

For her valiant services, U.S.S. *Chandeleur* was awarded six bronze engagement stars for operations at Guadalcanal, Bougainville, Saipan, Palau, Okinawa, as well as air operations off the coasts of China, Korea, and Japan, and participation in the early occupation of Japan.

During these operations, the ship and crew survived a number of withering attacks by Japanese vessels and aircraft, including a near miss by a Kamikaze bomber off Okinawa, sustaining multiple battle casualties and deaths of her crew members and air crews.

Soon after her return from the Pacific, U.S.S. *Chandeleur* was "mothballed" at the Philadelphia Navy Yard, and later scrapped, but the ship's company and aviators have remained close.

They have gathered periodically in reunions widely separated across the United States, from Boston to San Diego. For their 27th reunion on the 50th anniversary of the victory they so valiantly helped to bring about, they have gathered in the ship's "native" city, San Francisco, where they will be together at the Marine Memorial Club from September 27 through October 1, 1995.

It is fitting that on the 50-year anniversary of this historic mission that the ship's companies and aviators gather once again in the ship's home city of San Francisco. And, on behalf of the United States Senate, I would like to extend my most sincere welcome to those gathering to remember the valiant mission of the U.S.S. *Chandeleur*.●

THE 100TH ANNIVERSARY OF THE VILLAGE OF EMPIRE

● Mr. LEVIN. Mr. President, I rise today to commemorate the 100th anniversary of the village of Empire. The community of Empire has planned many events for this significant milestone.

The Village of Empire is known today as the home of the Sleeping Bear Dunes National Lakeshore Park Headquarters. The residents of Empire are renowned for their friendliness in welcoming over a million visitors to the lakeshore each year. With its beautiful beaches, hiking trails, abundant natural resources, and rich history, Empire is a recreational haven known the world over.

Empire was settled in the mid 1850's. It quickly established itself as a lumbering center, the largest and best equipped hardwood mill in the State. Many Norwegians, recruited to operate the mill, settled here. With the manpower, modern equipment, and plentiful supply of wood, this mill produced up to ten million feet of lumber each year, and was a model of efficiency across the State.

The village of Empire formally incorporated on October 16, 1895. It was probably named after the *Empire State*, a steamer-sidewheeler that ran

aground nearby in 1849, and the *Empire*, a schooner that also ran aground in the area in 1865.

The lumber mill burned in 1917, and the residents of Empire quickly adapted to produce agricultural products. Lands which had been cleared by the lumbering industry were replanted with fruit trees or became grazing for livestock. Empire drew many seasonal workers anxious to work the harvest, and fruit companies and slaughterhouses sent representatives to view and buy the goods Empire produced.

In 1949, the Empire Air Force Station was established. The 752d Aircraft Control and Warning Squadron was assigned 300 personnel, almost doubling Empire's population. This station remained a part of Empire until the 1980's. The former station is now controlled by the FAA and provides essential radar services to the area.

Empire's long and rich history was recognized through the authorization of the Sleeping Bear Dunes National Lakeshore in 1970. The National Park Service has improved the recreational resources in the area, while preserving cultural resources. The partnership between the residents of Empire and the national lakeshore will continue to draw many visitors in the years to come. Michigan is fortunate to boast of the contributions of the village of Empire.●

MEDICARE

● Mr. JEFFORDS. Mr. President, I rise today to address one of the most important legislative changes the Congress will be addressing this year—changes in the way we finance and the way senior citizens and persons with disabilities receive Medicare coverage. I wholeheartedly support reducing the Federal deficit, as well as, moving the Government out of the role of running a health plan, for the elderly and disabled, and into the role of contracting with private health plans. I commend Chairman ROTH and the Finance Committee for its commitment to these very important goals.

Having studied the health care system in the United States for many years I have come to the conclusion that the reason the Government's health care spending is out of control is really twofold. First, is the way we have chosen to pay for and purchase services. When Medicare was designed in the 1960's it was modeled after private Blue Cross fee-for-service plans. The Government paid providers directly for each procedure.

Paying for services rendered at a distance without any effective utilization control has been a disaster. Our failed attempts to control costs, by continuing to cut payments to providers and increasing costs to beneficiaries, is a major reason why our Federal deficit is so exorbitant.

I hope that in our efforts to reduce the deficit, we have not set ourselves up to cut too deeply into the Medicare

payment system. Many technical changes have been suggested by the Finance Committee to the reimbursement policies for hospitals and providers. Some of these changes have allocated additional funding to rural areas. I look forward to discussing the total cost impact on Vermont with both the hospital association as well as other provider groups in Vermont, as well as with my colleagues on the Finance Committee.

Second, by segregating the elderly and disabled, into separate risk pools, the Government has become responsible for providing health insurance for the riskiest members of society. This segmentation has not provided any incentives for the private sector to find innovative ways to manage the highest cost cases in the delivery system. Unfortunately, it was the private market's failure to provide affordable coverage on reasonable terms, to the elderly and disabled, that led to the political demand for the Government to create Medicare and Medicaid in the first place.

Providing Medicare beneficiaries a choice of private health plans is a wonderful idea and one that I have been advocating. Hopefully, the impact will not be the same as the greatest criticism against the Federal employee plan. One experience with this program has found adverse selection among plans—that is the people that need the most care seem to migrate to the high option Blue Cross fee-for-service plan—creating an upward cost spiral for members of this plan.

Now I'd like to turn to the two charts I have here. The first chart was duplicated from hearings on the Eisenhower administration's health reinsurance legislation back in 1954. This was before we had Medicare and Medicaid. As you can see, 41 percent of the population had no insurance protection at all and 36 percent of the population had what I would call limited coverage. More startling only 3 percent of the population has what most Americans take for granted today—comprehensive coverage.

Compare this chart with my second chart which does not emphasize the type of coverage but the source of coverage. Over 55 percent of Americans in 1993 had coverage provided through their employer. As you can see, 15 percent of the population is uninsured—compared to 41 percent in 1953. Medicare is the primary insurance for 12 percent of the population and 9 percent of the population receives coverage through Medicaid.

As we tackle one of the biggest problems for the Federal Government, our deficit, we must keep in mind a goal we all agreed to last year—the goal of moving towards universal coverage for all Americans. We must keep in mind that any changes we make to the public programs of Medicare and Medicaid must not add to the rolls of the uninsured, especially if it is due to unintended consequences of our changes to

these programs. More uninsured Americans will only increase total costs to the health care system.

We must keep in mind that Medicare and Medicaid were created because proper incentives were never placed in the private market to enable it to accept the risks associated with insuring the elderly and disabled. As we encourage the Medicare population to move into private health plans we must be sure to do what President Eisenhower tried to do over 40 years ago—we must be sure to place the proper incentives in the private market that will encourage it to compete for the chronically ill high cost population on quality and price.

As we move to a system in which we offer Medicare beneficiaries throughout the country greater choice and coordinated care, we must not forget to address the following concerns. First, what types of choices will be available for rural and underserved areas which have little or no penetration of the private managed care marketplace? Second, how can we provide coordinated care for beneficiaries who decide to stay in the current fee-for-service Medicare program? Third, how can we address the bifurcated finances and benefits offered to the aged and disabled population through the Medicare and Medicaid programs?

Many rural and underserved areas of this country, like Vermont, which do not have an over abundance of hospitals and other health providers, have not seen the benefits experienced by a mature managed care marketplace such as Minnesota or Washington. I was very pleased to see that the Finance Committee has recommended that the AAPCC be modified to increase the per month payment per Medicare beneficiary in rural area. Hopefully, more managed care plans will decide to start up business in rural parts of this country. But this change will take some time.

Market alternative's to managed care health plans have been springing up all over rural America. For example, although Vermont does not have a multitude of managed care health plans operating, providers have been developing networks that offer a continuum of care to Vermonters. Networks that provide acute, home health and residential care. They provide direct medical care, as well as, the personal services needed for individuals to manage their own care needs. This coordination of care is very similar to what Blue Cross of western Pennsylvania is providing its fee-for-service clients through case management. Like Blue Cross, many private sector fee-for-service health plans have begun to provide case management on a voluntary basis to individuals with high-cost conditions, generally chronic or catastrophic care cases. These programs offer greater flexibility in the array of services needed, on a case by case basis, and have proven very cost effective.

HCFA has demonstrated that a small proportion of Medicare beneficiaries account for a high proportion of payments. In 1992, about 9.8 percent—3.5 million—of all Medicare enrollees accounted for 68.4 percent—\$82.6 billion—of all Medicare payments. The experience for the last 20 years of the program has shown that 80 percent of the beneficiaries account for only 20 percent of the costs of the Medicare program. In the Medicaid program 30 percent of the population, the aged and disabled, accounts for 70 percent of Medicaid expenditures. Furthermore, this is the cost in the Medicaid Program that is growing the fastest. Finding a means to manage high cost cases in these two programs is essential if we are going to reduce costs in both of these programs.

To add to the distortion and inefficiencies in providing care for elderly and disabled persons is that many of these people are both Medicare beneficiaries and Medicaid recipients. These people are termed dually eligibles today. This creates numerous clinical, operation, and financial problems, particularly as these two programs are taking extraordinary steps to control spending. In order to access the full range of care that is necessary an individual must deal with two very different systems. The care received by a dually eligible consumer is therefore, often fragmented, reimbursement driven, and inappropriate.

Service decisions are routinely made by providers based on which program pays better. This result is not always a care plan that is in the best interest of the consumer or the most cost effective. Because two payors offering distinct yet overlapping benefit packages with different sets of rules are responsible for the same consumer, much confusion exists for all parties. It is often impossible for States to know what service decisions, which ultimately tap Medicaid funding, are being made while the senior citizen is in the Medicare system. Another source of much provider discontent and inefficiency is the dual administration of claims payments. One of the major reasons for this problem is that Medicare and Medicaid claims processing systems are not compatible and Medicare and Medicaid payment policies differ. The result is needless inefficiencies and expense.

As attempts to control Medicare spending and to block grant Medicaid move forward, the problem of dual eligibles becomes an obstacle to achieve both goals. Medicare cannot control the cost of this population unless Medicaid funded services are used to lower Medicare's acute care costs. Medicaid cannot manage and coordinate the care of the elderly and disabled unless it is given responsibility for the full continuum of care. One answer is a case managed system for the dual eligibles which merges Medicare and Medicaid coverage and is administered by the States on Medicare's behalf. This would be a thoughtful approach in ad-

ressing the highest cost cases in both programs by replacing the fragmented, costly and inefficient system of today with an integrated, managed care approach designed to keep people healthier and lower costs for both public programs.

I have been working with Senators KASSEBAUM, COHEN and CHAFEE on this very key issue as we look forward to restructuring our public programs. Once we have created a delivery system that provides high quality, appropriate, cost effective care for the people who need the system the most—we will have restructured a health care system that works for all Americans. Mr. President, I look forward to working with my colleagues on both sides of the aisle in a thoughtful debate on how to modify both Medicare and Medicaid.●

WELFARE REFORM VOTES

Mr. ABRAHAM. Mr. President, during the Senate's consideration of the welfare reform bill there was often very little time available for Senators to debate the amendments which were offered. I would like to take a moment of the Senate's time now to comment on various votes which were cast during that debate.

Mr. President, no single issue dominated our deliberations more than the subject of illegitimacy. Republican or Democrat. Liberal or Conservative. I believe nearly every Senator emphasized the need for our society to curtail the dramatic rise in illegitimacy—or else face the tragic consequences.

Given our near universal expression of concern and the overwhelming urgency of the situation, the logical question became: What steps do we in Congress take to combat this vexing problem?

A number of proposals were presented for the Senate to consider. There was the family cap: Essentially denying additional benefits to mothers already on welfare for any additional children they have. There was the issue of denying any assistance at all to unwed teen mothers. And there was the illegitimacy ratio bonus which would provide additional financial assistance to States which successfully lowered their out-of-wedlock birth rate.

My general philosophy when it comes to an issue such as welfare reform is to give the States maximum flexibility in designing and operating their own programs. I think this is especially important when dealing with the matter of illegitimacy. While a great deal of attention has been paid to this issue lately, at present, there is no concrete evidence that any specific program or approach has proven to be consistently effective in stemming the tide of illegitimacy.

Mr. President, the States have shown they are best suited to serve as laboratories where experimentation can take place and truly innovative solutions will be found. However, if this is to