form some of the principles that I am about to mention.

The first would be preventive care. Today we had a major decision from the Supreme Court about abortion and, whether one is pro-life or pro-choice, there is no argument about one thing. Regardless from which philosophical perspective you may come, the fact is that we can save the lives, the livelihoods, the health, the ultimate welfare and well-being of those children much more effectively if we provide universal access to health care delivery; for pregnant mothers, more opportunities to give that new child an opportunity to live in good health; for that fetus an opportunity to grow and be nurtured under the guidance of a health care provider.

For all of those who are so concerned about the issue either way, I challenge them to come forth and to join with us in the realization that we must provide extensive prenatal care and neonatal care to every single child in this country. You cannot have a health care delivery system unless you start with that. I do not care what it is, I do not care what kind of a plan you put forth, it has to start with that. Primary care, wellness promotion, preventive care starts with the child, starts with the pregnancy, starts with access for that pregnant mother, who for the first time, would have hope that she and her child could be healthy. What is more fundamental than that? What is more sensible than that? What could be more economically efficient than to provide access to health care with the cheapest and most inexpensive approach rather than to wait until complications develop? I am told that the cost-effectiveness ratio of prenatal care could be 100 to 1 to one. That is, you save $100 for every $1 you put into a prenatal care program. If it is that extraordinary, then why are we not doing it today?

The second principle, it seems to me, is pretty simple as well. You have to have a budget. If there is one thing I hear every time I return home, and I return home often, it is people who walk up and say, "Tom, the thing you ought to do is run Government like a business or a family. We all have a budget, why do you not? You have to run it like a business. You have to run it like a family. You have to live within some confines; you just cannot go out there and spend until you get blue in the face."

I think they are right. I am not sure families and businesses always do it as well as we would like, as well as they would like, but certainly you have to give them extraordinarily high marks for effort.

But what are the marks when it comes to health care in this country? Where is the budget? Where is this notion of running a government entity like a business or a family when it comes to health care? We spend as if there is no tomorrow. We do not have any limits, either in the private sector or in the Government sector, when it comes to health care. And the results are economically cataclysmic.

The distinguished Senator from Nebraska made it very clear: We are spending extraordinary amounts of money unnecessarily and with costs that we have not even begun to realize simply because we do not have a budget. We have to begin appreciating the need for a budget if we are going to deal with health care costs.

A couple of months ago we had a very vigorous debate about capping Medicare and Medicaid, and there were those on the other side who said we have to cap them because that is the only way we are going to control them. And, to a certain extent, I can subscribe to that argument. But if we are indeed, going to cap Medicare and Medicaid, are we not then acknowledging the need for a budget? I would argue we are, and I would argue that it is time we not only cap Medicare and Medicaid but that we cap every other part of health care spending and realize that our resources are limited and, if they are limited, come to some better approach to how we allocate those resources.

The third principle: Let us also acknowledge that we have way too many payers in the system today. The General Accounting Office has indicated to the Congress that a big reason why we see fraud in the current system—and that fraud was $70 billion last year—is tied directly to the fact that with our multipayer system, there is no one minding the store. There is no way to ensure that all of this money does not fall down an ever increasing rat hole because of fraud. And they said of all of the reasons why fraud exists, the biggest is the hundreds and hundreds of payers in our current system, 1,200 to 1,400 payers today. And the duplication not directly related to fraud is equally as expensive.

The plethora of payers is driving administrative costs sky high. We are told administrative costs alone could be 20 to 25 percent of the overall health care budget. Twenty-five percent, Mr. President, is over $200 billion that we are spending on paperwork, that we are spending on administration and all of those other costs not directly related to health care, and that is wrong.

Small businesses are among the biggest victims of all. Their costs are substantially higher than those of large corporations; 40 percent of the premiums small businesses pay today go to insurers' administrative costs, 4 percent. So we have a gas-guzzler system, a system that takes too much to get from here to there in providing the health care we all want.

The fourth principle: some kind of decisionmaking entity. A Federal health board is essential. The one real encouragement I have received in recent months in talking about this issue on both sides of the aisle is the realization that there has to be some decisionmaking authority, some way for us to start making better allocation decisions, better cost-containment decisions, better decisions relating to where the dollars go in primary care. Those kinds of issues have to be decided by someone, and a health care delivery mechanism that includes a decisionmaking authority is absolutely essential.

The fifth principle is one about which I feel very strongly. I know that it is somewhat controversial, but I do believe that as we continue to evolve into a more realistic health care delivery mechanism, that new mechanism, that new reform movement is going to at long last delink health-care insurance from employment.

For the life of me, I do not understand how it was that it got to this point in the first place. Employers do not take care of our housing; they do not take care of our education; they do not take care of our clothing or our other necessities in life. Why and through what method was it that we came to the conclusion they are responsible for our health care? They are not responsible in any other country. So if they are not in any other country, why would they be in this country, which proclaims its competitiveness and its ability to compete anywhere in the world with the most competitive features of our capitalistic system?

What is competitive about requiring employers pay up to $500 to $700 a month in insurance costs? That cost, Mr. President, is driving our employers to a position which is not competitive and is having a devastating effect on their ability to compete internationally. An economist told us, candidly, a couple of months ago that one of two things is going to happen within 20 years: either we will have come to ours senses and broken that link between employment and health care delivery or our large employers will have left the country to evade that responsibility.

I think he is right. It is the most inefficient and complex way of providing insurance there can be. General Motors estimates that its obligation for retirees' health benefits exceeds its total assets today.

So let there be no mistake; the cost of continuing to require employers to pay health care is wrong, uncompetitive, extremely inefficient, expensive, and an anachronism.

I do think employers ought to have the opportunity, should they so choose, for whatever reason—recruitment, retention, whatever reason it may be—to provide health care. That ought to be their choice. But to require under law that an employer does so, to me, ought to be changed.

Those are the principles, Mr. President: Breaking the link between employment and health care, having some kind of a decisionmaking authority, reducing the number of payers, having a budget,ensuring that we have preventive care, are principles that I hope Democrats and Republicans alike could support and could use as the basis upon which to build comprehensive health care reform.

Mr. President, there is one other point that I would like to make before I yield the floor. It has to do with some comments made by the Secretary of Health and Human Services a couple of weeks ago before the Senate Finance Committee. The Secretary indicated that a new study had just been released by Dr. Robert Blenden of the Harvard School of Public Health. It was presented at a recent meeting of the Association of Health Services Research. He stated that in that study physicians found the Canadian system virtually unacceptable.

I do not want to paraphrase inaccurately the Secretary's remarks. I ask unanimous consent that his remarks be printed in the RECORD.

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

Canadian doctors, according to a recent report, are deeply concerned about their ability to get access for their patients to special care and medical technology.

In addition, let me report, a large majority of doctors in Canada and Germany also believe their systems require major overhaul.

And also, Senator CHAFEE, the source for that citation of the Canadian doctors is a study by Dr. Robert Blenden of the Harvard School of Public Health.

And there was an article citing the study in the Wall Street Journal on June 9, just a few days ago. And this was a study funded by the Robert Johnson Foundation.

Mr. DASCHLE. The reason I raise the issue, Mr. President, is because it goes to a larger point. The larger point is, regardless of whether or not we subscribe to a Canadian system or a German system or any one of the foreign systems, I happen to believe that the adoption of a foreign system is wrong; that we can adapt American principles and American health care reform standards and American health care practices to a comprehensive health care reform system that has little to do with what is done in Canada or what is done in Germany or what is done in Britain or Japan.

But just because I do not subscribe to a Canadian system or a German system does not mean I believe we cannot learn from a German system or a Canadian system. And if we are going to learn from one of these systems, it seems to me we ought to get our facts straight and not, for whatever reason, distort the facts to make a point, only to obfuscate the issue and not learn at all.

Oftentimes that seems to be the case as we debate health care reform. Outrageous claims or accusations are made about other systems that so undermine our ability to understand, undermine our ability to debate the issue in an objective and enlightened way I think the purposes are defeated. And so it is in that interest I would attempt to lay the record straight with just a few points made in the very study the Secretary cited in his testimony 2 weeks ago.

Point No. 1, "Canadian and West German physicians were found to be more satisfied with their system than were U.S. physicians"—more satisfied. That was not the impression left by the Secretary, but that is what the study says.

Second, "physicians in the U.S. were unique among the three countries in reporting a serious problem with obtaining care for patients who could not afford treatment."

The Secretary made quite a point of saying that there are long waiting lines in Canada, that certain kinds of care were not provided, and he cited this study as his basis for making that claim. Now we find that the study is very clear. It says physicians in the United States were unique in pointing out that our system presented serious problems for obtaining care for patients who could not afford treatment.

The third point, "U.S. physicians reported more patients who should have sought care earlier.

"U.S. physicians reported the most external interference from third-party payers in their medical practice decision making."

We are seeing that today with the managed care concept. External interference from third-party payers. How much more can we expect in the future by an employer or someone who says we are not going to pay that for you; you are not going to get it. As a result, it is up to you. External interference may or may not be a good thing. But if it is haphazard, if is done without standards, then I would argue, Mr. President, we are making a mistake. And the United States has more external interference than that of other countries.

"Only 23 percent of United States doctors believe the system works pretty well as compared to 33 percent of doctors in Canada and 48 percent of German physicians."

And then finally, "More than two-thirds of American physicians said they thought fundamental changes are needed to make the system work better."

I think that is a phenomenal figure. Two-thirds of American physicians said they thought fundamental changes are needed to make the system work better. We are not talking about patients here. We are not talking about rank and file American workers. We are talking about people on the front lines, those in the surgical suites, those in the emergency rooms, those who ought to know the system best. Those people are saying by two-thirds that fundamental changes, not tinkering around the edges, are needed in the current system.

Dr. Ted Marmor of Yale University may have summed it up best at the end of the hearing, referring to the incredible array of misguided and absolutely inaccurate information broadcast about the Canadian system, when he said, "I think I've heard the intellectual equivalent of acid rain." We're sending unwanted verbal pollution across the Canadian border.

I think there is a lot of intellectual acid rain when it comes to health care delivery. We have to separate fiction from fact. We have to understand what the real facts are so that we can make objective decisions about what it is we need and what it is we want. I hope over the course of the next several months we will have that opportunity in committees and on the floor.

I appreciate very much the attention of my colleagues to this issue this evening.

Mr. President, I yield the floor.

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Senate

THURSDAY, FEBRUARY 20, 1992

(Legislative day of Thursday, January 30, 1992)

PRESIDENT BUSH'S HEALTH PLAN

● Mr. KERREY. Mr. President, I wish to continue the debate on President Bush's message to the American public regarding health care. There is no issue that entails more personal involvement or governmental expenditure than our health care system. The increasing fear and anxiety of all Americans regarding coverage, preexisting illness, and rising costs gave hope that the President would give us direction and a meaningful plan to initiate debate. Instead we were given old thoughts with old solutions and no real hope for the future.

President Bush's health plan is, of course, no plan. It is only a politically expedient idea to tantalize families with the possibility of insurance reform, to place the financial burden back on the States, and to offer insufficient tax credits to obtain a comprehensive health plan. It promises to continue the paperwork and bureaucracy for both the consumer and providers without relief. Our long wait for the President's message was unjustly rewarded by his presenting a stale, incremental approach to reform of an industry that consumes 14 percent of our gross national product. And even for these partial solutions, the President says we must wait until 1997 for complete phase-in. This inability of the President to lead the health care community—hospitals, doctors, nurses consumers—to a comprehensive solution is a reflection of his desire for reelection but not real solutions.

American medical costs have progressed to a critical point. These costs are rising at twice the annual inflation rate. Yet the administration has failed to recognize the necessity of developing a comprehensive strategy for excellence in health care while preserving fiscal responsibility. Our failing economy and consequent unemployment has revealed the inability of the insurance industry and providers to offer health care for all Americans at affordable prices. This sole reliance upon market-based approaches in health care to protect all Americans in times of duress has proven unsatisfactory and led to fragmented and discontinued service.

Tax credits are the major component of the President's proposal. However, because they do not approximate the present costs of a comprehensive health insurance program, these credits will either not access most of the working poor or they will simply assure health insurance involving little option or choice. If spiraling health care costs are not more actively controlled, the tax credits will be of little value, go largely unused, and do little to establish real uniform access.

The President's plan suggests that small businesses would offer but not pay for health insurance. He assures us that health care can be made available to this group by using health insurance networks. These have been available in the past without wide-

spread success. The real fact remains: Small business health insurance reform without effective cost controls will either serve to raise the premiums of all of the insured or ensure that insurance coverage remains unavailable to those who need it the most and can afford it the least.

The President believes his ideas will be effectively implemented by the insurance industry. Even though this industry is in the midst of change, reform of our system needs to allow consumers, health care professionals and hospitals to participate in this debate. American consumers deserve to have a voice both in the choice of systems as well as the services to be provided. To entrust the country's health care system to only one part of the health care industry is simply to ensure the status quo, an unacceptable proposal.

George Bush's message will allow states to receive the tax credit moneys and add them to the already depleted Medicaid funds to establish inadequate state health plans; plans that will take choice away for the consumer; plans that will assure that users of the State program will be low-cost-plan recipients, reaffirming their nonimportance to the administration.

The President talks about prevention. No one could argue with incentives for better personal health responsibility. However, the administration's plan does nothing to ensure preventive care such as mammograms, cervical cancer screening and immunization. Furthermore, this administration has abdicated its other roles in prevention with its appalling record on pollution control and occupational safety standards.

While President Bush demagogs the new taxes required for each of the comprehensive Democratic proposals, he fails to mention the revenue source of the 5-year $100 billion estimate his plan will cost. The President realizes health care costs money; what he doesn't mention is that under his new plan we will be paying a huge amount for a system that neither controls cost nor gives adequate service or access.

The Democratic Congress is unified in its support for equal and complete access for all Americans in a comprehensive program. The President's plan for access, choice, and cost containment is neither plausible nor possible. This is not a plan; this is an afterthought. The American public deserves better. They should know their children with heart disease will get affordable, quality care; they should know their parents' long-term care will not bring them into poverty, and they should know that insurance costs will not rise such that each year they must choose between food and clothing or health care. Not only does the President fail to answer these issues; he even fails to address them.

Americans are concerned about their health care. They want to continue to receive high quality medical care. At the same time they consistently recognize the need for significant improvements to access, delivery, and cost in the present system.

After many months of delay and the onset of an election year, the President has finally recognized that a problem exists. But he continues to side-step a real comprehensive, long term solution to this domestic issue. Americans are paying for this oversight; today we are paying with the health of our Nation.●

Our ability to eliminate the trade distorting aspects of the keiretsu represents one of the single most important challenges the United States faces in this new era of economic competition.

If President Bush travels to Japan in January, one point must be made loud and clear: Japan must reform its keiretsu system, or relations with the United States will deteriorate.●

ACCESS TO AFFORDABLE HEALTH CARE

● Mr. KERREY. Mr. President, I have made it clear in the past, that the time to reform our Nation's system of financing health care is long overdue. Reforming our Nation's health care system is not only a humanitarian issue, it is a vital economic issue. It is eroding our standard of living and threatening our ability to compete in an aggressive international marketplace.

Access to affordable health care is moving beyond the reach of the working American families. Health care costs are rising as incomes are falling. Individuals and families are spending more for health care and receiving less coverage while they are earning lower wages.

Last July, I introduced the Health USA Act of 1991 to restructure how our Nation pays for health care. Since then, I have received many letters from Nebraskans on the topic of health care and the adverse effects of its rising costs. In a recent letter from Mr. Timothy Deal of Hastings, NE, he illustrates very specifically and honestly how an increase in his families' health care premiums, accompanied by a decrease in the amount of coverage, has put his family on the edge of financial devastation.

Mr. Deal's situation is extremely troublesome. But, tragically, it's not that unusual. Rapidly rising health care costs are crowding out wage and salary increases, impairing the American people's standard of living, and putting the fear of financial ruin resulting from a serious illness into their hearts.

Mr. President, I ask that Mr. Deal's letter be printed in the RECORD. I encourage all of my colleagues to read this letter and realize that the specific situation that Mr. Deal has shared with us, is the norm throughout the Nation.

The letter follows:

HASTINGS, NE, *August 4, 1991.*

DEAR SENATOR KERREY: May I begin by saying that it is indeed a privilege of fortune to enjoy the benefits of life in America. Furthermore, should the wheels of corporate gains and industrial economics suddenly and unexpectedly cease to turn, there is no better place in the world than the USA that I would choose to be. Having made this clear, I do however wish to share with you my personal opinion and perception of present social and economic concerns.

I am well aware that you have great concerns, as do I, of current existing health care deficiencies, and have addressed these pending concerns with your own innovative health care plan. I applaud your efforts and want you to know I support your philosophy with regard to this issue. I am also aware that many have been critical of this plan and voiced openly their opposition toward its economic support. Please share my letter with them! Please note the following information reflects an honest glimpse of my family's personal income and dispersement of spending. Note as well that I am not venting discontent with these salaries, as they likewise reflect an economic portrait far above the numbers realized by many less fortunate than myself.

My wife and I are both gratefully employed full time and our family's net monthly income is $1150.00 after deductions for federal and state taxes, social security, health insurance, daycare, and education savings. Our monthly expenses are as follows:

$550.00—Housing (house payment and average utilities).

$100.00—Transportation (1977 Honda, 1981 Escort, no maintenance).

$50.00—Auto and Home Insurance.

$25.00—Medical insurance deductible.

$25.00—Dental and Optical expenses (not covered by insurance).

$25.00—Copayment of insured medical expenses (Blue Cross/Blue Shield 80/20 on all medical expenses covered under the current policy).

Total—$775.00.

As you can see, this allows only $375.00 to be appropriated for food for four, household purchases, recreation and entertainment, gifts and contributions, telephone and postal, newspaper and garbage expenses. Clothing, I do not include, but with the exception of socks and undergarments, all clothing for the family is purchased from garage sales and thrift shops.

We have been able to juggle these appropriations each month without the use of credit cards, thus we have our needs met and have therefore remained secure economically. Recently, however, our medical insurance premiums increased from $80.00 a month to $95.00 while our coverage decreased. Please note the seriousness that this change has invoked with regard to our economic stability. As of August 1st, our policy, which previously covered 100 percent of hospitalization and emergency costs with the exception to a small number of exclusions, has been amended to cover 80 percent of all medical whether basic or major medical. This policy included a $3000.00 copayment stop loss annually. I can not express effectively, the concern this presents our family. Allow me to convey it this way. I have two young children, ages 6 and 1, both of which have been hospitalized in the past 2 months for ear surgery. One of the children, our 6 year old, was hospitalized twice as an inpatient and once as an outpatient. Altogether, these medical expenses totaled several thousands of dollars. Had this medical dilemma occurred now, instead of prior to August 1st, our family could be faced with an economic hardship of such magnitude that I hesitate to ponder it. Sad as it seems, more and more medical policies have increasingly diminished in coverage while premiums increase.

Please Mr. Kerrey, I have been frank with you throughout this letter, I have disclosed valid information reflecting average midwestern economics. Please take this letter to the Senate floor and read it. If your opponents scoff at its contents, then they, not I, suffer greater social inequity.

Sincerely yours,

Timothy J. Deal

P.S. note that the $95.00 premium makes up only 20 percent of the policy's total monthly cost. My employer's benefit is nearly $400.00 a month.●

ACCESS TO QUALITY MAMMOGRAPHY SCREENING

● Mr. D'AMATO. Mr. President, I rise today to cosponsor two bills that address the urgent need for expanded access to quality mammography screening for all American women.

Expanding access to mammography screening and ensuring that such screenings meet the highest standards of quality is vital to reducing the unacceptably high death rate associated with breast cancer in this country. It is estimated that in 1991, 175,000 women will be diagnosed with breast cancer, and 44,500 women will die from the disease. This makes breast cancer the second leading cause of cancer death among women in the United States.

Mr. President, next to a cure—and we must do far more at the federal level to speed research on effective treatments for breast cancer—our best defense against this horrible disease is early detection and treatment. Such early detection, through regular mammograph screening, can, according to the Centers for Disease Control, reduce breast cancer mortality by 30 to 40 percent for women aged 50 and older.

Unfortunately, far too few Americans women receive early cancer detection tests on a regular basis. In 1987, only 25 percent of women over age 50 reported having a mammogram within the preceding 2 years.

We need to encourage and facilitate the use of these tests by American women—and that is why on April 23, 1991, I joined Senators MACK and BREAUX in introducing S.891, legislation which provides a tax credit of up to $250 against the costs of early cancer detection procedures.

Today, I am cosponsoring two bills that I believe will further promote the availability of quality mammograms. The first, Senate Resolution 184, is a sense-of-the-Senate resolution that calls on insurance companies throughout the country to include periodic mammography screening services as part of their basic coverage for women. New York State has required health insurance policies to include coverage for annual mammography screenings since 1988. I am hopeful that this far-sighted bill, introduced by my colleague from Illinois, Senator DIXON, will encourage insurance companies in every state to follow suit.

The second bill, S.1777, will establish national quality standards for mammography to assure that every mammogram a woman receives is safe and accurate. The need to establish national standards was underscored by the findings of a recent General Accounting Office report which found that existing professional standards are not uniformly followed at many screening

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Senate

THE HEALTH CARE SYSTEM

Mr. KERREY. Mr. President, I was struck this morning by a column in the Washington Post by Robert Kuttner. Mr. Kuttner relates, in rather moving detail, how two of his friends have approached decisions about their own deaths—how a middle age man decided to die with dignity at home as he lost a battle with cancer, and how an elderly woman has reacted to the onset of physical frailty by contemplating suicide.

Mr. Kuttner argues that in both cases, our Nation's health care system failed his friends by failing to provide for services, such as home health care. He concludes by stating, quite correctly:

> Dilemmas that join questions of medical ethics and public policy are invariably painful, but our failure to have a coherent health care system makes them excruciating.

What struck me most, however, was what Mr. Kuttner described as the argument used by the health care establishment against providing such services as home health care on a universal basis. Mr. Kuttner writes.

> While many insurance companies now pay for hospice care as an alternative to hospitalization for terminal diseases, few pay for extended home-nursing care. Yet an entitlement to a daily visit from a nurse, as part of a treatment plan, would cost the health system perhaps one-tenth the cost of an extended hospitalization. Private insurers resist this approach because of belief in the "woodwork effect." An entitlement to nursing care would bring potential claimants who now suffer in silence out of the woodwork.

Those words stopped me, because that is an argument I have often heard as I have worked over the past 2½ years to develop a national plan for universal health care coverage. I often heard people in the health care establishment say:

> If you provide universal coverage, utilization will explode. If you pay for prescription drugs, it will bust the bank. If you cover long term care, people who got by just fine without it before will demand it. In other words, people will come out of the woodwork.

Coming out of the woodwork refers, of course, to vermin; insects, like ants and termites, who swarm mindlessly out of a piece of wood when it gets hot or damp. It is not a pretty image, Mr. President. But I believe it is a very telling metaphor.

It tells us something about the attitude of too many of those who have power in our health care system toward those who do not. Fundamentally, it implies a lack of trust in people to regulate their consumption of health care services in a responsible manner. Scratch the woodwork metaphor, and you will hear a comfortable, elitist voice grumbling to itself:

> If you make basic health care a universal entitlement, I would consume it responsibly; my family would consume it responsibly; the people in my neighborhood would consume health care responsibly; but those people—those people—simply can't be trusted; they'll break the bank.

The fact is, Mr. President, the bank is already broken. The costs of our health care system are so out of control that they conjure up the image of some malignancy, relentlessly feeding off the body of its host. For despite the miracles that American medicine delivers, that system is consuming well over $600 billion of our national income each year; sometime this decade it will consume over $1 trillion. Those costs are chipping away at the paychecks of our workers, the savings of our retirees, the budgets of our States, and the competitiveness of our firms. Our patchwork system of financing health care has led to cost shifting and risk skimming; it has resulted in more deductibles and less coverage; it has caused wasteful redundancy and crimped accountability.

And still we hear, Mr. President, that we cannot afford to have those people come out of the woodwork. Mr. President, I have a different idea about what a universal system of health care would accomplish.

I do not believe universal access to home health care would bring unworthy consumers out of the woodwork. I believe it would afford dignity to millions who could be cared for in their own homes rather than in some expensive, antiseptic institution.

I do not believe universal access to prenatal care would be a windfall to the undeserving. It would be godsend to a nation where too many children reach school unable to learn because their brains and bodies lacked adequate care during gestation.

And I do not believe universal access to diagnostic screening would open the gates to a stampede of hypochondriacs. It would open an era in which American women could reach middle age with far less worry about dying from ovarian cancer or breast cancer.

Throughout our history, the working men and women of America have had to press the case for the full exercise of their rights against the smug and the comfortable who maintained that an expansion of rights was not necessary. Women, America was told, are not well informed enough to vote. Workers do not need the right to organize in order to protect themselves. Blacks do not really want to sit in the same restaurants as white folks.

In this age, we are told that the American people do not really need a universal system of financing health care. And lurking behind all the cost estimates, and all the utilization charts, and all the econometric studies are the same self-satisfied voices who have forever seen the extension of rights as a problem of people coming out of the woodwork, rather than an opportunity to bring people out into the sunlight.

Mr. President, the time has come to turn away from those cynical, mistrusting voices, and toward a universal system of financing health care that can save our Nation money, strengthen America's economy, improve our country's health, and enhance the dignity and happiness of our people.

Mr. President I ask unanimous consent that Mr. Kuttner's article be printed in the RECORD.

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

WHY NOT HOME HEALTH CARE?

(By Robert Kuttner)

Last year, I lost a good friend to cancer. He was 58. When his cancer was diagnosed as incurable, he decided that he would forgo heroic treatment and eventually die at home in his own bed.

His wife and daughter served as his primary care-givers, seeking to make him as comfortable as possible. His health-insurance plan, more flexible than most, allowed for an occasional visiting nurse.

At times, however, when his fever spiked and the nurse was urgently needed, she was hard to reach. The health-care system is not geared up for this manner of dying. Visiting him during one such moment, I figured his wife deserved better than unanswered phone calls. She deserved a medal.

Not only did my friend die with more dignity than people whom I have watched expire helplessly, hooked up to futile high-tech contraptions, his manner of dying saved the health system hundreds of thousands of dollars.

A day in a hospital now costs several hundred dollars just for the bed. Cancer treatment can easily run to $1,000 a day. Six figures is normal for the full course of the disease. A home visit from a registered nurse averages about $60, according to the Visiting Nurse Association.

While many insurance companies now pay for hospice care as an alternative to hospitalization for terminal diseases, few pay for extended home-nursing care. Yet an entitlement to a daily visit from a nurse, as part of a treatment plan, would cost the health system perhaps one-tenth the cost of an extended hospitalization.

Private insurers resist this approach because of belief in the "woodwork effect." An entitlement to nursing care would bring potential claimants who now suffer in silence out of the woodwork.

I have another friend, an elderly woman, who is rationally contemplating suicide. She is now in her 80s and has lived a full, rich life. Mentally, she retains all her faculties, though she is beginning to fail physically.

Her concern is that when she becomes more frail, or seriously ill, the choice of whether to end her life will be taken from her. Once she is in the clutches of any sort of institution, dignified suicide will be logistically impossible and institutionally impermissible.

She is also, quite rationally, hesitant even to consult a psychiatrist to discuss her concerns. She is worldly wise enough to know that one does not visit a psychiatrist to obtain advice on whether to commit suicide, much less on how to do it. A psychiatrist would likely pronounce her "depressed," and prescribe medication or, worse, institutionalization.

She is, of course, not depressed at all. As her expected life span draws near its end, she is contemplating her options rationally, with far more realism than the health system.

These dilemmas, and others like them, occur at the crossroads of the ethical, the financial and the political. We would like to think that moral choices about how to die are entirely personal. Unfortunately, they are hopefully bound up with the fabric of law, policy, regulation and reimbursement.

The choice of whether to pursue heroic treatment in a hospital versus a potentially more dignified terminal illness at home is complicated by the vagaries of health insurance, professional liability and the deeply ingrained reluctance of the medical profession to permit death to take its course. The issue of suicide is even thornier.

As a nation, we deceive ourselves into thinking that by not having a comprehensive system of health care or coherent policies, we somehow facilitate personal choice. In truth, this form of freedom, as that moral philosopher Janis Joplin once observed, is just another word for nothing left to lose.

Our present non-system permits choices only for those with extremely deep pockets. For the rest of us, our choices are constrained by the arbitrariness and social irrationality of what insurance will pay for. And you can be sure that as costs keep escalating, insurance will pay for less and less.

A comprehensive system—besides its other virtues of universal coverage and reduced administrative costs—would force doctors, hospitals, policy makers and the public to look these issues in the eye. It would force the system to come up with defensible criteria instead of backing into these decisions as the incidental byproducts of scattered cost-containment or liability-avoidance maneuvers.

Surely a national system would decide that home health care, not just for terminal patients but also as an alternative to expensive nursing-hme care, should be far more broadly available. That might also ease the fear of an elderly person contemplating suicide as a way of avoiding institutionalization.

Dilemmas that join questions of medical ethics and public policy are invariably painful, but our failure to have a coherent health systems makes them excruciating.