term limits would make it possible not only for more people to serve but for groups of people that have previously been unrepresented to have the opportunity for running in elections where there are open seats. Those open seat elections are the kinds of elections that can provide opportunity for newcomers to the process—the minorities, the women who would seek to be candidates.

Incumbency is such an advantage that that tilted playing field, added to the disadvantage of people who do not have a heritage of running for public office, makes their access to public office almost impossible. Term limits would help remedy that problem. We need to return to the concept of a citizen legislature. We need a new respect for ideas that come from the people, not from the power. When we allow the voice of the people to be heard, we will really again begin to see a restoration of the public confidence in American Government.

Now, the problem of term limits and the enactment of term limits is a significant one, and it is compounded by the events of recent days. Last year, the executive branch, the Clinton administration, sent its lawyers from the Justice Department into court to argue in the Thornton case against the right of States to impose term limits on Members of Congress. So the executive branch has clearly stated—at least the Clinton administration has—that it is against the right of the people as expressed in 23 of the States already that tried to impose term limits on their States and on their State's representatives to the Congress. The Clinton administration has said that door is slammed shut. The executive branch opposes that, went to court, and argued in the Supreme Court against it.

The people know that there are three branches of Government, and they looked to the judicial branch, they looked to the Supreme Court until last spring when the Supreme Court again slammed the door of self-government in their faces, saying you do not have a right in your State to say how long any individual would be eligible for service in the U.S. Congress. It is not up to you. We know better than you here in Washington. We will slam that door shut.

Having exhausted the potential of the executive branch and having experienced the disappointment of a ruling in the judicial branch, the people of America, seeking a branch of Government confident in the voice of the people, confident in wanting to recognize the inputs of people, wanting to swing wide the door of self-government rather than to hold it shut, the people of America are looking now to the Congress, the House of Representatives and the Senate.

Earlier in the year, we scheduled that on this day and the day preceding—yesterday—we would devote these 2 days to a debate of term limits and a vote on term limits. It would be the first time in history that we would have done so, and we would have been able to vote on an amendment that passed out of the Judiciary Committee.

That amendment was passed out not only with a majority but with a bipartisan majority and sent to the floor of this Senate for consideration, and, well, we are simply not debating that. As a response to our change in plans, I simply do not want us to avoid confronting this issue that the American people expect us to confront.

Will we win a vote? Since the Thornton case, where the State of Arkansas's laws were struck down by the Supreme Court, it means that we will have to have 67 votes in order to win enough support for a constitutional amendment in this Chamber and two-thirds, of course, in the House of Representatives. Frankly, that is unlikely. But that does not mean we should not begin. And the American people deserve a vote on this issue because we promised them we would give them a vote on this issue and because they deserve a vote on this issue to identify who the supporters are and who the supporters are not.

Seventy-four percent of the people of this country registered their approval for term limits; 23 States have actually tried to enact them on a State-by-State basis in spite of the fact that the Supreme Court has said it cannot be done, and two additional States will be voting on term limits in the South in the next couple weeks.

I think it is time for us Members of the Senate to respond to our own commitment to have a vote on term limits, and that is why I have offered an amendment to this measure which is now being considered on our relationship to our neighbor to the south, to Cuba, and saying we need a sense of the Senate providing a marker for every Member of this body to cast a ballot either in favor of term limits or against term limits. I look forward to a vote on that amendment. I look forward to a vote on that amendment in the near future, a vote that will not be binding, no, because it is just a sense of the Senate—not binding, but it will be revealing, a vote that will finally allow the American people to know where Senators stand on this very important issue.

I believe term limits provides an opportunity for us to justifiably regain the confidence of the American people because a vote on term limits is something we promised the American people. It is something we should deliver, not just because we promised it but because the people of America want it. It is a part of the agenda of the American people and as such it must be a part of the agenda of the Senate.

Mr. President, I thank the Chair for this opportunity, and I yield the floor.

Mr. President, I observe the absence of a quorum.

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

The legislative clerk proceeded to call the roll.

Mr. HARKIN. Mr. President, I ask that further proceedings under the quorum call be dispensed with.

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

FRAUD IN THE MEDICARE SYSTEM

Mr. HARKIN. Mr. President, I could not believe my eyes this morning when I opened up the front page of the newspaper. And here is the headline, Mr. President: ''Gingrich places low priority on Medicare crooks, defends cutting anti-fraud defenses.''

Well, what is this all about, Mr. President? Well, what it is about is the House bill, the House bill on Medicare reform, which I think ought to be titled, ''The Scam Artist Protection Act.'' But, Mr. President, do not take my word for it. Here is a letter dated September 29 from the inspector general's office of the Department of Health and Human Services.

It says:

However, if enacted, certain major provisions of H.R. 2389—

The House bill.

would cripple the efforts of law enforcement agencies to control health care fraud and abuse in the Medicare program and to bring wrongdoers to justice.

''Would cripple their efforts.'' And so the Speaker yesterday says, ''It is all right. No big deal.'' He said that it is more important to lock up murderers and rapists than dishonest doctors. Well, it is important to lock up murderers and rapists. You bet it is. But what does that have to do with Medicare fraud? Talk about using a logic that just about takes all right there.

But even more astounding is this quote attributed to the Speaker. When he was pressed on it, he said that they might be willing to negotiate on it. He said—this is a quote attributed to the Speaker—''We can be talked out of it if there is enough public pressure.''

I will repeat that:

We can be talked out of it if there is enough public pressure.

Talked out of what? Talked out of easing the antifraud measures that we now have in the law?

I think in that statement is a tacit acknowledgment by the Speaker that they are, indeed, opening the doors to more fraud and abuse in Medicare. But he said if there is enough public pressure, we can change it.

If we can slip it through in the dark of night, if we can do it behind closed doors, if we can ram it through in a hurry and the public does not know about it, we will do it. But if the public finds out about it and they put pressure on us, well then, we will change it.

Mr. President, I am here to start putting pressure on us. The public ought to put pressure on us, because what has been happening in Medicare is billions of dollars in proportion. The ripoffs, the fraud, the waste and abuse is ongoing and getting worse instead of better,

and the few minimal laws that we have that permit the inspector general's office to go after the crooks in Medicare are now being weakened in the House bill and the inspector general said so. She said it would cripple the efforts of law enforcement agencies to control health care fraud and abuse.

Mr. President, I ask unanimous consent to have printed in the RECORD a letter dated September 29 from the inspector general's office outlining the provisions in the House bill that would, indeed, cripple their efforts.

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

DEPARTMENT OF HEALTH
& HUMAN SERVICES,
Washington, DC, September 29, 1995.

Re H.R. 2389: ''Safeguarding Medicare Integrity Act of 1995.''

Hon. TOM HARKIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR HARKIN: You requested our views regarding the newly introduced H.R. 2389, which we understand may be considered in the deliberations concerning the ''Medicare Preservation Act.'' We strongly support the expressed objective of H.R. 2389 of reducing the fraud and abuse which plagues the Medicare program. The proposed legislation contains some meritorious provisions. However, if enacted, certain major provisions of H.R. 2389 would cripple the efforts of law enforcement agencies to control health care fraud and abuse in the Medicare program and to bring wrongdoers to justice.

The General Accounting Office estimates the loss to Medicare from fraud and abuse at 10 percent of total Medicare expenditures, or about $18 billion. We recommend two steps to decrease this problem: strengthen the relevant legal authorities, and increase the funding for law enforcement efforts. Some worthy concepts have been included in H.R. 2389, and we support them. For example, we support:

A voluntary disclosure program, which allows corporations to blow the whistle on themselves if upper management finds wrongdoing has occurred, with carefully defined relief for the corporation from qui tam suits under the False Claims Act (but not waiver by the Secretary of sanctions);

Minimum periods of exclusion (mostly parallel with periods of exclusion currently in regulations) with respect to existing exclusion authorities from Medicare and Medicaid; and

Increases in the maximum penalty amounts which may be imposed under the civil monetary penalty laws regarding health care fraud.

As stated above, however, H.R. 2389 contains several provisions which would seriously erode our ability to control Medicare fraud and abuse, including most notably: making the civil monetary penalty and anti-kickback laws considerably more lenient, the unprecedented creation of an advisory opinion mechanism on intent-based statutes, and a trust fund concept which would fund only private contractors (not law enforcement). Our specific comments on these matters follow.

1. MAKING CIVIL MONETARY PENALTIES FOR FRAUDULENT CLAIMS MORE LENIENT BY RELIEVING PROVIDERS OF THE DUTY TO USE REASONABLE DILIGENCE TO ENSURE THEIR CLAIMS ARE TRUE AND ACCURATE

Background: The existing civil monetary penalty (CMP) provisions regarding false claims were enacted by Congress in the 1980's as an administrative remedy, with cases tried by administrative law judges with appeals to Federal court. In choosing the ''knows or should know'' standard for the mental element of the offense, Congress chose a standard which is well defined in the Restatement of Torts, Second, Section 12. The term ''should know'' places a duty on health care providers to use ''reasonable diligence'' to ensure that claims submitted to Medicare are true and accurate. The reason this standard was chosen was that the Medicare system is heavily reliant on the honesty and good faith of providers in submitting their claims. The overwhelming majority of claims are never audited or investigated.

Note that the ''should know'' standard does not impose liability for honest mistakes. If the provider exercises reasonable diligence and still makes a mistake, the provider is not liable. No administrative complaint or decision issued by the Department of Health and Human Services (HHS) has found an honest mistake to be the basis for CMP sanction.

H.R. 2389 Proposal: Section 201 would redefine the term ''should know'' in a manner which does away with the duty on providers to exercise reasonable diligence to submit true and accurate claims. Under this definition, providers would only be liable if they act with ''deliberate ignorance'' of false claims or if they act with ''reckless disregard'' of false claims. In an era when there is great concern about fraud and abuse of the Medicare program, it would not be appropriate to relieve providers of the duty to use ''reasonable diligence'' to ensure that their claims are true and accurate.

In addition, the bill treats the CMP authority currently provided to the Secretary in an inconsistent manner. On one hand, it proposes an increase in the amounts of most CMPs which may be imposed under the Social Security Act. Yet, it would significantly curtail enforcement of these sanction authorities by raising the level of culpability which must be proven by the Government in order to impose CMPs. It would be far preferable not to make any changes to the CMP statutes at this time.

2. MAKING THE ANTI-KICKBACK STATUTE MORE LENIENT BY REQUIRING THE GOVERNMENT TO PROVE THAT ''THE SIGNIFICANT'' INTENT OF THE DEFENDANT WAS UNLAWFUL

Background: The anti-kickback statute makes it a criminal offense knowingly and willfully (intentionally) to offer or receive anything of value in exchange for the referral of Medicare or Medicaid business. The statute is designed to ensure that medical decisions are not influenced by financial rewards from third parties. Kickbacks result in more Medicare services being ordered than otherwise, and law enforcement experts agree that unlawful kickbacks are very common and constitute a serious problem in the Medicare and Medicaid programs.

The two biggest health care fraud cases in history were largely based on unlawful kickbacks. In 1994, National Medical Enterprises, a chain of psychiatric hospitals, paid $379 million for giving kickbacks for patient referrals, and other improprieties. In 1995, Caremark, Inc. paid $161 million for giving kickbacks to physicians who ordered very expensive Caremark home infusion products.

Most kickbacks have sophisticated disguises, like consultation arrangements, returns on investments, etc. These disguises are hard for the Government to penetrate. Proving a kickback case is difficult. There is no record of trivial cases being prosecuted under this statute.

H.R. 2389 Proposal: Section 201 would require the Government to prove that ''the significant purpose'' of a payment was to induce referrals of business. The phrase ''the significant'' implies there can only be one ''significant'' purpose of a payment. If so, at least 51 percent of the motivation of a payment must be shown to be unlawful. Although this proposal may have a superficial appeal, if enacted it would threaten the Government's ability to prosecute all but the most blatant kickback arrangements.

The courts interpreting the anti-kickback statute agree that the statute applies to the payment of remuneration ''if one purpose of the payment was to induce referrals.'' United States v. Greber, 760 F.2d 68, 69 (3d Cir. 1985) (emphasis added). If payments were intended to induce a physician to refer patients, the statute has been violated, even if the payments were also intended (in part) to compensate for legitimate services. Id. at 72. See also: United States v. Kats, 871 F.2d 105, 108 (1989); United States v. Bay State Ambulance, 874 F.2d 20, 29–30 (1st. Cir. 1989). The proposed amendment would overturn these court decisions.

However, the nature of kickbacks and the health care industry requires the interpretation adopted by Greber and its progeny. to prove that a defendant had the improper intent necessary to violate the anti-kickback statute, the prosecution must establish the defendant's state of mind, or intent. As with any intent-based statute, the prosecution cannot get directly inside the defendant's head. The prosecution must rely on circumstantial evidence to prove improper intent. Circumstantial evidence consists of documents relevant to the transaction, testimony about what the defendant said to business associates or potential customers, etc. These types of evidence are rarely clear about the purposes and motivations of the defendant. The difficulties of establishing intent are multiplied by the complexity, size, and dynamism of the health care industry, as well as the sophistication of most kickback scheme participants. Documents are ''pre-sanitized'' by expert attorneys. Most defendants are careful what they say. In most kickback prosecutions, the Government has a difficult task to prove beyond a reasonable doubt that even one purpose of a payment is to induce referrals.

If the Government had to prove that inducement of referrals was ''the significant'' reason for the payment, many common kickback schemes would be allowed to proliferate. In today's health care industry, very few kickback arrangements involve the bald payment of money for patients. Most kickbacks have sophisticated disguises. Providers can usually argue that any suspect payment serves one or more ''legitimate purposes.'' For example, payments made to induce referrals often also compensate a physician who is providing health care items or services. Some payments to referral sources may be disguised as returns on investments. Similarly, many lease arrangements that indisputably involve the bona fide use of space incorporate some inducement to refer in the lease rates. In all of these examples, and countless others, it is impossible to qualify what portions of payments are made for nefarious versus legitimate purposes.

Where the defendant could argue that there was some legitimate purpose for the payment, the prosecution would have to prove beyond a reasonable doubt, through circumstantial evidence, that the defendant actually had another motive that was ''the significant'' reason. For the vast majority of the present-day kickback schemes, the proposed amendment would place an insurmountable burden of proof on the Government.

3. CREATION OF AN EASILY ABUSED EXCEPTION FROM THE ANTI-KICKBACK STATUTE FOR CERTAIN MANAGED CARE ARRANGEMENTS

Background: There is great variety and innovation occurring in the managed care industry. Some managed care organizations, such as most health maintenance organizations (HMOs) doing business with Medicare, consist of providers who assume financial risk for the quantity of medical services needed by the population they serve. In this context, the incentive to offer kickbacks for referrals of patients for additional services is minimized, since the providers are at risk for the additional costs of those services. If anything, the incentives are to reduce services. Many other managed care organizations exist in the fee for service system, where the traditional incentives to order more services and pay kickbacks for referrals remain. In the fee for service system, the payer (like Medicare and private insurance plans) is at financial risk of additional services, not the managed care organization. While broad protection from the anti-kickback statute may be appropriate for capitated, at-risk entities like the HMO described above, such protection for managed care organizations in the fee for service system would invite serious abuse.

H.R. 2389 Proposal: Section 202 would establish broad new exceptions under the anti-kickback statute for ''any capitation, risk-sharing, or disease management program.'' The lack of definition of these terms would result in a huge opportunity for abusive arrangements to fit within this proposed exception. What is ''risk-sharing?'' Is not any insurance a form of risk sharing? What is a ''disease management program?'' Does not that term include most of health care?

Nefarious organizations could easily escape the kickback statute by simply rearranging their agreements to fit within the exception. For example, if a facility wanted to pay doctors for referrals, the facility could escape kickback liability by establishing some device whereby the doctors share in the business risk of profit and loss of the business (i.e., they would share some risk, at least theoretically). Then, the organization could pay blatant kickbacks for every referral with impunity.

If the concern is that the kickback statute is hurting innovation, as observed above, there is now an explosion of innovation in the health care industry, especially in managed care. No one in Government is suggesting that HMOs or preferred provider arrangements, etc., formed in good faith, violate the kickback statute. There has never been any action against any such arrangement under the statute.

4. INAPPROPRIATE EXPANSION OF THE EXCEPTION TO THE ANTI-KICKBACK STATUTE FOR DISCOUNTS

Background. Medicare/Medicaid discounts are beneficial and to be encouraged with one critical condition: that Medicare and/or Medicaid receive and participate fully in the discount. For example, if the Medicare reasonable charge for a Part B item or service is $100, Medicare would pay $80 of the bill and the copayment would be $20. If a 20 percent discount is applied to this bill, the charge should be $80, and Medicare would pay $64 (80 percent of the $80) and the copayment would be $16. If the discount is not shared with Medicare (which would be improper), the bill to Medicare would falsely show a $100 charge. Medicare would pay $80, but the copayment would be $0. This discount has not been shared with Medicare.

Many discounting programs are designed expressly to transfer the benefit of discounts away from Medicare. The scheme is to give little or no discount on an item or service separately billed to Medicare, and give large discounts on items not separately billed to Medicare. This scheme results in Medicare paying a higher percentage for the separately billed item or service than it should.

For example, a lab offers a deep discount on lab work for which Medicare pays a predetermined fee (such as lab tests paid by Medicare to the facility as part of a bundled payment), if the facility refers to the lab its separately billed Medicare lab work, for which no discount is given. The lab calls this a ''combination'' discount, yet is a discount on some items and not on others. Another example is where ancillary or noncovered items are furnished free, if a provider pays full price for a separately billed item, such as where the purchase of incontinence supplies is accompanied by a ''free'' adult diaper. Medicare has not shared in these combination discounts.

H.R. 2389 Proposal. Section 202 would permit discounts on one item in a combination to be treated as discounts on another item in the combination. This sounds innocent, but it is not. Medicare would be a big loser. Discounting should be permissible for a supplier to offer a discount on a combination of items or services, so long as every item or service separately billed to Medicare or Medicaid receives no less of a discount than is applied to other items in the combination. If the items or services separately billed to Medicare or Medicaid receive less of a discount than other items in the combination, Medicare and Medicaid are not receiving their fair share of the discounts.

5. UNPRECEDENTED MECHANISM FOR ADVISORY OPINIONS ON INTENT-BASED STATUTES, INCLUDING THE ANTI-KICKBACK STATUTE

Background: The Government already offers more advice on the anti-kickback statute than is provided regarding any other criminal provision in the United States Code.

Industry groups have been seeking advisory opinions under the anti-kickback statute for many years, with vigorous opposition by the Department of Justice (DOJ), and the HHS Office of Inspector General (OIG) under the last three administrations, as well as the National Association of Attorneys General. In 1987, Congress rejected calls to require advisory opinions under this statute. As a compromise, Congress required HHS, in consultation with the Attorney General, to issue ''safe harbor'' regulations describing conduct which would not be subject to criminal prosecution or exclusion. See Section 14 of Public Law 100–93.

To date, the OIG has issued 13 final anti-kickback ''safe harbor'' rules and solicited comment on 8 additional proposed safe harbor rules, for a total of 21 final and proposed safe harbors. Over 50 pages of explanatory material has been published in the Federal Register regarding these proposed and final rules. In addition, the OIG has issued six general ''fraud alerts'' describing activity which is suspect under the anti-kickback statute. Thus, the Government gives providers guidance on what is clearly permissible (safe harbors) under the anti-kickback statute and what we consider illegal (fraud alerts).

H.R. 2389 Proposal. HHS would be required to issue advisory opinions to the public on the Medicare/Medicaid anti-kickback statute (section 1128B(b) of the Social Security Act, as well as all other criminal authorities, civil monetary penalty and exclusion authorities pertaining to Medicare and Medicaid. HHS would be required to respond to requests for advisory opinions within 30 days.

HHS would be authorized to charge requestors a user fee, but there is not provision for this fee to be credited to HHS. Fees would therefore be deposited in the Treasury as miscellaneous receipts.

Major problems with anti-kickback advisory opinions include:

Advisory opinions on intent-based statutes (such as the anti-kickback statute) are impractical if not impossible. Because of the inherently subjective, factual nature of intent, it would be impossible for HHS to determine intent based solely upon a written submission from the requestor. Indeed, it does not make sense for a requestor to ask the Government to determine the requestor's own intent. Obviously, the requester already knows what their intent is.

None of the 11 existing advisory opinion processes in the Federal Government provide advisory opinions regarding the issue of the requestor's intent. An advisory opinion process for an intent-based statute is without precedent in U.S. law.

The advisory process in H.R. 2389 would severely hamper the Government's ability to prosecute health care fraud. Even with appropriate written caveats, defense counsel will hold up a stack of advisory opinions before the jury and claim that the dependent read them and honestly believed (however irrationally) that he or she was not violating the law. The prosecution would have to disprove this defense beyond a reasonable doubt. This will seriously affect the likelihood of conviction of those offering kickbacks.

Advisory opinions would likely require enormous resources and many full time equivalents (FTE) at HHS. The user fees in the bill would go to the Treasury, not to HHS. Even if they did go to HHS, appropriations committees tend to view them as offsets to appropriations. There are no estimates of number of likely requests, number of FTE required, etc. Also, HHS is permanently downsizing, even as it faces massive structural and program changes. The possible result of the bill is a diversion of hundreds of anti-fraud workers to handle the advisory opinions.

For the above reasons, DOJ, HHS/OIG and the National Association of Attorneys General strongly oppose advisory opinions under the anti-kickback statute, and all other intent-based statutes.

6. CREATION OF TRUST FUND MECHANISM WHICH DOES NOT BENEFIT LAW ENFORCEMENT

Background: In our view, the most significant step Congress could undertake to reduce fraud and abuse would be to increase the resources devoted to investigating false claims, kickbacks and other serious misconduct. It is important to recognize that the law enforcement effort to control Medicare fraud is surprisingly small and diminishing. There is evidence of increasing Medicare fraud and abuse, and Medicare expenditures continue to grow substantially. Yet, the staff of the HHS/OIG, the agency with primary enforcement authority over Medicare, has declined from 1,411 employees in 1991 to just over 900 today. (Note: 259 of the 1,411 positions were transferred to the Social Security Administration). Approximately half of these FTE are devoted to Medicare investigations, audits and program evaluations. As a result of downsizing, HHS/OIG has had to close 17 OIG investigative offices and we now lack an investigative presence in 24 States. The OIG has only about 140 investigators for all Medicare cases nationwide. By way of contrast, the State of New York gainfully employs about 300 persons to control Medicaid fraud in that State alone.

Ironically, the investigative activity of OIG pays for itself many times over. Over the last 5 years, every dollars devoted to OIG investigations of health care fraud and abuse has yielded an average return of over $7 to

the Federal Treasury, Medicare trust funds, and State Medicaid programs. In addition, an increase in enforcement also generates increased deterrence, due to the increased chance of fraud being caught. For these reasons, many fraud control bills contain a proposal to recycle monies recovered from wrongdoers into increased law enforcement. The amount an agency gets should not be related to how much it generates, so that it could not be viewed as a ''bounty.'' The Attorney General and the Secretary of HHS would decide on disbursements from the fund. We believe such proposals would strengthen our ability to protect Medicare from wrongdoers and at no cost to the taxpayers. The parties who actually perpetrate fraud would ''foot the bill.''

H.R. 2389 Proposal: Section 106 would create a funding mechanism using fines and penalties recovered by law enforcement agencies from serious wrongdoers. But none of the money would be used to help bring others to justice. Instead, all the funds would be used only by private contractors for ''soft'' claims review, such as, medical and utilization review, audits of cost reports, and provider education.

The above functions are indeed necessary, and they are now being conducted primarily by the Medicare carriers and intermediaries. Since the bill would prohibit carriers and intermediaries from performing these functions in the future, there appears to be no increase in these functions, but only a different funding mechanism.

These ''soft'' review and education functions are no substitute for investigation and prosecution of those who intend to defraud Medicare. The funding mechanism in H.R. 2389 will not result in any more Medicare convictions and sanctions.

* * * * *

In summary, H.R. 2389 would:

Relieve providers of the legal duty to use reasonable diligence to ensure that the claims they submit are true and accurate; this is the effect of increasing the Government's burden of proof in civil monetary penalty cases;

Substantially increase the Government's burden of proof in anti-kickback cases;

Create new exemptions to the anti-kickback statute which could readily be exploited by those who wish to pay rewards to physicians for referrals of patients;

Create an advisory opinion process on an intent-based criminal statute, a process without precedent in current law; since the fees for advisory opinions would not be available to HHS, our scarce law enforcement resources would be diverted into hiring advisory opinion writers; and

Create a fund to use monies recovered from wrongdoers by law enforcement agencies, but the fund would not be available to assist the law enforcement efforts; all the monies would be used by private contractors only for ''soft'' payment review and education functions.

In our view, enactment of the bill with these provisions would cripple our ability to reduce fraud and abuse in the Medicare program and to bring wrongdoers to justice.

Thank you for your attention to our concerns.

Sincerely,

JUNE GIBBS BROWN,
Inspector General.

Mr. HARKIN. Mr. President, over the last several years when I was Chair of the Subcommittee on Appropriations that funded HCFA and Medicare, we held a series of hearings, and I requested GAO to do a number of studies on waste, fraud, and abuse in the Medicare system.

What we have uncovered is mind boggling: HCFA paying for 240 yards of tape per person per day—Medicare paying that. Medicare paying over some $200 for a blood glucose tester that you can buy down at Kmart for $49.99. Medicare is paying thousands of dollars for devices that only cost $100. Foam cushions that cost about $50 that Medicare is paying $880 each for.

The list goes on and on and on, and we know it is happening out there. We know how medical suppliers are scamming the system, double billing going on. We have documentation. GAO has documented this in the past.

Last year, I asked the GAO to do a study just on medical supplies—just on medical supplies. They started their study in about May or June 1994, and the study was completed in August of this year. They issued their report.

GAO went to Medicare and said, ''We want to take a representative sample of bills that you have paid for medical supplies.''

You have to understand, Mr. President, that when Medicare pays a bill for medical supplies, they do not even know what they are paying for, because all of the supplies are put under one code, 270. So Medicare pays a bill, code 270, medical supplies, $20,000. They have no idea what is in there, because they do not require it to be itemized. Imagine that.

So GAO went to Medicare, got a representative sample, went behind the code to the suppliers, to the nursing homes, to the hospitals and said, ''OK, we want the itemized account.''

Guess what they found? Now this will knock your socks off. They found that that 89 percent—89 percent—of the claims should have been totally or partially denied; 61 percent of the money spent should never have been paid out—61 percent.

Then you ask the question: How much did Medicare pay last year for medical supplies? The answer, $6.8 billion. If you can extrapolate from this sample and say that 61 percent of that money should not have been paid out, you are talking about $4 billion—$4 billion. Maybe we cannot get it all, but could we get $3 billion? I bet we could. How about even $2 billion? We ought to be able to save that. Multiply that over 7 years, which is what we are talking about here, and you can see that is a pretty good chunk of money. And that is just medical supplies, that is just tape and bandages, things like that. We are not even talking about durable medical equipment. We are not talking about the double billing that goes on. That is just one, just medical supplies. It does not include oxygen, and it does not include ambulances, orthotic devices. It does not include durable medical equipment. It is just the bandages, $6.8 billion, and 61 percent should not have been paid.

A lot of this is fraud. A lot of it comes about because scam artists know that they can game the system.

Why would they do that? Are there not enough penalties? Would they not be afraid of getting caught? The fact is that in 24 States, the inspector general's office does not even have a presence. They are not even in 24 States.

Right now, Medicare reviews about 5 percent of the claims. So if you want to scam the system, you want to put in fraudulent claims, your chances are 5 percent that you are even going to be reviewed, and out of the reviews, they may or may not do something based upon that. If you are in one of the 24 States where there is not an inspector general operating, the sky is the limit.

That is why fraud is so rampant in the Medicare system today. What the Speaker says is that is fine, that is a low priority. We do have some antifraud legislation on the books, as inadequate as it is right now. The House bill weakens it even further, and the Speaker says that is fine, but he says if the public catches on to it and they put on enough pressure, maybe we will change it.

I hope the public does put on the pressure, because we do have to change it. The House will say, well, they put more money into the IG's office, they put $100 million into the inspector general's office. So you give more money into the inspector general, then you put the handcuffs on it by making it so they cannot prove fraud. That is exactly what they have done.

Mr. President, we have to not put waste, fraud, and abuse in the back seat, we ought to put it in the front seat. We have to attack that. I do not think it is right, I do not think it is fair for this Congress, for the Speaker of the House to say, ''OK, we're going to double your premiums for the elderly, we're going to double your deductibles, but we're going to let the crooks go, we're not going to crack down on them.''

Oh, yeah, from what I read, they are going to let the doctors off, too. They are not going to have to belly up to the bar.

One other item before I finish on fraud. I have another report from the inspector general's office issued just this month in October. Here is what they found: 13 percent of nursing homes have been offered inducements in exchange for allowing suppliers to provide products to patients in their facilities; 17 percent of nursing homes with Medicare-reimbursed products have been offered these inducements. The inducements range from free trial products to cameras, blenders, and diamond rings. Fraud, and yet the Speaker says it is too tough the way it is, we have to make it even less tough. We have to ease up. One other thing, Mr. President, that has disturbed me, came to my attention in the last 24 hours. It has to do with the block granting of Medicaid to the States. The Finance Committee—the Senate Finance Committee, of which I am not a member, but I follow closely what it has done—adopted an amendment offered by a Republican, Senator CHAFEE, that says, OK, if you block grant it to the States,

we still want to have some guarantees. What do we want to guarantee? We want to guarantee that pregnant women who fall under the poverty line get medical help under Medicaid; we want to guarantee that all children under the age of 12 get Medicaid medical help; we want to guarantee that all disabled continue to get medical help, as they are today. Plus, they want to guarantee that we continue the provisions in law that provide that a spouse does not have to spend all of his or her money down to nothing and give up their income before Medicaid will start paying for their spouse's long-term care in a nursing home. It is called the spousal impoverishment provision. It says you cannot impoverish a spouse simply because his or her husband or wife is in a nursing home. What does it say? It says basically that, minimum, a spouse can keep, I think, a little over $14,000 in assets and can make a little over $1,200 a month.

Now, in my view, if a couple saved up all of their lives and they have $50,000 in the bank, and one spouse gets Alzheimer's and cannot be cared for and has to go to a nursing home and the other spouse has to spend that $50,000 until they get to $14,000 and then Medicaid will kick in and start paying, that $14,000 is not a lot of money to have in the bank for a rainy day when you are getting old.

So these provisions were left in the Senate-passed Finance Committee bill. It passed, as I understand, by a vote of 17 to 3. I picked up this publication, the National Journal of Congress, dated Friday, October 13, this morning. Here is what it says:

''Thursday, Senator Jay Rockefeller said GOP leaders were trying to undo a compromise that preserved the disabled's right to Medicaid,'' the Associated Press reported. Rockefeller and Senator John Chafee won a 17 to 3 Finance panel vote to keep the Medicaid entitlement for poor children and pregnant women, as well as the disabled. But GOP Governors have protested overly prescriptive and onerous provisions in the bill. Roth said Thursday evening, ''It is a matter that is still open.''

The AP said, ''Sheila Burke, Dole's Chief of Staff, told reporters, ''The disabled will not be an entitlement.'' Chafee and six other moderates wrote Dole, asking him to ''stand fast in your support for at least a minimal level of support provided to our Nation's most vulnerable populations.''

Mr. President, I hope this is not true. I hope this is not true that now the Republicans on the Senate Finance Committee are going to throw out the disabled in our country, that they are going to say, OK, all right, we will keep pregnant women in and children up to age 12, but the disabled, you are out the door, you are not entitled to be covered, we are not going to guarantee you coverage—the most vulnerable of our population, those who are disabled.

Mr. President, here is another thing I cannot believe. We got a letter the other day, sent to Senator DOLE on October 6, signed by 24 Republican Governors, saying that they wanted the block granting of the Medicaid bill. They supported that, but they said there are some things they do not like.

I will read this from the letter of 24 Republican Governors:

The bill includes a number of overly prescriptive and onerous provisions that will mitigate against the States' ability to implement reforms.

What are those onerous provisions? They are that the Senate Finance Committee, by a vote of 17 to 3, on a bipartisan basis, said you have to cover pregnant women who fall under the poverty line with medical care, you have to provide for children to age 12 who are in poverty, you have to cover the disabled, and you have to have provide against espousal impoverishment. The Republican Governors said that is onerous.

I have to ask this, Mr. President. These Governors have said, ''Turn Medicaid over to the States. We will take care of it better than the Federal Government can take care of it.'' What makes you think that these Republican Governors do not care for the disabled, poor, and the women as much as Congress? Well, they cannot have it both ways. If these Republican Governors say they do not want these provisions in there that mandate that they continue to cover the disabled, then are they then saying they want to have the freedom to throw the disabled out? If the Republican Governors are saying they do not want the provision in there that says we will ensure against spousal impoverishment, are they then saying that they, the Republican Governors, are willing to throw that out?

Well, if they are not saying that and if the Republican Governors are saying, oh, no, no, no, no, we will make sure we keep provisions against spousal impoverishment, we will cover the disabled, pregnant women, and the children, why do they care if it is in there? You cannot have it both ways.

These Republican Governors have shown their hand. If we turn Medicaid over to the States without these provisions, they are going to go cut the disabled, pregnant women, children, and cut back on the provisions against spousal impoverishment. It is right here in this letter, signed by 24 Republican Governors.

So I think it is becoming clearer as the days roll by, Mr. President, that on the Medicare side, the Speaker and the GOP are turning a blind eye to the concerns of seniors. But they are giving a wink and a nod to the Medicare crooks.

When it comes to Medicare, Mr. GINGRICH and his allies are willing to tell the seniors they have to pay more, double their premiums, double their deductibles. They want to take $270 billion out of Medicare and use it for a tax cut for some of the most privileged in our society. Yet, they are not willing to crack down on those that are scamming the system, bilking the system of billions of dollars a year. Oh, no, we do not want to do that. Well, I think the public ought to know about it. I think the public is becoming aware of it, Mr. President. I think the public is now beginning to wake up to the fact that we do not need to cut $270 billion out of Medicare.

The head of Medicare said that maybe $90 billion would get us through the next 10 years; $90 billion would provide for the security of the Medicare system through 2006. Think about that. GAO said that 10 percent of Medicare goes for waste, fraud, and abuse. That is about $18 billion a year. Well, $18 billion a year for 7 years is $126 billion, which, over the next 7 years, will go for waste, fraud, and abuse. If we cannot get all the $126 billion, can we get $90 billion of it? We might be able to squeeze enough out of waste, fraud, and abuse to ensure the viability of Medicare at least for the next 10 years. But, no, Republicans say, though, they want $270 billion out of Medicare. Sock it to the seniors, make them pay double for premiums, double for deductibles, and then they will take that money and give a $245 billion tax cut for the most privileged in our society. Not fair, not right. I think the people and the public are beginning to understand that.

Now, on the Medicaid side, $187 billion of cuts in Medicaid and then block granted to the States. I think the Senate Finance Committee cast a conscientious vote last week when they said, ''Look, we will block grant to the States but we want to make sure that we cover all pregnant women who are eligible for Medicaid, all children who are eligible for Medicaid, and the disabled.''

Now, I understand that they are willing to throw out the disabled. That is unconscionable—unconscionable that some would be willing to throw out the disabled to say that, ''No, we are not going to cover you. You just go plead your case in the States. Go to the Governors.'' Well, the Governors told us what they wanted to do in their letter. They found those provisions onerous.

Mr. President, it is becoming clearer, in Medicare it is the seniors who get hit. In Medicaid, it is the poor.

Here it is right here in contrast, Wednesday, October 11, the Washington Post. Here it is. This is it, right here. Two stories, side by side, that tell it all.

On the right hand side, it says: ''Leaders Pledge Full Tax Cut By Senate GOP.'' Full $245 billion tax cut. ''Leaders Pledge Full Tax Cut By Senate GOP.'' The story right next to it: ''Working Poor May Pay the High Price for Reform.''

There you go. It cannot be said any better than that.

In Medicare, the disabled, if you are disabled, forget it. You will not have any protections. We throw you out.

Well, I hope that is a wrong report. I hope everything I have said here today will prove not to be so. I hope that the Senate Finance Committee will not jettison the most vulnerable in our society, the disabled. If they do, if that is what comes here to the Senate floor,

that we have a Medicaid bill—I do not care how it is wrapped up. If it is wrapped up in reconciliation, as you know, we cannot filibuster that under the rules. But if they jettison the disabled, I hope and trust that President Clinton will veto that the second it lands on his desk and say to this country that we are not going to make the most vulnerable in our society, those who have disabilities, pay for the $245 billion tax cut for the most privileged in our society.

I yield the floor.

Mr. President, I ask unanimous consent that the article be printed in the RECORD.

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

[From the Washington Times]

GINGRICH PLACES LOW PRIORITY ON MEDICARE CROOKS

DEFENDS CUTTING ANTI-FRAUD DEFENSES

(By Nancy E. Roman)

House Speaker Newt Gingrich yesterday defended GOP moves to reduce penalties and enforcement efforts against Medicare fraud by saying it's more important to lock up murderers and rapists than dishonest doctors.

The Georgia Republican cited ''murderers out after three years'' and ''rapists who don't even get tried'' in response to a question at a seniors gathering to promote the GOP Medicare overhaul. ''For the moment, I'd rather lock up the murderers, the rapists and the drug dealers,'' he said. ''Once we start getting some vacant jail space, I'd be glad to look at it.''

The GOP bill in the House would weaken laws against kickbacks and self-referrals in the Medicare program. The Congressional Budget Office has estimated the seven-year cost of relaxing those laws to be $1.1 billion.

Gerald M. Stern, special counsel for health care fraud at the Justice Department, said one provision would overturn a common interpretation of Medicare anti-kickback case law and increase the burden of proof in criminal prosecutions.

Rep. Pete Stark, the California Democrat who drafted the anti-kickback and self-referral statutes, called Mr. Gingrich's comments ''arrogant and gratuitous.''

''To put O.J. Simpson, the Menendez brothers and Claus von Bulow in the same category as physicians who get kickbacks and who steal from the government is not the issue,'' Mr. Stark said. ''Republicans are in the position of having weakened protections that we put in [Medicare law] at the urging of the Reagan and Bush administration.''

Mr. Stark said Republicans weakened the provisions to shore up support from the American Medical Association, a wealthy lobby representing 300,000 doctors.

Rep. Tom Coburn, Oklahoma Republican and obstetrician who helped draft the new anti-kickback provisions, said the changes simply would put medical professionals on equal footing with other professionals subject to such laws.

Courts have interpreted the Medicare anti-kickback law to prohibit a payment if ''one purpose'' of it is to induce referrals of services paid for by Medicare.

The GOP bill would change that to ''the significant purpose,'' which Mr. Stern and others said is much harder to prove in court. Under this standard, he said, the government would not have won two big cases this year that led to fines of hundreds of millions of dollars.

Kern Smith, an assistant commerce secretary under Presidents Johnson and Kennedy, posed the question about lighter fraud rules to Mr. Gingrich at a forum sponsored by the Coalition to Save Medicare, a group backing the GOP reforms.

The 73-year-old Democrat said he's gone ''around the country selling your plan'' but found seniors vexed by the new fraud rules. He said they were hard to defend.

''I've been around Washington for a long time, and you are giving the Democrats something to clobber you with,'' Mr. Smith said.

Mr. Gingrich said Republicans are willing to negotiate on fraud and abuse provisions, leaving open the possibility of the bill being changed on the House floor.

''We can be talked out of it if there is enough public pressure,'' he said.

A senior House aide yesterday said the legal standard in the anti-kickback law was changed to make it consistent with other such laws ''without a lot of thought, and it is something that could be changed.''

Republicans spent much of the summer discussing Medicare changes with seniors, and many found that fraud topped constituents' complaints. Many seniors erroneously thought eliminating fraud and abuse could solve Medicare's money woes.

Republicans have created other ways to reduce fraud, such as: allowing seniors to keep a portion of money recovered from fraud cases they report; establishing a voluntary disclosure program for corporate managers who uncover wrongdoing in their companies; and increasing the maximum civil penalties for health care fraud.

The CBO estimates that these changes would save $2 billion over seven years.

Democrats support some of these changes but argue that relaxing kickback and self-referral laws would undermine the success achieved in reducing Medicare fraud.

After Democrats upbraided Republicans for going soft on fraud, the House Ways and Means Committee added $100 million to the budget of the Inspector General's Office to prosecute fraud and abuse. The CBO estimates that the additional money would produce $700 million more in Medicare fraud fines.

Rep. Sam M. Gibbons of Florida, ranking Democrat on the Ways and Means Committee, said it will be difficult to block the softer fraud rules without public outcry.

''The Republicans are all marching in lock step,'' Mr. Gibbons said. ''In my lifetime I've never seen anybody march in lock step like this.''

Mr. HARKIN. Mr. President, I ask unanimous consent that the letter be printed in the RECORD.

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

REPUBLICAN GOVERNORS ASSOCIATION,
Washington, DC, October 6, 1995.

HON. ROBERT DOLE,
Majority Leader, U.S. Senate, Capitol Building, Washington, DC.

DEAR SENATOR DOLE: Collectively we desire to express our gratitude for the working relationship with you and Republican governors. We share your commitment to balancing the budget and returning responsibilities to the states. Your leadership on these matters is acknowledged and admired. We are writing to you to convey our deep concern with provisions that were included in the Medicaid portion of the reconciliation bill approved by the Senate Finance Committee on September 30.

Since January of this year, Republican governors have worked in good faith with Republican leadership on concepts to bring meaningful, urgently needed reforms to the Medicaid program while achieving the Congressional budget targets. As governors representing the unique needs of our individual states, we have not been in total agreement on all aspects of the program. However, throughout this lengthy partnership, we have consistently argued that the fiscal and functional integrity of the program demand freedom from individual and provider entitlements and other mandates on states. The Senate Finance Committee bill ignores this principle.

The bill includes a number of overly prescriptive and onerous provisions that will militate against the states ability to implement reforms. Among these are individual entitlements, which create both a huge potential cost shift to states and unlimited potential for litigation; a set-aside for one class of providers; and mandated federal requirements on spousal asset protection.

Further, we are concerned that the bill reported out by the Senate Finance Committee will be amended on the Senate floor with additional mandates on states. While we support efforts to reduce the deficit and balance the federal budget we will not sit idly by while the costs associated with this program are shifted to the states.

We have kept our commitments to Republican leadership throughout a difficult process of negotiating reforms that states can implement, while protecting the interests of all of our citizens. We are fully prepared to provide health care for our most vulnerable populations, without prescriptions and mandates from the federal government. We are pleased with the flexibility provisions incorporated in the House measure and intend to work for inclusion of such provisions in the final bill.

We are hopeful that we can work with the Senate leadership on this most important issue. We urge you to remove mandates and other prescriptive provisions from the Senate bill.

It is our sincere hope that we can resolve these issues quickly. As those charged with the actual administration of these programs, we cannot support a combination of individual entitlements and mandate provisions that will subject us to unlimited ligation, and still meet the budget targets.

Sincerely,

Michael O. Leavitt, Bill Weld, Fife Symington, John G. Roland, Christine T. Whitman, John Engler, Marc Racicot, Gary E. Johnson, George V. Voinovich, Frank Keating, William J. Janklow, George Allen, Jim Edgar, Fob James, Jr., Pete Wilson, Phil Batt, Terry E. Branstad, Kirk Fordice, Stephen Merrill, Edward T. Schafer, Tommy G. Thompson, David M. Beasly, George Bush, Jim Geringler.

Mr. HARKIN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. HELMS. 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 BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, every day since February 1992, I have reported to the Senate the exact total of the Federal debt, down to the penny, as