

day with three of those veterans. We just heard two of them. Senator WARNER, Senator GLENN, and Senator CHAFEE all served admirably during that difficult time. All came back to serve this country in other capacities with great dignity and extraordinary valor.

President Kim this afternoon, during the dedication, remarked again that freedom is not free. That statement reminded me of a comment made several years ago while I visited East Germany that democracy is something one either has to fight for or work at. But we do not have the luxury of doing neither. These three distinguished veterans of the Korean war understand the need to do both. They fought for freedom and, ever since returning, have worked at democracy. So I know I speak for all Senators in our expression of personal gratitude to them for their achievements and for the contribution that they have made to this country.

Mr. President, "The struggle of man against power is the struggle of memory against forgetting."

Those words, by the Czech writer Milan Kundera seem especially poignant today as America dedicates a memorial to those "forgotten veterans," which Senator GLENN so eloquently addressed, the men and women who fought and died in the Korean war. And it is a honor that is long overdue.

The other day, I had the privilege of visiting with two Korean war veterans from South Dakota, who had come to Washington this week for the dedication.

Don Jones was 22 years old when his foot was ripped apart by a hand grenade in North Korea on October 1952. He spent 6 months recuperating in a Tokyo hospital, and then he went back to Korea to fight some more.

Orville Huber was 24 years old when he was hit in the head by a piece of shrapnel in July 1953, just 2 weeks before the war ended.

They both won the Purple Heart.

After the war ended, they returned to South Dakota. There were no parades, no fanfare. When I asked them what they would like to hear the American people say after all this time about the sacrifices that they made in Korea, Orville responded simply: "We would just like to hear that people remember."

Perhaps the reasons the Korean war has receded in our memories is because it was unlike either the war that preceded it or the war that followed. Rationing brought World War II into every American home, and television brought the Vietnam war into our homes.

But Korea was different. Except for those who actually fought there, Korea was a distant land and, eventually, a distant memory.

So today, as we dedicate our Nation's Korean War Veterans Memorial, it is fitting that we remember what happened in Korea and why we went there in the first place.

The wall of the Korean War Veterans Memorial bears an inscription that reads: "Freedom is not free." It was repeated by President Kim yesterday in the joint session of Congress, and repeated again by the President of the Republic of Korea today during the dedication.

In the case of South Korea, the price of repelling Communist aggression and preserving freedom was very high indeed.

Nearly 1½ million Americans fought to prevent the spread of communism into South Korea. It was the bloodiest armed conflict in which our Nation has ever engaged. In 3 years, 54,246 Americans died in Korea—nearly as many as were killed during the 15 years of the Vietnam war.

Freedom is not free.

Nearly 1½ million Americans sacrificed part of their lives to preserve freedom in Korea—and more than 54,000 Americans sacrificed all of their lives. The nobility of their sacrifice, at long last, is now recorded for all of history at the Korean War Veterans Memorial.

Look into the faces of the 19 soldier statues that make up the memorial and you can feel the danger surrounding them. But you can also feel the courage with which our troops confronted that danger. So it is a fitting tribute indeed to the sacrifices of those who fought and died in that faraway land.

But there is also another tribute half the world away, and that is democracy—democracy—in the Republic of South Korea. Over the past four decades, the special relationship between our two nations that was forged in a war has actually grown into a genuine partnership. Our two nations are more prosperous, and the world is now safer, because of it.

As the writer said, "The struggle of man against power is the struggle of memory against forgetting."

The free world won an important battle in the struggle against power more than four decades ago when we beat back the forces of communism in South Korea.

Today, it is the responsibility of all those who value freedom to remember the struggle and the honor and the commitment of all of those who fought and who ought to be remembered in perpetuity. The Korean War Veterans Memorial is one way that we can truly live up to that responsibility.

Freedom is not free. We must recognize—and I hope future generations will always recognize—that democracy truly is something we must either fight for or work at.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. WELLSTONE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. WELLSTONE. Mr. President, I am assuming that we are going to be going to the gift ban reform very soon.

Since there is this break, I ask unanimous consent that I be allowed to speak as in morning business for up to 10 minutes.

The PRESIDING OFFICER. The Senate is in morning business.

The Senator is recognized to speak for 10 minutes.

#### MEDICARE'S 30TH ANNIVERSARY

Mr. WELLSTONE. Mr. President, on July 30, 1965, President Lyndon Baines Johnson traveled to Independence, MO, and he signed Medicare into law. That simple ceremony marked the beginning of a new era of health and economic security for America's seniors.

Prior to Medicare, only half of America's elderly had health insurance. Today, more than 36 million elderly and disabled Americans, including more than 630,000 Minnesotans, are protected by Medicare. Mr. President, Medicare is a program with overwhelming support in Minnesota among seniors, their children, their grandchildren, and all Minnesotans.

Many of us remember what it was like for seniors before Medicare. Many seniors lost everything paying for necessary health care, and many others simply went without it.

Mr. President, the Medicare Program, imperfections and all, made the United States of America a better country. Prior to Medicare, what often happened was that as people became elderly and no longer worked, they then lost their health care coverage. Many people could not afford good health care.

This was a program, along with Medicaid, that made our country more compassionate. It made our country a fairer country. It made our country a more just country.

I can say, Mr. President, having had two parents with Parkinson's disease—and the Presiding Officer and I have talked about Parkinson's disease before, and we both have a very strong interest and support for people who are struggling; I think the Presiding Officer has a family connection also with Parkinson's disease—for my mother and father, neither of whom are alive, Leon and Minnie, the Medicare Program, I think, was the difference at the end of their lives between dignity and just economic disaster. It is a terribly important program.

Mr. President, Medicare also is important to Minnesotans because we, as a State, I think, have had a great deal to do with its creation. Hubert Humphrey, Walter Mondale, and Don Fraser, among others, worked tirelessly on its creation.

This was a project of countless Minnesotans, advocates for seniors from all across our State, our universities, our communities, all came together during the early part of the decade of the 1960's, and finally culminating in 1965

on July 30, when we passed this hallmark legislation.

In many ways, I argue today on the floor of the Senate, Medicare is a product of Minnesota. It reflects Minnesotans' values. It reflects the tradition of my State: A tradition of respect for seniors and a commitment to those members of our community who need a helping hand. As Hubert Humphrey, a great Senator, said in support of Medicare, "Our country's strength is in the health of our people." That was the premise of the Medicare Program.

This year, the 30th anniversary of the Medicare Program, all too many Republicans have resolved to cut the program by \$270 billion over the next 6 years. While the budget deficit clearly needs to be reduced, the Republican proposal to finance a tax cut to the tune of \$245 billion—most of it going to high-income and wealthy people—and at the same time putting into effect severe and, I think, draconian cuts in the Medicare Program, a program which has played such a central role in improving both access to and quality of health care services for our country's elderly and disabled, is unacceptable, I argue—and we will have a debate about this, as time goes on—and unconscionable.

Mr. President, while I believe the Medicare Program could and should be improved, I want to be quite clear that I do not think that this program will be improved by cutting \$270 billion over the next 6 years.

Mr. President, a dramatic restructuring of Medicare not based on sound public policy would be a grave mistake. A dramatic restructuring of Medicare of the kind that has been proposed now by too many Republicans, not based on sound policy, would not be a step forward for Medicare beneficiaries in Minnesota or across the country, but would be a huge step backward.

Republicans have proposed, Mr. President, to fundamentally change the program from universal health insurance for seniors to a fixed amount of cash which each Medicare beneficiary could use to purchase coverage in the marketplace. This would effectively transfer the risk of Medicare inflation and medical inflation to the elderly, in order to relieve the Government from bearing the risk.

Mr. President, seniors would be expected to pay the difference between the cost of a health plan and the Medicare voucher amount. The elderly in our country, Mr. President, already pay four times more out-of-pocket expenses for medical costs than those under 65 years of age. This does not include the enormous cost of nursing homes, which is now nearly \$40,000 a year.

While Republicans claim that they want to use a voucher system to emulate the health care cost containment successes of the private sector, they neglect to mention that their budget cuts will only allow Medicare costs to grow at a rate of less than 5 percent

per person, while private health care costs are projected to grow at a rate of 7 percent per person. Those are exactly the figures. That is exactly the information.

Mr. President, that means that even if the Medicare Program, which cares for the sickest and the frailest members of our society—the same members, I might add, Mr. President, who have been systematically excluded by the insurance companies from coverage because of preexisting conditions—even if Medicare can capture all of the efficiencies of the private sector, there still would not be enough money to cover the costs of this program.

Mr. President, Minnesotan providers have already suffered from inadequate payments for Medicare. For example, Minnesota's HMO's are currently offered inadequate payments for the Medicare population. As a result, many of our HMO's have declined to participate in the Medicare Program on a capitated basis. Minnesota, compared to California, compared to New York, compared to Florida, sometimes only receives half of the reimbursement per person.

Mr. President, what I am saying is that we, in Minnesota, have kept the inefficiencies out of the system. We have already cut the fat. If these payments come to Minnesota, capitated at a fixed amount way under the cost of providing care to beneficiaries under a voucher-type scenario, seniors will be forced either to pay more out of pocket—and we are not talking about a high-income population when we talk about the elderly in Minnesota or in our country—or they will have to go without coverage.

Mr. President, beyond the impact of Medicare cuts felt by seniors and the disabled community, we will all pay the costs of Medicare indirectly. We will pay it in one of two ways: Either as children or grandchildren, we will have to help pay the costs of our elderly parents or grandparents.

Many families are already under a tremendous amount of economic pressure. The bottom 70 percent of the population has been losing ground economically over the last 15 years. I think it is rather naive to believe that families will have a lot of extra income to pay this additional cost.

Or, when the hospitals, clinics, and doctors are in a position to do so, and I do not blame them for this, they will just shift the costs. It is like Jell-O. Put your finger in one part of the Jell-O and it just shifts. What they will do, since the Medicare reimbursement will be significantly under the cost of providing care—that is already the case in Minnesota—these cuts will not work in my State, I tell Members now. This slash-and-burn approach will not work in Minnesota. It will not only hurt Medicare beneficiaries. It will also hurt care givers and providers and, in addition, those care givers and providers in the metro area, if they can, will shift the cost of private health insurance.

Then the premiums will go up, then the employers will have a difficult time carrying insurance, and more will be dropped from coverage.

This is crazy public policy that some people are advocating around here.

Mr. President, Medicare Dependent Hospitals, which have a Medicare load of 60 percent or more—

The PRESIDING OFFICER (Mr. ABRAHAM). I inform the Senator his 10 minutes has expired.

Mr. WELLSTONE. Mr. President, I ask unanimous consent for 5 extra minutes.

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

Mr. WELLSTONE. Mr. President, Medicare dependent hospitals—and the definition of a Medicare dependent hospital is a hospital that has Medicare patient loads of 60 percent or more—have significantly lower overall margins than other hospitals, and will face two choices: Either those hospitals will close down or they will have to reduce services.

Minnesota has four Medicare dependent hospitals in the urban areas, and we have 40 of those Medicare dependent hospitals in the rural areas. In addition, 43 percent of Minnesota's hospitals currently lose money on Medicare patients. If the proposed Medicare cuts are enacted, 67 percent of Minnesota's hospitals would lose money on Medicare patients.

Small, isolated rural hospitals require a stable funding source in order to provide care. I will tell you right now, in many of our smaller communities, in many of our greater Minnesota communities, in many of the communities in rural America, what is going to happen is that those hospitals with a Medicare patient mix of sometimes up to 80 percent are simply not going to be able to make it. And when those clinics and hospitals close, that means not just Medicare recipients but other citizens as well do not receive the care that they need.

Medicare has come to symbolize this Nation's commitment to health and financial security for our elderly citizens and their families. It is a successful program that has played a central role in improving both access to and quality of health care services, not only for our country's elderly and disabled, but for all of us. We are talking about our parents and our grandparents.

Mr. President, I will, as we go to the 30th anniversary of Medicare, vigorously oppose all efforts or any effort to dismantle a Medicare system in order to give a tax cut that will disproportionately benefit those people who need it the least.

Let me repeat that. I will resist any effort to dismantle the Medicare Program in this country in order to give tax cuts to those citizens who, in fact, least need the financial assistance.

Thirty years ago, Medicare was part of a Democratic vision for a better America. Mr. President, today it still is. I come from a State that has made

an enormous contribution to our Nation. I come from a State that has made a contribution through a great Senator and a great Vice President, Hubert Humphrey—Hubert Humphrey and Walter Mondale and Don Fraser—and Minnesota had a lot to do with the beginning of the Medicare Program and with support for this program, which has made such a positive difference in the lives of people, our senior citizens around this country. I intend to fight hard to make sure that we keep this as a high quality program.

My mother and father depended on this program. They are no longer alive, but for them, if not for Medicare it would have been financial disaster. So I do not intend to see this program dismantled—not on my watch as a Senator from Minnesota. And the more we get into this debate, the more people in Minnesota and all across this country are going to say: Senators, whether you are Democrats or Republicans, this is unacceptable and unconscionable. Do not be cutting Medicare, do not be cutting Medicare and quality of services for elderly people in our country, all for the sake of tax cuts for wealthy people in our country. There is no standard of fairness to that.

Mr. President, I ask unanimous consent that an article by Ted Marmor titled “Medicare and How It Grew—To Be Confused and Misjudged” be printed in the RECORD.

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

[From the Boston Sunday Globe, May 7, 1995]

MEDICARE AND HOW IT GREW—TO BE  
CONFUSED AND MISJUDGED

CONFUSION ABOUT THE PROGRAM'S PAST IS  
CLOUDING ITS FUTURE

(By Ted Marmor and Julie Berlin)

Medicare, budget deficits and the race for the presidency have once again come into intense and very public conflict. On Monday, President Clinton publicly rejected the suggestion by House Speaker Newt Gingrich that Medicare's forecasted budget be reduced substantially (some \$250 billion) so as to “save” the valued, but beleaguered program. On Wednesday, the president reiterated his “defense” of Medicare before the White House Conference on Aging, rejecting both the Gingrich diagnosis and the remedy of a bipartisan national commission proposed by Senate Majority Leader Bob Dole, an announced contender for the Republican presidential nomination. By the end of the week, Republicans were on the defensive, repeatedly referring to the recent report by Medicare's trustees that, without cost control, the program's hospital “trust fund” will run out of money by 2002.

The Republicans find themselves caught among conflicting promises: to balance the budget, to enact tax cuts and to protect both Medicare and Social Security. The country finds itself in the midst of a bewildering mix of crisis talk, fact-throwing and ideological name-calling.

To make sense of this debate requires historical perspective on what Medicare was expected to accomplish, some understanding of what its 30-year history has wrought and some realistic discussion of what its real problems are and what can be done about them.

Medicare, enacted in 1965 and fully operational in 1966, has historical origins that are difficult to understand in the political environment of the 1990s. Perhaps the best way to understand Medicare is to appreciate how peculiar the program is from an international perspective. The United States is the only industrial democracy that has compulsory health insurance for just its elderly citizens. Even those countries that started national health insurance programs with one group of beneficiaries did not start with the elderly. Almost all other nations began with coverage of their work force or, as in the case of Canada, went from special programs for the poor to universal programs for one service (hospitals) and then to another (physicians).

This means that peculiarly U.S. circumstances, rather than some common feature of modern societies, explain why it is that compulsory government health insurance began in the United States with the recipients of Social Security cash pensions.

The roots of this particular history lie in the United States' distinctive rejection of national health insurance in the 20th century. First discussed before World War I, the idea fell out of favor in the 1920s. When the Great Depression made economic insecurity a pressing concern, the Social Security blueprint of 1935 broached both health and disability insurance as controversial items of social insurance that should be included in a more complete scheme of protection. From 1936 to the late 1940s, liberals called for incorporating universal health insurance within the emerging welfare state. But the conservative coalition in Congress defeated this attempt at expansion, despite its great public popularity.

The original leaders of Social Security, well aware of this frustrating opposition, reassessed their strategy during President Truman's second term. By 1952, they had formulated a plan for incremental expansion of government health insurance. Looking back to the 1942 proposal that medical insurance be extended to Social Security contributors, the proponents of what became known as Medicare shifted the category of beneficiaries while retaining the link to social insurance.

Medicare became a proposal to provide retirees with limited hospitalization insurance—a partial plan for the segment of the population whose financial fears of illness were as well-grounded as their difficulty in purchasing health insurance at modest cost. With this, the long battle to turn a proposal acceptable to the nation into one passable in Congress began.

These origins have much to do with the initial design of the Medicare program and the expectations of how it was to develop over time. The incrementalist strategy assumed that hospitalization coverage was the first step in benefits and that more would follow under a common pattern of Social Security financing. Likewise, the strategy's proponents assumed that eligibility would be gradually expanded. Eventually, they believed, it would take in most if not all of the population, extending first, perhaps, to children and pregnant women.

All the Medicare enthusiasts took for granted that the rhetoric of enactment should emphasize the expansion of access, not the regulation and overhand of US medicine. The clear aim was to reduce the risks of financial disaster for the elderly and their families, and the clear understanding was that Congress would demand a largely hands-off posture toward the doctors and hospitals providing the care that Medicare would finance. Thirty years later, that vision seems odd. It is now taken for granted that how one pays for it affects the care given. But in the

buildup to enactment in 1965, no such presumption existed.

The incrementalist strategy of the '50s and early '60s assumed not only that most of the nation was concerned with the health insurance problems of the aged. But it also took for granted that social insurance programs enjoyed vastly greater public acceptance than did means-tested assistance programs. Social insurance in the United States was acceptable to the extent that it sharply differentiated its programs from the demeaning world of public assistance. “On welfare,” in American parlance, is a form of failure, and the leaders in the Social Security administration made sure that Medicare fell firmly within the tradition of benefits “earned,” not given. The aged could be presumed to be both needy and deserving because, through no fault of their own, they had lower earning capacity and higher medical expenses than any other age group. The Medicare proposal avoided a means test by restricting eligibility to persons over 65 (and their spouses) who had contributed to the Social Security system during their working life. The initial plan limited benefits to 60 days of hospital care; physician services were originally excluded in hopes of softening the medical profession's hostility to the program.

The form adopted—Social Security financing and eligibility for hospital care and premiums plus general revenues for physician expenses—had a political explanation, not a philosophical rationale. Viewed as a first step, of course, the Medicare strategy made sense. But after 30 years, with essentially no serious restructuring of the benefits, Medicare seems philosophically, and practically, at sea.

The main outline of Medicare's operational experience can be summarized in three chronological periods.

The first—roughly from 1966 to 1971—was one of accommodations to US medicine, rather than of efforts to change it. To ease the program's implementation in the face of heated resistance from organized medicine, Medicare's first administrators resisted radical changes. They adopted benefits and payment arrangements that exerted inflationary pressure and hindered the government's ability to control increases in program costs over time. For example, paying hospitals their “reasonable costs” and physicians their “reasonable charges” proved to be significant loopholes that prompted energetic gaming strategies on the part of doctors and hospitals. Unusually generous allowances for depreciation and capital costs were a further built-in inflationary impetus. The use of private insurance companies as financial intermediaries provided a buffer between the government and physicians and hospitals but it weakened the capacity of government to control reimbursement.

The truth is that in the early years, the program's leaders were not disposed to face the confrontations necessary to restrain costs. They felt they needed the cooperation of all parties for Medicare's implementation to proceed smoothly. Medicare's designers, fully aware of the need for cost control, were initially reluctant to make strong efforts for fear of enraging Medicare's providers.

With the benefit of hindsight, it is easy to criticize this. At the time of its enactment, however, Medicare's legislative mandate was to protect the elderly from the economic burdens of illness without interfering significantly with the traditional organization of American medicine. It was with this aim in mind that Medicare's leaders were accommodating so as to ensure a smooth, speedy start to the program. It was not until the 1980s that Medicare came to be seen as a powerful means to control the costs and delivery of medical care.

The results were quite predictable: efficient administration of a program with inflation built in. The average annual rate of growth in the daily service charge of US hospitals between 1956 and 1971 was 13 percent. Medicare's definition of reasonable charges paved the way for steep increases in physicians' fees as well. In the first five years of Medicare's operation, total expenditures rose over 70 percent, total expenditures rose over 70 percent, from \$4.6 billion in 1967 to \$7.9 billion in 1971. Over the same period, the number insured by Medicare rose only 6 percent (19.5 to 20.7 million people).

By 1970, there was broad agreement that health inflation had become a genuinely serious problem. Criticism of Medicare was part of this dialogue, and, for some, Medicare was the cause of what became a pattern of medical prices rising at twice the rate of general consumer prices. Throughout most of the 1970s, however, adjustments of Medicare took a subordinate political position to nationwide medical change. That does not mean Medicare was inert. But it does mean that its changes—experimentation with different reimbursement techniques in the early 1970s; the 1972 expansion of Medicare to the disabled and those suffering from kidney failure; administrative reorganization in the late 1970s that took Medicare out of Social Security into the newly created Health Care Financing Administration—all became the subject of intense but low-visibility interest-group politics. This politics, followed closely by the nation's burgeoning medical care industry, elderly pressure groups and specialized congressional committees, was not the stuff of Medicare's original legislative fight or of the ideological battle over national health insurance.

By the end of the 1970s, alarm had grown over both the troubles of medical care generally and the costs of Medicare specifically. The struggle over national health insurance ended in stalemate by 1975 and the effort to enact national cost controls over hospitals had also failed by 1979. This meant that Medicare, like American medicine as a whole, was consuming a larger and larger piece of the nation's economic pie, seeming to crowd out savings on other goods and services. US health expenditures in 1980 represented 9.4 percent of GNP, up from 7.6 percent in 1970. Medicare alone amounted to some 15 percent of the total health bill in 1980, up from 10 percent a decade earlier.

For the past 15 years, the politics of the federal deficit have driven Medicare. This has had two consequences. The first is that Medicare is no longer an intermittent subject of policy makers' attention, but has become a constant target of the annual battles over the federal budget. Second, concerns over Medicare's effect on the deficit have enabled far-reaching changes in the ways it pays medical providers. In contrast to the accommodationist policies of Medicare's early years, federal policy makers have implemented aggressive measures to hold down Medicare expenditures. They gave priority to the government's budgetary problems over the interests of hospitals and physicians. The result of these changes was a considerable slowdown in the rate of growth in Medicare expenditures that did not compromise the program's universality.

Ironically, these changes in Medicare payment policy received almost no public attention. There has been little recognition of the effectiveness of the 1980s federal cost-containment measures. As a result, the public has a distorted sense of Medicare's experience of inflation, viewing it as inevitable. The experiences of the past decade demonstrate that Medicare costs can actually be restrained through regulatory adjustments, and that these savings do not require a de-

parture from Medicare's basic design as a social insurance program open to beneficiaries regardless of income.

While the changes in Medicare payment policy did not receive widespread public attention, a concurrent expansion of benefits did. For a brief period in the late 1980s, the addition of so-called catastrophic protection to Medicare coverage became a topic of media interest. The passage and repeal of the catastrophic health insurance bill was a searing experience for Washington insiders, but it left little lasting impact on the nation's citizenry. What remained from the 1980s was a large federal deficit, and it was fiscal politics (along with presidential politicking), not Medicare's performance, that has controlled the pace and character of attention Medicare has received.

Before turning to how to cope with Medicare's problems, critical attention should be given to two claims in the recent debate. One is the mistaken view that because Medicare faces financial strain, the program requires dramatic transformation. The experience of the 1980s showed that Medicare administrators, when permitted, can in fact limit the pace of increase in the program's costs. The second misleading notion has to do with the very language used to define the financial problems Medicare faces. Republican critics (and some Democrats) continue to use fearful language of insolvency to express dread of a future in which Medicare's trust fund will be "out of money." This language represents the triumph of metaphor over thought. Government, unlike private households, can adjust its pattern of spending and raising revenues. The "trust fund" is an accounting term of art, a convention for describing earmarked revenue and spending both in the present and estimated for the future. The Congress can change the tax schedule for Medicare if it has the will. Likewise, it can change the benefits and reimbursement provisions of the program. Or it can do some of both. Channeling the consequences through something called a "trust fund" changes nothing in the real political economy. Thinking so is the cause of much muddle, unwarranted fearfulness and misdirected energy.

To view the crisis-ridden debate about Medicare's finances as misleading is not to suggest that the program is free of problems. But it is important to understand that Medicare can be adjusted in ways that fully preserve the national commitment to health insurance and the elderly and disabled.

What should be done? One place to start is reduction of the growing gap between the benefits Medicare offers and the obvious needs of its beneficiaries. What Medicare pays for should be widened to include the burdens of chronic illness; that means incorporating prescription drugs and long-term care into the program, which is precisely what the Clinton administration hoped to do in connection with its ill-fated health insurance overhaul.

Widening the benefit package does not mean, contrary to what many claim, that total expenditures must rise proportionately. Expenditures represent both the volume of services and their prices. Many other nations have not only universal coverage and wider benefits than Medicare, but spend less per capita than we do for their elderly. Canada, for example, is able to do this because they pay their medical providers less, spend less on administration and use expensive technology less often. Medicare's expenditures should be restrained below the current projected growth rate of 10 percent a year. There is no reason that the program's outlays need rise at twice the rate of general inflation—or more. What has to be changed is the amount of income medical providers of all sorts receive from the Medicare program.

Medicare's financing also could use some overhauling. Raising payroll taxes will have to be part of the answer. This option appears to be ruled out of the current debate, a good example of fearfulness defeating common sense. But, the breadth of public support for Medicare suggests it is possible to mobilize popular backing for a tax increase to support the program where the problem is clearly defined and the justification convincingly offered. As for beneficiaries, it is time to reconsider the idea of charging wealthier beneficiaries more for Medicare's physician insurance program, another idea likely, if explained, to have popular support.

We need a debate as well over how Medicare should be improved. What we do not need is one that scares the country about Medicare's future by disseminating false claims about its affordability. It would indeed be a "crisis" if we concluded that the legitimate health costs of our aged and disabled were unaffordable. What is unsustainable is the pattern of increasing health expenditures at twice the rate at which our national income rises.

Medicare's early implementation stressed accommodation to the medical world of the 1960s. Its objective was to keep the economic burden of illness from overwhelming the aged or their children. Thirty years later, the setting is radically different. The difficulties of Medicare are those of American medicine generally. We pay too much for some procedures and we do too many things that either do some harm or do little good in relation to their costs. In the world of private health insurance, cost control has arrived with a vengeance. Medicare is unsettled and is likely to remain so in the context of budget-deficit politics unless we accept that containing what we spend on Medicare need not mean transforming the program. It will mean, necessarily, that the burdens of cost control will have to be borne. Our suggestion is that they should be borne by those whose incomes are higher, both payers and payees.

#### THE DEDICATION OF THE KOREAN WAR VETERANS MEMORIAL

Mr. HEFLIN. Mr. President, on the Mall this afternoon, just across the reflecting pool from the Vietnam Veterans Memorial, another unique symbol commemorating the sacrifice of our Nation's veterans was dedicated. The long-overdue memorial to our Korean war veterans was finally and officially opened to the public today, July 27, 1995, the 42d anniversary of the armistice agreement ending that conflict.

This stirring memorial truly deserves its rightful place on the national Mall, for, as a Washington Post editorial succinctly put it yesterday, "'Korea' was a convulsive but finally proud event in the tradition of the presidents honored on this hallowed national ground." On the Korean Peninsula over 40 years ago, brave Americans led a score of nations in successfully thwarting Communist aggression. "It was a moment in the history of freedom, and the 54,000 Americans who died and the many others who fought there earned the benediction in stone and steel now \* \* \* bestowed."

Some have called the Korean war "the forgotten war," since it did not