the prosecution has now had him plead guilty.

The third person referred to was Webb Hubbell. We know that case. Webb Hubbell has pled guilty. It is a sad day. He is a good friend. But it was nothing that related to Whitewater Development Corp., absolutely nothing that related to Madison Guaranty, nothing whatsoever. Web Hubbell pled guilty to overbilling his clients; nothing to do with the RTC, nothing to do with Whitewater; totally irrelevant.

If we continue spreading this dragnet out further, if we go after every person that has ever had contact with Bill Clinton or Hillary Clinton or James McDougal or whatever, if they have ever made a phone call to them, if they have ever borrowed money or given them a campaign contribution, Lord only knows how long this investigation is going to go. It will go beyond the year 2000.

I just hope that our colleagues on the Banking Committee will realize that we must focus this investigation as it relates to Whitewater and to its original mission.

Mr. President, I thank the distinguished Senator, ranking member, and the distinguished chairman for yielding me this time.

I yield the floor.

Mr. SARBANES. Mr. President, I am prepared to yield back time.

Mr. D'AMATO. Mr. President, we yield back the remainder of our time.

The PRESIDING OFFICER. All time having been yielded, the question is on agreeing to the resolution.

On this question, the yeas and nays have been ordered, and the clerk will call the roll.

Mr. FORD. I announce that the Senator from Massachusetts [Mr. KENNEDY] is necessarily absent.

The legislative clerk called the roll.

The PRESIDING OFFICER (Mr. SANTORUM). Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 96, nays 3, as follows:

[Rollcall Vote No. 171 Leg.]

YEAS—96

Abraham	DeWine	Inouye
Akaka	Dodd	Jeffords
Ashcroft	Dole	Johnston
Baucus	Domenici	Kassebaum
Bennett	Dorgan	Kempthorne
Biden	Exon	Kerrey
Bond	Faircloth	Kerry
Boxer	Feingold	Kohl
Bradley	Feinstein	Kyl
Breaux	Ford	Lautenberg
Brown	Frist	Leahy
Bryan	Gorton	Levin
Bumpers	Graham	Lieberman
Burns	Gramm	Lott
Byrd	Grams	Lugar
Campbell	Grassley	Mack
Chafee	Gregg	McCain
Coats	Harkin	McConnell
Cochran	Hatch	Mikulski
Cohen	Hatfield	Moseley-Braun
Conrad	Heflin	Moynihan
Coverdell	Helms	Murkowski
Craig	Hollings	Murray
D'Amato	Hutchison	Nickles
Daschle	Inhofe	Nunn
Packwood	Roth	Specter
Pell	Santorum	Stevens
Pressler	Sarbanes	Thomas
Pryor	Shelby	Thompson
Reid	Simpson	Thurmond
Robb	Smith	Warner
Rockefeller	Snowe	Wellstone

NAYS—3

Bingaman	Glenn	Simon

NOT VOTING—1

Kennedy

So the resolution (S. Res. 120) was agreed to.

Mr. D'AMATO. Mr. President, I move to reconsider the vote by which the resolution was agreed to.

Mr. SARBANES. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. THURMOND addressed the Chair.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. THURMOND. Mr. President, I ask unanimous consent to speak as in morning business.

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

Mr. THURMOND. I thank the Chair.

(The remarks of Mr. THURMOND pertaining to the introduction of S. 812 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Mr. DOLE addressed the Chair.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. DOLE. Mr. President, it has been our hope that we could work out some agreement on H.R. 483, the so-called Medicare Select bill. I know Senator ROCKEFELLER has some concerns about it. What we would like to do is bring the bill up, and if anybody has amendments, they can offer the amendments and see if we cannot complete action. It is a program that expires on June 30. I am not an expert on the program itself. I think Senators PACKWOOD and CHAFEE will be happy to manage the bill. I will not do that.

I would like to ask unanimous consent that we turn to the consideration of H.R. 483, the Medicare Select bill, but I am not going to make that request yet.

Is the Senator from West Virginia prepared to object to that?

Mr. ROCKEFELLER. I am afraid I will have to.

UNANIMOUS-CONSENT REQUEST

Mr. DOLE. Mr. President, I ask unanimous consent that the Senate turn to consideration H.R. 483 under the following time agreement: 1 hour on the bill to be equally divided between the chairman and ranking member of the Finance Committee, with one amendment to be offered by Senator ROCKEFELLER relative to Medicare, 1 hour for debate to be equally divided in the usual form, and that no motion to table be in order; further, that following disposition of the Rockefeller amendment, the bill be advanced to third reading and that final passage occur without any intervening action or debate.

The PRESIDING OFFICER. Is there objection?

Mr. ROCKEFELLER. I do object.

The PRESIDING OFFICER. Objection is heard.

EXTENDED USE OF MEDICARE SELECTED POLICIES—MOTION TO PROCEED

Mr. DOLE. In light of the objection, I move to proceed to the consideration of H.R. 483.

The PRESIDING OFFICER. The question is on the motion to proceed.

Is there debate on the motion?

Mr. ROCKEFELLER addressed the Chair.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, this is not one of the most broadly understood issues. But it is a very important one, Medicare Select. There are, I guess, two issues that concern me. One—and this is less important, but nevertheless important to me—is the area of process. I had written Senator DOLE, the majority leader, a number of months ago asking for a hearing on the subject of Medicare Select. I was told in a letter back from the majority leader that we would have hearings on Medicare, obviously, and that Medicare Select would be a part of those hearings. The Finance Committee has not had any hearings on Medicare Select and, therefore, that constitutes a problem.

Second, there is a study on Medicare Select which is going to be completed by the end of the summer, and it is not a frivolous study or a frivolous problem. It is a serious problem involving seniors and Medicare supplementary insurance. Currently, 15 States are participating in the 3½-year experimental Medicare Select Program. This bill would expand Medicare Select to all 50 States for 5 years.

One of the States that has Medicare Select is, in fact, the State of Florida. I cosponsored legislation sponsored by Senator GRAHAM that would temporarily expand Medicare Select for another year. So this is not just a question of those States that have Medicare Select wanting to continue to expand it, or to make it permanent, or whatever. We have genuine concerns.

There are other issues involved. One of the conclusions of the preliminary evaluation of this study which I have been referring to, which will be completed at the end of the summer—and that is why I hoped we could wait until that time, this being the first year of a 2-year session—was that about half of the savings in the form of cheaper MediGap premiums for beneficiaries came about as a result of discounting payments to hospitals.

Now, theoretically, if seniors are having their care actually managed, the Medicare Program would realize savings from the lower use of health care services.

If, in fact, the savings are merely the result of hospital discounting arrangements, the Medicare Program is not going to benefit at all financially. Again, that is not an overwhelming factor, but a very important factor in view of the overall Medicare cuts we are looking at this year.

CBO, in fact, scored the expansion of the Medicare Select Program as budget neutral, not as saving or costing Medicare, but budget neutral. They said it does not cost and it does not save the Medicare Program any dollars at all.

Now, my colleagues and friends on the other side talk about expanding choice and restructuring Medicare by getting more seniors into managed care in general. Yet Medicare Select, one of the managed care options already available under the Medicare Program in at least 15 States, does not save the Medicare Program money.

So far, therefore, claims from the other side on the so-called magic of the marketplace does not seem to be doing anything to save costs for Medicare. That is the point I am trying to make. Many people believe that managed care is not going to save the amount of money that some people think it is because the elements of managed care are not enough. There is the cost of technology and more people getting older faster—that number is increasing very fast.

The Consumers Union testified before the House Commerce Health Subcommittee that:

> Lawmakers should not make permanent a managed care form of insurance to plug gaps in Medicare coverage because of very serious questions about the supplemental's plan deceptive pricing practices and its effectiveness at holding down health care costs. We should not make this program permanent and expand it to other States until we know that it is really a good deal for the customers.

That is all I am saying. I am simply requesting that the study which will be ready by the end of the summer, which is already in progress, which has already issued a beginning report, be allowed to be completed, that we see if, in fact, it is good for consumers, before we take any further steps.

Consumers Union has raised concerns that because of insurance underwriting practices, seniors may be locked into Medicare Select managed care policies and be unable to purchase another MediGap policy.

We looked at MediGap 5 years ago, in 1990. We passed legislation on MediGap. It was very good legislation and it cut down on abuses and consumer confusion. Seniors, for the most part, do have Medicare supplemental policies. Sometimes they use it to help pay part of their premiums. Sometimes they use it to get more services that Medicare does not offer. But it is very, very important.

HCFA, the Health Care Financing Administration, has voiced a concern about a lack of quality assurance requirements for Medicare Select managed products.

Medicare HMO's are required to have an active quality assurance committee headed by a physician that gathers and analyzes data and works for continuous quality improvement. That is important. There is no comparable requirement for Medicare Select managed care products.

Medicare HMO's are required to provide data on such indicators as waiting times for appointments in urgent care, telephone access to HMO, both during and after hours. There is no comparable requirement for Medicare Select managed care products.

Understand, I am not condemning Medicare Select. Fifteen States are using it. Some of those States want it to be made permanent. Some are less happy about it, but this bill is a major expansion. Therefore, it is something that we need to look at closely.

To go from 15 to 50 without the benefit of at least the study Congress ordered so that we could make an orderly decision about this, just does not seem to me to make sense. It is for that reason that I am here talking, hoping that we can do something about it.

If Medicare Select managed care is to be made permanent as a Medicare option, beneficiaries should be guaranteed the same level of assurance on issues of quality, issues of access, and, for example, grievance rights, as they have already in other Medicare managed care options. That seems sensible. Do the 15 have it? Do all of them have it? Do none of them have it? We need to know.

A preliminary analysis of the Medicare Select experiment that was completed last year by the Research Triangle Institute concluded that from Medicare's perspective, unless Medicare Select reduces use or directs use to providers that cost Medicare less money, it offers little benefit to Medicare.

The preliminary case study also indicates:

> Aggressive case management and restriction of networks to the more efficient providers in the communities are rare. Thus, it appears unlikely that Medicare Select will result in claims cost savings for HCFA.

Now, Mr. President, I do not think that these concerns mean that we should end the Medicare Select Program. I want to be very certain on that. I think that experimentation—State experimentation—is tremendously important. I believe in it.

However, I do think that several serious issues have been raised about the Medicare Select Program, and as a result I have grave reservations about extending this program to all 50 States—that would be 35 more States—in 5 years.

Instead, to avoid any potential disruption in those States that currently are participating in the Medicare Select experiment, we ought to extend their programs so that they do not have to stop enrolling new people on June 30, 1995.

Now, that is an important point to make. We have a drop dead date we are facing rather quickly. They cannot take new enrollees unless we extend the current States that have the programs, which I am very much for doing, so that we can learn more from those programs.

I would sincerely hope that before expanding it beyond those States that now have it, we take a much closer look at the Medicare Select Program in the committee of jurisdiction, which is the Finance Committee.

Then I go back again to the process question. I asked the majority leader by letter if he would hold hearings on this subject. He answered me earlier, some months ago, that we would hold general Medicare hearings in the Finance Committee, and Medicare Select would be part of those hearings.

They have not been part of those hearings. They have not been even mentioned in these hearings. That is important to me because I think that process and the knowledge that one gains from that is tremendously important.

I find it somewhat disturbing that my friends on the other side of the aisle who want to cut Medicare by $256 billion to balance the budget and pay for tax cuts, and who talk on a daily basis about restructuring Medicare, will not even take the time to consider a final evaluation of the Medicare Select Program. Congress mandated that this study be done. This was not somebody's whim. It was a congressionally mandated study. The Federal Government has already paid for this study to be done. But my colleagues are apparently not willing to wait a couple of months to consider the results of that congressionally mandated study.

In some ways it seems to me that we are here more because the Senate is looking for something to do. I do not think this is the right way to handle the problem of the Medicare Select Program. This came up suddenly and here we are with it.

I want to make it very clear why I have objected to the idea of the Senate simply rubberstamping a bill passed by the other body. There is absolutely no reason for us to be using up the time of the Senate on this at this time. If the majority leader would simply give the committee of jurisdiction the chance to review the legislation and the study through something as basic as a hearing or a partial hearing or a subcommittee hearing, then we could work out a course of action based on a responsible process and careful thought about the substance which I have raised, which is very much in question. The Senate should, I think, not acquiesce to a cavalier way of doing business, and that is what concerns me.

The majority leader wants the Senate to rubberstamp a bill that would turn a limited demonstration program, called Medicare Select, into an open-ended national program. I am very concerned about an attempt to pass legislation affecting the Medicare Program

without having it carefully considered by anyone in the Senate.

I ask my colleagues, who are not present on the floor with the exception of the distinguished Presiding Officer, how many of them can really tell me much about the Medicare Select Program? How many could give me one short paragraph on what the Medicare Select Program is? I would daresay it is probably six people; probably six people. And here we are at a moment when there is not much else to do, awaiting the budget resolution, but with some time to kill, and we are about to expand into a national program something which is being experimented with locally, by the States.

If anything is clear these days, the Senate should know what it is doing when it changes Medicare. We are about to enter into a major debate on Medicare as it concerns the budget resolution. So anything that has the word Medicare in it, we ought to be precise, knowledgeable, and informed rather than having an hour's discussion and then a vote of some sort, affecting profoundly what happens in this country. Medicare affects 33 million people—36 million to 37 million people when you add on end-stage renal disease and the disabled, as well as those over 65. It has enormous consequences. It has enormous consequences.

As we learned during the MediGap debates, it is very hard, often, for seniors to resist buying policies which are constantly offered to them. That was what the MediGap legislation was about. It was to discipline this proliferation of policies to ensure folks could not prey on seniors who could not necessarily understand all the small print, or even read the small print in the policy. So this is about protecting seniors; about not misleading seniors; about making sure that seniors get the quality assurances that are verbally offered to them by those who would sell Medicare Select.

It just seems to me that if we are about to talk about a $256 billion cut in Medicare, we really ought to know what we are talking about when we do anything about Medicare, much less add on a new program, whether it costs or not.

Just yesterday Dr. June O'Neal, who is the new head of CBO, the Congression Budget Office, and whom I had not seen before, testified before the Finance Committee that quality—hear this, ''The quality will suffer under the Medicare Program if we enact Medicare cuts of $256 billion.''

She said that seniors will have to pay more to get the same level of quality that they are currently receiving under Medicare. And I think this is a very serious consequence. In fact, by the year 2002, I think they will be paying $900 more per year and I think on an aggregate basis they will be paying close to $3,500 more between now and the year 2002. When you consider the fact that only a very tiny proportion of Medicare recipients have incomes of higher than $50,000 a year and that the enormous majority of them are way down at $15,000 or $10,000 or below, in that area, something like that becomes an enormous consideration. An additional $3,500? They already spend over 20 percent of their income on health care.

In fact, we had an interesting minidebate yesterday on whether or not the cuts in Medicare will in fact cut Social Security for seniors. Of course, if that were to be the case, that would be a kind of third-rail item on the American scene because cutting into Social Security is something we have all decided not to do. We came up with the judgment, not so much during the hearing but after the hearing, that because of the increases in premiums, et cetera, in copayments, seniors will have to pay for more costs for Medicare, that in effect their COLA increases under Social Security in many cases will be wiped out entirely.

Will seniors see that as a cut in Social Security? I think it is quite possible they will. Because it is interesting—I would not have guessed this, I say to the Presiding Officer—that Social Security and Medicare are looked upon, in many ways, as the same by the people of this country and by the seniors of this country. That whereas we said before ''Do not cut Social Security,'' people look upon Medicare as the same sort of a sacred contract, so to speak, that the American Government and the American people have with each other, and not another incidental program.

So I think this is a very serious problem. The Health Care Finance Administration, HCFA, has voiced a concern about lack of Medicare Select quality assurance requirements. HCFA is not a radical organization. It is a big organization, 4,000 people, who in fact are very expert. Nobody knows they exist but they do, and they do all kinds of complicated work. They are expressing concern about Medicare Select quality assurance requirements, that they do not exist in this legislation and they do exist for other managed care options. As I said, Medicare HMO's are required by law to have active quality assurance committees.

So I think there is lot at question here, and I just hope we could work this out. I had suggested a variety of alternatives, options; that we could take the States that now have Medicare and extend those for a year and a half or 2 years. Some people say if you extend it for a year, that does not really give the managed care company that is interested in looking at Medicare much incentive to move ahead. It sounds like a year-by-year basis. Maybe we could do it for longer than that. Maybe we could add on some more States, add on four or five more States and allow that to happen.

But to take the entire country and open it up to Medicare Select when a study which has already raised questions is still out there and questions have been raised by health care experts in HCFA about insurance problems, plus the fact that it is Medicare, which is probably the most sensitive subject that could be discussed on the floor of this Chamber, we ought to be careful. That is why I am not for going ahead at the present time with expanding this the way the majority leader seems to want to do.

I will have more comments. But I do not see anybody at this point who wishes to say anything. So I yield the floor and note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. ROCKEFELLER. 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. ROCKEFELLER. Mr. President, I note the presence of the distinguished Senator from Rhode Island on the floor. I know he wants to speak. I will not take long. I talked a moment ago about the concerns of the consumer groups and the Medicare Select Program. One of their concerns is called attained age rating. Just as insurance companies charge older people more for insurance in the under 65 market, MediGap insurers charge older seniors more for their MediGap policies as they grow older. In the under 65 market, insurers claim that age rating is a sound business practice because older people use more health care services and because older people are better off financially than those who are 20 years old or younger. This argument does not work at all for those who are over 65 years old. In that important market, 85-year-olds are generally, as I hope we all know, a lot poorer than 65-year-olds.

Another question that has been raised is the so-called one time open enrollment period. When we worked in the Finance Committee—I know the Senator from Rhode Island worked very hard on that also—on the MediGap legislation in 1990, we required insurers to have a one-time, 6-month open enrollment period when seniors first turned 65 so that they would have 6 months to simply enroll. During this 6-month period, an insurer under the MediGap Program is not allowed to deny insurance to any senior based upon their health status. That is an enormous statement in the health insurance industry. It is an enormous statement. They are not allowed during those first 6 months to make any health status judgments and thus say no to people. Consumer groups have raised a concern that if seniors sign up with a Medicare Select managed care product and decide that they do not like that product, they may be unable to buy a MediGap policy later because the open enrollment period would have gone by, especially, of course, if their health status is poor.

I want to just add those things.

I yield the floor.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island.

PRIVILEGE OF THE FLOOR

Mr. CHAFEE. Mr. President, I know the distinguished Senator from North Carolina is waiting to give a brief statement, and then I would like to speak. Let me discuss it with the Senator from Oregon.

But meanwhile, I ask unanimous consent that privileges of the floor be granted to a member of my staff, Douglas Guerdat during today.

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

Mr. CHAFEE. Thank you.

Mr. HELMS addressed the Chair.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. HELMS. I thank the Chair.

(The remarks of Mr. HELMS pertaining to the submission of S. Con. Res. 14 are located in today's RECORD under Submission of Concurrent and Senate Resolutions.)

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. PACKWOOD. Mr. President, let me make a few comments on the so-called Medicare Select policies and explain first what they are.

Medicare does not cover all medical expenses. So a popular policy that is sold in this country is called MediGap. You can buy it. It is voluntary. You do not have to buy it. You can buy it. It basically fills in the holes that Medicare does not cover. There are different kinds of MediGap policies. You can get some that are more expansive and with more coverage than others and they cost a bit more. But I emphasize they are voluntary.

Medicare Select is a particular form of MediGap policy. It is one of the most popular policies that are around. It is about 40 percent less expensive than other policies. It exists now in 15 States. You have to have Federal permission to sell it. The authority to issue these policies expires on June 30 of this year.

The House has passed a bill—let me check my figures—I think 408 to 14, to extend Medicare Select to the rest of the Nation. This is hardly a partisan issue with that kind of a vote. And if we, frankly, get a vote on it in the Senate, it is going to pass probably 80–20 or 90–10, unless I am mistaken. So do not let anybody be of the impression this a Republican-Democrat issue. This has overwhelming support.

The National Association of Insurance Commissioners is one group that supports it, and they monitor complaints about insurance policies throughout the Nation. There are about 500,000 people enrolled in just these 15 States in Medicare Select, and of those 500,000 policies, in 1994, all of the insurance commissioners in those 15 States had 9 complaints—9—in comparison with 967 complaints against other types of MediGap policies, nonselect MediGap policies.

We passed this in the Senate 5 years ago. We were awaiting a report. The report was due in January. It is not going to be out until next January now. It is late. It is not going to come.

And again, Medicare Select has overwhelming support. I am going to read just a list of the groups that support expanding this to the 50 States: The American Group Practice Association, the American Hospital Association, the American Managed Care and Review Association, the Association of Public Pension and Welfare Plans, Blue Cross and Blue Shield Association, California Association of Hospitals and Health Systems, the Federation of American Health Systems, the Group Health Association of America, the Health Insurance Association of America, the Medical Group Management Association, the National Association of Insurance Commissioners, the National Conference of State Legislatures, and the National Governors' Association.

Now, Mr. President, you are not going to get a much better group than that in terms of breadth and philosophical support. Our problem is that this apparently is going to face an objection to coming up and apparently a filibuster. I have no question but what the filibuster is going to be broken and going to be broken overwhelmingly. We will get the 60 votes. But one of the problems the leader faces, of course, is that once we are on to a bill and once cloture has been invoked, you cannot go to anything else. You can pull it down. And he would like to get onto the budget bill.

I say again, this is the middle of May. The authority for these programs runs out next month. This Congress goes on recess in about 10 days. And so unless we act now, these people who like these policies, to which there is almost no complaint, will be faced with rising premiums because they cannot be sold to anyone else.

So I hope that the leader will be successful in bringing this bill up, that we would have a short debate. I will be happy to agree to a time limit on amendments or a time limit on the bill and get to final passage. I will emphasize again it passed 408 to 14 in the House of Representatives.

I thank the Chair.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER (Mr. GREGG). The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, I see the distinguished Senator from West Virginia in the Chamber. I would be glad to pose him some questions if he is available to respond.

As the chairman of our committee just pointed out, we are talking about Medicare Select. But what is Medicare Select, anyway?

Medicare Select is the name of a type of MediGap policy. It is something that seniors can buy to cover their Medicare deductibles and copayments.

Medicare Select is a type of MediGap policy that permits managed care; that is, a managed care MediGap policy. That is what it is.

What was the problem in getting this plan started and why the restrictions? Why could not the insurance companies offer Medicare Select if they wanted to? Because when MediGap legislation was originally passed in the House of Representatives, there were some objections to Medicare Select. A Representative from California did not believe in managed care. Consequently seniors were not able to have these plans.

Well, finally, after patiently working at this several years ago in late evening sessions, we arranged that there would be 15 States that could try this and see how it worked out. And so 15 States have done it, and as the chairman of our committee pointed out, it has worked very well. The trouble is that the option of these 15 States to offer this policy ends June 30; which is what—a month and a half from now.

As the chairman pointed out, there is now a danger that we cannot extend Medicare Select because of having to deal with the budget, and so forth, and then all these people who have these MediGap policies—and, indeed, it is a MediGap policy—will not be able to buy it or renew it.

Indeed, there is question about enrollments right now: Should a senior enroll in a MediGap policy that has this managed care plan or should I not? What happens if the plan is going to disappear?

Our point is not only should we extend Medicare Select but should we also make it permanent.

But what about the rest of the States? Why should not seniors in other States have this option? In my State, for example, why should not my citizens have the option of buying a MediGap policy that is $25 to $27 less per month, depending on the situation, than they are paying for other MediGap policies?

Mr. ROCKEFELLER. Will the Senator yield?

Mr. CHAFEE. Let me just finish. The Senator is objecting to that. What I find puzzling is the Senator, a distinguished member of the Finance Committee, has twice voted in the Senate Finance Committee and twice on the floor to pass a permanent 50-State extension of legislation that is before us. What has changed?

Mr. ROCKEFELLER. What has changed, I say to the distinguished Senator from Rhode Island, is that I had correspondence with the majority leader of the Senate, a letter that I ask unanimous consent to have printed in the RECORD, and also the majority leader's response to this Senator.

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

U.S. SENATE,
Washington, DC. March 21, 1995.

Hon. ROBERT DOLE,
U.S. Senate,
Washington, DC.

DEAR SENATOR DOLE: As ranking member of the Finance Subcommittee on Medicare, Long-Term Care, and Health Insurance that you chair, I would like to propose a hearing on the Medicare SELECT program for oversight and an education on its results so far.

As you know, Congress approved a 3-year, 15-state Medicare SELECT demonstration project as part of the Omnibus Reconciliation Act of 1990. Medicare SELECT offers seniors less expensive Medigap premiums in exchange for receiving their health care services from a selected network of health care providers. Under current law, Medicare SELECT's authorization—which was extended temporarily last October—is due to expire on June 30, 1995, unless Congress takes further action.

Personally, I would support extending this program for another six months to maintain program continuity, with a strong interest in avoiding the program's disruption while allowing Finance Committee members an opportunity to fully examine the knowledge available so far on the SELECT demonstration. A temporary extension would give the Subcommittee an opportunity to have a full hearing on the Medicare SELECT program that would include results of a formal evaluation of the demonstration project.

It is my understanding that preliminary results of an evaluation study that is being performed by Research Triangle Institute will be ready by the end of the summer. Information that will be available includes data gathered from insurer and beneficiary surveys, as well as claims analyses that will examine the impact of SELECT enrollment on the use and costs of Medicare services. Therefore, I believe it would not be appropriate or prudent to extend this program on a permanent basis to all 50 states until Finance Committee members have the most up-to-date information on which to base future legislative action.

Thank you in advance for your attention to this matter, and I hope to work with you on this issue. Mary Ella Payne is the contact on my staff.

Sincerely,

JOHN D. ROCKEFELLER IV.

U.S. SENATE,
OFFICE OF THE MAJORITY LEADER,
Washington, DC. April 3, 1995.

Hon. JOHN D. ROCKEFELLER IV,
U.S. Senate,
Washington, DC.

DEAR JAY: Thank you for your letter regarding the Medicare Select Program. I agree with you that this issue deserves careful consideration, particularly if Congress intends to extend the program permanently.

I know that the Chairman plans to hold extensive hearings at the full committee level on the Medicare program—it's costs, it's benefits, and what changes need to be made to improve it. I have been assured by the Chairman that through this process we will take a close look at Medicare Select, as we will all parts of the Medicare program.

The Committee will obviously have its work cut out for it this year. I look forward to working with you as we debate some very important and complex issues.

Sincerely,

BOB DOLE.

Mr. ROCKEFELLER. I wrote the majority leader on March 21, and I said this problem is going to be coming up. We know there is a deadline. I am fully aware of that. He wrote back on April 3, and he told me, ''I agree with you that this issue deserves careful consideration, particularly if Congress intends to extend the program permanently. I know that the chairman,'' that being Senator PACKWOOD, ''plans to hold extensive hearings at the full committee level on the Medicare Program.'' And, ''We will take a close look at Medicare Select, as we will all parts of the Medicare Program.''

What I would say to my friend from Rhode Island is that we have not done that. In the meantime, Congress mandated a study to be done, and the study is in the process of being done. The study has also already raised several questions. Other groups raised other questions about quality, about being able to buy other medigap policies. So there are a number of questions that needed to be answered. I wished to do all of this somewhat earlier, and I was given the promise that we would do this somewhat earlier. It is just that the promise was not fulfilled.

I should say also that a number of questions have been raised which have somewhat changed the atmosphere in the last several months. Before the Senator came to the floor, I talked about questions which had been raised by a number of groups—pricing games, medigap availability, illusory costs, and things of that sort. The Senator from West Virginia wants to be sure.

Mr. CHAFEE. Well, the Senator from West Virginia may wish to be assured, but I do not know how far we have to go. The National Association of Insurance Commissioners supports the extension of this program. We just had the list of those who were supporting Medicare Select read by the chairman of our committee. You can go on and on and find reasons not to do something.

But we are really in a very, very difficult situation here. This program expires in 30 days from now or 45 days from now. It seems to me we ought to get on and extend it, and not only extend it but let the other States in on it.

Some mention was made about the Consumers Union's concerns about Medicare Select. But the fact of the matter is the Consumers Union's problems that were raised apply to all medigap policies, not focused in on Medicare Select.

Mr. ROCKEFELLER. Will the Senator yield?

Mr. CHAFEE. Yes.

Mr. ROCKEFELLER. Mr. President, obviously, we need to work this out. The time problem is not, in fact, a constraint on those States which currently have Medicare Select because I already said I would be perfectly happy to go ahead and extend them.

The question is: How can we, looking at some of these complaints about not being able to change MediGap policies, discrimination of various sorts, how can we arrive at some kind of compromise which gives consumer protection for these Medicare beneficiaries that would choose Medicare Select? How can we give them some kind of consumer protection over and above what is contemplated in the law that the Senator from Rhode Island wants to get passed right away?

Would the Senator be willing to discuss those matters, if not publicly, privately?

Mr. CHAFEE. Mr. President, the Senator says we have to wrestle with these problems. Who says there is a problem?

Let me just touch on one matter that the Senator raised, and that is the so-called attained-age rating, with a suggestion that Medicare Select, this type of managed care policy, MediGap policy, has this attained-age rating.

Well, the fact is that the attained-age rating is permitted under current MediGap law. It is not restricted. The attained age is not something peculiar to Medicare Select. That is permitted under the current MediGap law.

And so while it is true that most medigap policies and most Medicare Select policies do not use the attained-age method, I do not see why you focus in and say that is something peculiar to MediGap or Medicare Select, because it is not.

Mr. ROCKEFELLER. The Senator from West Virginia did not say it was peculiar, but I said it was a problem as far as the Medicare extension is concerned. Whether it applies to more medigap policies is not, at the moment, of concern to me. I want to make sure that, in Medicare Select, we can.

HCFA has concerns about quality and concerns about access. They are not a frivolous organization.

I just think we have a chance to try to find an accommodation, hopefully in a quorum call, in which we could address some of the consumer concerns and perhaps also accommodate the Senator from Rhode Island, the majority leader, and the Senator from Oregon in the process, since I am, obviously, very well aware of where the votes are in the situation. I just want to do the best I can to build in consumer protection for a program which is young, which is actually only in 14 States, and is not at all in all 50 States.

Mr. CHAFEE. Mr. President, I do not concede that there are all these problems or that there are these problems. It seems to me what the Senator from West Virginia is doing is applying a higher standard to the Medicare Select, these managed care MediGap policies, than he is to the regular MediGap policies. I do not think that is fair. I do not think it is fair to say, ''No, in Medicare Select, you cannot have attained age,'' whereas it is permitted in the other MediGap policies.

The suggestion here is that we ought to have hearings on this. Well, I cannot speak for what the majority leader said, but all I do know is that the Senate has passed a permanent extension of this proposal twice in the past 4 years. It was included in every major health reform proposal last year, including Senator Mitchell's, Senator

DOLE's and Senator PACKWOOD's bill, and in the mainstream coalition bill. All of them had Medicare Select in them. So it is not that we are coming up against some unknown item here that we better be terribly cautious of. As I say, it has been out in these States. In 15 States, it is authorized. I cannot challenge the Senator's information when he says it is actually in practice, I believe he said, in 14 States.

All I know is that I think it is a good option that is less expensive and that we ought to give all the citizens a chance at it. And the citizens from my State would like a chance at this. If they do not want to use it, that is their business. But if they have a right to choose a MediGap policy that is less expensive than the current ones, I think they ought to have it and not be prevented from doing so because this Congress refuses to extend Medicare Select to all the States.

Again, no one is more thoughtful and compassionate in this Senate than the Senator from West Virginia, so I am not sure why he takes this particular position. Because, as we mentioned before, this passed in the House 408 to 14. You could hardly get a motherhood resolution passed by that amount.

Mr. ROCKEFELLER. If the Senator will yield, I think one could practically rewrite the Constitution in the House of Representatives by that vote in the current climate.

If the Senator would further yield, he talked about standards being higher for Medicare Select than for other medigap things. I think high standards are important and I know the Senator from Rhode Island does, too. I want to see the Senator from Rhode Island and his State be able to have this program if that is what the State and the Senator wants.

I think the time crisis that the Senator refers to can be handled in 60 seconds. That can be changed in 60 seconds.

My point is that for 2 months I have suggested extending the program to the 14 States with the program already in effect. What I am really suggesting now is that we first look at the evaluation of the program before we open the door to all the other States. What I am really suggesting is that, if we could perhaps suggest the absence of a quorum, we could work something out on this.

Mr. CHAFEE. Mr. President, our staff asked the Health Care Financing Administration [HCFA] for suggested changes. Any problems? What do you think we ought to do? They did not have any. They had no suggestions for us.

Maybe the Senator from West Virginia can find, what we cannot find, any documented quality problem with this program. Now, some beneficiary somewhere may object, I am sure they have, just like they have objected to a host of other medigap policies.

But, as I say, this has received a favorable report by the Consumers Union and by Consumers Report magazine and by the State insurance commissioners.

So, I do not have anything particular to offer. I would be glad to talk with the Senator from West Virginia. Whatever ideas we have, we would have to transmit them. Obviously, I would have to speak to the chairman of the Finance Committee, whom I do not see on the floor here.

Mr. ROCKEFELLER addressed the Chair.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. The Senator from Rhode Island made mention of no particular problems being raised by HCFA. I think that raises, therefore, this very important point. Because, in fact, Donna Shalala has written to the Honorable BILL ARCHER, chairman of the Committee on Ways and Means, on March 7 of this year.

And one paragraph says:

> The case study portion of the Medicare Select evaluation has already raised a number of questions about the Medicare Select demonstration.

That is from HCFA.

> As managed care options under Medicare are expanded, we want to ensure that our beneficiaries are guaranteed choice and appropriate consumer protections.

That is precisely what the Senator from West Virginia was asking for.

Donna Shalala goes on:

> In addition, many of the select plans consist solely of discounting arrangements to hospitals.

The Senator from West Virginia mentioned that at the beginning.

Donna Shalala goes on:

> We would be concerned if the discounting arrangements under Medicare Select were to be expanded to Medicare supplementary insurance part B services. Discounting arrangements, particularly for part B services, may spur providers to compensate for lost revenues through increased service volume. Consequently, we are concerned that such an expansion would lead to increased utilization of part B services rather than contribute to the efficiency of the part B program through managed care.

Then she says:

> We would, therefore, oppose such a change.

There is honest and open debate on this matter. I am still willing to talk with the Senator from Rhode Island. I think we can work something out. Again, I, unfortunately, can count the votes, but the Senator would like to have some consumer protection in this, and I think the Secretary of HHS would, too. I think, frankly, George Mitchell, in his bill, had open enrollment and major insurance reforms, and the Senator from Rhode Island knows that well.

The Mitchell bill, in fact, did not propose to make Medicare Select permanent in the absence of coordinated open enrollment.

So I think there is room to work something out here, Mr. President, because I think everybody is talking with good will on both sides on this matter.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, the problem here is—I know the Senator is concerned about this—but the points he raises affect not Medicare Select but affect the whole MediGap range. In other words, when he says he is interested in open enrollment, there is no open enrollment now in the MediGap policies. He is saying he wants it for Medicare Select. But that means you want it presumably for all of MediGap.

Now, that is a very big separate issue that can come up any time. You do not have to tag it on to a Medicare Select policy which, as I say, is just one of a whole series of medigap policies.

If the Senator wants to do that, that is changing the rules for the whole series of policies that are issued under medigap.

Mr. ROCKEFELLER. Will the Senator yield?

Mr. CHAFEE. I will make one other point, if I might, and that is, as you recall, when I said my staff spoke to the Health Care Financing Administration, what I said was they asked for suggested changes and none came back. In the letter the Senator quoted from Secretary Shalala, he mentioned somewhere in there concerns about expansion into the part B plan. We do not do that. There is no expansion into that in this Medicare Select.

So I will be glad to talk with the Senator. If he would like, we can suggest the absence of a quorum and have a little chat here.

Mr. ROCKEFELLER. The Senator from West Virginia would like to do that, but if I might add one more thing, that is, the Senator is right about part B, and the Senator from West Virginia just got carried away and read too much of a paragraph, which was a mistake on the part of the Senator from West Virginia.

Donna Shalala, on the other hand, is referring to the Medicare Select evaluation. She is referring to the Medicare Select evaluation in this letter which she wrote back on March 7, which should have been available to all of us.

Bruce Vladeck, in his testimony on February 15 in front of the House Committee on Energy and Commerce, raised a major concern with the adequacy of beneficiary protections under Medicare Select.

If that is not HCFA speaking, I do not know what is. Bruce Vladeck said:

> There is no requirement for States to review the actual operations of the Select plans once they are approved to assure that quality and access standards are being met.

He does not like that. He is worried about that, and he says:

> We feel strongly that beneficiaries should not have to worry about the quality and access provisions on their Medicare choices. We look forward to working with the subcommittee * * *

And then Bruce Vladeck, the head of HCFA, said:

Our second concern is whether Medicare Select will make any contribution to increasing the efficiency of the Medicare program.

I think that goes off into another area. It is the consumer protection area, I say to my friend from Rhode Island, which concerns me the most.

I might suggest the absence of a quorum in order for some conversation to go on.

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. KENNEDY. 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. KENNEDY. Mr. President, the Medicare Select is a demonstration program. Evaluation will not be completed until December 1995. While the demonstration program technically expires on June 30, the regulations governing the program clearly state that insurers must continue their coverage of current enrollees, even if no extension is approved.

There is no overwhelming urgency to pass this legislation. I do favor a temporary extension, and I am prepared to support such an extension today. But I have a number of concerns about permanent extension of the Medicare Select Program.

First, extension of Medicare Select should be considered in the context of a whole range of managed care options we might wish to make available to Medicare beneficiaries. There is a great deal of interest on both sides of the aisle in expanding choice. The administration is working on development of a PPO option. Before we make the Medicare Select Program permanent, we should understand its impact and balance it against other options.

Second, Medicare Select raises significant concerns about beneficiary protections. HHS has stated concerns about quality oversight. Most important, Medicare Select requires enrollees to receive their care from a limited set of providers. This may be perfectly acceptable to younger, healthier, enrollees. As beneficiaries age and become sicker, however, they may find themselves dissatisfied with providers in the select network. They can find themselves permanently locked out of regular MediGap coverage, with no ability to buy a policy to protect themselves from the costs that Medicare does not cover.

This seems to me to be an excessive denial of choice that we should not enshrine in permanent legislation without more consideration.

These concerns have been raised by Consumers Union and other consumer advocates. Consumers Union, Families USA, and the National Council of Senior Citizens all are on record as opposing this legislation. These concerns are serious and they deserve to be addressed.

We must always be especially concerned about the frailest and the most vulnerable elderly. We want to provide options that improve the choices available, not limit them. We want to provide benefits and services that seniors need, not deprive them of necessary care. We should move with great care in considering a measure that might have that affect.

It is not my intention to terminate the Medicare Select demonstration or put it out of business. I would be willing to support the short-term extension of the program or a permanent program if these concerns are considered and addressed.

It is ironic that this particular Medicare issue should surface just a day before we are to consider a budget resolution which would strike a mighty blow at the integrity of the Medicare Program as a whole and at the retirement security of senior citizens it was designed to secure.

This budget plan proposes to break America's compact with the elderly, and all to pay for an undeserved and unneeded tax cut for the wealthiest Americans.

The cuts in Medicare are unprecedented: $256 billion over the next 7 years. By the time the plan is fully phased in, the average senior is likely to pay $900 more a year in Medicare premium and out-of-pocket costs.

An elderly couple would have to pay $1,800 and, over the life of the budget, would face $6,400 in additional costs. Part B premiums, which are deducted right out of the Social Security check, will rise to almost $100 a month at a cost of an additional $1,700 over the life of the budget plan.

The typical senior needing home health services will have to pay an additional $1,200 per year. Someone sick enough to use the full home care benefit will have to pay $3,200. The fundamental unfairness of this proposal leaps out from a few simple facts.

Because of gaps in Medicare, senior citizens already pay too much for the health care they need. The average senior pays an astounding one-fifth of their total pretax income to purchase health care, more than they paid before Medicare was even enacted. Lower income older seniors pay even more.

Medicare does not cover prescription drugs. Its coverage of home health care and nursing home care is limited. Unlike virtually all private insurance policies, it does not have a cap on out-of-pocket costs. It does not cover eye care or foot care or dental care.

Yet this budget plan heaps additional medical costs on every senior citizen, while the Republican tax bill that has already passed the House, gives a tax cut of $20,000 to people making more than $350,000 a year.

I ask any of our colleagues to travel to any senior citizens' home in their State and have a visit with retirees. Ask the retirees by a show of hands how many pay $50 a month or more for prescription drugs. Anywhere from 25 percent to 50 percent of the hands will go up in the air. Ask them how many pay $25 a month or more for prescription drugs, and the spontaneous groan in the audience will be enormous. It is an expression that they are astounded that we do not understand that they are paying at least $25 a month or more and now 80 percent to 90 percent of the hands go into the air.

What has been the cost of the prescription drugs over recent years? They have been rising at more than double, sometimes even triple, the Consumer Price Index.

Look also at the profits of the major pharmaceutical companies. It is an interesting fact that they are some of the most profitable companies in America, while at the same time the cost of prescription drugs, which are absolutely essential in order to relieve suffering or to even live life in many instances, is going right up through the roof.

Now, that is a real issue for the seniors. That is an issue that we ought to be debating out here this afternoon. That is an issue of prime concern to every senior citizen.

I daresay, if any Member of the Senate went to a group of senior citizens and asked them this afternoon, ''What do they want the U.S. Senate to be focusing on? The issue of prescription drugs or Medicare Select?'' Ninety-nine percent would say, ''Look after the problems that we are facing with prescription drugs.'' ''Look after the problems we are facing in terms of dental care and eye care.'' Look around the room and count the number of senior citizens who are wearing glasses. Look around the room at the numbers who need help and assistance with dental care. Look around the room at the number of seniors who need the care of a podiatrist.

Our seniors think the U.S. Senate ought to be focusing on Medicare here this afternoon. But we should not focus solely on Medicare Select, until we have a full and complete evaluation of that program, which has the potential of some very important adverse effects, as well as some potentially beneficial effects.

We ought to insist that we have all of the facts before we move forward on a program that will unquestionably mean enormous profits to some companies and industries. It will perhaps give at least the appearance of security to some of our senior citizens for a period of time, but that security will be illusory unless it is carefully crafted and there are built-in kinds of protections which are not evidenced in the proposal that we are reviewing or considering this afternoon.

It is interesting, Mr. President, to compare the generous benefits that the authors of the Senate resolution enjoy under our Federal Employees Health Benefit Program plan available to every Member of Congress to the less adequate benefits provided for Medicare.

We are going to find out that while the measure we will be debating here in

the U.S. Senate cuts back on protections for our senior citizens, we sure are not cutting back on the protections for any of the Members in the U.S. Senate. That is an interesting irony.

We heard so much in the early part of the year about how we will make sure that every law that we pass in the Congress is going to be applicable to the Members of Congress. Remember those speeches? We heard them from morning until eveningtime here in the Senate. And it is right that we do that. But how interesting that we do not say we are going to provide for the American people all the benefits that we have here in the U.S. Senate.

If we wanted to, we could give to the American people the kind of health benefits that we have, by extending the Federal Employees Health Benefit Program. Many of us have supported this in the past; many of us fought last year to try to make this available. FEHBP affects 10 million Americans. We have 40 million Americans who do not have health care coverage, and 16 million of those who are children. We could do very well if we just provided the extension of the Federal Employees Health Benefit Program to all Americans. But, again, we are not debating that issue here. We are not involved in that debate here on the floor of the U.S. Senate.

We are talking about the Medicare Select issue, a very narrow, very defined issue. We will be debating, tomorrow, and perhaps the day after tomorrow, and for a series of tomorrows, the proposed cuts that are coming in Medicare, in the budget proposal, that will not be utilized for health care reform as we tried to do last year. We tried to provide some prescription drug benefit. We tried to provide some home care. We tried to provide some community-based care. We tried to provide some additional protections for our elderly.

But no, this year we are going to go ahead and cut the Medicare Program to set aside a little kitty of $170 billion that can be used someday in the future for tax cuts for the rich. Take benefits away from the seniors in the Medicare Program, raise their copayments, raise their premiums, raise their deductibles, raise all of their costs so that we can put over here a little saving account that can be drawn down to allow tax cuts for the wealthiest individuals.

That is what we will be debating. And it is also amazing to me that we will have a time constraint on this issue that is going to affect the quality of life for our senior citizens in such a dramatic way. We do not have that time restraint this afternoon, when we are debating Medicare Select, but we will have it when that budget bill is called up.

It is important that we put some of these measures into proportion. This issue, Medicare Select, is being pressed this afternoon. We are on the eve of what will be a very important debate, not only here on the floor of the U.S. Senate but across this countryside; whether or not we want to say to our senior citizens we are going to cut your benefits so we can use those savings, those cuts, those resources that we have captured from you to give a tax cut to the wealthiest individuals.

Maybe that is what the election was about last November. It certainly was not about that in my State of Massachusetts. People will say, out here on the Senate floor: They voted for change. Is this the kind of change that the people voted for, Mr. President, $256 billion in Medicare cuts so we can provide $170 billion for tax reductions for the wealthiest individuals? Is that what the election was about last fall?

I do not believe so. And I think that is why all of us are seeing, in our own States, that those who are paying increasing attention to what we are debating and what we are acting on, are going to be so concerned by this particular budget proposal.

Sure we have to get some savings in Medicare. Sure we have to have some reductions in expenditures. But what we did last year, when we proposed comprehensive health care reform, was to try to bring about the kinds of changes that over the long term are going to provide important quality health protections for our senior citizens, and second, to get a handle on health care costs. We need to get a handle not only on Medicare and Medicaid costs but also on the total health care system, since Medicare costs are only 15 percent of total national health expenditures. The notion that we can deal with escalating health care costs by cutting Medicare alone, shows a fundamental lack of understanding of the basic elements of the health care debate.

Medicare provides no coverage at all for outpatient prescription drugs, but they are fully covered under the most popular plan in the Federal Employees Health Benefit Program. The combined deductible for doctor and hospital services under the average Blue Cross and Blue Shield plan is $350; for Medicare the combined deductible is $816. Blue Cross and Blue Shield covers unlimited hospital days with no copayments; under Medicare, seniors face $179 per day copayments after 60 days; $358 after 90 days. After 150 days Medicare pays nothing at all.

Compare the differences between what our seniors are facing and what the Members of the U.S. Senate are facing. Medicare covers a few preventive services but does not cover screenings for heart disease, for prostate cancer, for other cancer tests—all FEHBP benefits. Dental services are covered for Members of Congress. We have them for Members of Congress—not for the Medicare recipients. Members of Congress are protected against skyrocketing out-of-pocket costs by a cap on their total liability. There is no cap on how much a senior citizen has to pay for Medicare copayments on deductibles.

Members of Congress earn $133,600 a year. The average senior's income is $17,750. For the limited Medicare benefits seniors receive they pay $46.10 a month, but for their comprehensive insurance coverage Members of Congress will pay a grand total of $44.05 a month. Seniors actually pay $2 more out of incomes about an eighth as large.

Is that something for our seniors to hear about as we are going to be considering a program that is going to cut their programs even more—and yet not affecting the Members of Congress at all? We have had this debate, some of us, for a number of years. Let us just give to the American people what we give to the Members of Congress. But we are not doing that, not with Medicare. We are being told to go ahead and provide additional burdens on the senior citizens that are not being asked of the Members of Congress.

No wonder people wonder what this is about. Is this the change that we voted for? I would love to ask a group of citizens in any State, is this the change you voted for last November? For further cuts on the Medicare benefits, increasing copayments, increasing deductibles to the tune of $256 billion, taking $170 billion of it and reserving it over here for tax cuts? Is that what the American people wanted as the change? Or did they believe in what we have as Members of the U.S. Senate, and what more than 9 million other Americans have, the Federal employees? Surely they were thinking when they voted, ''OK, if it is good enough for the Members of Congress it ought to be good enough for all Americans, young and old alike?''

This debate is going to be important in these next several days. I hope and urge our seniors to watch this debate and listen carefully. Listen carefully to those who are making recommendations to cut Medicare. Listen to their responses to the challenges about equity to our seniors.

This President has indicated he will listen. He will listen to proposals to cut Medicare if they are about total health care reform. This means that we are going to do something for our seniors that is going to enhance the quality of health care in such areas as prevention, home care, and community-based systems. It means making a difference by reducing deductibles or making payments for pharmaceuticals so seniors will not be distressed every time they take much-needed prescription drugs; so they do not need to decide whether they can afford to go down and get that prescription for $50, $75, $100 per month, when they do not have enough food on their table or heat in their home? We will have the chance to debate that. We welcome the opportunity to do so.

The authors of the budget resolution do not seem to understand how limited the incomes of senior citizens are. Because of their budget, millions of senior citizens will be forced to go without

the health care they need. Millions more will have to choose between food on the table, adequate heat in the winter, paying the rent, or medical care. This budget resolution is cruel. It is unjust. Senior citizens have earned their Medicare payments. They have paid for them, and they deserve them.

Medicare cuts in this resolution harm more than senior citizens. These proposals will strike a body blow to the quality of American medicine by damaging hospitals and other health care institutions that depend upon Medicare. These institutions provide essential care for Americans of all ages, not just senior citizens. And progress in medical research and training of health professionals depends upon their financial stability. The academic health centers, the public hospitals, and the rural hospitals will bear especially heavy burdens. As representatives of the academic health centers that are the guarantors of excellence in health care in America said of this budget, ''Every American's quality of life will suffer as a result,'' because there will be less funding to support the best health professional education and training to the young people of this country, and there will be a diminution in support for the research that is associated with the great medical centers in this country.

In addition, massive Medicare cuts will inevitably impose a hidden tax on workers and businesses, who will face increased costs and higher insurance premiums as physicians and hospitals shift even more costs to the nonelderly. According to the recent statistics, Medicare now pays only 68 percent of what the private sector pays for comparable physician services; for hospital care, the figure is 69 percent. The proposed Republican cuts will widen this already ominous gap.

The impact of these cuts on local communities will be astounding. In my State of Massachusetts we have 123 hospitals. Historically, one of the best and most efficient hospitals has in Barnstable County, not far from my home on Cape Cod. But it has had increasing difficulty serving its patients in recent years. What changed? The doctors have not changed. The nurses have not changed. The ability to get the good kind of equipment has not changed. The training that they went through has not changed. What has changed? The percentage of Medicare beneficiaries being attended to in that hospital changed.

In my State of Massachusetts, any hospital that gets close to 55 and 67 percent Medicare is headed for bankruptcy because of the reimbursement rates. What are we doing? Do you know what happens? Hospitals must cut back on the nurses; they cut back on their outreach programs in the community to work with children; they cut back on their training programs; they cut back, as much as they regret it, on the quality of care people get—not just for the elderly people, but for all the people being served.

What happens locally? Communities raise local taxes to try to assist hospitals, or they appeal to the State house and try to get additional resources. They try to get the revenues from someplace. Either localities accept a decline in health care quality or they have to raise additional resources locally or at the State level. Maybe some other States are experiencing generous surpluses, but you are not going to find many that are in our region of the country.

Financial cutbacks that have occurred in the past have made it difficult for hospitals to provide the excellent services they are used to providing, and the kinds of cutbacks being discussed by the Republicans now will only exacerbate this problem.

The right way to slow Medicare cost growth is in the context of a broad health reform program that will slow health inflation and in the economy as a whole. That is the way to bring Federal health care costs under control without cutting benefits or shifting costs to the working families.

In the context of a broad reform, the special needs of the academic health centers, the rural hospitals, and inner-city hospitals can also be addressed. Unilateral Medicare cuts alone, by contrast, could destroy the availability and the quality of care for the young and old alike.

The President said that he is willing to work for a bipartisan reform of the health care system, but our friends on the other side have said no. The only bipartisan shift they seem to be interested in is the kind that says, ''Join us in slashing Medicare.'' That is not the kind of bipartisanship the American people want.

The authors of the budget resolution claim to protect Social Security while making draconian cuts in Medicare. But the distinction is a false one because Medicare is part of Social Security. Like Social Security, it is a compact between the Government and the people that says, ''Pay into the trust fund during your working years and we will guarantee decent health care in your old age.'' This Republican budget breaks that compact.

As the ceremonies on V–E Day this past week remind us, today's senior citizens have stood by America in war and in peace, and America must stand by them now. The senior citizens have worked hard. They brought us out of the Depression. They fought in the Second World War. Their sons fought in the Korean war, and the Vietnam War. They have sacrificed greatly to advance the interests of their children. They played by the rules.

If this country is the great country that all of us believe that it is, it is really a tribute to the senior citizens. They have contributed to Medicare. They have earned their Medicare benefits. And they deserve to have them.

This Republican budget proposes to take those benefits away, and it should be rejected.

Mr. President, 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. SPECTER. 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 UNITED STATES EMBASSY IN ISRAEL

Mr. SPECTER. Mr. President, I have sought recognition this afternoon to respond to those who have raised an issue about the current efforts to have the United States Embassy moved to Jerusalem, the capital of Israel, instead of its current location in Tel Aviv.

There have been some suggestions that we are motivated for political purposes in 1995 to raise this issue. The history of these efforts conclusively refutes that contention. A bill was introduced on October 1, 1983, S. 2031, cosponsored at that time by 50 United States Senators, which sought to have the United States Embassy and the residence of the American Ambassador to Israel hereafter be located in the city of Jerusalem.

That resolution was referred to committee and was not called for a vote, but it was later noted that in addition to the 50 U.S. Senators, there were 227 Members of the House of Representatives who joined in endorsing that transfer of the U.S. Embassy from Tel Aviv to Jerusalem.

Then on March 26, 1990, Senate Concurrent Resolution 106 was introduced, which called for the recognition of Jerusalem as the capital of Israel, and that resolution was passed in the Senate by a voice vote.

Then, following those actions, on February 24, 1995, a letter was sent to Secretary of State Warren Christopher signed by 92 U.S. Senators evidencing strong bipartisan support, again calling for the moving of the U.S. Embassy from Tel Aviv to Jerusalem.

Mr. President, I was an original cosponsor of S. 2031 which was introduced back on October 31, 1983; supported Senate Concurrent Resolution 106 back in 1990; and joined in the letter of February 24, 1995, evidencing my consistent support for this program.

Recently, the Prime Minister of Israel, Yitzhak Rabin, was in Washington, and the issue was raised as to whether or not action by the Congress of the United States in calling for the removal of the Embassy from Tel Aviv to Jerusalem would be an impediment to the peace process which is ongoing at the present time because obviously we do not wish to interfere with the peace process. At that time, Prime Minister Rabin responded that it was a