United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 104th CONGRESS, SECOND SESSION

Vol. 142 WASHINGTON, THURSDAY, APRIL 18, 1996 No. 50

Senate

The Senate met at 9:30 a.m., and was called to order by the President pro tempore [Mr. THURMOND].

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

In our prayer this morning, let us think magnificently about God so that we may serve Him magnanimously throughout the day.

O God, whose love never lets us go, whose mercy never ends, whose strength is always available, whose guidance shows us the way, whose spirit provides us supernatural power, whose presence is our courage, whose joy invades our gloom, whose peace calms our pressured hearts, whose light illuminates our path, whose goodness provides the wondrous gifts of loved ones, family, and friends, whose will has brought us to the awesome tasks of this Senate today, and whose calling lifts us above party politics to put You and the good of our Nation first, we dedicate all that we have and are to serve You today with unreserved faithfulness and unfailing loyalty.

To God be the glory. Amen.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The able majority leader, Senator DOLE, is recognized.

SCHEDULE

Mr. DOLE. Mr. President, we will immediately begin consideration of Calendar No. 205, S. 1028, the Health Insurance Reform Act of 1996. Amendments are expected to be offered. Rollcall votes can be anticipated throughout the day and into the late evening. We want to finish this bill today. We had hoped to start it last evening.

It is also possible that the Senate could resume immigration legislation if agreement can be reached with respect to relevant amendments. That is probably unlikely.

Then, on next Monday, or tomorrow, we hope to start the debate on term limits. We will be announcing more on that later. But we do hope to complete action on the Health Insurance Reform Act of 1996 today or tomorrow. So we will be making an announcement about votes on tomorrow later today.

Mrs. KASSEBAUM. Mr. President, I suggest the absence of a quorum.

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

The assistant legislative clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

HEALTH INSURANCE REFORM ACT

The PRESIDING OFFICER. Under the previous order, the Senate will now proceed to consider S. 1028, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1028) to provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes.

The Senate proceeded to consider the bill, which had been reported from the Committee on Labor and Human Resources with an amendment to strike all after the enacting clause and inserting in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Reform Act of 1995''.

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

SEC. 2. DEFINITIONS.

As used in this Act:

(1) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(8)).

(2) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of

● This ''bullet'' symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(3) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

(4) EMPLOYEE HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''employee health benefit plan'' means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))) that provides or pays for health benefits (such as provider and hospital benefits) for participants and beneficiaries whether—

(i) directly;

(ii) through a group health plan offered by a health plan issuer as defined in paragraph (8); or

(iii) otherwise.

(B) RULE OF CONSTRUCTION.—An employee health benefit plan shall not be construed to be a group health plan, an individual health plan, or a health plan issuer.

(C) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(5) FAMILY.—

(A) IN GENERAL.—The term ''family'' means an individual, the individual's spouse, and the child of the individual (if any).

(B) CHILD.—For purposes of subparagraph (A), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(6) GROUP HEALTH PLAN.—

(A) IN GENERAL.—The term ''group health plan'' means any contract, policy, certificate or other arrangement offered by a health plan issuer to a group purchaser that provides or pays for health benefits (such as provider and hospital benefits) in connection with an employee health benefit plan.

(B) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(7) GROUP PURCHASER.—The term ''group purchaser'' means any person (as defined under paragraph (9) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)) or entity that purchases or pays for health benefits (such as provider or hospital benefits) on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. A health plan purchasing cooperative established under section 131 shall not be considered to be a group purchaser.

(8) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a group health plan or an individual health plan.

(9) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(10) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

(11) SECRETARY.—The term ''Secretary'', unless specifically provided otherwise, means the Secretary of Labor.

(12) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

SEC. 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) NONDISCRIMINATION.—Except as provided in subsection (b), section 102 and section 103—

(A) a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase such coverage; and

(B) an employee health benefit plan or a health plan issuer offering a group health plan may establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements under the terms of such plan, except that such requirements shall not be based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability.

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall prevent an employee health benefit plan or a health plan issuer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering a group health plan may cease offering coverage to group purchasers under the plan if—

(A) the health plan issuer ceases to offer coverage to any additional group purchasers; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)), if required, that its financial or provider capacity to serve previously covered participants and beneficiaries (and additional participants and beneficiaries who will be expected to enroll because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer is required to offer coverage to additional group purchasers.

Such health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer offers coverage to group purchasers under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(c) CONSTRUCTION.—

(1) MARKETING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering group health plans to actively market such plans.

(2) INVOLUNTARY OFFERING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to require a health plan issuer to involuntarily offer group health plans in a particular market. For the purposes of this paragraph, the term ''market'' means either the large employer market or the small employer market (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees).

SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) GROUP PURCHASER.—Subject to subsections (b) and (c), a group health plan shall be renewed or continued in force by a health plan issuer at the option of the group purchaser, except that the requirement of this subparagraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the group purchaser in accordance with the terms of the group health plan or where the health plan issuer has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser;

(C) the termination of the group health plan in accordance with subsection (b); or

(D) the failure of the group purchaser to meet contribution or participation requirements in accordance with paragraph (3).

(2) PARTICIPANT.—Subject to subsections (b) and (c), coverage under an employee health benefit plan or group health plan shall be renewed or continued in force, if the group purchaser elects to continue to provide coverage under such plan, at the option of the participant (or beneficiary where such right exists under the terms of the plan or under applicable law), except that the requirement of this paragraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the participant or beneficiary in accordance with the terms of the employee health benefit plan or group health plan or where such plan has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to an application for coverage or claim for benefits;

(C) the termination of the employee health benefit plan or group health plan;

(D) loss of eligibility for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.); or

(E) failure of a participant or beneficiary to meet requirements for eligibility for coverage under an employee health benefit plan or group health plan that are not prohibited by this Act.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection, nor in section 101(a), shall be construed to—

(A) preclude a health plan issuer from establishing employer contribution rules or group participation rules for group health plans as allowed under applicable State law;

(B) preclude a plan defined in section 3(37) of the Employee Retirement Income Security Act of

1974 (29 U.S.C. 1102(37)) from establishing employer contribution rules or group participation rules; or

(C) permit individuals to decline coverage under an employee health benefit plan if such right is not otherwise available under such plan.

(b) TERMINATION OF GROUP HEALTH PLANS.—

(1) PARTICULAR TYPE OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of group health plan, a group health plan of such type may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each group purchaser covered under a group health plan of this type (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 90 days prior to the date of the discontinuation of such plan;

(B) the health plan issuer offers to each group purchaser covered under a group health plan of this type, the option to purchase any other group health plan currently being offered by the health plan issuer; and

(C) in exercising the option to discontinue a group health plan of this type and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status or insurability of participants or beneficiaries covered under the group health plan, or new participants or beneficiaries who may become eligible for coverage under the group health plan.

(2) DISCONTINUANCE OF ALL GROUP HEALTH PLANS.—

(A) IN GENERAL.—In any case in which a health plan issuer elects to discontinue offering all group health plans in a State, a group health plan may be discontinued by the health plan issuer only if—

(i) the health plan issuer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan; and

(ii) all group health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(B) APPLICATION OF PROVISIONS.—The provisions of this paragraph and paragraph (3) may be applied separately by a health plan issuer—

(i) to all group health plans offered to small employers (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees); or

(ii) to all other group health plans offered by the health plan issuer in the State.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any group health plan in the market sector (as described in paragraph (2)(B)) in which issuance of such group health plan was discontinued in the State involved during the 5-year period beginning on the date of the discontinuation of the last group health plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A network plan (as defined in paragraph (2)) may deny continued participation under such plan to participants or beneficiaries who neither live, reside, nor work in an area in which such network plan is offered, but only if such denial is applied uniformly, without regard to health status or the insurability of particular participants or beneficiaries.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an employee health benefit plan or a group health plan that arranges for the financing and delivery of health care services to participants or beneficiaries covered under such plan, in whole or in part, through arrangements with providers.

(d) COBRA COVERAGE.—Nothing in subsection (a)(2)(E) or subsection (c) shall be construed to affect any right to COBRA continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition based on the fact that the condition existed prior to the coverage of the participant or beneficiary under the plan only if—

(1) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan;

(2) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth or placement for adoption (as determined under section 609(c)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(c)(3)(B)), was covered under the plan; and

(3) the limitation or exclusion does not apply to a pregnancy.

(b) CREDITING OF PREVIOUS QUALIFYING COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (4), an employee health benefit plan or a health plan issuer offering a group health plan shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage. With respect to an individual described in subsection (a)(2) who maintains continuous coverage, no limitation or exclusion of benefits relating to treatment of a preexisting condition may be applied to a child within the child's first 12 months of life or within 12 months after the placement of a child for adoption.

(2) DISCHARGE OF DUTY.—An employee health benefit plan shall provide documentation of coverage to participants and beneficiaries whose coverage is terminated under the plan. Pursuant to regulations promulgated by the Secretary, the duty of an employee health benefit plan to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such employee health benefit plan provides documentation to a participant or beneficiary that includes the following information:

(A) the dates that the participant or beneficiary was covered under the plan; and

(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such plan.

An employee health benefit plan shall retain the documentation provided to a participant or beneficiary under subparagraphs (A) and (B) for at least the 12-month period following the date on which the participant or beneficiary ceases to be covered under the plan. Upon request, an employee health benefit plan shall provide a second copy of such documentation to such participant or beneficiary within the 12-month period following the date of such ineligibility.

(3) DEFINITIONS.—As used in this section:

(A) PREVIOUS QUALIFYING COVERAGE.—The term ''previous qualifying coverage'' means the period beginning on the date—

(i) a participant or beneficiary is enrolled under an employee health benefit plan or a group health plan, and ending on the date the participant or beneficiary is not so enrolled; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) or under a public or private health plan established under Federal or State law, and ending on the date the individual is not so enrolled;

for a continuous period of more than 30 days (without regard to any waiting period).

(B) LIMITATION OR EXCLUSION OF BENEFITS RELATING TO TREATMENT OF A PREEXISTING CONDITION.—The term ''limitation or exclusion of benefits relating to treatment of a preexisting condition'' means a limitation or exclusion of benefits imposed on an individual based on a preexisting condition of such individual.

(4) EFFECT OF PREVIOUS COVERAGE.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition, subject to the limits in subsection (a)(1), only to the extent that such service or benefit was not previously covered under the group health plan, employee health benefit plan, or individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) LATE ENROLLEES.—Except as provided in section 104, with respect to a participant or beneficiary enrolling in an employee health benefit plan or a group health plan during a time that is other than the first opportunity to enroll during an enrollment period of at least 30 days, coverage with respect to benefits or services relating to the treatment of a preexisting condition in accordance with subsections (a) and (b) may be excluded, except the period of such exclusion may not exceed 18 months beginning on the date of coverage under the plan.

(d) AFFILIATION PERIODS.—With respect to a participant or beneficiary who would otherwise be eligible to receive benefits under an employee health benefit plan or a group health plan but for the operation of a preexisting condition limitation or exclusion, if such plan does not utilize a limitation or exclusion of benefits relating to the treatment of a preexisting condition, such plan may impose an affiliation period on such participant or beneficiary not to exceed 60 days (or in the case of a late participant or beneficiary described in subsection (c), 90 days) from the date on which the participant or beneficiary would otherwise be eligible to receive benefits under the plan. An employee health benefit plan or a health plan issuer offering a group health plan may also use alternative methods to address adverse selection as approved by the applicable certifying authority (as defined in section 202(d)). During such an affiliation period, the plan may not be required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(e) PREEXISTING CONDITION.—For purposes of this section, the term ''preexisting condition'' means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before the effective date of the coverage (without regard to any waiting period).

(f) STATE FLEXIBILITY.—Nothing in this section shall be construed to preempt State laws that—

(1) require health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than those provided for under this section; or

(2) allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 30-day period provided for under subsection (b)(3);

unless such laws are preempted by section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 104. SPECIAL ENROLLMENT PERIODS.

In the case of a participant, beneficiary or family member who—

(1) through marriage, separation, divorce, death, birth or placement of a child for adoption, experiences a change in family composition affecting eligibility under a group health plan, individual health plan, or employee health benefit plan;

(2) experiences a change in employment status, as described in section 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of eligibility for coverage, other than COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(3) experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan because of a change in the employment status of a family member;

each employee health benefit plan and each group health plan shall provide for a special enrollment period extending for a reasonable time after such event that would permit the participant to change the individual or family basis of coverage or to enroll in the plan if coverage would have been available to such individual, participant, or beneficiary but for failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or placed for adoption shall be deemed to be covered under the plan as of the date of such birth or placement for adoption if such child is enrolled within 30 days of the date of such birth or placement for adoption.

SEC. 105. DISCLOSURE OF INFORMATION.

(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.—

(1) IN GENERAL.—In connection with the offering of any group health plan to a small employer (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees), a health plan issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) the provisions of such group health plan relating to renewability of coverage;

(C) the provisions of such group health plan relating to any preexisting condition provision; and

(D) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

Information shall be provided to small employers under this paragraph in a manner determined to be understandable by the average small employer, and shall be sufficiently accurate and comprehensive to reasonably inform small employers, participants and beneficiaries of their rights and obligations under the group health plan.

(2) EXCEPTION.—With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under applicable law shall not be subject to the disclosure requirements of such paragraph.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State reporting and disclosure requirements to the extent that such requirements are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(b) DISCLOSURE OF INFORMATION TO PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) that is not a material reduction in covered services or benefits provided,''; and

(B) by adding at the end thereof the following new sentences: ''If there is a modification or change described in section 102(a)(1) that is a material reduction in covered services or benefits provided, a summary description of such modification or change shall be furnished to participants not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Reform Act of 1995, providing alternative mechanisms to delivery by mail through which employee health benefit plans may notify participants of material reductions in covered services or benefits.''.

(2) PLAN DESCRIPTION AND SUMMARY.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(A) by inserting ''including the office or title of the individual who is responsible for approving or denying claims for coverage of benefits'' after ''type of administration of the plan'';

(B) by inserting ''including the name of the organization responsible for financing claims'' after ''source of financing of the plan''; and

(C) by inserting ''including the office, contact, or title of the individual at the Department of Labor through which participants may seek assistance or information regarding their rights under this Act and the Health Insurance Reform Act of 1995 with respect to health benefits that are not offered through a group health plan.'' after ''benefits under the plan''.

Subtitle B—Individual Market Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.

(a) LIMITATION ON REQUIREMENTS.—

(1) IN GENERAL.—With respect to an individual desiring to enroll in an individual health plan, if such individual is in a period of previous qualifying coverage (as defined in section 103(b)(3)(A)(i)) under one or more group health plans or employee health benefit plans that commenced 18 or more months prior to the date on which such individual desires to enroll in the individual plan, a health plan issuer described in paragraph (3) may not decline to offer coverage to such individual, or deny enrollment to such individual based on the health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability of the individual, except as described in subsections (b) and (c).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent a health plan issuer offering an individual health plan from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion or disease prevention.

(3) HEALTH PLAN ISSUER.—A health plan issuer described in this paragraph is a health plan issuer that issues or renews individual health plans.

(4) PREMIUMS.—Nothing in this subsection shall be construed to affect the determination of a health plan issuer as to the amount of the premium payable under an individual health plan under applicable State law.

(b) ELIGIBILITY FOR OTHER GROUP COVERAGE.—The provisions of subsection (a) shall not apply to an individual who is eligible for coverage under a group health plan or an employee health benefit plan, or who has had coverage terminated under a group health plan or employee health benefit plan for failure to make required premium payments or contributions, or for fraud or misrepresentation of material fact, or who is otherwise eligible for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) or under an equivalent State program.

(c) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering coverage to individuals under an individual health plan may cease enrolling individuals under the plan if—

(A) the health plan issuer ceases to enroll any new individuals; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)), if required, that its financial or provider capacity to serve previously covered individuals will be impaired if the health plan issuer is required to enroll additional individuals.

Such a health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering coverage to individuals under an individual health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) MARKET REQUIREMENTS.—

(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) CONVERSION POLICIES.—A health plan issuer offering group health plans to group purchasers under this Act shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(3) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering coverage to individuals under an individual health plan to actively market such plan.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

(a) IN GENERAL.—Subject to subsections (b) and (c), coverage for individuals under an individual health plan shall be renewed or continued in force by a health plan issuer at the option of the individual, except that the requirement of this subsection shall not apply in the case of—

(1) the nonpayment of premiums or contributions by the individual in accordance with the terms of the individual health plan or where the health plan issuer has not received timely premium payments;

(2) fraud or misrepresentation of material fact on the part of the individual; or

(3) the termination of the individual health plan in accordance with subsection (b).

(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—

(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of individual health plan to individuals, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 90 days prior to the date of the expiration of the plan;

(B) the health plan issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently being offered by the health plan issuer to individuals; and

(C) in exercising the option to discontinue the individual health plan and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status or insurability of particular individuals.

(2) DISCONTINUANCE OF ALL INDIVIDUAL HEALTH PLANS.—In any case in which a health

plan issuer elects to discontinue all individual health plans in a State, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each individual covered under the plan of such discontinuation at least 180 days prior to the date of the discontinuation of the plan; and

(B) all individual health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any individual health plan in the State involved during the 5-year period beginning on the date of the discontinuation of the last plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan issuer which offers a network plan (as defined in paragraph (2)) may deny continued participation under the plan to individuals who neither live, reside, nor work in an area in which the individual health plan is offered, but only if such denial is applied uniformly, without regard to health status or the insurability of particular individuals.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an individual health plan that arranges for the financing and delivery of health care services to individuals covered under such health plan, in whole or in part, through arrangements with providers.

SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

(a) IN GENERAL.—With respect to any State law with respect to which the Governor of the State notifies the Secretary of Health and Human Services that such State law will achieve the goals of sections 110 and 111, and that is in effect on, or enacted after, the date of enactment of this Act (such as laws providing for guaranteed issue, open enrollment by one or more health plan issuers, high-risk pools, or mandatory conversion policies), such State law shall apply in lieu of the standards described in sections 110 and 111 unless the Secretary of Health and Human Services determines, after considering the criteria described in subsection (b)(1), in consultation with the Governor and Insurance Commissioner or chief insurance regulatory official of the State, that such State law does not achieve the goals of providing access to affordable health care coverage for those individuals described in sections 110 and 111.

(b) DETERMINATION.—

(1) IN GENERAL.—In making a determination under subsection (a), the Secretary of Health and Human Services shall only—

(A) evaluate whether the State law or program provides guaranteed access to affordable coverage to individuals described in sections 110 and 111;

(B) evaluate whether the State law or program provides coverage for preexisting conditions (as defined in section 103(e)) that were covered under the individuals' previous group health plan or employee health benefit plan for individuals described in sections 110 and 111;

(C) evaluate whether the State law or program provides individuals described in sections 110 and 111 with a choice of health plans or a health plan providing comprehensive coverage; and

(D) evaluate whether the application of the standards described in sections 110 and 111 will have an adverse impact on the number of individuals in such State having access to affordable coverage.

(2) NOTICE OF INTENT.—If, within 6 months after the date of enactment of this Act, the Governor of a State notifies the Secretary of Health and Human Services that the State intends to enact a law, or modify an existing law, described in subsection (a), the Secretary of Health and Human Services may not make a determination under such subsection until the expiration of the 12-month period beginning on the date on which such notification is made, or until January 1, 1997, whichever is later. With respect to a State that provides notice under this paragraph and that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act, the Secretary shall not make a determination under subsection (a) prior to January 1, 1998.

(3) NOTICE TO STATE.—If the Secretary of Health and Human Services determines that a State law or program does not achieve the goals described in subsection (a), the Secretary of Health and Human Services shall provide the State with adequate notice and reasonable opportunity to modify such law or program to achieve such goals prior to making a final determination under subsection (a).

(c) ADOPTION OF NAIC MODEL.—If, not later than 9 months after the date of enactment of this Act—

(1) the National Association of Insurance Commissioners (hereafter referred to as the ''NAIC''), through a process which the Secretary of Health and Human Services determines has included consultation with representatives of the insurance industry and consumer groups, adopts a model standard or standards for reform of the individual health insurance market; and

(2) the Secretary of Health and Human Services determines, within 30 days of the adoption of such NAIC standard or standards, that such standards comply with the goals of sections 110 and 111;

a State that elects to adopt such model standards or substantially adopt such model standards shall be deemed to have met the requirements of sections 110 and 111 and shall not be subject to a determination under subsection (a).

SEC. 113. DEFINITION.

(a) IN GENERAL.—As used in this title, the term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health plan issuer that provides or pays for health benefits (such as provider and hospital benefits) and that is not a group health plan under section 2(6).

(b) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(1) Coverage only for accident, or disability income insurance, or any combination thereof.

(2) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(3) Coverage issued as a supplement to liability insurance.

(4) Liability insurance, including general liability insurance and automobile liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Coverage for a specified disease or illness.

(8) Hospital or fixed indemnity insurance.

(9) Short-term limited duration insurance.

(10) Credit-only, dental-only, or vision-only insurance.

(11) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(II) by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1995''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(2) ELECTION.—Section 2205(1)(C) of the Public Health Service Act (42 U.S.C. 300bb-5(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof;

(B) in clause (ii), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 2202(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 2206(3) of the Public Health Service Act (42 U.S.C. 300bb-6(3)) is amended by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb-8(3)(A)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this title.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) PERIOD OF COVERAGE.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(ii) by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1995''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(2) ELECTION.—Section 605(1)(C) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof;

(B) in clause (ii), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 606(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(3)) is amended by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i) by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section'';

(B) in clause (iv)(I), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this subclause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this subsection because of the provision of the Health Insurance Reform Act of 1995''; and

(C) in clause (v), by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(2) ELECTION.—Section 4980B(f)(5)(A)(iii) of the Internal Revenue Code of 1986 is amended—

(A) in subclause (I), by striking ''or'' at the end thereof;

(B) in subclause (II), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new subclause:

''(III) in the case of an qualified beneficiary described in the last sentence of paragraph (2)(B)(i), the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring on or after the date of the enactment of this Act for plan years beginning after December 31, 1996.

(e) NOTIFICATION OF CHANGES.—Not later than 60 days prior to the date on which this section becomes effective, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Cooperatives

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERATIVES.

(a) DEFINITION.—As used in this Act, the term ''health plan purchasing cooperative'' means a group of individuals or employers that, on a voluntary basis and in accordance with this section, form a cooperative for the purpose of purchasing individual health plans or group health plans offered by health plan issuers. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of insurance may not underwrite a cooperative.

(b) CERTIFICATION.—

(1) IN GENERAL.—If a group described in subsection (a) desires to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Secretary of such desire, the State, upon a determination that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall make a determination of whether such group meets the requirements of this section in a timely fashion. Each such cooperative shall also be registered with the Secretary.

(2) STATE REFUSAL TO CERTIFY.—If a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with the standards under this Act, the Secretary shall certify and oversee the operations of such cooperatives in such State.

(3) INTERSTATE COOPERATIVES.—For purposes of this section, a health plan purchasing cooperative operating in more than one State shall be certified by the State in which the cooperative is domiciled. States may enter into cooperative agreements for the purpose of certifying and overseeing the operation of such cooperatives. For purposes of this subsection, a cooperative shall be considered to be domiciled in the State in which most of the members of the cooperative reside.

(c) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each health plan purchasing cooperative shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the cooperative under this section. The Board shall be composed of a broad cross-section of representatives of employers, employees, and individuals participating in the cooperative. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of individual health plans or group health plans may not hold or control any right to vote with respect to a cooperative.

(2) LIMITATION ON COMPENSATION.—A health plan purchasing cooperative may not provide compensation to members of the Board of Directors. The cooperative may provide reimbursements to such members for the reasonable and necessary expenses incurred by the members in the performance of their duties as members of the Board.

(3) CONFLICT OF INTEREST.—No member of the Board of Directors (or family members of such members) nor any management personnel of the cooperative may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of any health plan issuer, health care provider, or agent or broker. Nothing in the preceding sentence shall limit a member of the Board from purchasing coverage offered through the cooperative.

(d) MEMBERSHIP AND MARKETING AREA.—

(1) MEMBERSHIP.—A health plan purchasing cooperative may establish limits on the maximum size of employers who may become members of the cooperative, and may determine whether to permit individuals to become members. Upon the establishment of such membership requirements, the cooperative shall, except as provided in subparagraph (B), accept all employers (or individuals) residing within the area served by the cooperative who meet such requirements as members on a first-come, first-served basis, or on another basis established by the State to ensure equitable access to the cooperative.

(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by a health plan purchasing cooperative. With respect to a State that has not established such rules, a health plan purchasing cooperative operating in the State shall define the boundaries of the area to be served by the cooperative, except that such boundaries may not be established on the basis of health status or insurability of the populations that reside in the area.

(e) DUTIES AND RESPONSIBILITIES.—

(1) IN GENERAL.—A health plan purchasing cooperative shall—

(A) enter into agreements with multiple, unaffiliated health plan issuers, except that the requirement of this subparagraph shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible;

(B) enter into agreements with employers and individuals who become members of the cooperative;

(C) participate in any program of risk-adjustment or reinsurance, or any similar program, that is established by the State;

(D) prepare and disseminate comparative health plan materials (including information about cost, quality, benefits, and other information concerning group health plans and individual health plans offered through the cooperative);

(E) actively market to all eligible employers and individuals residing within the service area; and

(F) act as an ombudsman for group health plan or individual health plan enrollees.

(2) PERMISSIBLE ACTIVITIES.—A health plan purchasing cooperative may perform such other functions as necessary to further the purposes of this Act, including—

(A) collecting and distributing premiums and performing other administrative functions;

(B) collecting and analyzing surveys of enrollee satisfaction;

(C) charging membership fee to enrollees (such fees may not be based on health status) and charging participation fees to health plan issuers;

(D) cooperating with (or accepting as members) employers who provide health benefits directly to participants and beneficiaries only for the purpose of negotiating with providers; and

(E) negotiating with health care providers and health plan issuers.

(f) LIMITATIONS ON COOPERATIVE ACTIVITIES.—A health plan purchasing cooperative shall not—

(1) perform any activity relating to the licensing of health plan issuers;

(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative relating to any group health plan or individual health plan;

(3) establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements for participants, beneficiaries, or individuals based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability;

(4) operate on a for-profit or other basis where the legal structure of the cooperative permits profits to be made and not returned to the members of the cooperative, except that a for-profit health plan purchasing cooperative may be formed by a nonprofit organization—

(A) in which membership in such organization is not based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability; and

(B) that accepts as members all employers or individuals on a first-come, first-served basis, subject to any established limit on the maximum size of and employer that may become a member; or

(5) perform any other activities that conflict or are inconsistent with the performance of its duties under this Act.

(g) LIMITED PREEMPTION OF CERTAIN STATE LAWS.—

(1) IN GENERAL.—With respect to a health plan purchasing cooperative that meets the requirements of this section, State fictitious group laws shall be preempted.

(2) HEALTH PLAN ISSUERS.—

(A) RATING.—With respect to a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative that meets the requirements of this section, State premium rating requirement laws, except to the extent provided under subparagraph (B), shall be preempted unless such laws permit premium rates negotiated by the cooperative to be less than rates that would otherwise be permitted under State law, if such rating differential is not based on differences in health status or demographic factors.

(B) EXCEPTION.—State laws referred to in subparagraph (A) shall not be preempted if such laws—

(i) prohibit the variance of premium rates among employers, plan sponsors, or individuals that are members of a health plan purchasing cooperative in excess of the amount of such variations that would be permitted under such State rating laws among employers, plan sponsors, and individuals that are not members of the cooperative; and

(ii) prohibit a percentage increase in premium rates for a new rating period that is in excess of that which would be permitted under State rating laws.

(C) BENEFITS.—Except as provided in subparagraph (D), a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative shall comply with all State mandated benefit laws that require the offering of any services, category or care, or services of any class or type of provider.

(D) EXCEPTION.—In those States that have enacted laws authorizing the issuance of alternative benefit plans to small employers, health plan issuers may offer such alternative benefit plans through a health plan purchasing cooperative that meets the requirements of this section.

(h) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to—

(1) require that a State organize, operate, or otherwise create health plan purchasing cooperatives;

(2) otherwise require the establishment of health plan purchasing cooperatives;

(3) require individuals, plan sponsors, or employers to purchase group health plans or individual health plans through a health plan purchasing cooperative;

(4) require that a health plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State;

(5) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefits plans; or

(6) confer authority upon a State (or the Federal Government) that the State (or Federal Government) would not otherwise have to regulate group purchasing arrangements, coalitions, or other similar entities that do not desire to become a health plan purchasing cooperative in accordance with this section.

(i) APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of parts 4 and 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101) shall apply to a health plan purchasing cooperative as if such plan were an employee welfare benefit plan.

TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS

SEC. 201. APPLICABILITY.

(a) CONSTRUCTION.—

(1) ENFORCEMENT.—

(A) IN GENERAL.—A requirement or standard imposed under this Act on a group health plan or individual health plan offered by a health plan issuer shall be deemed to be a requirement or standard imposed on the health plan issuer. Such requirements or standards shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act. In the case of a group health plan offered by a health plan issuer in connection with an employee health benefit plan, the requirements or standards imposed under this Act shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act.

(B) LIMITATION.—Except as provided in subsection (c), the Secretary shall not enforce the requirements or standards of this Act as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a State enforce the requirements or standards of this Act as they relate to employee health benefit plans.

(2) PREEMPTION OF STATE LAW.—Nothing in this Act shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements—

(A) not prescribed in this Act; or

(B) related to the issuance, renewal, or portability of health insurance or the establishment or operation of group purchasing arrangements, that are consistent with, and are not in direct conflict with, this Act and provide greater protection or benefit to participants, beneficiaries or individuals.

(b) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(c) CONTINUATION.—Nothing in this Act shall be construed as requiring a group health plan or an employee health benefit plan to provide benefits to a particular participant or beneficiary in excess of those provided under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan issued, sold, renewed, offered for sale or operated in such State by a health plan issuer meet the standards established under this Act pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the State enforcement plan.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—With respect to employee health benefit plans, the Secretary shall enforce the reform standards established under this Act in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State to substantially enforce the standards and requirements set forth in this Act with respect to group health plans and individual health plans as provided for under the State enforcement plan filed under subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, shall implement an enforcement plan meeting the standards of this Act in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this Act, each health plan issuer operating in such State shall be subject to civil enforcement as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(d) APPLICABLE CERTIFYING AUTHORITY.—As used in this title, the term ''applicable certifying authority'' means, with respect to—

(1) health plan issuers, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this Act for the State involved; and

(2) an employee health benefit plan, the Secretary.

(e) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this Act.

(f) TECHNICAL AMENDMENT.—Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting ''and under the Health Insurance Reform Act of 1995'' before the period.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. HMOS ALLOWED TO OFFER PLANS WITH DEDUCTIBLES TO INDIVIDUALS WITH MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 1301(b) of the Public Health Service Act (42 U.S.C. 300e(b)) is amended by adding at the end the following new paragraph:

''(6)(A) If a member certifies that a medical savings account has been established for the benefit of such member, a health maintenance organization may, at the request of such member reduce the basic health services payment otherwise determined under paragraph (1) by requiring the payment of a deductible by the member for basic health services.

''(B) For purposes of this paragraph, the term 'medical savings account' means an account which, by its terms, allows the deposit of funds and the use of such funds and income derived from the investment of such funds for the payment of the deductible described in subparagraph (A).''.

(b) MEDICAL SAVINGS ACCOUNTS.—It is the sense of the Committee on Labor and Human Resources of the Senate that the establishment of medical savings accounts, including those defined in section 1301(b)(6)(B) of the Public Health Service Act (42 U.S.C. 300e(b)(6)(B)), should be encouraged as part of any health insurance reform legislation passed by the Senate through the use of tax incentives relating to contributions to, the income growth of, and the qualified use of, such accounts.

(c) SENSE OF THE SENATE.—It is the sense of the Senate that the Congress should take measures to further the purposes of this Act, including any necessary changes to the Internal Revenue Code of 1986 to encourage groups and individuals to obtain health coverage, and to promote access, equity, portability, affordability, and security of health benefits.

SEC. 302. HEALTH COVERAGE AVAILABILITY STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary, representatives of State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits, shall conduct a two-part study, and prepare and submit reports, in accordance with this section.

(b) EVALUATION OF AVAILABILITY.—Not later than January 1, 1997, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning—

(1) an evaluation, based on the experience of States, expert opinions, and such additional data as may be available, of the various mechanisms used to ensure the availability of reasonably priced health coverage to employers purchasing group coverage and to individuals purchasing coverage on a non-group basis; and

(2) whether standards that limit the variation in premiums will further the purposes of this Act.

(c) EVALUATION OF EFFECTIVENESS.—Not later than January 1, 1998, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning the effectiveness of the provisions of this Act and the various State laws, in ensuring the availability of reasonably priced health coverage to employers purchasing group coverage and individuals purchasing coverage on a nongroup basis.

SEC. 303. SENSE OF THE COMMITTEE CONCERNING MEDICARE.

(a) FINDINGS.—The Committee on Labor and Human Resources of the Senate finds that the Public Trustees of Medicare concluded in their 1995 Annual Report that—

(1) the Medicare program is clearly unsustainable in its present form;

(2) ''the Hospital Insurance Trust Fund, which pays inpatient hospital expenses, will be able to pay benefits for only about 7 years and is severely out of financial balance in the long range''; and

(3) the Public Trustees ''strongly recommend that the crisis presented by the financial condition of the Medicare trust fund be urgently addressed on a comprehensive basis, including a review of the programs's financing methods, benefit provisions, and delivery mechanisms''.

(b) SENSE OF THE COMMITTEE.—It is the Sense of the Committee on Labor and Human Resources of the Senate that the Senate should take measures necessary to reform the Medicare program, to provide increased choice for seniors, and to respond to the findings of the Public Trustees by protecting the short-term solvency and long-term sustainability of the Medicare program.

SEC. 304. EFFECTIVE DATE.

Except as otherwise provided for in this Act, the provisions of this Act shall apply as follows:

(1) With respect to group health plans and individual health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1996; and

(2) With respect to employee health benefit plans, on the first day of the first plan year beginning on or after January 1, 1996.

SEC. 305. SEVERABILITY.

If any provision of this Act or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this Act and the application of the provisions of such to any person or circumstance shall not be affected thereby.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, Congress has spent significant time during the past 4 years debating comprehensive health care reform and major reforms to the Medicaid and Medicare Programs. While we have filled pages of newspapers and the CONGRESSIONAL RECORD and hearing records, our actions have not equaled our words.

Meanwhile, many American families worry about the availability, portability, and cost of their own health care coverage.

The health insurance problem is not merely one of perception. The health care market continues to transform itself. An example is the rapid movement toward managed care. At the same time, the number of uninsured and underinsured Americans has continued to climb. There are now over 40 million Americans without health insurance, and that number continues to grow.

Over 1 million working Americans have lost health insurance in the last 2 years alone, and over 80 million Americans have preexisting conditions that could make it difficult for them to maintain health coverage when they change jobs.

The current health insurance system provides too little protection for individuals and families with health problems and makes it too difficult for employers, particularly small employers, to obtain adequate coverage for their employees. It also locks people into jobs out of fear they will lose their health care coverage if they change jobs or if they lose their jobs.

Let me remind my colleagues that Federal law preempts States from providing portability to the majority of Americans who get their coverage through so-called self-insured health plans. Therefore, only Congress, only the Federal Government, can guarantee insurance portability and an end to job lock. That is one of the main reasons all major organizations representing the States have endorsed S. 1028.

The Health Insurance Reform Act before the Senate today passed the Senate Labor and Human Resources Committee in August by a unanimous vote. It now has 65 cosponsors, 27 Republicans and 38 Democrats. It is clear that, if this bill were to come to a vote in its current form, it would have more than enough votes to overcome any potential filibuster. The House of Representatives already has passed legislation containing health insurance reform similar to S. 1028.

Moreover, the bill has been endorsed by a wide range of organizations, including the National Governors' Association, the National Association of State Insurance Commissioners, the Consortium for Citizens with Disabilities, Small Business United, the National Association of Manufacturers, the National Federation of Independent Business, the U.S. Chamber of Commerce, the American Medical Association, American Hospital Association, Families USA, Consumers Union, the American Association of Retired Persons, and the AFL–CIO.

The portability provisions of this bill are even supported by many health insurers, including the American Association of Health Plans, Aetna, Prudential, Cigna, United Healthcare and the Blue Cross and Blue Shield Association, which is the largest health insurance carrier in the individual market.

Doctors, hospitals, insurers, HMO's, large business, small business, organized labor, and consumer groups all support the bill before us today. When one looks at the history of health care reform and the difficult tradeoffs and policy choices that must be made, that fact alone, I suggest, is remarkable.

The majority of these organizations have made clear that their support is conditioned on S. 1028 remaining free of contentious amendments.

We have a historic opportunity to pass limited, but real, health reform for the American people. We must not squander this opportunity by expanding the scope of this bill. The lessons of the past are clear. If we try to do too much, we will fail to do anything.

This bill is too important to people who may not have a voice in the Halls of Congress by any major organization, but who will be helped tremendously by this legislation. People like Tom Hall, a retired construction worker and farmer from Oklahoma City.

After 30 years of being covered by his employer, Tom started his own company and tried to buy an insurance policy for his family. However, the same insurer that had covered him while he was employed turned him down. Several years later, he did find an insurance policy that covers everything but his preexisting heart condition.

Mr. Hall testified before our committee, and it was very powerful testimony in its own significant way. Clearly, Mr. Hall would be protected by the group-to-individual portability provisions of this bill.

There are other families who would benefit. One is from Herndon, VA. A daughter who has cerebral palsy is excluded from coverage for at least 12 months every time the husband, Robert, changes jobs. While they have waited for these preexisting conditions to expire, they have had to pay both COBRA coverage and coverage under the new employer plan.

Mr. President, I also visited with a young woman who is an employee of the U.S. Senate. She has cancer. Her husband is completing his graduate work, and they hope to move to Florida. She is afraid to leave the coverage she has under her Federal employees health insurance for fear if they move to Florida, she may not be able to get insurance which would cover her because of her having cancer.

These are just some examples of people who would be helped directly by this legislation.

Only a year after President Clinton waved his veto pen and said he would not sign any bill that did not contain universal coverage, the President now says he will sign this carefully targeted health insurance portability bill. We should take him up on that offer.

The bill before us today does not achieve universal coverage. It is a far cry from the comprehensive health reform proposals that were considered by Congress only in the last Congress. However, it would immediately and measurably improve the lives of millions of Americans.

Through sensible, market-based reforms, the Health Insurance Reform Act would, first, limit the ability of insurers and employers to impose exclusions for preexisting conditions; second, prevent insurers from dropping coverage when an individual changes jobs or family members become sick; and third, help small companies gain more purchasing clout in the marketplace.

Despite its limited scope, the General Accounting Office estimates that the Health Insurance Reform Act would

help at least 25 million Americans each year, and the Congressional Budget Office predicts that it would do so without any cost to the American taxpayers.

Mr. President, I do not know whether it is 25 million. I do not know if it is 10 million or if it is 5 million. What matters is each and every one of us in this U.S. Senate knows someone it would help. And if it only helps those few that we know even, it would be well worth positive consideration on the floor of the Senate.

I believe the legislation has achieved broad consensus for two main reasons. First, it is narrowly focused. It does not contain employer mandates, mandatory purchasing alliances, new taxes or new bureaucracies. Instead, the legislation focuses only on those areas where broad bipartisan agreement existed during the health care debate in the 103d Congress and where State insurance reforms have demonstrated the ability to work.

Second, the legislation was crafted with a significant input from consumers, insurers, businesses, hospitals and doctors. It is carefully attuned to the rapidly changing private health care market.

The Health Insurance Reform Act is not without some detractors. We have worked closely with the health insurance industry, and insurers generally support the bill. For example, the Health Insurance Association of America submitted testimony in favor of the vast majority of the bill's provisions. However, some continue to raise concerns about one provision of the legislation that is designed to help individuals and families who have played by the rules to maintain health coverage if they lose their job or leave a job to work for an employer that does not offer coverage.

I believe, however, that this provision strikes a careful balance between the need to provide consumers access to individual coverage and the need to protect the fragile individual insurance market.

The Health Insurance Reform Act would provide access to individual insurance only for those who have maintained prior continuous coverage under an employer-sponsored health plan for at least 1½ years, who have exhausted their COBRA benefits, and who are ineligible for coverage under another group policy.

Moreover, S. 1028 contains no restrictions on premiums. There are many who wish that it did, and it leaves broader reforms, such as guaranteed issue for individuals who have not had prior coverage, guaranteed issue for self-employed and portability between individual health plans to the States.

As a result, the bill requires individuals to pay into the system before being able to use its provisions for continued health coverage. This group-to-individual portability provision is carefully circumscribed precisely to avoid potential premium increases and adverse selection problems that could result from broader individual market reforms.

The American Academy of Actuaries, the Congressional Budget Office, the Rand Corp., the Hay Huggins Group and other credible independent actuaries have confirmed that this narrow provision would have only a minimal impact on the cost of health coverage in the individual market. There are some who have vastly exaggerated what the premium increase would be, but those that I have mentioned are sources that have no ax to grind in this area and whose reliability on projections are totally objective.

The substitute goes even further. It expressly provides that if a State has adopted or adopts in the future a high-risk pool or other means of allowing individuals to maintain health coverage, that State law or program will apply in lieu of the group-to-individual portability provision contained in the bill.

Instead of preempting State reforms that are working or prescribing a one-size-fits-all solution from Washington, S. 1028 allows each State to fashion individual market solutions that are appropriate for individuals in that State. This is another reason why both the Governors and the State insurance commissioners support the bill.

Mr. President, I think we all know those who would be helped by this legislation, as I said. The Health Insurance Reform Act does not strike out in a bold new direction, but it is a positive step forward that will help reduce barriers to health coverage for millions of working Americans. It is also an opportunity to demonstrate to the American people that Republicans and Democrats can work together to address their most serious concerns regarding health care.

As Robert Samuelson stated in his column on April 17 in the Washington Post:

> The virtue of this proposal is its modesty. There is nothing wrong with constructive tinkering. We've had enough of grand reforms, which promise much and deliver little. However, if enacted, it would provide a little extra peace of mind for those who have already had employer-paid insurance.

He concludes:

> This legislation isn't exciting but then again good government often isn't.

Mr. President, it may not be exciting, but let me tell you, if you know one person this legislation would help, it is, indeed, exciting.

I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER (Mr. INHOFE). The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I want, first of all, as we begin the consideration of the legislation which can make such an extraordinary difference to millions of our fellow citizens in this country, mention at the outset my great respect, and I think the respect all of us in the Senate should have, for the chairperson of our committee of the Labor and Human Resources Committee.

I can remember going back the last time that the Senate was considering major legislation—we have had other legislation in the meantime—the comprehensive legislation that we considered now some 2 years ago. During that period of time, Senator KASSEBAUM was tireless in trying to find some common ground. We had some areas of agreement. We were unable, obviously, to get to the full measure of agreement during those considerations. But I think all of us who were a part of that effort knew that Senator KASSEBAUM was trying to find the areas of common ground on which we could move forward. At the end of the consideration of that legislation, I can remember a conversation that we had.

In her typical manner, she expressed a very compelling view that we should not let the issues of health care fall by the wayside and that we ought to try to look through the various proposals that had been considered at that period of time and that we ought to try to piece what we could together that could make an important difference for the American people and see if we could not work out a bipartisan effort.

It was really from that initiative and from that energy that she has spent hour after hour after hour in small meetings, large meetings, hearings, in visiting with various interested members of our committee and other Members of the Senate, and really helped in developing this legislation. In an extraordinary committee action, we were able to bring all the members and get a unanimous vote in support of this legislation, which is really an extraordinary achievement and accomplishment at any time. It certainly is now in this Congress, which in many instances has had more contentious debates and less agreement on many public policy issues.

But in this area, it is really a result of her own particular skills and talents and energy and strong commitment that we are here today with the extraordinary support that she has mentioned in regard to both Republicans and Democrats. I think all Members of the Senate, obviously, who know her and know her perseverance pay tribute to her extraordinary leadership on this issue.

I certainly at the outset of this debate and discussion acknowledge that and pay tribute to it. I think when the history of health policy is written, her imprint on not just this legislation but on so many other measures of health will be very, very much recognized, as it should be. It has been a personal pleasure to have the chance to work with her. I know all the members of the committee feel the same way.

Mr. President, the legislation we are considering today will end many of the most serious health insurance abuses and provide greater protection to millions of families. It is an opportunity we cannot afford to miss.

The abusive practices addressed by this bill create endless, unnecessary suffering. Millions of Americans are forced to pass up opportunities to accept jobs that would improve their standard of living or offer them greater opportunities because they are afraid they will lose their health insurance. Many others have to abandon the goal of starting their own business because health insurance would be unavailable to them or members of their families.

Children who age out of their parents' policies often find themselves unable to obtain their own insurance if they have any significant health problems. Early retirees can find themselves uninsured just when they are entering the years of highest health risks.

Other Americans lose their health insurance because they become sick or lose their job or change their job, even when they have faithfully paid their insurance premiums for many years.

With each passing year, the flaws in the private health insurance market become more serious. More than half of all insurance policies impose exclusions for preexisting conditions. As a result, insurance is often denied for the very illnesses most likely to require medical care. The purpose of such exclusions is reasonable to prevent people from gaming the system by purchasing coverage only when they get sick, but current practices are indefensible.

No matter how faithfully people pay their premiums, they often have to start over again with a new exclusion period if they change jobs or lose their coverage. And 81 million Americans have conditions that could subject them to such exclusions if they lose their current health care coverage. Sometimes the exclusions make them completely uninsurable.

Insurers impose exclusions for preexisting conditions on people who do not deserve to be excluded from the coverage they need. Sometimes insurers deny coverage to entire firms if one employee of the firm is in poor health or exclude that employee from the coverage. In other cases, entire categories of businesses with millions of employees are red lined out of coverage.

Even if people are fortunate enough to gain coverage and have no preexisting condition, their coverage can be canceled if they have the misfortune to become sick, even after paying premiums for years.

Robert Frasher from Mansfield, OH, works for an employer who offers health coverage to employees, but the insurance company will not cover him. Why? Because he has Crohn's disease.

Jean Meredith of Harriman, TN, and her husband Tom owned Fruitland USA, a mom-and-pop convenience store. They had insurance through their small business for 8 years until Tom was diagnosed with non-Hodgkin's lymphoma, and their insurance company dropped them. When the Merediths asked why, they were told they were no longer profitable insurance risks. Without health insurance, Tom Meredith had to wait a year to get the surgery he needed. After spending $60,000 of his own funds, his cancer recurred and he died of cancer about a year ago. Tom Meredith might still be alive today if he had not been forced to wait that year.

One of the most serious consequences of the current system is job lock. Workers who want to change jobs to improve their careers or provide a better standard of living for their families must give up that opportunity because it means losing their health insurance. A quarter of all American workers say they are forced to stay in a job they otherwise would have left because they are afraid of losing their health insurance.

Diane Bratten, from Grove Heights, MN, her family had insurance through Diane's employer. Because of a history of breast cancer—now in remission—Diane and her family will not be able to get decent coverage if she decides to change jobs or is laid off.

The legislation that Senator KASSEBAUM and I have introduced will address these problems effectively. The Kassebaum-Kennedy Health Insurance Reform Act is a health insurance bill of rights for every American and for every business as well. The legislation contains many of the provisions from the 1994 health reform debate which received bipartisan support, such as an increased access to health insurance, increased portability, protection of health benefits for those who lose their jobs or want to start their own business, and greater purchasing power for individuals and small businesses.

Those who have insurance deserve the security of knowing that their coverage cannot be canceled, especially when they need it the most. They deserve the security of knowing that if they pay their insurance premiums for years, they cannot be denied coverage, be subjected to a new exclusion for a preexisting condition when they change jobs, join another group policy, or when they need to purchase coverage in the individual market. Businesses, especially small businesses, deserve the right to purchase health insurance for their employees at a reasonable price.

Our Health Insurance Reform Act addresses these fundamental flaws in the private insurance system. The bill limits the ability of insurance companies to impose exclusions for preexisting conditions. Under the legislation, no exclusion can last for more than 12 months. Once someone has been covered for 12 months, no new exclusion can be imposed as long as there is no gap in coverage, even if someone changes jobs, loses their job, or changes insurance companies.

The bill requires insurers to sell and renew group health policies for all employers who want coverage for their employees. It guarantees renewability of individual policies. It prohibits insurers from denying insurance to those moving from group coverage to individual coverage. It prohibits group health plans from excluding any employee based on health status.

The portability provisions of the bill mean that individuals with coverage under a group health plan will not be locked into their job for fear that they will be denied coverage or face a new exclusion for a preexisting condition. These provisions will benefit at least 25 million Americans annually, according to the General Accounting Office. In addition, the provisions will provide greater security for the 131 million Americans currently covered under group health plans.

The bill will also help small businesses provide better and less expensive coverage for their employees. Purchasing cooperatives will enable small groups and individuals to join together to negotiate better rates in the market. As a result, they can obtain the kind of clout in the marketplace currently available only to large employers.

The bill also provides great flexibility for States to meet the objective of access to affordable health care for individuals who leave their group health plans.

During the debate on health reform in the last Congress, even the opponents of comprehensive reform urged Congress to pass at least the reforms that everyone supported—portability of coverage, guaranteed availability of coverage, and limitations on exclusions for preexisting conditions. These are exactly the provisions included in this bill.

Senator PHIL GRAMM, over 2 years ago said:

> We can fix the system and make it possible for people to change jobs without losing their health insurance. Every one of the proposals that has been made to reform health care—every single bill—has a provision that would make it possible for people to change jobs without losing their insurance.

Majority Leader DOLE, in his statement on the floor of the Senate in August 1994 said this:

> We will be back . . . And you can bet that health care will be near the top of our agenda. . . . There are a lot of plans and some have similarities. Many of us think we ought to take all the common parts of these plans, put them together and pass that bill.

Here is our chance. This is the bill.

The Health Insurance Reform Act is a modest, responsible, bipartisan solution to many of the most obvious abuses in the health insurance marketplace today. The bill was approved by the Senate Labor and Human Resources Committee last August by a unanimous vote of 16 to 0. It is similar to proposals made by President Clinton in his recent balanced budget plan.

The measures it includes are also virtually identical to provisions of legislation offered by Senator DOLE in the last Congress—legislation supported by virtually every Republican Member. Sponsors range from the most conservative Members of the Senate to the most liberal—because these reforms

represent simple justice. They are not issues of ideology or partisanship.

Support for the bill by outside groups is equally broad. Almost 200 groups have expressed their support. These include business associations like the chamber of commercve, National Small Business United, the National Association of Manufacturers, the ERISA Industry Committee, and the Association of Private Pension and Welfare Plans. The AFL–CIO has endorsed the program, so that on this issue business and labor are united. The program is also supported by the National Governors' Association and the National Association of State Insurance Commissioners, who believe the legislation represents an appropriate balance between Federal and State responsibilities.

Responsible insurance companies support this bill, including the insurance companies in the Alliance for Managed Care, the American Association of Health Plans, Phoenix Life Insurance Co., the Blue Cross/Blue Shield Association, and other insurance companies. Blue Cross and Blue Shield are the largest carriers in the individual insurance market. The American Association of Health Plans has millions of individual subscribers. These responsible companies know that the insurance system is broken and needs to be fixed.

The Independent Insurance Agents of America—the largest association of agents in the country—sees the tragedies created by the current system every day. They support this bill.

Doctors, hospitals, and other health providers see those tragedies as well, and they support the legislation. It has been endorsed by the American Medical Association, the American Hospital Association, and over 44 medical specialty societies. This bill also enjoys the support of a number of the consumer groups that understand the need for legislation so well, including the Consortium for Citizens with Disabilities, and Consumers Union.

In fact, the only opposition to this legislation comes from those who profit from the abuses in the current system.

In his State of the Union Address last January, President Clinton challenged Congress to pass this bill. Now that the legislation has been brought to the floor of the Senate, I believe it will pass overwhelmingly—unless some in the Senate insist on following the Republican majority in the House of Representatives by addressing controversial and harmful provisions like medical savings accounts, federalization of multiple employer welfare arrangements, Federal caps on malpractice awards, repeal of MediGap rules protecting senior citizens against profiteers, or provisions making it more difficult to combat the waste, fraud and abuse in the current Medicare and Medicaid Programs. Almost all of the 200 groups that support the legislation have urged the Senate to pass a clean bill, without these controversial amendments.

These objectionable provisions of the House bill may serve the special interests, but they have no place in this legislation. Their adoption will almost certainly kill this bill, and destroy the hopes of millions of Americans for the kind of modest but effective reform that leaders of both parties have supported in the past.

Medical savings accounts, which are included in a major amendment to be offered later in this debate are particularly objectionable. They are opposed by virtually every credible health policy expert. They attract the healthy and wealthy, and add up to an unjustified $1.8 billion Federal giveaway to those who need it the least. They are a gift to the insurance companies with the worst record of abusive practices—a poorly disguised reward for millions of dollars of campaign contributions. And by pulling the healthiest individuals out of the conventional insurance market, they will raise premiums for everyone else, including those who need coverage the most.

In fact, the Congressional Budget Office concluded that, ''In the long run, the existence of any type of catastrophic plus MSA option that would be attractive to a large number of people could threaten the existence of standard health insurance.''

Members of the Senate who are serious about insurance reform should vote against all controversial amendments—including medical savings accounts. Senator KASSEBAUM and I have agreed that we will vigorously oppose all such amendments—even those that we might support under other circumstances. The Democratic leader, and many other Senators of both parties have joined us in this pledge. This is a test of the Senate's seriousness and ability to put the interest of the American people ahead of the special interests.

This legislation is not comprehensive health reform. It will not solve all the problems in the current system. But it is a constructive step forward—a step that will help millions of Americans. I urge its adoption.

Mr. President, if we are looking for just a shorthand explanation of what the legislation achieves, effectively, it is the Health Insurance Reform Act, the health insurance bill of rights. It guarantees that your insurance cannot be taken away because you, first, lose your job; second, change your job; third, become sick; or, fourth, start your own business. It protects against unfair preexisting conditions exclusion which affect millions of American citizens who virtually have no control over those preexisting conditions. In an important way it increases the purchasing power of small businesses so that they will be able to provide health insurance to the millions of Americans who work in small businesses and have no coverage at this time.

This is a modest bill, an important bill. It deserves overwhelming passage. It deserves, most importantly, to become law. Every day that we delay the legislation, there are other fellow citizens in this country that continue to be unable to get the kind of protections that they need and that they deserve. Hopefully, we will have overwhelming bipartisan vote on this legislation.

Mr. President, I see a number of our colleagues that will be speaking. I just hope that those that do have amendments—we hope there are not many of those—will make their amendments available to us at the earliest possible time so we can have a chance to review those amendments and to see what disposal we can make of them.

PRIVILEGE OF THE FLOOR

Mr. KENNEDY. Mr. President, I ask unanimous consent that members of the staff, four fellows, Lauren Ewers, Susan Castleberry, Sara Thom, and Anna Marie Murphy, be granted privileges of the floor during the debate on health insurance reform.

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

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that Anne Rufo and Kevin McShane be extended floor privileges during the duration of the debate.

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

Mrs. KASSEBAUM. Mr. President, I want to express my appreciation to Senator KENNEDY for his thoughtful statement. He is one who has been involved in health care issues for many, many years and cares deeply about it. He would, I am sure, like to have expanded this bill much further. But we worked hard to construct, as he mentioned, something that we felt could be passed and could be approved by the widest number in both the U.S. Senate and the House of Representatives. So I have greatly appreciated his leadership in the Labor and Human Resources Committee, as we have worked hard and constructively on both sides of the aisle in the committee, as well as on the floor, to bring this to fruition today.

One who has been a great asset in working with us is the Senator from Tennessee, who is waiting to speak. Not only has he been an exceptional legislator on this issue, he comes to it also with an expertise that the rest of us do not have—as a renowned cardiologist. So we have valued his willingness to be very engaged in this issue.

I have greatly appreciated his help on the Labor and Human Resources Committee as the ranking member. Senator KENNEDY and I have worked together to achieve this bill we are presenting today.

I yield the floor.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Mr. President, I rise to congratulate Senators KASSEBAUM and KENNEDY for introducing what I consider to be a fair, balanced, focused, and excellent bill that will be to the

benefit of over 25 million Americans. I welcome this opportunity to focus today on the Health Insurance Reform Act.

The bill before us provides protection for some 25 million Americans, who, each year—it is a rolling number—are at risk for becoming uninsured. Too many Americans today have to live each day with that fear of the loss of health insurance for preexisting illness—for example, if they have heart disease or if they have a stroke—and for the lack of insurance portability when they move from one job to another job.

I commend Senator KASSEBAUM for her leadership in crafting this legislation because it truly is balanced, bipartisan, and focused. There has been much misinformation and misunderstanding of what the provisions in this bill truly accomplish. Its objectives are very well-defined, very specific.

I reject the notion that this bill, in any way, resembles, as has been alleged, or is similar to President Clinton's very large, massive, failed health care plan. This bill is very different and should not be confused with the President's. This bill contains the very provisions which had broad, very bipartisan support throughout the entire health care debate.

The bill before us today proves that we can move forward incrementally, rationally, step by step, to fix the problems in our health care system today—without a massive Federal Government takeover of the entire delivery system.

I am a physician, and as we talk about this bill and as we look at the provisions of this bill, I see those faces of hundreds—in fact, even thousands—of patients who I have had the opportunity to serve in the past. Too many of those faces, when I picture them, are faces of terror, of fear, that one day they will lose the insurance they have, which they have purchased and that they have been a player in purchasing, historically, that they will lose it, and that it will be taken away simply because they want to change jobs or leave a group plan, leave an insurance plan to go out and set up their own business.

As the only physician in this body, I do feel a very special responsibility to speak out loudly, clearly, and forcefully in support of those very practical solutions and patient protection when the Senate considers matters dealing with these challenging issues of health care. Each time I make a decision in this body regarding health care legislation, I apply some very stringent tests that go back to my experience as a physician delivering care to individuals, one on one, who need that care, who depend on that care for their quality of life and for their well-being.

In my practice as a heart and lung transplant surgeon, I shared daily the obstacles that patients face. They tell you about that every day in your office. For example, after a patient receives a new heart, has a heart transplant, and after they are ready to return to the work force and productive lives, there is a huge barrier there today, a barrier that, once we remove it with this bill, will allow that individual to live a more productive life, a life more fulfilling, a better quality of life. When I give a person a new heart today, the next day they start asking questions because they are petrified that they are not going to be able to go back to their old job, to go back and get insurance if they decide to change jobs.

They get trapped in a current situation for the rest of their lives because of this lack of portability of insurance coverage. The cost of their care, by no fault of their own, restricts their freedom of movement within the workplace.

I cannot help but to think back to last July during our Labor and Human Resources Committee when a man from Oklahoma, Tom Hall, testified before us. He reminded me so directly of the hundreds of patients who have told me this same story. He was denied individual coverage because of what we call a preexisting heart condition. But it was denied by the same insurer that he had insurance with for the last 30 years. It was denied because he wanted to go out and start his own company. The insurance company who he had worked with for 30 years—the same person, the same condition—when he wanted to go out and start his own company, initially denied that insurance. Eventually, yes, he got that insurance. But, remember, he had a heart condition. He got that insurance, but it did not cover his heart condition.

Well, this bill will address that. It passed the Labor Committee unanimously and is currently supported by well over half of the U.S. Senate. It limits exclusions for preexisting medical conditions, it guarantees renewability of health coverage, and it reduces this concept of job-lock—being locked in a job—by making health insurance coverage portable from one job to another. In other words, when this bill becomes law, people like Tom Hall will no longer be locked into jobs or prevented from starting their own businesses for fear of losing their health coverage.

As a doctor, there is nothing worse than having a patient tell me that he or she cannot afford health care due to denial of coverage by an insurance company. Tragically, over 1 million working Americans have lost health insurance over the last 2 years. Over 80 million Americans have preexisting conditions of some sort that could make it difficult, if not impossible, for them to maintain coverage when they change jobs. Many of these people are willing to pay the insurance premiums. In many cases, those insurance premiums could be costly. But they cannot find coverage at any price.

As a physician and as someone who is a real advocate of the free market system, I find this unacceptable, unconscionable. People who are willing to play by the rules—and again, this bill addresses people who currently have insurance coverage, who have paid in, or had their employer pay in, and have coverage. These are people who have played by the rules in the system. These people should not be denied the opportunity to lead productive lives.

I applaud Majority Leader DOLE, who has a long record of support for health care reform, for bringing this bill to the Senate floor. It is important to debate, and it is important for us to take this step and vote on this legislation.

Before I entered the public service as U.S. Senator a year and a half ago, the Senate had already debated and even passed provisions almost identical to this bill—debated and passed. Unfortunately, as the scope of many of these bills grew larger and larger, the support for the overall bill dwindled. As a result, we are here today still debating those long-awaited insurance reforms.

In closing, while this bill is not a cure-all—and we should not pretend it to be a cure-all, but it is a good first step—it is incremental, it is straightforward, it is rationale, it is focused, and it is direct. The bill will correct many of those imperfections in the market that we have today for health insurance.

I am confident that this Congress will be the one—this Congress will be the one—to deliver these much-needed reforms.

I thank the President. I yield the floor.

Mr. ROCKEFELLER addressed the Chair.

The PRESIDING OFFICER. The Senator from West Virginia.

PRIVILEGE OF THE FLOOR

Mr. ROCKEFELLER. Mr. President, I ask unanimous consent that Greg Jones, a legislative fellow in my office, be allowed privileges of the Senate floor.

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

Mr. ROCKEFELLER. Mr. President, I want to congratulate the Senator from Tennessee for the remarks just made. There is really an extraordinary synergy between Senator KASSEBAUM and Senator KENNEDY which has produced this legislation. It is interesting.

I was home last week in my State, and I was talking about this bill. As I talked, a lot of the feelings that a lot of us had 2 or 3 years ago began to come back. When the larger comprehensive health legislation failed, it was just pulled to the ground by Harry and Louise, special interests, and other things, there may be a feeling out there in the land that, well, since that did not pass, I guess things must be going better. Of course, that is not true. Things are really worse. The system is in worse condition than it was at that time, and people, I think, increasingly know that.

I think what we have to do is wait for a renewed demand, a broader demand, a broader anger on the part of the American people so that they will speak to

us with more clarity than happened in the last go-around and we can respond. But in the meantime, Senator KASSEBAUM and Senator KENNEDY saw an opportunity to take certain very specific and important parts of this problem and solve them, and they did so in a way which was so successful and so agreeable that the vote was unanimous from that committee. The Labor and Human Resources Committee has a reputation for having a good deal of bipartisanship. But it is also a committee where there are sharp differences of views and, therefore, the unanimity of the vote I think is a very, very good sign for the Health Insurance Reform Act of 1995.

I think that we have to be fully aware that people in this country desperately want and thoroughly deserve the security that health insurance will not disappear the way it does now. The Senator from Tennessee was talking about how he could see that fear in people's faces. I am not a physician, but I hear that constantly in my State of West Virginia. When it disappears, it disappears cruelly. It disappears without warning. It disappears often because people are simply just laid off because of downsizing or because of other economic factors. It always affects, it seems, millions of hard-working men and women, people who are playing by the rules every day. I think today is our chance to really do something. I think we can do our job for the West Virginians, for the South Dakotans, the Kansans, and other Americans everywhere who are out there doing their job but still fear the loss of health insurance.

Health insurance is a little bit like air. Sometimes you take it for granted. All of a sudden it is not there. You panic very quickly, and I think a lot more Americans are doing that. Some people, in fact, are estimating—a lot of people are—that by the year 2000, which is really only 3-plus years off, that 50 percent of Americans who work for a living—not 50 percent of Americans but 50 percent of Americans who work for a living—will not have health insurance.

So, this problem just continues to get worse and worse. Yet, the Labor and Human Resources Committee has made a substantial improvement if we are able to pass this bill and if we can do it without controversial amendments. I will have more to say about that as the day goes along.

I have, frankly, waited for this day for a long, long time, and I am filled with a sense of gratitude and a sense of relief that we are finally, as a body, going to do something which is meaningful. If everything really goes well, we may do this by the end of the night or tomorrow night. But the point is we really have a chance to do this.

I do not know of a great deal of criticism about this bill on the part of my colleagues. Relatively few people on the outside are criticizing it, and, therefore, I have a good feeling about it.

The so-called Kassebaum-Kennedy bill, the Health Insurance Reform Act, would establish some of the most fundamental and far-reaching changes in health insurance since the creation, in fact, of Medicare and Medicaid in 1965. I, therefore, again salute the two Senators, the chairman and the ranking member, for their really inspiring bipartisan partnership in crafting and advancing this very important legislation. I think we all remember, as I indicated—it seems like a long time ago, but it really was not—that there was a mighty debate in this body about guaranteeing health insurance for every man, woman, and child in this country. I believe that must still be the goal and the vision for America. I believe that as strongly as I did at the time. I believe in that even more strongly as I watch what is happening to more and more people as they lose their health insurance even though they are working.

Mr. President, that comprehensive effort at that time to reform our country's health care system was stopped. But, again, the problems of losing health insurance continue. That is why in a sense we have won, through the good work of Senator KASSEBAUM and Senator KENNEDY, we have won another chance to enact something which is really meaningful in the way of health care reform. The people of our States are still writing, calling, visiting, and asking for help. I am going to do whatever I can to make sure that we do not let this opportunity pass us by—that we will not fail on this and that we will make a real difference in people's day-to-day lives.

That is why we simply have to also exercise restraint and not kill this bill with extra baggage. It is tempting, but it cannot happen. Amendments, whether they are well-intentioned or not, which are controversial will have the effect of bringing this bill down, and we all know that. We have to be very careful as we go through this exercise that we do not accept controversial amendments.

I think this bill is going to solve some really horrible problems for real people. So why would we accept controversial amendments which we might otherwise support, as the Senator from Massachusetts said, when it could pull down the chance to do something really good for a lot of people?

During debate on comprehensive health care reform several years ago, many of my colleagues—especially those on the other side of the aisle—said repeatedly that we should only enact those health reforms on which there is a strong bipartisan consensus and support. Well, here we have it. Here we have that piece of legislation. That is the precise description of this bill, S. 1028, which is before us today. It was so carefully crafted by the chairman and the ranking member; it came out of the committee by unanimous vote; it is a bill which should be sent to the President for his signature, and I am certain, although one never knows, that he would sign it.

Loading up this bill with extraneous provisions which will please certain special interests but only delay enactment of health reform just does not make any sense at all. So, Mr. President, I intend to join the floor managers of this bill and Minority Leader DASCHLE in opposing any controversial amendment that will delay enactment of this bill—any controversial amendment, even if it means voting against amendments that, as I have indicated and so have others, have merit on their own and I would fight to enact in other terms and other circumstances. We cannot be distracted from the basic purposes of this bill, which are terribly important.

Almost 40 million Americans lack basic health coverage today. It is going up about a million plus every year, Mr. President. It has been doing that regularly, and it will continue to do that, perhaps at an accelerating rate. One cannot be sure. Most of the people who are not lucky enough to have health insurance, with cards in their wallets or back pockets, are in fact the people we revere and honor in this body, and that is they are the hard-working, middle-class families who are victims of layoffs and downsizing or just plain profit gouging.

This country offers the best health care in the world. Nobody has ever denied that. It is terribly true. Unfortunately, that health care continues to be beyond the reach of too many of our fellow citizens who do not deserve that lot in a country that is as outstanding and great as ours.

As both Senator KASSEBAUM and Senator KENNEDY said, this bill before us today will not solve all of the problems in the health care marketplace. I think it was Senator KASSEBAUM who said that the so-called guarantee issue, or guaranteed coverage, for that matter, for every man, woman and child in this country has not diminished. The bill is not going to solve it.

I still believe it is a fundamental right for each and every one of us, not just for those who can afford it or are healthy enough to keep insurance companies profitable. But again, the machinery of our health care system is breaking down, and this bill helps substantially. If we cannot therefore enact a complete overhaul, if we are not going to be able to do that in this session, we must enact the individual fixes and the individual reforms that will at least keep the engine of this system running.

Evidence of this need for an overhaul of our health care system is everywhere. It is found in the emergency rooms of our public hospitals, collapsing under the demand of the growing millions who need medical treatment but cannot pay for it. It is found in our schools where far too many children go without immunization and preventive care. It is found in the rooms of our nursing homes with so many residents

being uprooted from their homes and neighborhoods because of their inability to afford community-based alternatives. They are forced onto Medicaid. They are institutionalized because their savings have been exhausted, and on and on.

Mr. President, individuals and families go uninsured for several reasons. Often health insurance coverage is simply not available, or what is available is not affordable. The effect is the same. Health insurance often lapses after a worker is laid off and COBRA extensions that affect certain larger industries have expired.

Entrepreneurs who leave their jobs to start their own businesses, which is what we glory in America—IBM used to have it all and then people started going out and creating all kinds of other things. That is what we do in America. We are a country of entrepreneurs. Entrepreneurs who have to leave their jobs or want to leave their jobs to start their own companies because they think they have a better idea are sometimes unable to convert their group health insurance policies to an individual health plan, and, even more tragic, insurance coverage is often terminated by an insurer just when that insurance policy is needed the most, when an individual or a family member experiences a really serious, devastating illness or disability.

How reliable is a guarantee, so to speak, of health coverage when the health plan issuer acts in its own self-interest or cuts the safety line by either terminating a policy or increasing the premiums beyond the ability of the individual to pay, thus, in effect, accomplishing the same end—cutting that person off.

The Health Insurance Reform Act of 1995 makes significant strides to address each of these two problems, and that is why it is such a good bill and needs to be passed. The Health Insurance Reform Act will strengthen the safety net for millions of Americans by improving portability and security of private health insurance, especially in the small group and the individual insurance markets. I support this bill because I personally have heard the stories of hundreds of West Virginians who have fallen between the cracks of our health care system.

Mr. President, I wish to just give three personal examples that I know of and then end with a statement from the White House.

Mr. President, I want to start—and these are all people who would be helped by this bill, and the examples are so many—with one Norma Schoppert, who lives in Piedmont, WV—not large, near the top of our State. Several years ago, she developed diabetes. Lots of people do. When her husband was working, Mrs. Schoppert was covered by the health plan offered by his employer. That is understandable. But then he retired in 1991 and became eligible for Medicare. When that happened, she was able to extend her own health insurance coverage for 3 years because of the COBRA provisions that affected his health insurance, and thus she was able to pay monthly premiums of $354 and continue full health insurance coverage under COBRA for 3 years. But that only lasted from 1991 to 1994, those 3 years.

Mrs. Schoppert was offered an individual policy when her COBRA extension expired at a monthly premium, Mr. President, of $1,800. So you understand the effect, $354 in the COBRA extension, $1,800 without it. In effect, obviously, she could not pay that. She could not afford to pay this amount, so she has now no medical coverage at all. And unless the system is reformed, she will have to go without insurance until she qualifies for Medicare, which is still 3 years away.

Now, Mr. President, that means, as the Senator from Tennessee indicated, 3 more years of anxiety, 3 more years of fear, worrying about the risk of losing everything that she and her husband worked all of their lives to build. And we say that sentence so easily; it just rolls off our tongue. But these are gigantic tragedies in the lives of real people.

Second example. Juanita Taylor of Elkins, WV. Just a few years ago, she was a hard-working employee at Davis & Elkins, which is the local private college, but then she developed multiple sclerosis. She kept right on working, struggling to overcome the advancing weakness that her illness caused her. When she was, in fact, really too weak to meet the demands of her job, she lost her job and eventually the health insurance that had provided.

Her neighbors and her friends pitched in to help her pay for a wheelchair, so that she could stay connected and involved with her community, so that her morale would be better.

Those friends and neighbors told me that she was forced to pay out-of-pocket costs of $1,000 per treatment to help slow the advance of her multiple sclerosis. How many people can pay $1,000 per treatment? Although she now has Medicare, her medical expenses ate up all of her savings. Juanita Taylor courageously faced and fought a ravaging disease, only to be victimized by a system that cared more about how much money she had in her pocket than it did, quite honestly, about her health condition.

But the final story, and the saddest one of all, it seems to me, comes from Falling Waters, WV, which is in Berkeley County. In 1990, Walter McPeak and his wife, Karen, were granted custody of Mr. McPeak's two sons, Anthony and Thomas. They wanted these boys. Both the boys have severe hemophilia and hepatitis, as well as the social and the emotional difficulties that come from living in constant fear that even the slightest injury could result in terrible trauma or instant death.

At the time the boys came to live with them, both Walter and Karen McPeak were employed in high-paying management jobs. Together they earned a little over $80,000. But their employer's health plan would not issue coverage for Anthony or for Thomas. Their need for special clotting factors and other treatments means medical costs of several thousands of dollars each week.

So it was not long before the McPeak family had used up all of their savings. They had to sell their house and then they sold their first car, and then they sold their second car, but still the costs climbed and there was no help in sight. When they tried to apply for Medicaid—which you can imagine they did not want to have to do—because Medicaid would have helped pay for their sons' treatments, they were told that their family income was too high for the boys to be eligible for SSI, which would automatically make them eligible for Medicaid.

So, what choice did Walter and Karen McPeak have to make? In order to qualify the boys for SSI, which was their moral and parental responsibility, they gave up their management jobs, both of them, over $80,000 a year, and took minimum wage, unskilled jobs so their income would not exceed allowable limits for them to qualify for SSI and hence Medicaid.

This is a tragedy and this is a travesty. It should never happen in America. Anthony and Thomas got health insurance; yes, they did. But the McPeaks lost their savings, their home, their car, their jobs, probably a good deal of self-esteem—although not on a moral basis; and their employers, of course, lost two highly skilled managers. So we must pass health insurance reform in the form of this bill.

The bill we are considering is not a perfect solution and nobody has made that claim. But it will go a long way toward ensuring that working Americans and their families are able to keep the health insurance that they have, if they lose or if they change jobs. This legislation will mean that families like the McPeak's, who have children with special needs, will have the protection and have the security of insurance coverage. And it will mean that talented and hard-working individuals with new and creative ideas, entrepreneurs, will be free to go out and start their own businesses, because of this reform bill, without the fear of losing their health insurance.

Again, I thank and congratulate Senators KASSEBAUM and KENNEDY for their enormous leadership that gives us this historic—and it is historic—chance to do something that Americans deserve and want so badly. I conclude with a statement of administration policy. This is just for the edification of the membership.

I read from the administration's latest statement of administrative policy:

Certain provisions included in the House-passed bill are so controversial and so potentially damaging to the health care system that they jeopardize enactment of the insurance reform that Americans want signed

into law this year. Specifically, the inclusion of amendments that, one, provide for medical savings accounts, MSA's; two, deregulate multiple employer welfare arrangements—MEWA's; three, impose federally defined caps on punitive and noneconomic medical malpractice awards; four, undermine Medicare fraud and abuse efforts; and, five, weaken the ban on the sale of duplicative insurance policies to the Medicare beneficiaries, would call into question the seriousness of the commitment of the Senate to health insurance reform this year.

The administration views such provisions as an effort to undermine a bipartisan consensus on health reform. If such amendments are adopted, they would create a grave risk to the passage and enactment of this bipartisan legislation.

Mr. President, I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I thank my friend and colleague from West Virginia for an excellent presentation on the current legislation and also for his really extraordinary leadership on the whole health care issue. As he mentioned, he was right in the vanguard of leaders when we debated the more comprehensive program over a year ago. I think he is tireless, as a member of the Finance Committee, in pursuing good health care policy. So I thank him for his comments. I am very hopeful he will be involved during the course of debate on this measure, because he brings great interest and knowledge to his comments.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I second those observations. Senator ROCKEFELLER has cared for a long time, as well, about a wide breadth of health issues, particularly as regards to children. I ask unanimous consent that the Senator from New Mexico [Mr. DOMENICI] be added as the 66th cosponsor of the bill before us.

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

Mrs. KASSEBAUM. The next speaker is the leader of the Republican health care task force. Senator BENNETT has been a very, very strong and constructive Member of the Senate, working with health care issues. I have certainly valued his advice and support in this endeavor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. Mr. President, I thank the Senator from Kansas for her kind and generous words. It has been an interesting odyssey for me to get involved in the health care issue. It came up in the 1992 campaign, when I ran for the Senate in the first instance. I must confess, the first time the question came up I was pretty much stumped for any kind of an answer as to what we ought to do on health care. I do not like being stumped for an answer, so I have plunged into this issue ever since I have been in the Senate, and the more I get into it, the more certain things become clear.

One of the things that is very clear is that we need insurance reform now. It is something we can do now. And we should be careful not to attempt a complete overhaul of the system just to get insurance reform. That was one of the errors, in my view, that was made strategically by the President of the then majority party in the last Congress.

I always said, and repeat again, that the President deserves credit for having raised this issue. It is such a thorny issue that the instinct of most politicians is to flee from it. I learned in the days when I was working with the Congress, before I came here, that all you needed to do in order to defeat a bill was, not convince Congress that it was a bad bill, all you had to do was convince them that it was a controversial bill and they would flee from the controversy. So I salute the President and have always done so, since coming to the Senate, for his courage in raising the issue.

But in the last Congress, I seriously departed from the President because of his insistence that the entire system had to be fixed at once with a single bill and a single Congress. I thought that was the height of arrogance and, ultimately, it proved to be impossible.

I remind people that the Clinton health care plan was not voted down in the 103d Congress. It simply died, collapsed of its own weight, and a vote was never taken on it because it could never be put together in such fashion that it was ready for a vote.

So I commend the Senator from Kansas and the Senator from Massachusetts in their willingness to say, ''Let's step aside from the attempt to do everything in a single bill. Let's pick out the most pressing problems and see if we can address those.''

Those of us who tried to put forth this strategy in the last Congress were attacked as incrementalists, and we were denounced as being insufficiently compassionate and concerned. I do not know anybody in this body who is more compassionate and more concerned than the Senator from Kansas. I stand now to say that the incremental approach that we proposed in the 103d Congress is now bearing fruit in the 104th, primarily due to her leadership and her compassion and her concern. So I am delighted to be a cosponsor of the bill and to participate in this debate.

I do have to make a few general observations, however, before I get into talking about this bill, so that people who have heard me on health care in the past will know that I have not abandoned those observations.

I believe that we have the system that we have in the country today primarily because of the tax laws in this country. We have a system that is distorted, for a whole series of reasons. Not to go through the whole litany but to, again, lay down certain principles so that I am not accused of abandoning them, we have not one health care system in this country but two.

The first one is the delivery system, and it is run by doctors and nurses and hospital administrators and researchers and research hospitals and foundations and all of the rest of it, and it is dedicated to delivering the finest health care medical result for our citizens as possibly can be.

The second system is the payment system, and it is run by insurance companies and adjustors and, to a very large extent, the Federal Government. Forty percent of the health care bills in this country are paid by the Federal Government.

The payment system, to a certain extent and certainly to a larger extent than is proper, in my view, distorts the delivery system. Delivery system decisions are made on the basis of payment system decisions, and that is where we get into all of the difficulty, in my view.

If we could devise a way that the delivery system goes forward with the focus primarily on producing the best medical result for the patient, undistorted by the payment system, we would have the ultimate circumstance.

If I may give us an example—I realize it is not perfect, but it is one we ought to look at—I have been in Shriners hospitals. The Shriners raise every dollar that they spend for health care, which means that they do not interface with a single insurance company or a single Government bureaucrat. They simply raise the money to pay the bill for the kids, and they make the decision as to what will be done in a Shriners hospital solely and entirely on the question of medical need.

Here is the result of not having to deal with insurance companies or the Government at the Shriners Hospital in Salt Lake City: The cost per day, per-bed night, or whatever the appropriate medical term is, in the Shriners Hospital in Salt Lake City is $95. What could we do in medical costs if the per-night cost in a hospital were $95 for every 24-hour period?

The administrative costs of running the Shriners hospital system are 4 percent, which means that 96 percent of every dollar they raise to take care of the medical needs of these kids goes to the kids and only 4 percent goes to administration.

That is what happens when you do not have to deal with an insurance company or with the Government bureaucrat. That is the goal for which we should aspire somewhere out there to clean up the enormous costs and complexity of the system in which we are engaged.

I think the answer to that lies in restructuring our tax laws in the way we deal with health insurance. That is a speech I have given before; it is not a speech I will give today, but I lay that down because I do not want anyone who is listening to me to think that for one moment I have abandoned that as my ultimate goal: To get to the circumstance where we clear up the enormous complexities that now beset the whole health care issue.

That having been said then, Mr. President, let me address S. 1028 and my support for it. As I said at the outset, I believe in the incremental approach. I believe that when you are dealing with a trillion dollars' worth of economic activity, trying to fix it all at once with a single piece of legislation is a major mistake, and I think we learned that lesson in the 103d Congress.

The most pressing issue for most Americans is the question of job lock, the question of insurance through the employer keeping people tied to a particular employer or to a particular job.

During the campaign, whenever this came up, I had a little exercise I would go through, and it never failed to produce exactly the same result. As people would turn to me and say, ''What is the biggest problem with health insurance,'' I would answer with a question. I would say, ''How many of you here know of someone—either yourself, a member of your family, or friend—who is locked in a job he or she hates because he or she is afraid to lose health insurance?''

I would just sit back and watch the hands go up, and they would always go up in sufficient number around the room to make my point: That portability of health insurance is, for most Americans concerned with this issue, the No. 1 challenge, and portability of health insurance is at the core of S. 1028.

If we can make it possible for people to ultimately control their own destiny and not be under the control of their employer, then we have solved the problem for many, many Americans.

I am not one who subscribes to the statistics about the tremendous number of uninsured. I point out that for most of the uninsured, they are just passing through that category. I give this example.

In my own family, I have a son who, when he turned 24, went off the family policy. The insurance company says he should be through with school at age 24. I said, ''I agree with you he should be through with school at age 24, but he's not, so what do we do?''

Well, I called him up and said, ''Jim, go down to the student health center and sign up for the student health policy at the University of Southern California.''

He said, ''Sure, dad, I'll take care of that.''

Those of you who have children know that it took about 6 months for him to finally get around to taking care of that. During that 6-month period, he was one of those statistics of the uninsured. He had gone off my policy because he was too old to be a dependent and he had not gotten around to signing up with the other, and so he ended up in that statistical pool of the uninsured.

Frankly, it is not my son, Jim, we are worried about here. It is the people who, in that statistical pool, have a real problem.

I raise that only because I think it is unfair to use the huge statistical number of 37 or 40 million or whatever it may be, to try to highlight the problem that is really severe and significant for roughly a third or even a quarter of that number. But the people who are in that quarter, the 10 million, whatever, have real problems, and this bill addresses those problems.

We should understand that this terror of losing health insurance that has caused job lock can become more than just a personal problem for the individual involved. It can have consequences throughout the entire economy.

The Senator from West Virginia spoke about the entrepreneurs who leave a secure business to go start another one. I have been one of those entrepreneurs and had the experience of walking out of a secure company where I had health insurance, being told, ''OK, you have COBRA coverage for 18 months, and in that 18-month period, good luck in lining up some other kind of health insurance.''

I was able to line up another kind of health insurance for me, but discovered a very difficult problem. My secretary, who left with me when I left the company to start my own activity, was also covered by COBRA, and in that COBRA period while we were putting together a health insurance plan for our little tiny company—just the two of us; we were the only two employees—she came into my office one day and said she had to see a doctor, she was not feeling well. She came back from the appointment and said, ''I have a brain tumor. It is operable. It can be handled, but the problem of dealing with it is going to take a timeframe longer than the 18 months of COBRA. What are we going to do?''

I will not bore the Senate with the details. We were able to solve the problem. We were able, through the State of Utah and some of the things that it does on health insurance, to find an insurance pool that would accept her. But I saw firsthand how difficult that can be. People who are normal and healthy and have no problems at all in the 18-month period of COBRA are suddenly faced with this kind of circumstance.

So that is why I have joined in cosponsoring S. 1028. It is focused on a single problem. It is not an attempt to solve all of the issues simultaneously and thereby get gummed up in all of the challenges that face our health insurance and health care problems. It deals with the most pressing problem for most Americans who fall in this category. It does so in such a way that it does not close the door to the kinds of solutions I want to see down the road. It does not close the door to the kind of tax reform that I think will ultimately bring us the ultimate health care solution.

So, for those who say, ''Well, Senator BENNETT, you have been a voice for the entrepreneurial approach, the market approach, and don't endorse anything until you can restructure everything,'' I say, we have not got that luxury. We have to deal with the problem of job lock, the problem of portability of health insurance as quickly as we can, even as we have these other discussions for the solution a long way down the road.

Again, Mr. President, I congratulate the Senator from Kansas for her leadership and her tenacity. I say, as I have said before, that the loss of her membership in this body will be keenly felt. She brings an aura of civility and intelligence, combined with a tenacity and a sense of steel in her back that sometimes her pleasant exterior will cause people to misjudge. We have been honored with her service in the Senate. I think this will be a monument to her service in the Senate. I am delighted to be one of those who raises a voice in support of that concept. Mr. President, I yield the floor.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER (Mr. FRIST). The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I would like to express appreciation to the Senator from Utah, who gave such a very thoughtful opening statement, I think, by example, showing concretely why the provisions of this bill are important. I know that the majority leader, the senior Senator from Kansas, has also over the years been cognizant of the very things that Senator BENNETT, as the leader of the Republican health care task force, spoke so eloquently and sincerely about. I am very appreciative.

Mr. DOLE. Mr. President, I understand there are a number of my colleagues who wish to make opening statements. I just want to indicate that I am prepared to offer the so-called tax amendment. We are trying to get some agreement that is acceptable on both sides as far as a motion to strike one provision of that. So I ask unanimous consent that, following opening statements, I be recognized to offer the amendment.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. First of all, I would like to thank the distinguished Senator from Vermont for permitting me to go ahead of him. I know he has been waiting. I assured him my statement would be brief, so I am going to be held to that.

Mr. President, I would like to take this opportunity to reaffirm my support for the Kassebaum-Kennedy health reform legislation. The sponsors of this legislation have worked for a number of years to enact reforms in the private insurance market. I applaud them for their considerable efforts in bringing this legislation to the floor.

It is interesting to note this legislation is quite similar to that which Senator Durenberger first presented in

the Finance Committee, as I recall, or perhaps in the Labor Committee several years ago. Although he has left the Senate, I think he would be pleased to know we are making progress with the legislation he was so involved with.

In the wake of attempts in recent years to completely overhaul our health care system, this legislation has been characterized, as the distinguished Senator from Utah noted, as incremental. It has been criticized as even meager. But I urge my colleagues, as the Senator from Utah noted, not to underestimate the importance of this legislation.

One of the major failings of our health care system in this country is the difficulty thousands of Americans face each year when they change jobs or look for new jobs. But they find they cannot change jobs because they will no longer be eligible for health insurance. This is what is known in the trade as ''job lock.'' This problem for many Americans would be addressed under the Kassebaum-Kennedy bill. Insurers would be required to offer coverage, with no preexisting condition exclusions, for those moving from one group plan to another or from a group plan to an individual plan.

I expect, Mr. President, we will see many amendments to this proposal, many of which I have supported in the past. Though laudable, these additional provisions could jeopardize the more immediate and important goal of enacting insurance market reforms. Those of us who worked to enact health care reform 2 years ago know all too well the consequences of attempting to do too much with respect to health care reform. We failed to enact comprehensive health care reform in 1994. You try to do too much and you end up getting nothing. We have been through that experience, Mr. President, not only with the health care measure that we tried in 1994, but in other efforts in the past.

In the last 2 years, over a million Americans lost their health insurance coverage. Although this proposal, the Kassebaum-Kennedy proposal, does not include many of the health reforms which I advocated 2 years ago, I strongly support its enactment as a sound first step toward reform and improvement in our Nation's health care system.

So I congratulate the two principal cosponsors of this legislation and am delighted to be listed as a cosponsor myself. I thank the Chair.

Mrs. KASSEBAUM. I thank the Senator from Rhode Island. He, too, has been a long-time worker in the vineyards of health care, a staunch leader in the last Congress to find some answers and to bring people together to present health care reform. I value his support in helping us work through the language in this bill.

Mr. JEFFORDS addressed the Chair.

The PRESIDING OFFICER. The Senator from Vermont.

PRIVILEGE OF THE FLOOR

Mr. JEFFORDS. Mr. President, first, I ask unanimous consent that Theresa Stathas, a fellow in my office, be granted the privilege of the floor for the duration of the consideration of S. 1028.

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

Mr. JEFFORDS. Mr. President, I rise today in support of the Kassebaum-Kennedy bill. Before I do that, I want to express my deep appreciation for the efforts that were put in, in 1994, by Senator CHAFEE, in trying to reach a consensus on what we can do to move health care forward. We worked long and hard, many of us, and the issues which we are involved with today in S. 1028 were some of those which gave us the greatest concern.

I also want to thank Senator BENNETT for his work with the Republican task force on health care. His work has been invaluable to us as we move forward to try and find, again, the kind of consensus that is necessary to get us good health care reform. What a refreshing experience it is to have Senator Frist with us, who has given us the invaluable knowledge of a practicing physician, who kept us from going too far astray in our efforts. It is wonderful that we have this kind of a coalition. Senator ROCKEFELLER, who I have worked with, also, is so helpful in the health care reform area.

I am beginning to feel confident that we will do something constructive here in health care reform, and hopefully it will happen in the next few days. Of course, my chairman and my ranking member, Senator KENNEDY, who both have shown outstanding leadership in getting our committee to come out 16 to 0 on a bill, this is a miracle in itself. I am deeply appreciative of all their efforts.

I rise in support of the Kassebaum-Kennedy Health Insurance Reform Act. If we send this legislation to the President, the 104th Congress will be remembered in history for taking the first steps toward real market-based health care reform. Market reform is not as easy as it may sound, for the simple reason you must take into consideration the State's responsibility for regulating insurance versus the Federal responsibility for regulating ERISA, employee benefit plans.

That word, ERISA, is one that troubles many. The reason it troubles people is because there is not much there. We have the authority and the responsibility to provide good health care conditions for the self-funded plans, but we have exempted the self-funded plans from State regulations. That is why we are here today and why this is an important move forward.

Finding the right balance between insurance regulation and employee benefits, while trying to incrementally reform the market, is something like mastering the Rubic's cube. Just when you think you have all the sides lined up, you find out one square is out of place. Last August, the Labor and Human Resources Committee lined up that Rubic's cube and it all seemed right with the world.

As I mentioned, in a unanimous 16 to 0 vote, the committee voted favorably on S. 1028, the Health Insurance Reform Act of 1995. I must commend the chairman and the ranking member for that incredible feat. It is not an easy task putting together a health care reform bill that every member of the committee can vote for, but it happened. The Health Insurance Reform Act makes great strides in addressing many of the problems in the insured market and also begins to level the playing field in the self-funded ERISA market by apply the same national rules to both segments of the marketplace.

Chairman KASSEBAUM's approach from the beginning was to build a bill around two areas of consensus—portability and elimination of discriminatory treatment of preexisting condition rules. The Kassebaum-Kennedy bill provides Americans the security of knowing that their health insurance will be portable from job to job and that all people who have insurance today will be able to purchase affordable insurance tomorrow even if they get sick. That is a critical phrase—even if they get sick, or change or lose their jobs.

This is accomplished by converting the rules in today's insurance market which reward excluding people into rules where health plans can take all comers. There is a tendency to want to exclude sick people, naturally. You make more money if that happens. This will step in and say, ''Hey, no.'' S. 1028 provides much-needed improvements at the national level, but at the same time allows States the flexibility they need to move ahead in their own reform efforts.

As we attempt to make coverage more widely available, we must also not lose sight of affordability, particularly in a market where employers and individuals are not mandated to purchase insurance. We must be very careful as we reform the insurance market, because if we are not, reforms that we hope will reduce costs and improve access may do just the opposite.

How is this possible? Today, over 92 percent of the people who have private health coverage are part of a group—92 percent are part of a group. Most of these people get it through their employer under an ERISA health benefit plan. The key concern regarding ERISA is the risk segmentation that occurs in the private market due to the preemption clause. ERISA preemption effectively blocks States from regulating most employer-based health plans. ERISA preempts States from being in this area.

Although many employers still purchase health coverage from a State-regulated health insurer that is subject to State insurance regulation, employer plans that cover 44 million people have elected to self-fund and avoid

the State insurance laws. These laws deal with financial solvency, market conduct, benefit coverage, and premium taxes. States impose taxes on insurers for general revenues, as well as for financing specific programs like State guaranty funds and high-risk pools.

Preemption made a lot of sense 20 years ago when the multistate employers and unions were looking for a way to offer uniform benefits to employees throughout the country. Most of the plans were offered through insurers. Most of the plans were offered through insurers. As States started to weigh down the insured market with mandated benefits, employers saw self-funding as a means of flexibility and plan design.

These are two reasons why employers have left the insured marketplace. In a preliminary report I just received from GAO, the estimated additional costs of these mandated benefits range from a high in Maryland of 22 percent additional cost and low in Iowa of 5 percent.

Mr. President, I ask unanimous consent that excerpts of the GAO preliminary estimate be printed in the RECORD.

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

GENERAL ACCOUNTING OFFICE,
Washington, DC, April 15, 1996.

Hon. JAMES M. JEFFORDS,
U.S. Senate.
Washington, DC.

DEAR SENATOR JEFFORDS: The Congress is considering proposals intended to enhance the availability of health insurance. This debate has led to specific questions about the state regulation of health plans, including mandated benefit laws. In particular, you asked us to provide information on—

1. state requirements affecting fully insured health plans and how they compare with federal requirements affecting self-funded health plans,

2. the number of states that have enacted particular mandated benefit laws,

3. estimates of the costs of mandated benefits in particular states, and

4. the extent to which commonly mandated benefits are provided by self-funded health plans that are exempt from state laws.

This letter provides interim information based on our ongoing work for you on the factors affecting the costs of state health insurance regulation. As part of this effort, we interviewed officials from the National Association of Insurance Commissioners (NAIC); several state insurance commissions; and national organizations representing actuaries, health insurers, and self-funded employers. We reviewed documents and used data provided by these groups as well as available studies on mandated benefits. In addition, we included and updated information from previous GAO reports on state insurance regulation and the Employee Retirement Income Security Act of 1974 (ERISA). Our review was conducted between January and March 1996 in accordance with generally accepted government auditing standards. We expect to issue a report to you later this year that will provide a more detailed analysis of the factors affecting the costs of state health insurance regulation.

RESULTS IN BRIEF

We found that states have an average of 18 mandated benefits that health insurers must cover but the number of mandated benefits varies from a low of 6 in Idaho to a high of 39 in Maryland. However, assessing the costs of mandated benefits is difficult because their impact varies depending on state laws and employer practices. Published studies provide a range of cost estimates. For example, a recent study found that Virginia's mandated benefits accounted for about 12 percent of claims costs; earlier studies estimated that mandated benefits in Maryland cost 22 percent of claims and in Iowa cost 5 percent of claims. In general, cost estimates are higher in states with more mandated benefits and in states that mandate more costly benefits, such as mental health services and substance abuse treatment. We also found that self-funded health plans often offer similar benefits, even though they are exempt from state-mandated benefit laws. For example, a survey by KPMG Peat Marwick found that a large percentage of self-funded health plans offer benefits similar to those mandated for health insurers in many states.

REGULATORY FRAMEWORK DEPENDS ON WHETHER A HEALTH PLAN IS FULLY INSURED OR SELF-FUNDED

While states are able to regulate health insurance, state regulation does not directly affect everyone with private health coverage. ERISA preempts states from directly regulating employer provision of health plans. This results in a very different regulatory framework depending on whether an employer purchases its health care coverage from an insurer that the state regulates or self-funds its health plan is not directly affected by state regulation.[1]

States focus their regulation on the financial soundness of insurers and their market conduct, including benefit coverage. In addition, states impose taxes on insurers for general revenues as well as for financing specific programs. While federal requirements include fiduciary and other responsibilities, in many other areas no federal requirements exist for self-funded health plans that are comparable to state requirements for health insurers. In particular, self-funded health plans are exempt from state laws that mandate insurers to include coverage for specific benefits. Table 1 companies the requirements that fully insured and self-funded health plans must meet.

TABLE 1.—COMPARISON OF RELEVANT STATE AND FEDERAL PROVISIONS AFFECTING FULLY INSURED AND SELF-FUNDED HEALTH PLANS

	State insurance regulations affecting fully insured health plans	ERISA provisions affecting self-funded health plans[1]
Financial requirements:		
Licensing	States license insurance companies and the agents who sell insurance to ensure that companies are financially sound and reputable and that agents are qualified.	No comparable requirements.
Financial solvency	States set standards for and monitor financial operations of insurers to determine whether they have adequate reserves to pay policyholders' claims. States restrict how insurers invest their funds.	No solvency requirements but fiduciary duty to act in a prudent manner solely in the interests of plan participants and beneficiaries.
Rate reviews	States review and approve rates to ensure that they are both reasonable for consumers and sufficient to maintain the solvency of insurance companies.	No comparable requirements.
	Some states regulate insurer rating practices in the small group market to determine the factors insurers may use in setting premiums[2].	No comparable requirements.
Market conduct requirements:		
Plan benefit coverage and description	States review and approve insurance policies to make sure that they are not vague or misleading and to ensure that they meet state requirements, such as mandatory benefit provisions.	Disclosure requirements to provide summary plan description to participants and the Department of Labor. No requirements to provide specific benefits.
Consumer protections and complaints	States monitor insurers' actions to make sure that they are not engaging in unfair business practices or otherwise taking advantage of consumers by investigating their complaints, answering questions, and conducting educational programs.	Plan must reconsider denied claims at participant's request. States have no authority to pursue consumer complaints regarding self-funded plans. Department of Labor has responsibility for complaints regarding self-funded health plans.
Small group reforms	Most states require insurers selling to small employers to accept and renew employees who want health insurance coverage, establish short waiting periods for preexisting conditions, and require portability of coverage even when an individual changes jobs or insurers[2].	States are preempted from applying small group reforms to self-funded health plans.
Tax requirements:		
Premium taxes	States assess premium taxes on insurers	States are preempted from assessing premium taxes on self-funded health plans.
Guaranty funds	States assess insurers to finance guaranty funds that provide financial protections to enrollees who have outstanding medical claims in the case of an insurer insolvency.	States are preempted from requiring self-funded health plans to participate in guaranty funds.
High-risk pools	Some states assess insurers to finance losses in high-risk pools that provide health coverage for individuals who otherwise had been denied health coverage due to a medical condition.	States are preempted from requiring self-funded health plans to participate in high-risk pools.

[1] ERISA requirements apply to all private employer and union health plans, including fully insured and self-funded health plans. See Employer-Based Health Plans (GAO/HEHS–95–167, July 25, 1995). While states are preempted from regulating self-funded health plans directly, some states regulate third-parties that provide administrative services for self-funded health plans and stop-loss insurance carriers that reimburse self-funded health plans for claims that exceed a predetermined threshold.

[2] For a listing of states that have enacted these reforms, see Health Insurance Regulation: Variation in Recent State Small employer Health Insurance Reforms (GAO/HEHS–95–161FS, June 12, 1995).

NUMBER AND TYPE OF MANDATED BENEFITS ADOPTED BY STATES VARY

On average, states have enacted laws mandating about 18 specific benefits. As shown in figure 1, 15 states have over 20 mandated benefits while 9 states have 10 or fewer mandates. Maryland (39), Minnesota (34), and California (33) are the states with the highest number of mandated benefits. In contrast, Idaho has only 6 mandated benefits; Alabama, Delaware, Vermont, and Wyoming each have 8 mandated benefits.[2]

States most frequently mandate coverage for preventive treatments like mammograms and well-child care or for treatment of mental illness or alcohol and drug abuse. (See table 2.) In addition, states often require coverage for some types of providers like optometrists and chiropractors. States typically mandate that insurers cover specific benefits in all plans sold, whereas some states merely mandate that each insurer make this service available in at least one plan that it offers. In some cases, the mandates are limited to particular types of plans such as health

maintenance organizations or group insurance plans.

TABLE 2.—COMMONLY MANDATED BENEFITS

	Number of States		
	Cover	Offer	Total
Treatment-related:			
Mammography screening	42	4	46
Alcoholism treatment	23	16	39
Mental illness	15	16	31
Well-child care	21	4	25
Drug abuse treatment	13	10	23
Pap smear	17	0	17
Infertility treatment/in vitro fertilization	12	2	14
Temporomandibular joint disorders	11	3	14
Off-label drug use	13	0	13
Maternity care	11	2	13
Breast reconstruction following mastectomy	9	2	11
Provider-related:			
Optometrists	46	1	47
Chiropractors	43	3	46
Psychologists	42	0	42
Podiatrists	38	0	38
Social workers	26	0	26
Osteopaths	21	0	21
Nurse midwives	15	0	15
Physical therapists	14	0	14
Nurse practitioners	13	1	14

Source: NAIC, Compendium of State Laws on Insurance Topics: Mandated Benefits (Kansas City, Missouri: NAIC, 1995).

STUDIES VARY IN THEIR ESTIMATES OF THE COSTS OF MANDATED BENEFITS

Studies conducted in several states between 1987 and 1993 provide varying estimates of the costs associated with mandated benefits. (See table 3.) Among the most recent, the Virginia State Corporation Commission has required insurers to report cost and utilization information annually for each of the mandated benefits in the state. Overall, the commission reports that Virginia's mandated benefits accounted for about 12 percent of group health insurance claims in 1993. An earlier study in Maryland, the state with the most mandated benefits, estimated that mandated benefits represent 22 percent of average claims costs in 1988. At the other extreme, a 1987 study in Iowa estimated that the potential costs of introducing several commonly mandated benefits would be about 5 percent of claims costs.

TABLE 3.—STUDIES OF THE COSTS OF MANDATED BENEFITS IN SELECTED STATES

State	Year	Percent of total claims costs
Maryland	1988	22.0
Massachusetts	1990	18.0
Virginia	1993	12.2
Oregon	1989	8.1
Wisconsin[1]	1989	7.9
Iowa[2]	1987	5.4

[1] Includes six mandated benefits: alcohol and other drug abuse treatment, chiropractic care, diabetes care, home health care, skilled nursing facility care, and kidney disease treatment.

[2] The study in Iowa examined potential costs of six commonly mandated benefits, including mental health, alcohol and drug abuse, podiatrists, optometrists, registered nurses, and physical therapists. Iowa has not adopted all of these mandates; according to the Blue Cross and Blue Shield Association, Iowa's current mandates are mammography screening, well-child care, chiropractors, dentists, registered nurses, optometrists, and diabetic education.

To some extent, the differences in the cost estimates reported by the various studies are related to the number of mandated benefits included in each state. For example, the studies that showed the highest estimated costs were for Maryland and Massachusetts, states that have more mandated benefits than most states. Thus, these cost estimates cannot be generalized to other states.

While the studies report varying cumulative costs in different states, they generally agree that several specific mandated benefits account for a large share of the additional costs. In particular, mental health and substance abuse are often cited as the most costly mandated benefits whereas other commonly mandated benefits, such as mammography screening, account for fewer than 1 percent of costs. Furthermore, in some cases, mandated benefits covering services offered by some alternative types of providers, such as nurse midwives, may reduce costs because they substitute for more costly forms of care. However, some provider mandated benefits may also increase the demand for services, thereby increasing costs. For example, while chiropractic services may be a less expensive alternative for some treatments, mandating their coverage may also lead to increased use.

One limitation of most studies on mandated benefits is that they have examined the impact of mandated benefits on claims costs, which does not necessarily capture the actual effect on employers' costs. In particular, multistate employers note that varying state-mandated benefits result in additional administrative cost. Employers that purchase health insurance must modify their plans to meet these differences in state-mandated benefits. Furthermore, employers are concerned that mandated benefits limit their flexibility in designing the most cost-effective health benefit plan to best meet the needs of their employees.

SELF-FUNDED HEALTH PLANS OFTEN COVER BENEFITS COMMONLY MANDATED BY STATES

The actual cost impact of mandated benefits to employers also depends on whether the employer offers a comprehensive or limited health plan, which in turn is often related to the size of the employer. Many of the commonly mandated benefits are often offered by employers, even those who self-fund and are not subject to the state mandates. In general, large employers are more likely to self-fund their health plans and also tend to offer more comprehensive benefits than small employers. For small employers, who typically purchase fully insured health plans and are less likely to offer health coverage at all, mandates may impose claims costs for benefits that they otherwise might not have covered.

Studies have shown that self-funded health plans typically offer many of the benefits that are commonly mandated by states for fully insured health plans. For example, as shown in figure 2, a KPMG Peat Marwick survey of employer benefits among all firm sizes indicates that self-funded health plans are more likely to offer well-child care outpatient alcohol treatment, outpatient drug treatment, mental health benefits, and chiropractic care than fully insured health plans. This survey also reports similar patterns for other benefits that are not typically mandated, including prescription drugs, adult physicals, and dental benefits.[3] Similarly, a survey of Wisconsin insurers also found that: ''self-funded health plans provide at least as many of the managed benefits as insured health plans and in some cases provide more generous coverage.''

This result may partially be due to the tendency of large employers to both self-fund and offer more comprehensive benefits.

Although self-funded plans often offer the same types of benefits as are commonly mandated by states for insurers, they may include features that differ from the requirements of state mandates. For example, state mandates generally specify a minimum number of days of care that insurers must cover for inpatient mental health care. One employer association indicated that many employers prefer designing more flexible mental health benefits; for example, requiring case management rather than specifying a limited number of days of care. Thus, even though 97 percent of self-funded plans offer inpatient mental health care services, all these plans would not meet the state requirement for fully insured health plans.

Assessing the cost differences between self-funded and fully insured health plans resulting from mandated benefits is difficult. To the extent that self-funded health plans offer benefits that are similar to state-mandated benefits, they do not have lower claims costs due to their exemption from state-mandated benefit laws. For less commonly offered benefits, such as in vitro fertilization, self-funded employers would face additional claims costs if they were required to meet the state mandates.

Please contact me at (202) 512–7119 or Michael Gutowski, Assistant Director, at (202) 512–7128 if you or your staff have any questions. Other major contributions to this letter are John Dicken and Carmen Rivera-Lowitt.

Sincerely yours,

JONATHAN RATNER,
Associate Director,
Health Systems Issues.

FOOTNOTES

[1] ERISA preemption effectively blocks states from regulating most employer-based health plans, but it permits states to regulate health insurers. The majority of employers purchase health coverage from a third-party insurer that is subject to state insurance regulation. However, for plans covering about 44 million people in 1993 the employer chose to self-fund and retain at least some financial risk for its health plan. Because these self-funded health plans are not deemed to be insurance, ERISA preempts them from insurance regulation and premium taxation. For a fuller discussion of the regulatory differences, see Employer Based Health Plans (GAO/HEHS-95–167, July 25, 1995).

[2] The calculation of the number of mandated benefits includes requirements that insurers provide or continue coverage for specific populations, such as dependent students, as a mandated benefit. Thus, the number of mandated benefits per state includes these requirements as well as treatment-related and provider-related mandated benefits. See Blue Cross and Blue Shield Association, State Legislative Health Care and Insurance Issuers: 1995 Survey of Plans (Washington, D.C.: Blue Cross and Blue Shield Association, 1995) for a list of mandated benefits for each state.

[3] The data in figure 2 represent the percentage of covered workers in conventional health plans. KPMG Peat Marwick reports similar findings for workers in preferred provider organizations and point-of-service plans that are either self-funded or fully insured. KPMG Peat Marwick is currently examining to what extent these differences in the rates of benefits coverage among self-funded and fully insured health plans can be explained by differences in firm size and premium levels.

Mr. JEFFORDS. Because the employer frequently pays a significant portion of the premium, a large majority of the eligible employee—both young and old, sick and healthy—choose to enroll in an employer-sponsored plan. Since so many people participate in group plans, the average per employee price of coverage stays relatively low and remains affordable for each employee, since the insurance risk is spread over a large pool of people.

The individual market, on the other hand, contrasts in many ways from the group market. For instance, those who buy individual health insurance pay the entire premium out of their own pockets, whereas, in most cases, a business picks up most of the tab. If an individual buys it, it is out of his own pocket. Not only do the people receive no subsidy from the employer, they also do not receive the same tax advantages afforded to employer-sponsored health plans. This is a critical difference. Therefore, costs to the individual is a major concern. When individuals leave a group coverage situation

and decide not to purchase in the individual market, it is because they cannot afford it or because they are healthy and have decided they do not need the coverage and do not want to pay the amount of money they would have to pay.

The individual market is so price sensitive, as prices go up, healthy and less costly people leave the market, causing the prices to continue to spiral upward. This vicious cycle makes it inevitable that individual coverage will become less affordable for hundreds of thousands, if not millions, of Americans.

What is the solution? We must encourage purchasing cooperatives in the individual and small group market. Group purchasing is the first tool to bring down costs of individuals. The key concern regarding ERISA is the risk of segmentation.

I was very pleased when Senators KASSEBAUM and KENNEDY included in the health plan purchasing coalition section my own bill which I offered with Senator NUNN, S. 1062. I believe that the key to making health insurance more affordable for individuals and small employers is properly designed voluntary group purchasing arrangements.

Employer group purchasing is not in the concept. Many employers have been pooling funds and contracting with entrepreneurs to offer health benefits to their employees at reduced rates for many years through something defined as multiple employer welfare arrangements, referred to as MEWA's, under ERISA. A MEWA is an arrangement where two or more employers group together to purchase health benefits. The more that group together, the lower the per employee cost or employer cost.

While a number of MEWA's form important gaps in our health care system, some MEWA administrators have taken advantage of the confusion as to who bears responsibility for regulatory oversight, the Feds or the States. It is very, very confusing. They have been able to create and run ponzi schemes, designed to take premium payments with no intention of covering any major health claims. My esteemed cosponsor of S. 1062, Senator NUNN, led the effort to uncover the corruption of fraudulent MEWA's when he chaired the Senate Permanent Committee on Investigations. He was instrumental in drafting the section of the bill that addresses MEWA reform. It is important. I bring it up, also, as I will mention later, because of what is in the House bill.

The bill Senator NUNN and I introduced makes clear, once and for all, that the States are responsible for regulating all MEWA's. Therefore, the number of States that have moved forward in this area will no longer have to be involved in costly litigation, using precious State resources, to prove they are regulated.

I must say, I am very concerned about the way the House bill handles the group purchasing in the small group market. First, continuing to segment the market by creating different rules for insured and self-insured MEWA's is a mistake.

Second, giving the Department of Labor the additional responsibility of now being the insurance regulator for all self-insured MEWA's takes away a current State responsibility and hands it over to the Federal Government. This seems totally inconsistent with the philosophy and fiscal reality of less Federal Government and more responsibility for the States. I think we should be careful when we are looking at this in the conference committee.

Requiring purchasing cooperatives to offer only fully insured products, as in the case of S. 1028, is a much better solution. Although the group purchasing section of the Kassebaum-Kennedy bill is good, I hope we will be able to improve upon it in conference with the House. I hope we can take the lead from Governor Whitman accomplished in New Jersey. She saw the need to look at the impact overburdened State-mandated benefits laws can have in a small group market and developed a variety of distinct benefit packages that small employers can choose to purchase for their employees. This strikes me as a critical step at expanding health care coverage.

Fixing what is broken in our current health insurance system should be what is accomplished in this year of incremental reform. Although I believe the Kassebaum-Kennedy bill is a good bill, I believe it can be a great one. That is the main reason Senator SIMON and I plan to offer an amendment that would raise lifetime limits, caps, to $10 million. We want to ensure that this bill lives up to its basic promise. What good does it do to pass a law that prevents insurers from excluding individuals with preexisting conditions if you let employers set lifetime caps at $50,000—which is probably 1 day or 1 week for those people—to meet the needs of those conditions?

It is critically important, in my mind, that we make sure that we make this remain a good bill and that we pass a good bill. I will mention that I offered this amendment in committee, and they said at that time that we wanted to come out with a 16 to 0 bill. This was the step that people have to understand—that I would not offer this in committee, but I said I would offer it on the floor. There was some concern raised about having amendments to this bill. But I point out that this is important to the bill in order to make it work.

This is not an extraneous amendment, unrelated to the purpose of the bill. If we do not prevent insurers from reducing lifetime caps, then we have the very likely situation where they will reduce the caps if they have to take sick people in. If we do that, we will have lost the great benefit of what we are trying to do today.

Let me talk about the lifetime cap amendment. In a letter I received from the American Academy of Actuaries addressing my amendment, they stated:

> . . . this amendment is unlike State mandates that require coverage of specific medical services. This is a Federal mandate that appears to greatly increase the security provided plan participants by raising their potential benefits to $10 million.

This is also important. CBO has estimated that premiums would only increase by 0.16 of a percent, while at the same time reducing Federal and State expenditures in the Medicaid Program. So what we would do is to prevent the horrendous situation we have now.

How do you take care of the sick people in this country that have an insurance policy that has a lifetime cap? What happens? You reach the cap and then you have to, under the present situation, drain all your resources until you are poor. And then you apply for Medicaid, and you are eligible for Medicaid. I want to point out that I think that is a terrible way to handle things.

I also point out that other information that we have received from reputable organizations has backed us up in the fact that this is a de minimus cost to most employers, and it is a huge benefit to the Federal budget. The National Taxpayers Union has said that the net savings could be as much as $2 billion in Federal savings and $3 billion in State and local savings by just passing this amendment, at a very minimal cost to employers.

As U.S. Senators, we have the peace of mind in knowing that our health insurance will be there if a catastrophic illness or injury strikes one of our families. In our plan, there is no cap. Anything can be covered. In a large number of HMO's, there are no lifetime caps, and in some other group policies there are no lifetime caps. So I want to focus your attention on that. Hopefully, in the time before I offer the amendment, you will learn more about this and agree with us.

For now, I would like to, once again, commend both Senators Kassebaum and Kennedy for bringing this bill to the floor of the Senate. I urge my colleagues to vote for its passage. I am hopeful that when we finally do get to my amendment, you will keep in mind that what we will do will be almost an unmentionable expense to most employers, but will save people from incredible experiences of having to go through bankruptcy in order to get health care coverage, and also will allow us to reduce the cost of Medicaid to State, local, and Federal Government.

Mr. President, I yield the floor.

Mr. KERREY addressed the Chair.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

PRIVILEGE OF THE FLOOR

Mr. KERREY. Mr. President, I ask unanimous consent that Karen Davenport, a fellow in my office, be allowed privileges of the Senate floor during our debate and consideration of S. 1028.

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

Mr. KERREY. Mr. President, I rise to support the Kassebaum-Kennedy bill, S. 1028. I believe it is a long-overdue change. As the Senator from Rhode Island and others have said already, it is regarded by some as very incremental. I regard it as one of those very important pieces of legislation.

Earlier, we enacted a piece of legislation, ironically, that Senator KASSEBAUM actually took the lead on last year, which consolidated the job training programs and gave the States a lot more flexibility in designing their own programs. I said at the time that I thought this law was the second most important thing we could take up this year because we know, with certainty, that it is going to effect some 20 million people. It does not cost the taxpayers any money. It does make a change of the law, the Federal law and will alter the way the market works. But it is not the first time that we have interfered with the health care market.

One of the most expensive interferences that we have with the health care market is that we allow health insurance to be deducted with offsets against FICA by employers, as well. It is a very important deduction, but it also must be seen by citizens as an interference with the market because it is for upper income people in particular. For people like myself, if I am buying private health insurance, it provides me with a substantial subsidy.

It has been a very important way to allow people who otherwise would not be able to purchase health insurance to buy it. So it is not as if this kind of action is without precedent. There is no doubt that close to 21 million Americans will be positively affected by this. They will be able to purchase with their own money health insurance, and still in many cases it is going to be quite high. But nonetheless they are going to have an opportunity to buy it. They are not going to be denied the opportunity to purchase. It does not obliterate the high-risk pool States like Nebraska. We started one when I was Governor. It does not affect States that worked on this for years to try to provide some way to have all of us share a bit of the risk.

This bill, as I see it, is designed to accommodate or rather radically change the economy where we are seeing a lot of downsizing, particularly in larger corporations. You have individuals that are covered by group policies from those corporations. They will find themselves very quickly running out of their benefits and having to purchase individual policies. And very often they find themselves faced with the inability to make the purchase. This law will basically say we are all going to share the risk of that in the marketplace so that these individuals can make the purchase. As has already been pointed out, nearly 25 percent of all working Americans who have private sector jobs have job lock as a result of the lack of portability and the lack of ability to be able to purchase with preexisting conditions. Nearly 3.8 million American workers lost their jobs in March. It is a rather substantial paradox that it has become a fact of life that even at a time when the economy continues to grow, even as we have a recovery underway, that we have layoffs that are close to the same number that were occurring during the last recession that we experienced in the early 1990's. Thus, this change in the law accommodates rather substantial change in our economy.

One of the things that a lot of us who are older—I am 52—sometimes fail to recognize is that the cost of health care as it has gone up has changed the way people in the market, working people and particularly younger people, face health care expenditures. For example, when my babies were born 20 and 19 years ago I was able to pay cash for them. I did not insure against the risk of having a baby because it was a relatively modest amount of money. You paid for it out of pocket. It was not considered to be a big deal. Today you need to be insured because the normal delivery is expensive. But almost any extended stay in the hospital can put a young family in a great deal of financial distress.

That is just one of many, many examples that one could cite; a very relevant example because it is a rather common experience. There are 4 million live births a year in the United States, and an awful lot of those births are in families that are uninsured. This will make it more likely that those families will have insurance and have coverage.

It certainly will not get us to where I would like to see us; and, that is, at a point where every single American and legal resident knows with certainty that they have insurance. I hope this is a first step.

I will support Senator KASSEBAUM's and Senator KENNEDY's request to vote against all amendments. I believe that this bill needs to go across in an amendment-free fashion. I do not know if I ever stated what Senator KASSEBAUM is going to support. But I believe this bill is too important for me to be supporting, as Senator JEFFORDS earlier indicated, an amendment that I would under normal circumstances support. I will vote against that amendment because I believe the bill needs to be clean and clear. It came out of the Labor Committee with unanimous support. We have an opportunity to help 21 million Americans. I think it is very important, in spite of my respect for the Senator from Vermont and admiration for him personally, as well as my normal inclination to vote for that amendment. I believe an amendment-free strategy is the right one to adopt.

Mr. President, one of the things that I think we need to do as we move toward universal coverage—and I hope that is the goal—we spend $400 billion a year in Federal direct spending in tax benefits for health care. We spend a sufficient amount. If we would change the way eligibility occurs, one of the things we have to do in order to be able to get there is we all have to face the true cost of health care and very often we do not. Somebody else is paying for it. The insurance company is paying for it—the Government. So we really do not worry about whether or not the bill is high or the bill is low. The more that we can face that cost directly and understand that, if we do not have the resources to pay for it—it is paid for out of an insurance pool, paid for with Medicaid or Medicare, somebody else is essentially paying our bills—the more that we can face that fact the more likely it is that we will move quickly to a point where, if you are an American or legal resident, you will know for certainty that you have health insurance.

This morning June O'Neill, the Director of the Congressional Budget Office, appeared before the Senate Budget Committee and laid down a rather stark warning; that is, even if the President's budget or the Republican budget were adopted, we still have not controlled the growth of entitlement programs. I say that to colleagues because I think once we get beyond the Presidential election we are going face in 1997 a really rather difficult fact. And I believe June O'Neill laid it out for us this morning; that is, we have commitments on the mandatory side that are going to make it difficult for us to fund education, to fund transportation, to fund defense, to fund space, to fund law enforcement, and to fund all sorts of other things that are going on. Unfortunately, very often that occurs because people believe that they have a right to something, that they have a benefit that actually is paid up, the money is all there, and it is set aside for them—no problems, do not worry about it—when in fact that is not the case.

It gets back, it seems to me, to a problem that we have whether it is the tax deductibility, or whether it is Medicare part B. There is sort of a sense that somebody else is paying for it. Why should I have to worry about it? As a consequence, we just are not engaged personally as we ought to be in trying to control the cost of health care, and as a result, it seems to me, it is difficult for us to take the next step.

So again I want to say how much I really appreciate very much and applaud the determination of the Senator from Kansas, and the Senator from Massachusetts. They and the Labor Committee voted this out unanimously, and 21 million Americans will be affected positively. Taxpayers will not be on the hook for this thing. It has been measured. It will cost no more than 2 percent in premiums across the country and with reasonable changes in the law given what is happening out in the marketplace.

I hope this body will pass it as quickly as possible and get it on to the President for his signature.

I yield the floor.

Mr. JEFFORDS. Mr. President, I want to comment briefly on the comments of the Senator from Nebraska about my amendment. I point out that, unlike all of the other amendments, this one is very relevant to this bill and will improve the bill. It is not extraneous to it. If we do not keep track of what the lifetime caps are, then this bill will be a mockery because, if we require the insurers to take sick people on, one way of getting out of that is to reduce the lifetime caps so that as soon as they come in they are out the other end. It was offered in committee with the understanding that it would be brought forward at this time.

I just wanted to bring that to the Senator's attention and hope that I will make an exception to his decision in that regard.

Mr. President, I yield to the Senator from Iowa.

Mr. GRASSLEY addressed the Chair.

The PRESIDING OFFICER (Mr. SANTORUM). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I am very glad that this debate is taking place before this body. Having had an opportunity on two separate occasions to push concepts similar to what is in this legislation to accomplish the same goal in maybe not exactly the same way, I am glad that we are here today and that there is a bipartisan effort to get this legislation passed. I think being truly bipartisan is a continuation on these issues of guaranteeing some health insurance to people who can afford it—things that we have tried to accomplish before in a bipartisan fashion.

I respect Secretary of Treasury Bentsen because when he was chairman of the Senate Finance Committee he had proposals which I think were bipartisan with the ranking Republican at that time included in H.R. 11, a major tax bill. And those health insurance provisions went through without any debate on the floor of this body because they were accepted as things that should be done. To see that happen was good. Obviously, President Bush vetoed that bill because he did not like the tax provisions that were in it.

Then, if you remember the next step, there was a fairly bipartisan effort to make these provisions part of basic law. It was during the health care reform debate of 1993 and 1994. They were relatively noncontroversial provisions of much more controversial efforts by the Clinton administration to have the Government totally dominant in the delivery of health care in America and do it through a provision that we called employer mandates, meaning every employer, large or small, would have to provide health insurance to their employees.

Of course, that came down to total defeat in 1994 because the middle class and the small business people of America woke up to a couple of things: First, that small-business America could not afford an employer mandate because they could not pass it on to their consumers like big corporations can do; second, middle-class, taxpaying people saw their rates going up, or if their rates did not go up the services that they received from the health care industry and from the health insurance industry would have gone down.

You remember that was part of a big effort we had in 1993 and 1994 where we were going to insure everybody. Obviously, when there is 13 or 14 percent of the people who do not get insurance and a large percentage of them that cannot afford it, somebody is going to pay. There is no doubt about it. There is no free lunch in our system of doing business in America.

The middle class saw this problem, that we were trying to reduce the coverage, affordability and quality of health care to middle class working America as we were trying to solve the problems of the 13 or 14 percent of the American people who did not have any health insurance. Of course, it only took about 3 or 4 months until working, taxpaying American citizens found out what Congress was proposing to do, and they turned against the Clinton health care proposal.

Then that message really did sink in to the President of the United States because after the November election in 1994, when the Republicans took over the Congress, the President said he was not going to attempt to have that complete overhaul of the American health care provisions he incorporated in his 1993 and 1994 proposals, and that if he was going to do anything it was going to be done incrementally.

So you have a President, thankfully, waking up to the realities of what grassroots America wants, particularly what middle class America wants, they liked their health care plans and wanted to keep them from being diluted. You have the President waking up to that reality, on the one hand, and then you have Republicans who had accepted these noncontroversial parts of the President's health care provisions, the noncontroversial parts, being debated in this Chamber today, which bring together the bipartisan efforts that are going to make this legislation very successful.

So I just wanted to give that background before I express my words of support for and cosponsorship of this very important piece of legislation, because the American people for the last 6 or 7 years, as expressed by this history I just gave you, believe it is high time Congress passed legislation which provides basic health insurance protections for individuals and small businesses. The Kassebaum bill is our opportunity to respond to these concerns.

This bill would assure greater portability of health insurance for individuals. It would limit the ability of insurers to deny health insurance coverage because an individual has a preexisting condition. It would require insurers to offer health insurance to individuals who have lost jobs and seek such insurance. And it would require insurers to issue health coverage to individuals who want to purchase insurance for their employees on a group basis.

The bill defers to health insurance reforms passed by the States. This is very important for my State of Iowa, because in my State we have enacted a very good health insurance reform law. It went into effect on April 1 just past.

Enactment of the Kassebaum bill should not disrupt the reforms that are going on in my State. So, in my State, Iowans would continue to receive health insurance under the terms of the Iowa reforms.

I thank Senator KASSEBAUM and her very capable staff for working with me and my staff and with some of the Iowans who helped put together the Iowa reforms. The modifications Senator KASSEBAUM will offer to her bill would help make sure that Iowa and similar State reforms would not be disrupted when this bill is enacted. As a consequence of these changes, Iowa, and probably several other States should be able to carry out their own reforms without undue interference from the Federal level.

For States which have not implemented their own reforms, this bill would then reform both the group and the individual health insurance markets in those particular States. As I said earlier, these reforms would respond to some of the most pressing problems encountered by small businesses and individuals when they need health insurance.

For the group market, this bill would require insurers who offer group health plan coverage to offer such coverage to all groups that apply. This would prohibit insurers from denying health insurance coverage to employers whose work force the insurer believes is not healthy enough to insure.

Next, the Kassebaum bill would require insurers to offer coverage to all individuals in a group without regard to their health status. This would prohibit insurers then from denying coverage for an individual member of a group plan based on that individual's health status. This legislation would require insurers to renew group health plans at the option of the employer. Renewal may not be denied for reasons of health status of those in the plan. Thus, an insurer would not be able to refuse to renew a health insurance plan to a group based on changes in the health profile of the individual.

This legislation would limit an insurer's ability to deny coverage for preexisting conditions to 12 months. This waiting period would be reduced by 1 month for every month during which an individual was continuously covered under a prior health plan. Thus, Mr. President, an individual who had maintained continuous coverage for 12 months could not be denied coverage because of preexisting conditions.

I think it is simple to say, Mr. President—as far as I can tell—the provisions I have just outlined in this bill, the provisions which apply to the group health insurance market only, are relatively unopposed.

This bill would also reform the individual market. This bill would guarantee the availability of health insurance coverage for individuals leaving group coverage, who want to get individual insurance coverage, as long as they have been covered under their previous group plan for 18 months.

If those individuals were eligible for coverage under current Federal law, and we call that law by the acronym COBRA, these individuals must have exhausted that coverage before they can be guaranteed coverage in the individual market. But that is the only requirement that keeps these individuals from getting insurance.

This legislation would require that health plan insurers renew individual policies at the discretion of the individual, similar to group policies being renewed at the discretion of the employer providing the group policy. Now, without a doubt, there has been a lot of concern expressed about this provision, and it continues to be expressed. It continues to be expressed by insurers who operate primarily in the individual market.

I might say to these companies that I am talking about here, that have this concern—and I am not going to say that this concern is not legitimate—but, as far as practical matters are concerned, I want to remind these companies that if we were to have passed the Clinton health reform plan of 1993, there would not have been any individual market out there. These companies would have been out of business. A lot of the companies in my State that do a majority of group coverage still have a vast minority of their business in the individual market. That portion of their market would have been wiped out. I hope these companies that have some concern about this provision I am speaking about here realize that they have a lot of friends in this body that believe in the free market and do not want to hurt individual insurance coverage. A lot of Americans want individual insurance coverage, not necessarily because it is better than group, but because that may be the only way they can have it and get the type of health care that they want. These companies have that business today because we stopped the Clinton health care reform plan that would have wiped out individual insurance coverage for health care.

Now, what do these companies fear? They fear that the group to individual provisions in the Kassebaum bill would have the ultimate effect of greatly raising premiums in the individual market and hence, I suppose, cutting out a lot of their business because some people might drop it. The marketplace kind of dictates as the price goes up you sell less of something. So these insurers feel the numbers of insured are going to go up. Some of them would say the numbers would increase greatly. But going up greatly, compared to not having any of this business had these reforms been adopted in 1993, is the difference between night and day, as far as I can tell.

It is the case that the bill would not forbid health insurers from rating individuals and charging them a higher premium if such rating indicates that they are greater health risks than any other individuals. I would think that would help this problem for these individual policy companies to some extent. But as far as we can tell from analysis done by the independent actuaries, the premium price increases caused by the bill should be very modest.

The analysis done by the health insurers' association, the Health Insurance Association of America, wants us to believe that the premiums would increase in the neighborhood of 15 percent. But in making my decision to support the Kassebaum bill vis-a-vis this problem I am just describing, I took into consideration the analyses done by independent actuaries such as the American Academy of Actuaries, and Hay Huggins, which was done under contract with the Congressional Research Service at the request of Senator KASSEBAUM, and even the nonpartisan Congressional Budget Office. All these found that any premium increases attributable to the enactment of this legislation should be very modest, in the range of 1 to 5 percent. The Congressional Budget Office estimates that this increase would be no more than 2 percent as a result of the group to individual portability provisions. If this bill is enacted, it should help provide some peace of mind for a lot of people.

But we should make it clear to the public what this bill would not do. As a lot of people have said here already, it would not solve the problems of those people who cannot afford to have health care insurance. But that is what the term ''incremental'' meant. When President Clinton, after the November 1994 election, when the Republicans gained control of Congress, was asked about health care reform, he indicated he had learned a lesson from the debate of 1993 and 1994, and he was going to promote the incremental approach. Basically that means we should provide a marketplace out there so people who want and can afford health insurance are going to be able to buy it.

We are going to be able to get a better handle on what the cost is out there, for those who cannot afford insurance. Maybe we can help those people without screwing up the best health care system in the world, which would have been done with the effective Government takeover of health care, if the Clinton health care proposal had gone through in 1993.

But peace of mind for this percentage of people that can afford it is only one goal. That peace of mind should not be enough for everybody to buy into this, because there are some shortcomings that we have to admit to the American people. This bill would not completely eliminate the denial of coverage for every preexisting condition. It would not require employers to offer insurance to their employees. It would not provide portability between different individual policies. And it would not necessarily mean that currently uninsured individuals would have to be sold a health insurance policy.

It is for these reasons that I support the addition to the bill of provisions which would increase the tax deductibility of health care costs for the self-employed. That is not only to pick up a hole that is in this bill but to also bring some equity to the difference between the deductibility at 30 percent of health insurance for self-employed and the 100-percent deductibility for health insurance for employees of corporations. In my State of Iowa, that is like saying that the farmers of my State are denied equity when they can only deduct 30 percent of their health insurance from their income tax, where John Deere, for its workers, can deduct 100 percent of the cost of insurance for that corporation.

I support the addition of medical savings accounts. Both the tax deductibility of health care costs for the self-employed and MSA's, together, at a minimum should make health insurance more affordable, improve portability, as well as providing a greater degree of tax fairness. In any case, if enacted, the bill would be a step forward. The majority of those who are paying attention to our debate since it began several years ago very much want to see Senator KASSEBAUM's bill enacted. We have been promising these reforms, as I indicated at the opening of my remarks, since the Bentsen bill passed this body in 1992, without any debate—indicating, then, that it was the best thing to do. It was a good thing to do. It was a bipartisan thing to do.

So most of us have been saying since that date in 1992, or years before that, we could easily enact such reforms as those that are in this bill. Remember, then, what incremental health reform is. Incremental reforms were what most Republicans were saying was the way to go and we have the President of the United States, in November 1994, saying the same thing. Now we have before us a bill that will deliver incremental health insurance reform if it is enacted. We should pass it.

We have before us a bill that will deliver these incremental health insurance reforms if this bill is enacted—and it will be enacted—and we should pass it. Thank you.

Ms. MIKULSKI addressed the Chair.

The PRESIDING OFFICER. The Senator from Maryland.

Ms. MIKULSKI. Thank you, Mr. President.

I rise to voice my very strong support for this health insurance reform.

This is a tremendous opportunity today to provide greater access to health care for millions of Americans and their families. The Kassebaum-Kennedy health insurance bill, of which I am a cosponsor, is an excellent step in that direction.

This bill will be a great relief for most working Americans. They will not have to worry about losing their insurance if they change jobs. Insurance companies will not be able to deny coverage or make it prohibitively expensive for a preexisting condition.

What this means, Mr. President, is that this bill is a safety net for working Americans and their families. This legislation will make health insurance portable and affordable, and it will give a benefit package that is both reliable and renewable.

I was disappointed that we were not able to enact comprehensive health insurance reform. After that debate came to a close, I pledged to continue the fight to reform health care. This is an important step in that direction, and Senator KASSEBAUM and Senator KENNEDY should be thanked for their great effort in bringing us this far.

Many Americans have medical histories of preexisting conditions that make it difficult for them to get insurance coverage. They stay locked in their jobs and unable to move to improve their standard of living because they fear they will not be able to get insurance coverage. This legislation will end job lock. This legislation will end the penalty for having a preexisting condition, like diabetes. People who work in small business, especially many women, will now be able to get health insurance.

The bill before us today goes a long way toward eliminating the barriers to coverage. For 81 million Americans who have preexisting medical conditions, insurance companies can no longer exclude them from coverage.

Millions of Americans will be able to be secure in the knowledge that if they change or lose their jobs, they will not lose their health insurance. And for those entrepreneurs who start and work in small business, this legislation will provide increasing purchasing power for them and their families.

I am pleased that the bill has the potential to help millions of women and their families. This legislation will help women who start a new job with an employer who provides health insurance. A woman will not be denied insurance for herself and/or family if there is a preexisting condition. Like when she is pregnant, she will be able to get immediate coverage for the pregnancy, even if she is already pregnant. Her newborn or adopted child will receive health insurance coverage as well.

This bill will stop the terrible practice of denying women insurance if they are victims of domestic violence. I think that is crucial. This bill will stop that horrible practice of denying women health insurance if they are victims of domestic violence.

There is much more that I would like to be able to do to make insurance coverage affordable, accessible, portable and undeniable. I would like to see coverage for long-term care, and I would like to see a comprehensive benefit package for women and children, but this is a very important step. We have a tremendous opportunity to improve the lives of many Americans, and I am pleased to support this bill.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. SHELBY). The Senator from Wyoming.

Mr. THOMAS. Mr. President, I rise in support of the Kassebaum bill. I suppose most of us today and on through the night will be saying much the same thing. We have not all said it yet, so we will have to keep doing it. But this is a bill that is very important to us, and we ought to comment on it.

It provides, I think, long-awaited reforms. We have all worked on health care for a very long time. I have had a particular interest in rural health care in that the delivery systems in rural States are necessarily quite different than they are in other States.

This is an incremental move, and I am for that. The portability is important so that people are not afraid to change jobs. Certainly, not prohibiting preexisting conditions and allowing small businesses to form purchasing cooperatives are terribly important. So these are practical and affordable reforms that we need—really relief from trying to change the whole system. I think Congress will meet this challenge.

The Health Insurance Reform Act helps each and every American, more than any other bill that has passed this year. Wyoming ranchers and farmers and owners of small businesses and folks in the mineral industry will no longer be excluded from care they deserve. S. 1028 is compassionate, and I challenge President Clinton to sign this bill for the sake of all Americans.

There has been a major shift in the debate, of course, over the last couple of years. It is historical when you look at how far we have come since we initially discussed health care reform. No longer are we considering the Clinton approach to a Government-run system. That was rejected by Americans, and I think properly so. Instead, we are going to move incrementally into some commonsense reforms. There will be some changes, and there have been some changes suggested by the managers, moving closer to the House proposal, in terms of high-risk pools.

In 1991, my State of Wyoming responded to the health care concerns of individuals with serious illnesses establishing a State insurance pool, a high-risk pool allowing States to continue these measures, rather than be forced to enact other individual insurance reforms. I think this is very helpful to rural States like Wyoming.

Moving incrementally does not mean keeping every worthwhile proposal off the table, however. I think we should promote solutions that expand health care choices and, most of all, in the final analysis, do something about cost. When you talk about health care, what do you usually end up talking about? Cost. Availability, of course, then cost.

I happen to favor medical savings accounts. I think this gives the kind of discipline to health care costs that individuals give when they are responsible for making some of the decisions.

Self-employed deductibility is fair and equitable, and we should have done it long, long ago. Eighty percent of that is good. Administrative simplification, of course. And I believe when we talk about costs, we ought to concern ourselves with malpractice reform. I do not think there is any question but what there are substantial costs there.

Mr. President, I have been dismayed that the President is threatening to veto health insurance reform over some of these provisions. I believe the veto flies in the face of what the American people want.

As part of the changes that have occurred in Washington last fall, I am committed to bringing quality health care to rural America, some equity to rural America, and that is why I have an amendment to offer that corrects the formula used to set payments for rates under managed care plans that participate under Medicare. We will see increasing numbers of managed care plans, and more and more people in Medicare going into them.

The formula is not fair, the formula is not equitable, and we need to make some adjustments. To give an example, the payments made in rural areas of South Dakota are $177 a month. Payments for similar services in New York are $678 a month based on historical utilization. That needs to be changed. That is unfair. When we have a program like Medicare that is treated somewhat uniformly, that is a 367-percent gap, and we can change that, and I think we should.

The longer these disparities exist, the longer rural seniors will be left with less health care choices.

So I am in support of this bill. I think it could be stronger. I hope it is. But I am supporting it. I think we should have this bill. Access to health insurance is, of course, a little comforting for those who need it.

Mr. INHOFE. Will the Senator yield?

Mr. THOMAS. Yes, I yield.

Mr. INHOFE. I recall the Senator bringing up and discussing some of these things that need to be done within our health care system. I remember so well back when we had the proposal by the President to have Government take over a system that has been run well but needed some improvements, we committed ourselves at that time to incremental improvements.

I think the bill that is before us today is good. But I also think that the amendments that will be offered, some of the provisions of which the Senator

has talked about, are going to make it better. The MSA element of this bill I think is very significant. You know, this is the only product or service anywhere in America where it has built in a factor to pay more. I do not know of anyone in America, that once they pay their deductible on a health policy, watches what they spend as much as if they were paying their own money. This is human nature.

I am hoping that this bill that is a good bill, can be made a much better bill and we can come through and take care of some of the things that the Senator is talking about. I am particularly interested in some items that are not going in there. I would like medical malpractice reform but I also realize that would be a very heavy thing that would cause it to go down and perhaps cause a veto. I think with these very moderate and modest reforms that the Senator is talking about, I think it will be a better bill, better bill for our health delivery system in America. I applaud the Senator for bringing these up and discussing them.

Mr. THOMAS. I thank my colleague. Before I sit down, I do want to compliment the Senator from Kansas. This is the product of a great deal of work and great deal of leadership and something that we do need to do. I want to say, however, in closing, that I think we have made some real progress in the last couple years in the industry, in the private sector. And even though I think there are some problems that we will have to deal with as we go about it, managed care has been helpful, managed care has done something to control prices.

I think more and more people are becoming aware of their responsibility with regard to payments. I think it is true that third-party payers have been part of the problem of costs. We can work that out. So in any event, I rise in support of the basic bill. It guarantees coverage of the type of insurance particularly important today, and I compliment the Senator for it. I yield the floor.

Mr. BREAUX addressed the Chair.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. I thank the Presiding Officer.

Let me start by saying what I would imagine has already been said a number of times; that is, to compliment the junior Senator from the State of Kansas, Senator KASSEBAUM, and the senior Senator from the State of Massachusetts, Senator KENNEDY, for bringing together a unique, I think in these times, coalition of Members to support a major, major legislative effort in one of the most important areas that this Congress could be dealing with, and that is the health care of the citizens of this country.

This body is going to miss the Senator from Kansas for her wisdom and her balance and her willingness to work in a bipartisan fashion to accommodate the various interests of the Members of this body. It has been a real pleasure to work with her in the so-called Chafee-Breaux Group where we have been trying to come together to come up with a balanced budget. I commend her for her efforts in that regard, but particularly in bringing this Kassebaum-Kennedy bill to the floor; and, of course, for the years of tireless service by the senior Senator from Massachusetts, because he has really been dedicated over the years in trying to come up with health care legislation that really serves the needs of the people of this country.

Let me start by saying that this indeed is a large coalition. It is a large coalition—65 Members of Congress in the Senate alone have endorsed and have agreed to cosponsor this legislation. So that in itself is very rare in today's atmosphere of high partisanship that we see more and more, unfortunately. So anytime you can get a coalition of 65 cosponsors of a major piece of legislation indeed that is very, very good news.

Let me also say that while the coalition is large, the coalition is very fragile. It is very fragile because it does not do as much as what many Members would like to see it do. And there are still things that this legislation does not do that it should address. It probably does more than some people would like to see done with requirements from a Federal level that certain things be required when you sell health insurance in this country.

But the real accomplishment of the two Senators in bringing this legislation today to the floor of the Senate is the fact that it is a large coalition, it is a bipartisan coalition. It does, I think, accomplish some very important things that need to be done in the area of health insurance for the people of America.

In my own State of Louisiana there are nearly a million people who are uninsured, a million people who do not have enough money to buy a private insurance policy or who earn more than they are allowed to earn and qualify for Medicaid, the Federal-State health insurance program. So a million people walk around my State every day—go to work in most cases every day—but do not know how they are going to treat their children, their spouses, if they should get seriously ill other than through the charity of others or the charity of the hospital systems in my State of Louisiana.

Many people do not have insurance for reasons that are corrected by this legislation. For instance, there are many people who had insurance but when they got sick and needed it the most, it was canceled. How many of us as Members know a family or perhaps a member of our own families that have had health insurance, but then when they need it the most, when they get sick, after the illness is over, they get a little note in the mail from an insurance company that says, ''Well, we're going to cancel your insurance''? And the only reason they really give is because you got sick. That was what they bought insurance for in the first place. If you get sick you have insurance. It takes care of the hospital and the doctor bills.

But today, unfortunately, in this society we have people who get sick and then have their insurance canceled just when they need it the most. So they do not have it today. This legislation, for the first time, says that you are not going to be able to cancel someone's health insurance because they got sick—sort of a logical thing I think we should have done a long time ago. But this legislation does accomplish that.

The second point is, people, in my State and other States, that have tried to buy health insurance, and, sometimes, because they have had a preexisting condition, they are prohibited from buying a health insurance policy. I do not think that is basically fair. Health insurance shares the risks. There are a lot of sick people that are in the insurance pool. There are a lot of well people in the insurance pool. On balance, the insurance companies make money and people get health insurance.

That is how the system is supposed to work. So this legislation addresses the problem of people who have had preexisting conditions and brings them in a fair fashion into the system in a way that I think makes a great deal of sense.

The other problem of all those people who do not have health insurance in my State and, again, in the other 49 States is because they have had to change a job. And we all know in this mobile society as people change jobs because of downsizing, or because of changes in technology, they are able to get a better job through education and training, they could move on to another field, the problem is that many people will not change jobs, will not get a better job even if it means better economic conditions for themselves and their families. Guess why? Because they will lose their health insurance.

So we have a situation referred to as ''job lock'' where our people would like to move on to better jobs—or maybe even forced to change to a new job because of downsizing—and cannot do so because they lose their health insurance, which is one of the most important things that the job market can provide. But if you cannot be guaranteed that coverage you have today will be with you tomorrow when you are in a different job, well then, people say, ''I'm just going to stay right here.'' Or if they get laid off and they have to move to another job, they do so perhaps without any insurance because they are uninsurable when they move into the new position.

So what we have today through the Kassebaum-Kennedy legislation is a major, major health reform package which I enthusiastically am a cosponsor of and congratulate the people who have brought this monumental piece of

legislation to us. It will, when it passes, and President Clinton signs it, be, I think, a shining example of what Congress can do when we are willing to work in a bipartisan fashion to accomplish something as monumental as this legislation does.

I know the majority leader has a package of amendments that he is going to present at a later time. I as an individual Senator and a member of the Finance Committee looked over a lot of the suggestions in the proposed amendments that he has submitted. You know, a lot of them are good ideas. They have not yet worked their way through the committee. That gives me a little concern about how these new ideas are going to be paid for. Our staffs are now, as we speak, looking at the legislation and the series of amendments. I think, by and large, most of them are pretty good—80 percent tax deductibility for self-employed people who buy insurance. All the people around the country that are self-employed, now, can only deduct about 30 percent of their premiums. With this amendment, you would be able to deduct 80 percent of your health insurance premiums. I think that is pretty darn good, just like a company that contributes to a policy can deduct 100 percent of their contributions. So we should do something for the self-employed people in this country. That amendment does that.

Penalty-free IRA, individual retirement accounts, withdrawals for large medical expenses and for the unemployed to pay their health insurance premiums. That is a good idea. We have talked about that. I think this should be bipartisan in that amendment. I think that is good.

My point, as I reach to a conclusion here, is that we have a large coalition, but it is a fragile coalition. I suggest that if people come up with amendments that are very controversial, that there is not a consensus on, or that we have not had hearings on, or amendments that have not been reported out, like this bill has, by a full committee of the Senate, that we will run into problems, and we will miss what I think is a golden opportunity to, in fact, create legislation which makes a lot of sense for all Americans.

One of the amendments I will just mention is a so-called medical savings account. This is a classic example of ''if it sounds too good to be true, it probably is.'' I think that when you look at this concept—and I found after looking at it—that it, in fact, is too good to be true and causes problems that greatly outweigh the benefits. It is not to say that medical savings accounts do not have some benefits; they do. But I do not think that we are certain enough about those benefits as opposed to the negative problems that will occur to automatically accept this provision without a great deal of discussion.

I hope when that amendment is offered we will be able to strike out that section of the proposed Dole amendment and proceed to pass this legislation, hopefully with the other amendments that the majority leader is prepared to offer.

Let me tell you why I think medical savings accounts are a bad idea. I say, first of all, at one time I thought they were a great idea. At one time I introduced legislation to create medical savings accounts. Boy—they sound terrific. I asked my staff—''What is the problem?'' At the time, we—like many others—did not have the full picture to understand the problems. Few had analyzed the effects of medical savings accounts.

The problem was that while it is really terrific for healthy people, it is not so terrific, in fact, potentially very bad, for people who are not healthy. If you take, for example, young people—I have four children who are relatively young and very healthy, thank goodness—a medical savings account is very attractive for them. Their employer can contribute money to an account, and they would use that account to pay for their initial medical bills during the course of the year. If they did not have to use it at all, they get to keep the money. What a great deal if you are 20, 25 years old and very healthy.

So, in the past, we had only looked at how it affected one group of people—healthy, basically young people. A terrific idea for them. What we failed to look at is how it affected other people who buy insurance because they may get sick—generally, more elderly people, and people who do get sick during the course of their life. If they have a very high deductible policy, as high as $3,000 for a family, they have a problem, because they will incur medical expenses during the year. If they have to pay for it out of their pocket, it is a really serious problem for them. Again, it is not a problem for people who are young and never have to go to the doctor during the course of the year.

Incentives for the medical savings account have a tendency to suck out all the healthy people from the insurance pool, put them into a medical savings account where they will not be using a lot of medical health care, but leaving behind people who do get sick, who do have to go to the doctor and do have to go to a hospital during the course of a year. If the only people remaining in an insurance pool are people who have to use doctors and hospitals, the risk becomes so great because of the loss of healthy people, that their premiums would rise so high that insurance would soon be unaffordable for them as well.

My fear is that while a medical savings account takes care of one group of people, it causes far greater problems than are justified for everybody else, which is the vast majority of the remaining people in this country.

I think at the appropriate time we should set aside the medical savings account, with an amendment if we have to, look at the other amendments that Senator DOLE has offered, and I think most of them, from my personal observation, are good. I think we should accept them. But certainly not the medical savings account at this time.

Let me conclude, once again, saying to Senator KENNEDY and Senator KASSEBAUM, my congratulations to you for bringing to the Senate a real opportunity to do real health care reform in 1996. We hope that the Senate and the House would ultimately pass this legislation, and the President should sign it.

Mr. FEINGOLD. Mr. President, I rise in support of this bipartisan health insurance reform bill, a measure that I was pleased to cosponsor. There are a number of reasons to support this legislation introduced by my good friends, the Senator from Kansas and the Senator from Massachusetts.

Let me focus my remarks on ways in which this measure should provide some meaningful help for one group in particular. That is our Nation's small businesses.

From existing companies trying to maintain health care coverage to individuals who are trying to start a small business, this bill addresses several problems confronting smaller firms trying to provide health insurance for their employees.

First, Mr. President, and I want to emphasize this, the measure addresses the barriers often posed by preexisting conditions. An estimated 81 million Americans have some kind of preexisting medical condition that could, unfortunately, affect their insurability. The legislation limits the ability of insurers to impose exclusions for preexisting conditions.

In addition, the bill requires insurers to sell and renew group health policies for all employers who want coverage for their employees, and it prohibits group health plans from excluding any employee based on health status.

Now, Mr. President, this can be especially helpful to our small businesses. The problem of getting insurance does not just affect individuals with preexisting conditions. Whole industries have been denied coverage by certain insurers because they are not to employ people who are more likely than others to get sick.

A study by the Congressional Research Service found that several insurers routinely denied coverage to dozens of different types of businesses ranging from some of the following: auto dealers, barber shops, beauty parlors, hotels, lodges, and restaurants. Mr. President, even businesses and individuals that have health insurance cannot be sure of maintaining their coverage if illness strikes.

Insurers can, therefore, collect premiums for years and then just suddenly refuse to renew coverage in individuals or employees who begin to incur large health care costs. So, requiring insurers to renew policies can certainly help address that problem. This bill finally helps move us down this road.

Mr. President, the bill also guarantees renewability of individual policies and prohibits insurers from denying insurance to those moving from group coverage to individual coverage. We know that the inability to retain health care coverage once somebody leaves a job can trap many people in the jobs they wish to leave. This is often referred to as ''job lock,'' a problem, according to one survey, that may touch one quarter of all American workers—individuals that stay in jobs they would otherwise leave, because they fear losing their health care coverage.

Mr. President, this job-lock effect has an impact on small business, as well. Unless you inherit wealth, or maybe win the lottery, the chances are pretty good that anyone who wants to start a small business will be somebody's employee—at least as they make the decision to become a small business person. If you or a member of your family have any kind of preexisting condition, you may be faced with this job lock. The inability to get health insurance prevents those individuals from leaving their existing jobs to start their new business.

Mr. President, I think this barrier has a major impact on our economy by discouraging new business startups. We all know that small business is the real foundation of our economy. We have an insurance practice that discourages people from taking their good ideas and starting new businesses that will employ many more people. That is a real, real restraint on the growth of our economy.

Mr. President, finally, I want to commend the authors of this measure for the provisions that help make it easier for small businesses to form private, voluntary coalitions to purchase health insurance, and to also negotiate with providers in health plans.

While the economic power of big businesses has enabled many larger firms to contain health care costs and improve the quality of health care for their employees, small businesses continue to see health care costs climb.

The Senate Labor and Human Resources Committee reported that while health care costs for large employers declined 1.9 percent in 1994, small employers saw an average increase of 6.5 percent. This is a very large discrepancy, and one that really discourages small business at the same time that larger businesses are benefited.

By providing small employers and individuals with the kind of economic leverage in the marketplace that is currently enjoyed by large employers, these provisions should help bring the costs of health insurance down for small businesses and individuals.

Mr. President, as you know, there are over 50 cosponsors of this measure, pretty evenly divided between Democrats and Republicans. Of course, this is an indication of the broad desire for health insurance reform. But it is also an indication of the care taken by Senator KASSEBAUM and Senator KENNEDY in crafting a measure that, finally, has a real good chance of becoming law, at a time of very heightened political sensitivities on this issue.

Before any measure is enacted, it has to navigate the choppy waters of each body, a conference committee, going back to each body again, and, finally, receive Presidential approval.

That is no mean feat at any time, but it is especially difficult in the political environment of a Presidential election year.

If this bill becomes law, as I hope it will, its enactment would be in no small part due to the legislative skills of the Senator from Kansas and the Senator from Massachusetts, and, I might add, to the fondness and respect many of us in this body have for both of them.

Mr. President, I congratulate my friends, and I yield the floor.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

PRIVILEGE OF THE FLOOR

Mr. WELLSTONE. Mr. President, first of all, I ask unanimous consent that Dr. Maimon Cohen, a fellow on my staff, have the privilege of the floor during the pendency of this legislation.

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

Mr. WELLSTONE. Mr. President, I think every Senator who came to the floor has thanked both Senator KASSEBAUM and Senator KENNEDY for their fine work. I wish to join in that. I also say to the Senator from Kansas, who is chair of the Labor and Human Resources Committee, that along with everyone else, I will miss her. I think she has been a great Senator for Kansas and for the benefit the country. I mean that sincerely.

Mr. President, I think this is a very important piece of legislation for a number of different reasons. I would like to start out talking about that. I am going to be relatively brief, I say to other colleagues, who may want to come down to the floor for opening statements.

I think this is important because, first of all, we will not be able to have any kind of regulation if we do not do it at the Federal level because of ERISA exemption—in other words, preemption. In other words, so many citizens in our States are insured by self-insured plans, and really it is impossible for States—and Minnesota has run into this—to pass reforms that, in fact, will help people and cover everyone because self-insured plans are exempt from that coverage. We ran into this the other day when we marked up an important piece of legislation that I hope will come to the floor, where we said, look, you really do not want to have a family be put in the situation where a mother with a newborn is told, after 24 hours, regardless of circumstances, ''You are out.'' I mean, that is something that people in the country do not think is fair.

But the fact of the matter is that even though my State of Minnesota has passed such a piece of legislation, saying, no, that is not fair, there has to be a mother and a doctor and the family in consultation making decisions about what is good for that mother, about 40 percent of the citizens in Minnesota would not be covered because they are in a self-insured plan.

This is an extremely important piece of legislation. I hope it is not so weighted down with killer amendments that it does not pass. This is a bipartisan effort, and I think we ought to take this step for one reason more than any other; it is just a matter of elementary fairness. I have not seen polls on this, but I think the Senator from Kansas and the Senator from Massachusetts, and all the rest of us that are cosponsors, would go forward regardless, but I just bet that 99 percent of the country would agree with the proposition that if you have paid your premium on time, just because you now have a bout with breast cancer, or some other kind of illness, it would be outrageous to all of a sudden find yourself without coverage, or you should leave one job and go to another job and not be able to obtain coverage.

Most all Americans just find that to be an outrageous proposition. My wife, Sheila, has been my teacher when it comes to domestic violence issues. And with the support of both the Senators from Kansas and Massachusetts in markup, we have a provision in here that we think is important dealing with issues of family violence. I wish these issues were not out there. But we want to make sure battered women are not battered again. If a woman is beaten up and comes to a hospital with her children and reports that, which is what she should do, and which is the first step in being able to leave a very dangerous home—and, unfortunately, homes are not always the safest places in the world—she would not find herself without coverage for that condition.

So this is really a piece of legislation that is a matter of basic fairness. I know GAO has estimated that some 25 million Americans could benefit. I also want to make the point that most of the uninsured in our country are uninsured because they cannot afford coverage, not because they are denied coverage.

So, in other words, we have a piece of legislation that deals with accessibility and with portability. For those of you listening to the debate, that means you can go from one job to another and not lose your coverage or be locked out because of a preexisting condition. We are not still dealing with affordability. In Minnesota, there are 400,000 Minnesotans without insurance coverage, and 91,000 of them are children. In the main, that is not because of preexisting conditions, it is because the families cannot afford the coverage. Nationwide, the uninsured now number 40 million people.

I hope that we will get to the point, again, in this Congress when, in fact, we make sure that every citizen in our country has at least as good a health care coverage as we have as Senators and Representatives. This piece of legislation does not do all that, but it is an important step forward.

One other concern I have, Mr. President—and I just want to make this point—you cannot do everything in one piece of legislation. I am out here to support it. I worry a little bit that what might happen is that the insurance companies might say, ''OK, when you shift from job to job, or you move from one job and now you want to set up your own small business, or whatever, we will not deny you coverage because of a preexisting condition, but we will raise your premium to $8,800 a year or $9,000 a year,'' in which case, my fear is that it will become the functional equivalent of preexisting condition discrimination. Let us hope we have the cooperation of the insurance industry. But I just flag that as a potential problem.

Last point, Mr. President. I have been doing a lot of work with my colleague from New Mexico, Senator DOMENICI. A couple of years ago, we started a working group on mental health. Both of us, and other Senators, feel very strongly about this issue. We are working on an amendment that I think is real important. It is an amendment that would provide equitable health care coverage for mental illness and substance abuse services. In other words, what we want to make sure of is that we, once and for all, put a stop to the discrimination that all too often takes place in the health care field. We are simply talking about parity—parity in coverage for physical and mental health and substance abuse services, and not different co-pay requirements, not arbitrary caps on visits with physicians or other health care providers. I have to say that I believe this amendment, which we have worked very hard on, is an extremely important amendment.

I believe that Senators, regardless of political party—Senator DOMENICI and I certainly do not agree on all issues, but we have been immersed in this issue for several years now. We have seen all of the ways in which people, who are struggling with these health care problems, fall between the cracks. We have seen the discrimination. And this amendment, which will really focus on the importance of parity, which will make sure there is no discrimination in this area, I think, is extremely important.

I will have data to bring to the floor. I will talk about some of the insurance plans right now that do not discriminate and will talk about why this part is so important. I will talk about the differences it can make for women and men being able to work, to live lives of dignity, and to contribute to the community.

But I do look forward at some point in time as we move along with this piece of legislation to bringing this amendment to the floor with my colleague, Senator DOMENICI. Mr. President, I do not know that there has been another Senator who has been a stronger voice in this area for those citizens who are struggling with mental illness. The same thing can be said for his wife Nancy. For Sheila and I, this has emerged as a professional and a personal friendship. I look forward to being able to proudly bring this amendment out to the floor with my colleague and good friend, Senator DOMENICI, and I hope in the spirit of what I think is bipartisanship that we will be able to get good, strong support.

I yield the floor.

Mrs. KASSEBAUM. Mr. President, may I respond for a moment to the Senator from Minnesota, who is a valued member of the Labor and Human Resources Committee?

When he mentioned the rate increase possibly coming if we do not cap any of the premiums, I would just say also that we do not preempt States from doing community weighting or a cap, if a State so desires. That is one of the flexibilities that I believe is important. It is one of the reasons we have the strong support of the State insurance commissioners. That flexibility which has been built into this also has strong support from the National Governors' Association.

Mr. WELLSTONE. Mr. President, I never argue or disagree with the chairman of my committee. I think it is a point well taken. I do hope at the State level we will have in fact that oversight and that accountability.

Mr. WYDEN addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon is recognized.

Mr. WYDEN. Mr. President, thank you very much.

Mr. President, I take the floor today to speak on behalf of this extremely important bill. In doing so, I want to commend the chair, Senator KASSEBAUM, and also Senator KENNEDY for what I think is exactly the kind of spirit of bipartisan effort that is needed to produce an important health bill.

The reason this legislation is very important is it will provide a new path for upward mobility in American life. I have seen again and again in my home State—this goes back to the days when I was director of the Grey Panthers, a senior citizens group at home—I have seen citizens cut off from economic opportunity because this bill was not law. You could have, for example, a young person just starting their career in Oregon. They are working hard. They are committed, doing well in the marketplace, playing by the rules, and showing the kind of discipline to get ahead in the work force. But they, in effect, end up being cut off because they have a medical problem. So, if they hear about a better job across town, another economic opportunity where they can make a better wage, they lose out simply because today's insurance system does not work all that well unless you are healthy and wealthy.

With this legislation, it is going to be possible to make the health insurance system work for all Americans so that all Americans can get access to health insurance and get it when they need it most, which is when they have serious medical problems.

I would like to give special thanks to the chair, Senator KASSEBAUM, and to Senator KENNEDY for their efforts to work with those of us from Oregon. Oregon has been one of the States, as the Chair knows, that has consistently been out in front in terms of health reform. We have done it with the Oregon Health Plan, for example, innovative in terms of senior programs, and we have been on the cutting edge with insurance reform as well. There is a very special State effort supported by Republicans and Democrats alike at home. We have initiated a number of important insurance reforms at the State level that we felt had to be protected. Through the good offices of the chair, Senator KASSEBAUM, and Senator KENNEDY that has been possible.

I have been notified in writing that the Oregon insurance reforms that have been initiated on a bipartisan basis are working well according to the insurance industry, and consumer groups alike are protected under this legislation.

Finally, Mr. President, let me add that no one should be mistaken about how much more is left to do in the area of health reform. If I had my way, for example, a very important, albeit modest, change that we would add to this legislation would be to open up the national practitioner data base to the public so that the citizens of this country could get access to the disciplinary record where the medical profession has disciplined one of their colleagues. I wrote this law as a Member of the House of Representatives—again, a statute that has bipartisan support. Today in that data bank lay thousands and thousands of names of physicians who have been disciplined formally by their colleagues, and the American people cannot find out about it.

Senator BOXER has done yeoman work on this issue. A number of our colleagues on both sides of the floor have approached me on this. If I had my way, we would be on the floor today including this important change that would be of benefit to consumers.

But as a number of our colleagues have noted, it is not possible to get all the way to health reform in America. It is not possible today to get all of the work done that needs to be done to protect consumers and to insure universal coverage. But I think it is quite clear that a major step forward is being taken as a result of the bipartisan work done by Senator KASSEBAUM and Senator KENNEDY.

I urge my colleagues to support this legislation and then, as it goes to conference, to reject the number of anticonsumer provisions that were added in the House. For example, in the House—it seems, again, incredible

to see this kind of anticonsumer retreat—the House wants to roll back the protections for older people who buy policies to supplement their Medicare care. The late Senator Heinz of Pennsylvania and others fought for years for this legislation. The House wants to roll it back. The House wants to roll back the fight against fraud and waste.

So, I hope today that the Senate will vote for this important bipartisan legislation—it is an important step forward—and then to reject the legislation in conference coming from the House.

Mr. President, I ask unanimous consent that my letter to Senator KENNEDY on the Oregon reform proposal and his reply to me be printed in the RECORD.

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

U.S. SENATE,
Washington, DC, March 29, 1996.

Hon. EDWARD M. KENNEDY,
Ranking Member, Committee on Labor and Human Resources, Russell Senate Office Building, Washington, DC.

DEAR SENATOR KENNEDY: The development of S. 1028, the ''Health Insurance Reform Act of 1995,'' certainly is one of the current Congress' most important advances in assuring access to quality health care. I look forward to the debate of this significant legislation on the floor of the Senate.

I am, however, concerned that our efforts to extend health insurance coverage and end ''job-lock'' not impede significant advances made by individual states in the health insurance reform arena. One such effort is coming to culmination in my home state of Oregon, and I write to you today to inquire if the Oregon reform proposal likely would be subject to a favorable exemption ruling by the Secretary under the language of Section 112 of your legislation. The section's flexibility in this regard will be an important element in my consideration of the overall legislation.

Embodied by Oregon State Senate Bill 152, our group-to-individual portability plan was designed by a working group of state insurance officials, insurance carrier representatives and health insurance agents. This enacted state law will extend affordable health insurance coverage by mandating that all state-regulated group insurance carriers offer portability plans to persons leaving groups after having had six months of continuous insurance coverage.

This plan also demands that carriers offer a choice between both a moderately priced insurance package based on the average of the State's most popular HMO plans, and a lower-priced, catastrophic coverage option.

Finally, group carriers that have individual products can offer them as their portability products as long as they offer both the prevailing (HMO average-best) and low-cost options.

The Oregon insurance reform program, due to go into effect October 1, 1996, with portability plans on the market by January 1, 1997, has other encouraging elements as well. For your information, I attach a copy of a March 22, 1996, letter to me by two members of the working group which produced the plan. Should you have any questions regarding this letter, please don't hesitate to contact me, or Steve Jenning of my staff at 224–1084.

Thank you for your consideration of this matter. I look forward to working with you on this issue, and on other important health matters.

Sincerely,

RON WYDEN,
U.S. Senator.

U.S. SENATE, COMMITTEE ON
LABOR AND HUMAN RESOURCES,
Washington, DC, April 18, 1996.

Hon. RON WYDEN;
U.S. Senate,
Washington, DC.

DEAR RON: Based on my understanding of the Oregon plan, it would clearly meet the requirements for an alternative State mechanism under the State flexibility mechanism of the Kennedy-Kassebaum bill. My understanding is that your program offers a program for all individuals leaving insured group coverage that allows them to remain in a pool with employed persons remaining in the entire insured market. For those individuals leaving self-insured coverage, access to an open high risk pool meeting the standards of the bill is guaranteed.

Yours sincerely,

EDWARD M. KENNEDY.

Mr. WYDEN. Mr. President, I yield the floor.

Mr. DEWINE addressed the Chair.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. Mr. President, I would like to say a few words in support of the pending legislation.

Our distinguished colleagues, the Senator from Kansas and the Senator from Massachusetts, I believe, have crafted a sensible piece of legislation that really represents the broadest possible consensus on health reform that we can achieve at this point.

Back in 1994 when I was a candidate for the U.S. Senate, the President was trying to get Congress to enact a health reform bill. That was a health reform bill that went substantially further than the national consensus on health care would allow. For better or for worse, the American people made a decision. They made a decision and determined that they would not support a bill that threatened a large expansion of Federal involvement in health care. They made the decision that that simply was not good.

During that debate when I was running for the Senate, I said that the failure to enact the President's plan did not mean that we would have to give up on health care reform. And we should not. In fact, what we should do, as I said at the time we should do, is to try to get a consensus, that there were things that we could agree on, there were things that Democrats and Republicans could agree on, liberals and conservatives. We ought to agree on those things. We ought to put that into legislation, and we ought to pass it. I think what we have in front of us today is just that. It is that bipartisan consensus. It is a consensus of what we can agree on.

There was, going back 2 years ago, a broad agreement on several aspects of this health care reform—disagreement on some areas but agreement on others. One of the areas where there clearly was agreement was on the problem of portability, or the challenge of portability or the need for portability. Basically, there was agreement on the issue of letting people who have preexisting conditions get health insurance. That was very important. Let small businesses form purchasing pools so their employees could get a better price for health insurance. There was and is agreement on that.

These are basic mainstream principles. I am happy to say that they are embodied in the legislation that we have before us today.

The Kassebaum-Kennedy legislation would create major positive changes in the health insurance market, and it would do so without imposing new mandates on employers or creating new Government bureaucracies. It would give workers the flexibility to change jobs without losing their health insurance coverage. It would protect families from losing their health insurance if a family member loses his or her job.

Mr. President, according to the General Accounting Office, the bill would provide health care security to 25 million additional Americans. This is genuinely a far-reaching health reform that I believe does in fact preserve the bipartisan support it is receiving in the Chamber. I am glad today to be able to add my voice in support of this legislation.

Let me, if I could, turn very, very briefly to another issue, and I had intended to speak and still intend to speak sometime today or tomorrow or early next week at length on this, but I wish to take a minute right now to call my colleagues' attention to this and also the American people.

Next week is National Organ Donor Awareness Week. I again will speak at length about this in the future. But the basic facts are that we lose people every day in this country, 7, 8, 9, 10 people, people who medical science, medical capabilities could save, but we lose these people, their families lose them, because they are on a waiting list, a waiting list to get an organ donor transplant.

They die because, frankly, there simply are not enough organ donations made in this country every day. The reason that there are not enough is very simple. It is that too many families, when faced with life's most horrible tragedy, and that is the loss of a loved one, do not really know what to do when they are asked whether or not they will donate their loved one's organ or organs.

I encourage my colleagues and families across the country to talk about this issue because I am convinced that the vast majority of American people are caring, loving people who want to help other people when they can and who, if they think about this for any period of time at all, will conclude that if, heaven forbid, something traumatic would happen to them and they would be killed, they would want their organs to be donated to somebody else, so somebody else could see, so somebody

else could live, so somebody else could carry on a productive life.

As I said, I will speak more about this at length later. I see my colleague from North Dakota is present and ready to speak. I am not going to hold him up at this point. But I just again call my colleagues' attention to this. National Organ Donor Awareness Week is next week. It is one of the rare times in public office or in public debate in this country where, when we talk about an issue, we can help solve it. It does not cost any money to do it. It is just a question of getting people to be more aware of the tragedy that occurs every single day to someone who could be saved, when someone who could remain with their family and be productive and live a good life dies because other individuals, not knowing really what to do, make a decision not to allow their loved one's organs to be donated.

So, Mr. President, I appreciate the Chair's indulgence and my colleagues' indulgence, and I will today or tomorrow be talking further at length about this important issue.

I thank the Chair.

Mrs. KASSEBAUM. Mr. President, I should like to recognize first the valuable work that the Senator from Ohio has done on the Labor and Human Resources Committee. Senator DEWINE has worked hard to help us get this put together. He was worked hard on all the other health issues that have come before the committee, and as he mentioned is a major leader along with Senator FRIST on the organ donation issue. So I appreciate his assistance with the legislation.

Mr. DORGAN addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I too commend the Senator from Ohio. I know he has done a great deal of work on the issue of organ donation—work that I support very strongly. I hope we will advance public understanding and knowledge about organ donation, not only in this legislation but in other pieces of legislation as we move forward.

I did want to say as I begin—and I will be very brief since there are others in the Chamber who wish to speak—I cannot think of two more able Senators to bring a piece of legislation like this to the floor than Senator KASSEBAUM and Senator KENNEDY. This Senate will be diminished when Senator KASSEBAUM leaves, but she has done outstanding work on this legislation and she and Senator KENNEDY deserves to be complimented for bringing this to the floor. In my judgment, the approach we've taken to this legislation—finding the issues that we all agree on—is the kind of thing we should be doing routinely. I did not support the Clinton health care plan. I did not cosponsor the Clinton health care plan because I believed then that it was too bureaucratic. But he was asking the right questions. We needed to address health care for two reasons. One, to provide broader access to health care. And two, to try to do something about the escalating costs of health care.

I happen to think the proposal that he made was too bureaucratic. It would have not advanced the solution in both of those areas that I think was appropriate. But that does not mean we do not have problems in both areas that we must address. This piece of legislation addresses one of those. It addresses the issue of access to health care.

Again, this is exactly what we should be doing when we have a disagreement, a substantial disagreement about a major policy issue. What we ought to do in those instances is find where is there an area of agreement, and that is what happened with this legislation.

This legislation addresses the issue of access. It brings together those varying viewpoints in the Senate into one bill on which we can all agree that, yes, this advances the issue of access to health care. That is why I am pleased to have been a cosponsor of the legislation and am pleased today to speak in favor of it.

The health care system in this country is a remarkable system. You do not see very many Americans who get sick and decide to get on an airplane and go to some other country for health care. That would be a very unusual thing to see. What you see instead is people getting on an airplane or getting on some other means of transportation and coming to America to get health care because we have a wonderful system of health care.

But we have two problems. One, not everyone has access to it, and, two, its cost is escalating. It has diminished a little bit in recent years, but it has been escalating double and triple the rate of inflation every year for many years, and that prices health care out of the reach of too many of our American citizens.

All of us understand that our health care system is a system that offers miracles to many Americans—new hips, new knees, cataract surgery, even heart transplants. The list is endless.

I would suggest that anyone who wonders about where all of this comes from might go out to the National Institutes of Health. Take a look at something they have out there called the ''Healing Garden,'' where they do research on a range of plants and all kinds of other things that produce all of these wonderful new medicines. They do research on a whole range of health care issues and develop new surgical techniques and new approaches.

We have invested a substantial amount of money that has produced enormous rewards for our society. And with all of those miracles and all of this wonderful medicine, the two remaining questions are, one, how do we provide to people more access to this wonderful system, and, two, how do we bring the cost down so it does not rise out of the reach of too many American people?

This bill addresses that issue of access—not for everybody, but it does it in a way that pulls together those things that we agree on. This includes dealing with the limits on exclusions for preexisting conditions. This bill is a very modest approach that solves part of that problem, a major part of that problem, for many of the American people.

A whole lot of people are locked in their jobs because of this issue of preexisting conditions. They are unable to move, because if they move they cannot carry that insurance with them and no other insurance carrier will pick them up because they have had a preexisting condition. This piece of legislation deals with that in the right way.

This legislation says to insurance companies: if someone has been a good customer of yours, buying your policy for years, you cannot drop coverage simply because that person gets sick. This piece of legislation also addresses the issue of portability, and does it in exactly the right way.

So I am pleased that we are here on the floor with this piece of legislation. It is exactly the kind of thing we ought to do. Instead of continually talking about what we cannot agree on, we should find the areas where we can agree to begin moving toward a solution to a problem. That is exactly what this piece of legislation does.

Let me end where I began, by complimenting the Senator from Kansas, Senator KASSEBAUM. This body will be diminished by your leaving at the end of this year, but you will have left your mark here in many, many ways. You and Senator KENNEDY will have left an indelible mark, if we can pass this legislation, by advancing this issue of access to a wonderful health care system to millions and millions of additional Americans who ought not be left out of the system.

So I compliment Senator KASSEBAUM and Senator KENNEDY for their diligent work and I hope we can do exactly the same thing on other issues in the coming weeks. If we disagree, let us figure out where we disagree, but then let us find the center. We ought to come to the floor to move toward solving problems, rather than being so intractable in our own camps and deciding we simply cannot solve problems.

I look forward to casting a final vote, an aye vote on this legislation. I hope it does not get too loaded down as it moves along. I hope the Senate will act with some haste to try to move this to a conference.

I yield the floor.

The PRESIDING OFFICER (Mr. CAMPBELL). The Senator from Idaho, [Mr. CRAIG], is recognized.

Mr. CRAIG. Mr. President, I come to the floor this afternoon in support of the intent of S. 1028. Let me join my other colleagues in thanking the Senator from Kansas for her work in getting this kind of health care reform legislation to the floor, and also the

Senator from Massachusetts for the work that he has done in this area.

Health care in some form has been on the congressional agenda for several years. It is an important issue, and I hope by the end of this process we will have a health care insurance reform proposal that will make health care insurance more accessible and more affordable.

The purpose of S. 1028, the Health Insurance Reform Act of 1995, is to increase access to health care insurance, improve the portability of benefits, give people greater security, and increase the purchasing power of individuals as well as small employers. The bill does this through a series of insurance market reforms. For example, the bill would reduce the duration of exclusions for preexisting conditions by crediting enrollees for maintaining continuous coverage through a previous employer. Another important component would be the portability of coverage from a group plan into the individual insurance market.

The bill also includes a proposal that would create new State-based health insurance purchasing cooperatives, or HIPC's, based on a program that was included in the Clinton-Mitchell health care reform bill. These HIPC's are intended to give small businesses and individuals greater purchasing power in negotiating more favorable rates.

Many Idahoans complain that they are locked into their current jobs because they fear losing their health care insurance. Several of my colleagues have been on the floor in the last few hours, giving examples of this kind of very real problem that Americans face. In some instances, entrepreneurs avoid starting their own businesses because they are unsure that they would be able to provide health care insurance for their families in the way that they were covered under their current employer. This is a problem that has existed in this country in an increasing way over the last decade, and it simply needs to get corrected. This legislation offers that correction.

Another problem commonly raised is that individuals who have had major illnesses or preexisting conditions cannot obtain coverage if they change jobs. In other words, once you have a medical record, insurance companies, by that record, can disallow you coverage for that problem under a new insurance policy. These kinds of fears are real. Real life examples are given, and they are faced by individuals and families every day. The security issue I mentioned, as part of the intent of this bill, is a very important component of health care insurance reform.

We must all be mindful that health insurance reform will have an impact on the marketplace. These kinds of reforms that are being proposed in this legislation are not without cost. As we cause the insurance market to change, the marketplace will price itself differently. In our effort to improve access to health care coverage we need to be extremely cautious and ensure that there is a minimal impact on the cost, or the increased costs of insurance, especially in the individual market.

One thing we can do is to address the issue of cost in this bill. A number of valuable provisions for addressing these consumer concerns were included in the Balanced Budget Act. However, that was vetoed by the President, so they are not yet available to correspond with this legislation when it becomes law.

Therefore, Mr. President, while I agree on the intent of S. 1028, to improve access, I do have concern about the issue, of affordability. In order to fully address access to health care coverage we must look at affordability. While we create potential flexibility in the marketplace, if we drive the cost beyond the reach of the individual, the family or the employer, then what have we solved? What old problems have we only changed into new ones?

In order to fully address access to health care coverage, we must look at the whole issue of affordability. There are several key amendments that I think are going to be offered by the leader which will help us a great deal in solving this potential problem, such as increasing tax deductions and implementing medical savings accounts, or MSA's, as the public has grown to know them. MSA's should be a part of this bill. That amendment will be offered. I certainly hope the Senate will respond as they should to the question of affordability, rounding out this legislation by addressing the cost component.

Title III of this legislation, S. 1028, includes a sense of the committee language that MSA's should be enacted. If they should be enacted—and that is what the committee says and what the legislation says—then why do we not do it? Let me read what the sense of the committee is.

> It is the sense of the committee on Labor and Human Resources of the Senate that the establishment of medical savings accounts, including those defined in . . . the Public Health Service Act . . . should be encouraged as part of any health insurance reform legislation passed by the Senate, through the use of tax incentives relating to contributions to, the income growth of, and the qualified use of, such accounts.

That is what the legislation says. That is what the law would say. But, if we do not add an amendment to it, it is fine rhetoric but it does not address the needs of the American people. And it does not, in my opinion, create the component of affordability that this Senate must be responsive to, if we are to bring about this kind of insurance reform.

I said the language is supportive, but it does not change anything. Instead of using this bill to speak to the issue, we should be using it as an opportunity to give consumers this valuable tool to finance health care costs.

MSA's work much like individual retirement accounts, something that the consuming public of this country knows about and likes. They are often coupled with a catastrophic health care policy, but some models have been conducted in combination with managed care plans. A limited amount can be deposited annually, usually equaling the amount of the high deductible. At the end of the year, the unused amount is rolled into the next year, allowing for savings to accrue.

If an individual does experience a catastrophic illness, savings can be used to meet the annual deductible, as well as cover any copayment that may be included as part of the catastrophic plan.

MSA's are portable because they belong to the individual. If we are reforming health care insurance, why do we not create a vehicle that provides increased opportunity for individuals to possess health insurance?

Regardless of your employment status, your MSA's stay with you. So, the job-lock question is less likely to occur. In addition, savings you accrue can then be taken with you and used to pay for insurance premiums if you are between jobs. If you want to start your own business and step away from an employer who provides insurance, the MSA stays with you. You can buy your own insurance with it.

It certainly creates tremendous choice and flexibility for the individual and families, and that is what we are concerned about here, the freedom of the individual and families to make sure they can provide for themselves. Health care insurance coverage and MSA's can play a tremendous role in doing just that.

Because MSA's have a higher deductible and lower premiums, they are a workable alternative for small employers who currently cannot afford to provide insurance as a benefit. So they even offer the small employer greater opportunity to provide health insurance benefits to his or her employees.

A catastrophic policy and a deposit in an MSA for the annual deductible are lower in cost than any other type of insurance coverage. In addition to the lowering of cost to the employer providing insurance, MSA's provide the beneficiary greater flexibility in how those health care dollars are spent and limit out-of-pocket exposure.

Finally, because savings can accrue, this is an opportunity to save over an individual's lifetime for those hefty, late-in-life health care costs such as long-term care. That is real health care reform. That is real health care insurance reform.

The cost of long-term care is a big problem that Senators have tried to deal with on this floor and that certainly the seniors of our country have faced themselves for a long time. Many of us at our age in life, who have parents who are nearing a time when they may need long-term care, all of a sudden begin to factor some of those financial costs into our own budget, if we are capable of doing so, in caring for the elderly of our family.

MSA's could help solve this problem in a generational way if this Senate and this Congress would simply quit talking about the value of them and allow them to become available to all Americans.

Mr. President, I have been frustrated by some of the references about MSA's, that they are an extreme idea that will help only the healthy and the wealthy. It could not be further from the truth. Rather, I argue that MSA's are a commonsense response to the current problems of our health care system, incorporating individual choice and responsibility. The American people understand that and I think the American people are ready to use this health care insurance tool in a way that works to their benefit.

The history of this issue has been one of bipartisan support. In both the House of Representatives and the Senate, MSA bills have been cosponsored and supported by Republicans and Democrats alike.

I have a copy of an old ''Dear Colleague'' letter on a bipartisan bill, S. 2873, the Medical Cost Containment Act of 1992. 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:

U.S. SENATE,
Washington, DC, September 8, 1992.

DEAR COLLEAGUE: The United States is faced with a crisis in health care on two fronts: access and cost control. So far, most of the proposals before Congress attempt to deal with access but do not adequately address the more important factor—cost control. We have introduced legislation that will begin to get medical spending under control by giving individual consumers a larger stake in spending decisions.

We have introduced a bill, the Medical Cost Containment Act of 1992 (S. 2873), which would allow employers to provide their employees with an annual allowance in a ''Medical Care Savings Account'' to pay for routine health care needs. This allowance would not be subject to income tax if used for qualified medical expenses. Any money not spent out of a given year's allowance could be kept by the employee in an account for future medical needs during times of unemployment or for long term care. In order to protect employees and their families from catastrophic health care expenses above the amount in the Medical Care Savings Account, an employer would be required to purchase a high-deductible catastrophic insurance policy.

Unlike many standard third party health care coverage plans, Medical Care Savings Accounts would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their ''own'' money. That is, money that they would otherwise be able to save in their account for future needs.

Once a Medical Care Savings Account is established for an employee, it is fully portable. Money in the account can be used to continue insurance while an employee is between jobs or on strike. Recent studies show that at least 50% of the uninsured are uninsured for four months or less.

Today, even commonly required small dollar deductibles (typically $250 to $500) create a hardship for the financially stressed individual or family seeking regular, preventive care services. With Medical Care Savings Accounts, however, that same individual or family would have this critical money in their account to pay for the needed services.

We feel that, while the Medical Care Savings Account concept does not provide the total solution to the crisis in health care access, it does begin to address the critical aspects of increasing costs and utilization by consumers.

We hope that you will join us as cosponsors of this legislation. If you have any questions please contact us or have your staff contact Laird Burnett of Senator Breaux's staff.

Sincerely,

JOHN BREAUX.
DAVID BOREN.
TOM DASCHLE.
RICHARD LUGAR.
DAN COATS.
SAM NUNN.

Mr. CRAIG. Mr. President, this letter outlines many of the beneficial aspects of MSA's, or medical savings accounts, in addition. I found it quite interesting that as part of his pension simplification proposal, President Clinton would allow withdrawals from individual retirement accounts for catastrophic health care insurance needs. That is a great idea. But that is an MSA. Whether Bill Clinton knew it or not, by his endorsement of this approach, he has, in effect, endorsed medical savings accounts, and I applaud him for doing so.

Since the healthy-and-wealthy assertions have been made, I want to take a moment to address this issue, because it is phony, phony, phony.

Anyone who has experienced chronic health problems or a catastrophic illness realizes how difficult it is to cover out-of-pocket expenses. If that health care problem is not covered by insurance, you get no assistance in helping finance the cost incurred. We have people who have minimal coverage and are making limited incomes, and they cannot afford the out-of-pocket costs to get across the deductible threshold to get the benefits of their insurance, in many instances. For families and individuals on fixed incomes, this is especially problematic.

I had a constituent who expressed to me a frustration that even though she had great health care insurance, it did not provide comprehensive dental benefits. She needed to get a tooth capped, which would cost her at least $500 out of pocket. Her alternative was that she should live with the discomfort until more serious problems occurred with the tooth that would be covered by her insurance.

Her frustration was that this was the only health care problem she had experienced in the last 2 years and the only cost incurred other than her annual physical and dental checkup. She had not met her deductible, but would have to find $500 in her monthly budget to pay for capping a tooth or go take out a loan, if she could qualify, to cap a tooth and then spread that cost over several months. If my constituent had an MSA, the $500 would have been covered by funds in her account.

Medical savings accounts would also benefit individuals with chronic illnesses, such as diabetes. A few years ago, several individuals who live with diabetes complained to me that many of the health care costs they incurred are not covered by insurance. For example, the glucose testing strips, the syringes for insulin, dieticians or nutritional services, and the pharmaceuticals are not always fully covered by insurance but are necessary in order to avoid more expensive, catastrophic illnesses.

With a medical savings account, a diabetic could pay for these expenses from his or her MSA. In addition, if they did experience a catastrophic illness, they would be covered once their high deductible was met.

Mr. President, some will claim that MSA's will cause people to forgo needed health care treatment. This is simply not the case. I must say, while that allegation is made, there is no proof that MSA's would have that effect. Unlike most health care coverage plans, MSA's give consumers an incentive to stay healthy because the money you spend is your own. In addition, they provide access to funds for preventive health care services which may not be covered by insurance plans.

Let me respond to the other half of the argument that MSA's are just another tax break for the rich. Working families will benefit greatly from MSA's. The United Mine Workers of America have a provision similar to MSA's in their current contracts. Mine workers and other working families, in my opinion, do not meet the definition of those who claim this is just for the rich. I think those are hard-working people who want and need good health care coverage for their families. That is exactly why the United Mine Workers Union negotiated it with their employers, because it was something the employers could afford and it gave those working men and women greater opportunities for coverage.

I must say I grow saddened by the kind of rich demagoguery that is played on the floor of this Senate on a variety of issues when we try to expand the base and expand the opportunity for all Americans by giving tax incentives or tax breaks that allow them to do certain things beneficial to their well-being.

Mr. President, regardless of income, if you get an MSA and catastrophic plan from your employer, your employer will be making the same contribution to your account. In addition, MSA catastrophic plans are a less expensive option for an employer, especially small businesses, providing another affordable option for employers who currently do not provide insurance. That is what insurance reform should all be about; as I said, to create affordability and to expand the opportunity for access to this kind of coverage.

Finally, MSA's give lower income individuals an account to draw from for primary care and other preventive services that otherwise would be paid

out of pocket. The out-of-pocket issue to those less fortunate in our country is a very real issue, Mr. President. In other words, MSA's eliminate the up-front deductible required with most insurance policies and provide, in essence, by this very action, first-dollar coverage.

For example, with a traditional employer-provided insurance policy, a deductible must be reached before the insurance policy kicks in. A low-income parent with a sick child has to find funding out of his or her monthly budget to pay for the doctor or for any prescription. With an MSA, the worry is gone because the money has been placed by the employer in the MSA. Furthermore, if the problem is catastrophic, once the deductible is met from funds in the MSA account, the catastrophic policy provides the coverage.

In most cases, out-of-pocket exposure for individuals with MSA's is less than with other types of insurance coverage policies. In fact, low-income families have an opportunity to benefit from the savings that would accrue in an MSA over time.

Consider the following: Janet earns $13,000 a year. She is 20 years old and keeps her MSA through to age 60. If her employer deposits $1,800 a year in her medical savings account and she remains in good health and spends an average of $250 a year from her MSA, by the age of 60, assuming an 8 percent interest rate per year, Janet would have $433,661 in her medical savings account. Now, that is an optimum scenario.

Let me give a more likely one. Under the same scenario, with Janet experiencing more health problems, and let us say she is spending $1,000 a year from her medical savings account for health care, she would still accrue $223,000-plus in her medical savings account by the time she is 60. That is the opportunity that exists today if this Senate and this Congress will awaken to what the American consuming public wants.

Under a traditional fee-for-service HMO–PPO program, Janet would have health care coverage as long as she stayed with her employer. She would have to pay her annual deductible out of pocket and a copayment for service once she met that deductible. At age 60, if she retired, she would have no health care insurance and no medical savings account. That is the current law. Even this legislation does not really address that problem upon retirement, for those individuals who are not yet 65. Medical savings accounts do.

So, let us change S. 1028 from rhetoric to reality by amending it and putting medical savings accounts in it. While Janet may not be a real person, there are plenty of real Janets waiting to benefit from medical savings accounts.

Mr. President, my home State of Idaho was one of the first States to implement a statewide MSA program. Early reports and reactions to Idaho's program have been very, very favorable. Ada County, the largest metropolitan county in my State, was the first major employer in Idaho to offer the plan. It is saving the county a lot of money and providing greater flexibility for county employees. Passing a Federal MSA plan will enhance what is already a beneficial program in my home State of Idaho. It will allow our MSA program to be even more effectively used across the State. In short, Mr. President, passing a federal MSA plan will enhance what is already a beneficial program in Idaho.

Let me tell you about one of our county commissioners in Idaho who has been a great advocate of medical savings accounts and was instrumental in bringing that county on line with an MSA policy once the State legislature passed the law. Gary Glenn, an Ada County commissioner, participates in the optional MSA plan, as do about 20 percent of the Ada County employees.

Ada County's medical savings account plan saves taxpayers' dollars, maximizes patients' choices, and rewards responsible health care consumption. The benefits to Gary's six-member family are illustrated in these examples. The county's old indemnity program provided Gary's family typical coverage, $100 per person deductible, with a maximum of $300 per family, plus a 20-percent copay. The monthly premium was $494, of which Gary and his family paid $158 a month.

Under the new MSA, Gary's family has catastrophic coverage with a $2,000 per person deductible—the maximum per family, though, is $3,000—and 100 percent coverage or payment above that deductible. The new monthly premium is $194. Gary still pays $158, but the county pays $36 per month instead of $336.00 for the old indemnity plan. This is a dramatic reduction in the overall cost of insurance on a per month basis. This provides a savings of $3,600 per year. Out of the savings, the county will deposit $2,100 in Gary Glenn's medical savings account.

Under the old indemnity plan, Gary's family faced a much higher financial risk. In the worst case, they would be forced to pay $5,100 in deductibles and copays out of pocket and after taxes. Under the medical savings account, with a $3,000 deductible, no copayment, and $2,100 in his medical savings account, the most they would have to spend out of pocket in 1 year would be $900. That is important to remember. Instead of $5,100 out of pocket, they would spend $900. And the county is saving literally thousands of dollars as the employer.

In addition, by reducing Gary's out-of-pocket family risk by 82 percent and providing them with maximum flexibility in how they spend their health care dollars, any portion of the $2,100 deposit in their account—Gary Glenn's account now—is left to spend on health care, state income tax-free, or to carry forward and earn interest.

So under the Idaho medical savings account plan in Ada County, the taxpayers of that county and Gary's family are realizing real benefits. Mr. President, why cannot we be smart enough to provide that to all Americans—to give them at least the option, the choice? That is real insurance reform. That is real flexibility. That is real portability. MSA's are an idea whose time has come. We ought to do it. Today, though, in this bill we only offer the rhetoric. I hope the amendment that will be offered by the majority leader will pass and become a part of this important law.

Let me say in closing that S. 1028 is a good bill. What I have talked about is making it a better bill, a more complete reform of the health care system. Not the adjustments around the edges, but major reform in a way that fits 21st century Americans. It gives them the freedom of choice, access, the individual decisionmaking authority, the buying power they need, and it is effective for all levels of our society, the poor and the rich alike. That is what it should be about.

Mr. President, I ask unanimous consent that an editorial from the Idaho Statesman be printed in the RECORD. The headline says ''Congress Can Follow County Lead on Medical Savings Accounts.''

This editorial urges this Congress, this Senate, and the President himself to become modern, to become thinkers and not prohibitors, and add to this major reform package the concept of medical savings accounts. I hope we can accomplish that.

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

[From the Idaho Statesman, Apr. 1, 1996]

CONGRESS CAN FOLLOW COUNTY LEAD ON MEDICAL SAVINGS ACCOUNT

Ada County is leading the way in health-insurance reform by its use of medical savings accounts. Too bad many Democrats in Congress and President Clinton are among those most afraid to follow.

The U.S. House endorsed medical savings accounts Thursday as part of its legislative package on health care, but the outcome in the Senate is less certain, especially with Clinton's threat of a veto looming over the whole bill.

The nation loses if medical savings accounts are stripped out of the final legislation in a compromise.

As local experience shows, they can be an effective way to save insurance expenses and give consumers more control over decisions about their own health care.

Instead of traditional and expensive health-insurance policies, Ada County buys only catastrophic policies for the 20 percent of its work force signed up for the program. The savings are put into the accounts of participating individuals and can be used for routine medical expenses.

The measures in Congress works about the same.

Individuals could make tax-deductible contributions of up to $2,000 (or $4,000 for families) in a medical savings account and would be required to purchase a high-deductible health insurance policy for catastrophic illnesses.

The system saves money because workers have an incentive to shop around for medical care. Bargain hunters can motivate doctors and hospitals to compete, which in turn injects needed market forces into the health industry.

By eliminating the middle man—insurance companies—the accounts allow people more direct control of how, when and where they spend their medical dollars.

Sadly the issue of medical savings account has become embroiled in partisan politics in Congress. But reforming health care and giving consumers more options should not be a partisan issue.

It is simply a matter of giving consumers greater clout as the nation seeks an improved health-care industry.

Mr. KENNEDY. Mr. President, just for the information of the Senators, we have been on the legislation since 9:30 this morning, 5 hours, and we have not had amendments. In the earlier part of the day, I think both Senator KASSEBAUM and I were urging our colleagues to come over and make comments about it. We have been blessed with so many bipartisan comments on the legislation.

We are expecting an amendment by the majority leader momentarily to be put down, also a unanimous-consent agreement in the process of being circulated so we might be able to move toward the consideration, or we are going to find a situation as the evening time comes that Members will say, ''Why can we not attend to some of our other responsibilities in the evening?'' We want to try and accommodate everyone, but we are open for business. But the first business, we had hoped, would be the majority leader's amendment, and then to have a good debate on that. Part of the debate will be on the medical savings account, and we will address that issue in a more complete way at that time.

I just wanted to at least give some indication to our colleagues about where we are in the course of the debate.

Mr. SIMPSON. Mr. President, I certainly will not take 10 minutes.

I want to add my voice to the bipartisan chorus of support for S. 1028, the Health Insurance Reform Act. I am proud to say I was an early supporter of this one. I signed on as a cosponsor back on July 17, 1995, just 4 days after it was introduced by Senator KASSEBAUM.

I commend her and I commend Senator KENNEDY for their determined efforts to advance this legislation through the Senate in the politically charged atmosphere of an election year. She has created a bill that deserves the support of Republicans and Democrats alike.

The provisions of this bill have been well covered—portability, guaranteeing availability and renewability of coverage, preexisting medical conditions, and maintaining continuous health coverage, making it easier for small employers to voluntarily form purchasing cooperatives—and would bring about changes that a vast majority of us agree upon.

Even President Clinton, in a dramatic departure from his earlier proposal for a Government-run health care system, has now embraced health insurance reforms that are remarkably similar to those which President George Bush proposed back in 1992. Whatever one might be attempted to say about the irony of all of that, it clearly indicates that we now have a unique opportunity to correct the problems that pose the most serious threat to the health coverage of millions of Americans.

Though each of us can think of various ways in which we would like to expand upon the pending legislation, the reality is that the bipartisan appeal of the bill will be lost if we go too far in amending. I intend to be very cautious about amendments that are offered for the Senate's consideration, even in cases where I might support the amendment on its merits. I say this because I would rather pass legislation that actually becomes law, even if it is not as far reaching and perfect as I would like it to be, than to make a legal statement with legislation that ends up in the great scrap heap of unfinished business—and there will be plenty of that in this session of Congress, things that stood on principle and could not get into law because you did not have the votes to get them into law. Unfinished business—that stack.

When I hold town meetings in Wyoming—I do not know how many of us still do that; I do—the message I always come away with is that people are thirsty for action. They are not interested in excuses or rhetoric or political maneuvers from either party. No matter how clever or imaginative we are in explaining ourselves, they just do not buy it. They have had a bellyful of petty partisan squabbles. What they long for is to see a Congress identify areas of agreement, as Senators KASSEBAUM and KENNEDY have done with this legislation, and then act in the best interests of the American people, without agonizing who will win or who will lose, who will be the top dog, who will be the underdog when it is finished, or politically, how to simply portray Members of the other party in the worst possible light.

The pending bill would allow us to do something beneficial, I think, for millions of Americans who are at most risk of losing their health coverage. The General Accounting Office reports as many as 21 million Americans would benefit if preexisting-condition exclusions are waived for people who maintain continuous health coverage, and, furthermore, another 4 million would no longer experience job lock if portability of health insurance is insured.

I believe it is time to move forward, adopt these protections to the extent that more sweeping measures are needed to make health insurance more affordable, more accessible. I will help with that. I surely agree that there is much more we can do.

I worked with Senators CHAFEE and BREAUX on issues of a bipartisan nature. I think that is very important. Let us consider those items separately that might serve to bring this down and view them at another time in such a way that we do not jeopardize the enactment of the pending bill.

I think what we need, sometimes, is an old-fashioned trait known as self-restraint. Perhaps we could even adopt self-restraint as the theme for the next several hours as we consider the bill. It would surely be an appropriate manner in which to recognize Senator KASSEBAUM's tremendous leadership on this issue, and to preserve a thoughtful bill that will provide important health insurance protections to millions of Americans.

Finally, I note the senior Senator from North Dakota is not on the floor. I hope he will have an opportunity to address my remarks. I admire him. He is a friend. We have worked together. He has come forward and said that we should put aside our agendas, put aside our own causes, work in harmony and concert. I hear that, yet I also hear each and almost every day my good friend from North Dakota stirring up some issue in some way, usually with a partisan twist. I think that if we are going to do that, just note the pending business of the Senate on the calendar. The pending business of the Senate is the illegal immigration bill. It is not moving simply because the Senator from North Dakota wishes to place an amendment on it with regard to the balanced budget and Social Security.

I am not speaking in a partisan way. I have been here before. I remember my dear friend Senator John Heinz placed amendments on illegal immigration bills. Even my ranking member has done such heinous activity from time to time, the Senator from Massachusetts. I have seen him do that. I am not talking about partisanship. If we are going to do this—we have a bill that is stalled right now. We will see how long it will stall out. There are three amendments ready to be voted upon. Where it is all held up, that bill is held up for a single particular reason: Because of the Senator from North Dakota, because of an eternal amendment that he has with regard to Social Security, saying that no balanced budget can ever be done, and we do not do anything with Social Security, which is an extraordinary thing in itself because Social Security is going broke. The people that are telling us it is going broke are the trustees, the stewards of the system, who are saying the system will go broke in the year 2020.

So how do you keep ducking it, unless you are just carrying water for the AARP and the Committee for the Preservation of Social Security and Medicare and other 800-pound gorillas in that particular Social Security debate.

So I hope that we will proceed. I say to my friend from North Dakota—my friend and sometimes adversary—heed thine own advice. I will be waiting.

Ms. MOSELEY-BRAUN addressed the Chair.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Ms. MOSELEY-BRAUN. Mr. President, about 2 years ago, this Congress blocked attempts to act on comprehensive health care reform. While that year's effort to achieve the major reforms that are so needed and so long overdue did not succeed, the problems that led the President to make that proposal have not disappeared. Far from it.

There are over 40 million Americans without health insurance, and over 23 million of those are employed. Over a million working Americans have lost health care coverage over the past 2 years; 60 percent or more of all Americans currently worry about losing their current health insurance coverage.

Over the last few years, the rate of private health care cost increases has dropped substantially, but there are now increasing concerns about the quality of care. Public health care costs continue to increase at an unsustainable rate. The case for reform, therefore, is perhaps even more compelling now than it was 2 years ago when we first took up this issue.

I am, therefore, proud to be one of the cosponsors of S. 1028, the Health Insurance Reform Act. It is not the comprehensive reform that we looked at to begin with, but it is a good and important step in the right direction. Indeed, this may well be the first step on the road to reform that everyone can agree upon. I say to the Senator from Kansas and the Senator from Massachusetts that this legislation is brilliant in its simplicity, precisely because it cuts to the heart of the issues that concern the American people most about health care coverage.

Mr. President, in my view, there are four cornerstones of health care reform: Universal coverage, cost containment, maintaining the quality of care that we enjoy in this country, and retaining freedom of choice for the American people in terms of health care delivery and the providers of health care.

This bill moves us in the direction of universal coverage by keeping people insured who might otherwise not be. If there is any concern which everyone has regarding health insurance, it is the trap of preexisting conditions. All too often, individuals find themselves excluded from coverage because of a preexisting condition. In some cases, the individuals themselves are not even aware of the existence of that preexisting condition.

By limiting exclusions for preexisting conditions, by making health insurance coverage available for small businesses, and by ensuring portability and ending job lock, this legislation deals with the concerns of millions of Americans. It will help to make health insurance coverage more available for millions of Americans and for small businesses, help hold down health care costs for Americans, and further help to expand access to health care. That, in my opinion, is real reform, or a step in the right direction.

In my own State of Illinois, over 2 million people are currently without health insurance. This bill will make a critical difference in their lives and in the lives of similarly situated people all across our Nation.

Those who are now without insurance are far from the only beneficiaries of this legislation. For Americans who might want to leave their jobs and start their own businesses, or who might have to leave their jobs because of corporate restructuring, but who might have a preexisting condition or family medical history that would currently make it difficult or impossible for them to purchase an individual health policy, this bill will make a huge difference. It will guarantee their ability to access health insurance.

This bill will also guarantee that small businesses with only a few employees would not lose their group health care coverage because one of the people in the group develops a serious health problem, as is the case now. Moreover, it will make health insurance more affordable for those small groups, making it more likely that more small businesses will provide health insurance benefits for their employees.

Families with small children suffering from a serious health problem will no longer face the prospect of being unable to obtain health insurance if the child's parent changes jobs, ensuring that the child's parents are not themselves job locked because of the condition of a member of the family. It is tough enough for families to deal with serious health problems affecting one of their children without having to face the additional problem of losing access to health insurance if they are laid off or restructured out of their jobs or if they want to change jobs for a new, perhaps better paying job that could help their families in other ways.

Women who have had breast cancer or other diseases will no longer face higher premiums or loss of access to health insurance altogether if they change jobs once this bill becomes law. And young college graduates starting their first jobs would not be barred from access to health insurance simply because they suffer from a childhood ailment or a continuing disability from an unfortunate accident.

The Health Insurance Reform Act, therefore, represents a practical, caring set of reforms to deal with the real health care problems facing so many Americans, based on their everyday realities. It does not require Americans to radically change their behavior. It does not add another bureaucracy or a huge new paperwork system. It does not require new Federal spending or new taxes. It does not create any new unfunded mandate on State or local governments. At most, it will increase the costs for private health insurance companies by less than one-quarter of 1 percent.

This bill is about incremental reform, but real reform nonetheless. It will help virtually every working American, as well as millions of Americans who are temporarily out of the work force. The bill itself will work because it is based on what is actually going on in the world of real people who need health care.

Mr. President, it is worth thinking a moment about those everyday realities. Statistics tell us that the average American works at a job for about 4½ years. Over the course of a working career, therefore, an average working American could hold seven or more jobs. That fact alone makes it all too clear just how important it is for the American people to have portable health care coverage. That fact alone is a good indication of how necessary it is to end preexisting condition restrictions that result in Americans having to pay enormous sums for new health care policies, losing access to the one they had, or end up with no access to health insurance at all.

Eighty-one million Americans have preexisting conditions that could affect their insurability. More than half of all American workers are enrolled in health insurance plans that impose some form of preexisting condition exclusion. As I stated earlier, when you consider that most of us will change jobs several times in the course of a lifetime, the preexisting condition problem affects virtually every American family.

Mr. President, every American wants and needs health care security. It is as important to them as retirement security, an objective that should command absolute consensus in this country. That vision and importance of retirement security led to the creation of Social Security. That is why we provide tens of billions of dollars in annual tax incentives to companies to provide pension plans for their workers. That is why we support pension plans and retirement programs and savings.

Health care security is no less essential to the American people than retirement security, not only because you cannot enjoy retirement if you are in poor health, but because lack of access to affordable health care insurance can literally mean bankruptcy. Being able to roll over your insurance coverage, therefore, is just as important as being able to roll over pension savings. Maintaining health security deserves the same level of attention that we give to retirement security, and measures that protect and enhance that kind of health security deserve the same kind of consensus support.

Mr. President, the really good news is that so many of our colleagues—57, in fact—and so many different organizations, and the President, support this legislation. The American people support this. Facing the fear of loss of health insurance, facing the preexisting exclusion, those kinds of uncertainties will be resolved when we take this step in the direction of incremental reform.

This legislation has been carefully worked out. It represents a real compromise by both Democrats and Republicans who support it. I congratulate the chairman of the Labor and Human Resources Committee, Senator KASSEBAUM, and the ranking Democratic member, Senator KENNEDY, for their leadership and for all the hard work they have put into bringing this bill to this point. As I said earlier, it really is brilliant in its simplicity. I congratulate them for the bipartisan nature of this debate so far and for the efforts in bringing us together as representatives of the American people, whatever political party, bringing us together to get this badly needed legislation passed.

If there is one matter that commands consensus, it is what this bill addresses because it addresses it so brilliantly, in my opinion.

I urge Senators on both sides of the aisle to put aside partisan differences, put aside other good ideas, and let us move forward and pass this legislation so that it can be law and so we will have done the job the American people have every right to expect that we will do.

Thank you very much.

I yield the floor.

Mr. GRAMM addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas, [Mr. GRAMM], is recognized.

Mr. GRAMM. Mr. President, I want to talk about the bill that is before the Senate and the amendment that Senator DOLE will offer on behalf of himself and others. I will also cosponsor that amendment. I want to try to explain why it is essential that we have measures which will promote efficiency and cost savings if we are going to adopt this bill.

Let me say that making insurance portable and permanent is something that I support. But I think that, if we are going to be honest with ourselves, it is very hard to do this with a straight face, which is what has been done in virtually every speech that has been given on the floor of the Senate this morning. We are talking about 25 million Americans who are going to benefit from this bill. This is a number that has been established independently of the Senate. We all rejoice in it—25 million beneficiaries of this bill, which is supposedly just a technical amendment. Yet I would point out to my colleagues, if you look through this bill, it does not appropriate one penny. It does not provide one cent.

Now ask yourself, how are 25 million people going to benefit from this bill, through greater availability of health insurance and lower prices, if the Government and the Congress which passes this bill are not providing one single penny? Is it somehow magic that through Government edict we can bestow billions of dollars of benefits on our fellow citizens at no cost and no dislocation whatsoever? The answer to that is clearly no.

I would like to begin by making a prediction. That prediction is, if we adopt this bill as it is written, at the end of the first full year of its implementation, the cost of individual private health insurance policies will rise by a minimum of 10 percent. I also believe that this is a conservative estimate.

I believe that group policy rates will go up because we are going to produce, through this effort, several undesirable effects. I want to go through them to be absolutely sure that anybody who really wants to understand can do so, and because I think they make the argument for medical savings accounts and other reforms to try to offset the basic cost increase that is going to result from this bill as it is currently written.

First of all, this bill guarantees that if a person wants private health insurance, they can get it. There may be a delay in the availability of benefits, depending on where the person works and when they have private health insurance, but under this bill, anybody who wants private health insurance at any time, under some circumstances, can get it. Furthermore, when someone comes into a group plan, no matter what the state of their health, they cannot be charged more than any other member of that group and if somebody leaves a private employer, they must be offered an individual insurance policy.

What is the result of this going to be? It seems to me there are going to be positive as well as negative results. The entire debate so far has been about the positive result: 21 million people that do not have private health insurance will be able to get it, because we are saying by law that insurance companies must sell it to them. An estimated 4 million people who are locked into their job because they fear the loss of their health insurance if they move will benefit since they will be guaranteed the issuance of health insurance when they change jobs. These are the positive impacts of the proposed changes.

But it is generally true, in the real world we live in, that not all impacts of dramatic changes are positive; let me outline some of the negative impacts.

No. 1, we are going to end up, by guaranteeing availability, distorting health coverage. Young, healthy people, knowing that they are going to be able to qualify for private health insurance in some form—either through a group or as individuals—are going to have a greater incentive to not obtain the coverage that they have today.

Why do young workers who are basically healthy buy private health insurance right now? Some might buy it because they are risk averse. But many buy it because they want to guarantee that in the future, when they may not be as healthy, they will have locked in their coverage.

What this produces is a balanced distribution of people who are buying private health insurance—many people who are young and healthy and who are very modest users of health care as well as many people who are older and less healthy and who are heavy users of health care are all buying insurance. Since many young people buy private health insurance in order to lock in guaranteed health coverage in the future, to the degree that we mandate that insurance companies sell people health insurance no matter what the state of their health is, we eliminate one of the primary reasons that young people buy private health insurance. So the first negative impact of this bill is the creation of a new incentive for young people not to buy private health insurance.

Under this bill we also have some rather extreme provisions. Before I mention one of them, let me say that I understand, when you are talking about health care, that it is hard to have a rational debate because you are talking about sick people who we can all empathize with. But I think it is important that we understand what we are doing if we are going to have a real debate in the Senate because, after all, that is our job—to understand what the implications are and to try to see that we make a rational decision.

Under this bill, not only will young people with guaranteed ability at a later point to buy private health insurance have an incentive not to buy it today, but in designating a series of health benefits for which there is no waiting period, we create a special class of people who will buy health insurance when they know they are going to need it, such as in a pregnancy, and then cancel the policy after they receive the benefit—only to buy another policy when they are ready to use the benefit again.

It is very difficult to quantify this, but anyone who read the article in the April 5 issue of the Wall Street Journal knows this is happening in States which have done exactly what we are proposing to do.

So the first negative impact of this bill is that it eliminates one of the prime incentives for young, healthy people to buy private health insurance, and the second negative impact is that it distorts the risk pool in the process.

The third thing it is going to do, which is part of the positive impact, is that the 21 million people who are sick today and as a result of being high risk have opted not to pay the going market rate—or in some cases they simply have not been able to afford health insurance—the positive thing for them will be that they will now be able to buy health insurance. The fact that they will opt for coverage, while younger healthier people, knowing they can get it later, will opt not to get the coverage, however, will further distort the risk pool of insurance. What this will mean is that in America there will be more young, healthy people who do not opt for health insurance than we have today, and there will be more

older, less healthy people who do. Given the inherent cost of changing the mix of people who are buying private health insurance, the inevitable result of this is going to be that you drive up the cost of insurance premiums.

This is not just something that is theoretical, I know we have some study which says that costs are going to go up by some minuscule amount. I do not believe, however, that anybody who has looked at the experience of States like Washington could possibly believe this. I think what we are really looking at in this bill, independent of any other changes, is younger, healthier people dropping out and older, sicker people opting in. The net result of these shifts is going to be a substantial increase in insurance rates for those who have bought health insurance, for those who, in many cases, bought it when they were young and healthy in order to have a guarantee of insurability. The net result of this bill is going to be rising insurance costs.

Now, this bill, in fact, anticipates this result and sets up a series of powers to help the States try to deal with these potential impacts. At some later point I am going to debate and possibly offer an amendment dealing with a provision on page 40 that gives the Secretary of Health and Human Services the power to disallow a State program to deal with rising costs unless it implements a mechanism to spread the risk and to limit rate increases. I do not think we ought to be dictating to the States what they can and cannot do in order to deal with a problem that this bill is going to cause.

We have before us a bill that is going to help people, 25 million of them, and for these individuals it is going to be a godsend. But another 100 million people, who already have private health insurance and who are going to see their rates go up, are going to be losers from this reform. We are going to change behavior by inducing younger people to not buy into the system, and as a result rates will be raised. We are also going to bring sicker people into the system, and the final result is going to be a spike in insurance rates—just as has happened all over the country in States with similar programs.

We have now some 29 States that have gone about this in a different way by creating risk pools to help people who have a preexisting condition get health insurance. We are, in essence, going to kill that off this approach by mandating that the insurance policy be sold in the way we dictate at the Federal level.

There is a way to get the advantages to the 25 million people who will benefit from the bill and offset the cost to the 100 million who will lose from it. The way to do that is with fundamental reform which, it seems to me, can take two basic approaches. No. 1 is with medical savings accounts as will be offered by the majority leader. The idea behind the medical savings account is to change the Tax Code to allow an individual or a family to choose a high deductible insurance policy instead of a low deductible policy, and to put the savings from the resulting lower premiums into an account which is designated solely for the purpose of paying the policy's deductible. At the end of the year, if they do not spend that money on the deductible, they can roll it over for their retirement or take it out as income and pay taxes on it.

What that means is that for routine type care they are spending their own money. Medical savings accounts empower the individual consumer to be cost conscious and provide a mechanism that will save the concept of fee-for-service medicine so those who do not want to be members of an HMO or a prepaid system can opt to stay in fee-for-service medicine and yet have incentives to be cost conscious.

If we adopt the amendment of the distinguished majority leader, we will fundamentally change the health care market, and those savings will offset several times over the cost that is involved in driving up insurance rates for 100 million Americans to help the 25 million who will be beneficiaries of this program.

A second reform, which is not contained in the Dole amendment, deals with medical liability. We have some estimates which indicate that 20 percent of the cost of medical care in America comes from expenditures that are aimed at keeping people out of the courthouse instead of keeping people out of the hospital and out of the grave.

If we are going to make the changes envisioned in this bill, which in essence transfers costs to the people who have private health insurance—by raising their premiums—from people who do not have health insurance today, the way to offset that burden on people who have in essence done what we wanted them to do—bought private health insurance—is by allowing for medical savings accounts and dealing with medical liability.

If we do not make these two changes, my fear is that 2 years from today, insurance rates, especially on individual policies outside of group plans—because under this bill we guarantee the availability of a policy to somebody who leaves their group plan—I am concerned that without medical savings accounts or without medical liability reform, we are going to see insurance rates spike and we are going to see States try to hold them down with rationing mechanisms and price controls. I think they are going to fail, as they are failing in Washington State today, and I think we are going to be right here 2 years from now debating a health care bill again, and the demand will be made to do something about exploding costs. Yet we will have produced these exploding costs with this bill.

We have it in our power to help 25 million people and yet not hurt another 100 million people in order to pay for it. The way to do that is with a medical savings accounts and medical liability reform.

In and of itself, this bill simply transfers income and assets from one group of Americans to another, and in the whole you have 25 million winners but you have 100 million losers.

With reform, we can see that virtually every American family wins. If all we are doing is simply shifting risk, we are not dealing with the fundamental health care problem in America.

So I hope my colleagues will vote for the Dole amendment. I think it is very important. I totally reject the idea that this is a simple bill and that we ought not to load it up with other items. If we do not have fundamental savings, this bill is going to cause insurance rates to explode, and we are going to be right back here 2 years from now debating socialized medicine again. I have debated that once, I am not eager to do it again, but if it is required, I certainly will.

I yield the floor.

Mr. HELMS. Mr. President, more than 80 percent of Americans younger than 65 are covered by health insurance, but if one of them changes jobs, or is laid off, he or she may be denied health insurance because of a preexisting problem, or because his health insurance cannot move with him or her. A genuine fear therefore exists that the security of health insurance could very well be lost. In fact, opinion polls show that as many as one-third of employees fear that if they switch jobs they will be unable to obtain new health insurance.

The American people believe, and I agree, that they should be able to change jobs without losing their health insurance. Congress needs to insist that health insurance be made portable so that the fear of losing their health insurance should not plague the American people when they change or lose their jobs. This bill permits insured employees who leave one employer to be covered immediately upon taking another job that offers employees health insurance, regardless of their health status.

This bill does not establish community rating. Community rating is a grave threat to the insurance market. I have heard many cite the dismal failure of guaranteed issue in States such as New York. These States coupled guaranteed issue with price controls that kept premium prices equal for everyone regardless of age, health status, etc. This combination ensures collapse of the health insurance market. However, S. 1028 narrowly defines guaranteed issue in order to avoid the devastating effects of pushing healthy people out of the health insurance market.

There must be a limit to preexisting condition restrictions that now prevent many citizens from obtaining or holding onto health insurance. I am convinced, Mr. President, that small businesses should be encouraged to form

groups to build joint purchasing power when buying health insurance for their employees.

These provisions of the Kassebaum bill will be welcome and overdue improvements in the health insurance market, and I wholeheartedly support them.

However, Mr. President, in the debate on health insurance reform, perhaps the most innovative solution has been given the shortest shrift—the medical savings account. This solution—that will provide the greatest freedom—has been successfully used by many businesses to keep their health care costs down and employee satisfaction up. In a truly American way, medical savings accounts harness the free enterprise profit motive to promote sorely needed efficiencies in the health care economy. MSA's confer upon individuals an incentive, a reason, to spend their health care dollars wisely by turning part of the savings over to the employees, in effect rewarding efficiency.

Mr. President, many private businesses are already using cash incentives and medical savings accounts to reduce their health care costs while, at the same time, achieving great employee satisfaction with the health care afforded them.

One company cut its health care costs significantly. In 1992, Forbes magazine was spending $2.3 million per year for health insurance from CIGNA at an average cost of about $5,000 per employee. In order to encourage employees to be more cost conscious, Malcolm Forbes, Jr., decided to reward his employees with a bonus for not filing major-medical and dental claims.

Forbes explained the choice to its employees: If, during the year, an employee minimized the number of claims filed with the insurance company, Forbes agreed to pay that employee a bonus of up to $1,200. Employees enthusiastically embraced this plan; insurance claims dropped dramatically. As of 1994, while premiums for other CIGNA clients rose between 21 and 25 percent, Forbes' major-medical premiums fell 17.6 percent.

The obvious lesson learned from the Forbes example is that employees will control their health spending—if they are allowed to keep the savings. Of course, in the case of employees who are really sick, they file the necessary claims and receive bonuses in lesser amounts. Employees choosing to pay out-of-pocket for routine health expenses instead of filing claims, get the bonuses at the end of the year.

Consider, Mr. President, how this kind of commonsense incentive will change the public attitudes about health care costs. For example, one Forbes employee regularly needs four different prescriptions filled, but as a result of the Forbes bonus program, this employee now shops around for the best price. Before, he didn't care how much a prescription cost because insurance paid it. And when insurance pays, we all pay, in the form of higher insurance premiums and lower income.

Forbes is not the only company to benefit from an incentive-based program. Dominion Resources, a public utility holding company in Richmond, VA, has likewise developed an innovative method of reducing its health care expenses, a medical savings account.

An MSA works: The employer buys its employees a health insurance policy with a high deductible. This kind of policy has two attributes: First, it protects the insured against catastrophic health care expenses; and second, its premiums are less expensive.

The employer then establishes a special account for each employee to pay for routine medical treatment. What the employee does not spend from the account, he keeps. This incentive encouraged 75 percent of Dominion's employees to enroll in a high-deductible plan. And guess what—since 1990, Dominion's health care costs have risen less than 1 percent per year; premiums have not increased in 3 years.

Forbes and Dominion Resources are but two examples of private industry enterprise coming up with health care solutions that work. Incentive-based solutions work for the company and they work for the employee. As one economist, Gerald Musgrave, put it, ''We have thousands of years of experience with how people handle their own money.''

So, why not let Americans continue to handle their own health care dollars and help them realize their role in cost savings? Time and time again, Americans have shown that they can and will make cost-conscious health care decisions when given a sensible incentive to do so.

So, Mr. President, insurance can be made more accessible by assuring Americans that their policies will not be canceled because of an illness or when they are changing jobs. These are some obvious flaws in the market and I believe further progress can be made by addressing the Tax Code. But I am convinced that we're on the right track.

Mr. President, I ask unanimous consent that an April 17, 1996 Wall Street Journal article entitled ''A Way Out of Soviet-Style Health Care'' by Milton Friedman be printed in the RECORD.

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

[From the Wall Street Journal, Apr. 17, 1996]

A WAY OUT OF SOVIET-STYLE HEALTH CARE

(By Milton Friedman)

In a chapter in his novel ''The Cancer Ward'' titled ''The Old Doctor,'' Alexander Solzhenitsyn compares ''private medical practice'' with ''universal, free, public health service'' through the words of an elderly physician whose practice predated 1918. A byproduct is an eloquent statement of the major advantages of medical savings accounts for the U.S. in 1996.

Mr. Solzhenitsyn himself had no personal experience on which to base his account and yet, in what I have long regarded as a striking example of creative imagination, his character presents an accurate and moving vision. The essence of that vision is the consensual relation between the patient and the physician. The patient was free to choose his physician, and the physician free to accept or reject the patient.

In Mr. Solzhenitsyn's words, ''among all these persecutions [of the old doctor] the most persistent and stringent had been directed against the fact that Doctor Oreschenkov clung stubbornly to his right to conduct a private medical practice, although this was forbidden.''

''EASIER TO FIND A WIFE''

In the words of Dr. Oreschenkov in conversation with Lyudmila Afanasyevna, a longtime patient and herself a physician in the cancer ward: ''In general, the family doctor is the most comforting figure in our lives. But he has been cut down and foreshortened. . . . Sometimes it's easier to find a wife than to find a doctor nowadays who is prepared to give you as much time as you need and understands you completely, all of you.''

Lyudmila Afanasyevna: ''All right, but how many of these family doctors would be needed? They just can't be fitted into our system of universal, free, public health services.''

Dr. Oreschenkov: ''Universal and public—yes, they could. Free, no.''

Lyudmila Afanasyevna: ''But the fact that it is free is our greatest achievement.''

Dr. Oreschenkov: ''Is it such a great achievement? What do you mean by 'free'? The doctors don't work without pay. It's just that the patient doesn't pay them, they're paid out of the public budget. The public budget comes from these same patients. Treatment isn't free, it's just depersonalized. If the cost of it were left with the patient, he'd turn the ten rubles over and over in his hands. But when he really needed help he'd come to the doctor five times over. . . .

''Is it better the way it is now? You'd pay anything for careful and sympathetic attention from the doctor, but everywhere there's a schedule, a quota the doctors have to meet; next! . . . And what do patients come for? For a certificate to be absent from work, for sick leave, for certification for invalids' pensions; and the doctor's job is to catch the frauds. Doctor and patient as enemies—is that medicine?''

''Depersonalized,'' ''doctor and patient as enemies''—those are the key phrases in the growing body of complaints about health maintenance organizations and other forms of managed care. In many managed care situations, the patient no longer regards the physician who serves him as ''his'' or ''her'' physician responsible primarily to the patient; and the physician no longer regards himself as primarily responsible to the patient. His first responsibility is to the managed care entity that hires him. He is not engaged in the kind of private medical practice that Dr. Oreschenkov valued so highly.

For the first 30 years of my life, until World War II, that kind of practice was the norm. Individuals were responsible for their own medical care. They could pay for it out-of-pocket or they could buy insurance. ''Sliding scale'' fees plus professional ethics assured that the poor got care. On entry to a hospital, the first question was ''What's wrong?'' not ''What is your insurance?'' It may be that some firms provided health care as a benefit to their workers, but if so it was the exception not the rule.

The first major change in those arrangements was a byproduct of wage and price controls during World War II. Employers, pressed to find more workers under wartime boom conditions but forbidden to offer higher money wages, started adding benefits in

kind to the money wage. Employer-provided medical care proved particularly popular. As something new, it was not covered by existing tax regulations, so employers treated it as exempt from withholding tax.

It took a few years before the Internal Revenue Service got around to issuing regulations requiring the cost of employer-provided medical care to be included in taxable wages. That aroused a howl of protest from employees who had come to take tax exemption for granted, and Congress responded by exempting employer-provided medical care from both the personal and the corporate income tax.

Because private expenditures on health care are not exempt from income tax, almost all employees now receive health care coverage from their employers, leading to problems of portability, third party payment and rising costs that have become increasingly serious. Of course, the cost of medical care comes out of wages, but out of before-tax rather than after-tax wages, so that the employee receives what he or she regards as a higher real wage for the same cost to the employer.

A second major change was the enactment of Medicare and Medicaid in 1965. These added another large slice of the population to those for whom medical care, though not completely ''free,'' thanks to deductibles and co-payments, was mostly paid by a third party, providing little incentive to economize on medical care. The resulting dramatic rise in expenditures on medical care led to the imposition of controls on both patients and suppliers of medical care in a futile attempt to hold down costs, further undermining the kind of private practice that Dr. Oreschenkov ''cherished most in his work.''

The best way to restore freedom of choice to both patient and physician and to control costs would be to eliminate the tax exemption of employer-provided medical care. However, that is clearly not feasible politically. The best alternative available is to extend the tax exemption to all expenditures on medical care, whether made by the patient directly or by employers, to establish a level playing field, in terms of the currently popular cliche.

Many individuals would then find it attractive to negotiate with their employer for a higher cash wage in place of employer-financed medical care. With part or all of the higher case wage, they could purchase an insurance policy with a very high deductible, i.e., a policy for medical catastrophes, which would be decidedly cheaper than the low-deductible policy their employer had been providing to them, and deposit all or part of the difference in a special ''medical savings account'' that could be drawn on only for medical purposes. Any amounts unused in a particular year could be allowed to accumulate without being subject to tax, or could be withdrawn with a tax penalty or for special purposes, as with current Individual Retirement Accounts—in effect, a medical IRA. Many employers would find it attractive to offer such an arrangement to their employees as an option.

Some enterprises already have managed to do so despite the tax penalty involved. MSAs have proved very popular with employees at all levels of income, and they've been cost-effective for employers. The employee has a strong incentive to economize, but also complete freedom to choose a physician, and the equivalent of first-dollar coverage. There are no out-of-pocket costs. Until the employee spends more than the total amount in the MSA. Such costs are then limited to the difference between the amount in the account and the deductible in the catastrophic policy. Moreover, the employee can use money in the MSA at his or her discretion for dental or vision care that is typically not covered under most health plans. No need to get ''authorization'' from a gatekeeper or an insurance company to visit a specialist or to have a medical procedure—until the catastrophic policy takes over.

LIMITING COMPETITION

The managed care industry has come to recognize that MSAs might threaten its growing control of American medicine by offering a more attractive alternative. As a result, the managed care industry has recently become a vigorous enemy of MSAs. Every believer in competition will recognize that opposition for what it is: a special interest using government to limit rather than expand competition.

Medical savings accounts are not a panacea. Many problems would remain for an industry that now absorbs about a seventh of the national product. However, I believe that they offer the closest approximation that is currently feasible to the private medical practice that Dr. Oreschenkov cherished.

Mr. BRYAN. Mr. President, today is remarkable. At long last—on the floor of the Senate—we are considering health care reform legislation that the American people both want and support. And at long last, it is legislation with significant bipartisan support.

I am proud to be a cosponsor of this bill. It will provide health care insurance protection for thousands of Nevadans, and millions of Americans. This incremental bill is our best opportunity to get working Americans the health care access they deserve.

We have been close to this point before. It seems like ancient history when I think back to cosponsoring former Senator Lloyd Bentsen's small business insurance health care reform. It too had incremental insurance coverage improvements that many in this body supported—yet once again, the final hurdle could not be overcome.

Many times—and over many years—Nevadans have shared with me their heart breaking stories. Families whose children have medical conditions that prevent the family from being able to purchase health insurance, because no insurer will take a child with a preexisting condition. Working individuals who develop chronic health conditions, and cannot leave their current employment for fear of not being able to get health insurance in their new job.

Health insurance is often denied for the very illnesses most likely to require medical care. Eighty-one million Americans have conditions that could subject them to such exclusions if they lose their current coverage, and sometimes these exclusions make them completely uninsurable.

People with preexisting conditions are penalized twice. First, they have a serious health care condition that requires medical care—a situation they did not choose. Second, they are at the mercy of insurers who decide whether they will have coverage, or be cut off.

For the person with a preexisting medical condition, who has been lucky enough to get health care insurance through his or her job, the secondary fear is keeping their job.

If the job is eliminated, it may mean no more health care insurance—ever. For the person who wants to better himself or herself by taking a new job, or starting a new business, it may mean no more health insurance—period. We can all imagine that fear.

These insurance company decisions affect working people who play by the rules. They pay their insurance premiums when they can get coverage. But they find themselves in untenable situations.

They are unable to have the most basic insurance of all—for themselves and their families—to not have to worry about health care coverage.

It is demeaning to all Americans if people cannot better themselves and their families' situations for fear of losing health care insurance. This legislation will free many working people from the stagnation of being unable to accept new job opportunities.

The Health Insurance Reform Act guarantees that private health insurance coverage will be available, renewable, and portable to working Americans.

This legislation will make it easier for individuals and employers to buy and keep health insurance, even when a family member or employee has a preexisting condition. This legislation makes health care coverage portable so workers would no longer be locked into jobs or prevented from starting their own business for fear of losing their health coverage.

Small businesses and self-employed individuals are particularly victimized under the current system, because they lack the bargaining power of larger corporations. This legislation addresses their problem by encouraging them to form private, voluntary coalitions for purposes of purchasing health plans and negotiating with providers. By forming these groups, the costs of health plans would be more competitive for small employers and individuals, as compared to large employers, by giving them more clout in the marketplace.

This bill is the foundation for incremental health reform. Although this insurance reform legislation will not solve all of the problems of the Nation's health care system, it will promote greater access and security for health coverage for all Americans. Private insurance carriers will compete based on quality, price and service, instead of by their ability to refuse coverage to those who need it the most.

We all know there will be attempts to add amendments to this legislation. Some of those amendments are going to be very hard to vote against.

But we must keep focused on what it is we are trying to accomplish here.

We have the opportunity to provide access to health care insurance for millions of Americans who each and every day face the uncertainty of whether they will have coverage.

We can do something to allay those fears.

Passing this bill is a big step to ensuring health care coverage is available to working Americans. Other steps are needed—but they need not be taken today.

Let us first take this big step, and get the job started. And from there, we can and will, work to ensure even better health care for all Americans.

Mrs. MURRAY. Mr. President, during the 103d Congress many of us worked very hard to try to enact comprehensive health care reform. Despite our efforts and what felt like endless debate, politics prevailed and we came up emptyhanded. Perhaps we were too optimistic to think we could accomplish such broad and sweeping reforms in 1993; but unfortunately health reform remains a critical high priority issue for every family in this country.

Well, political realities are still very real factors in determining the outcome of legislative initiatives here in Congress. And here we are again discussing health care reform, only in a much more limited and focused way.

I am encouraged that the dialogue is open once again, and that we are taking positive steps toward addressing the many health-related issues confronting people across our country.

If I had it my way, we would not just be talking about health insurance reform today. We would be doing more, especially for our most precious resource, children. We should be doing more, like: ensuring better pre- and post-natal care for women and their babies; boosting rates of immunization even higher for children across our nation; working even harder to reduce adolescent health problems like teen pregnancies, substance abuse and STD's; improving child nutrition programs and strengthening our overall national commitment to children and family health and well-being.

But, I recognize the realities of the 104th Congress, and realize that sometimes progress comes one step at a time. I am proud to be a cosponsor of S. 1028, the Health Insurance Reform Act. I believe this is a commonsense measure that will directly benefit working families across our country. I sincerely hope we can pass this bill and send it to the President for his signature.

We should not weigh this bill down with amendments that could undo the broad bipartisan support we so rarely see in this Congress. I applaud Senators KASSEBAUM and KENNEDY for their ongoing leadership and commitment to enacting this legislation.

S. 1028 was carefully crafted so that we could pass it overwhelmingly and see it enacted into law with the full support of the White House. For this reason, I will join my colleagues in opposing any controversial amendments that are offered, even those which I support in principle. We should learn from the past, Mr. President, and not try to bite off more than we can chew.

As I said, this bill is not a cure-all. We need to do more, of course. But, this is a reasonable, sensible first step and will go a significant distance toward guaranteeing coverage for millions of American workers and their families.

Mr. President, we owe it to those families to pass this bill, and pass it in its current form. To do anything which could jeopardize the fragile coalition of support for this bill would be irresponsible and bad public policy.

I appeal to my colleagues not to try and load up this bill with amendments that will ultimately kill the bill. Let us show our constituents that we can work together and we can put political differences aside for the greater good.

Much of what we are discussing here will not be news to people in my State. In 1993, we passed one of the most comprehensive health care measures in the country, and even after serious modification the people in Washington still have many of these same protections.

In some areas, like limits on pre-existing conditions, my State actually has a shorter limit of 3 months, which the Kassebaum-Kennedy bill will not preempt.

Earlier I said that we owe it to working families to pass this bill. I am talking about people across the country who have to worry about their health care coverage, people who want to work and take care of themselves and their families. People like:

The working family of three. Dad wants to change jobs to a higher paying company, but his daughter has multiple sclerosis. Under this bill, he wouldn't have to worry that she will not be able to get coverage under the new employer's plan. He plays by the rules, he pays his premiums—this family will not be confronted with a preexisting condition exclusion period.

By requiring insurance companies and employers to credit prior insurance coverage, this bill will give workers with disabled family-members peace of mind and the flexibility to change jobs without fear of losing their insurance.

Or a woman who had breast cancer who is starting a new job. Today, she could possibly be denied coverage or charged a higher premium because of her cancer history. But, tomorrow—under S. 1028—because insurance companies and employers would be prohibited from discriminating against workers because of past medical problems, this woman would be treated no differently than anyone else covered under the same plan.

And, the new small business owner and her three children. Mom was abused in her former marriage and is trying to start over. A woman in this situation is going to need all the help she can get to provide for herself and her kids.

Today, she could be facing not one but two obstacles to starting her new life for herself and her family. First, she could be denied coverage for herself for any preexisting condition that was caused by her years of being abused. Second, she is a new business owner and maybe can't afford to purchase insurance for her handful of employees.

S. 1028 will give this woman a chance to succeed. She will not be discriminated against because of her preexisting condition, and under the provisions of this bill—small businesses and individuals are permitted to form cooperatives to purchase insurance and negotiate with providers and health plans. This arrangement will spread administrative costs and empower the participants to negotiate for better prices.

In other words, S. 1028 will help this woman and her children put their troubled pasts behind them.

Mr. President, the examples are endless. We have heard many stories today, and as Senator KASSEBAUM pointed out—we all know someone who could be helped by this bill.

Even though this bill may not be as comprehensive as I personally would like, I want to reiterate my strong hope that we can pass S. 1028 without any controversial additions and move forward to address the many other issues facing America's families. That's why we're here.

Mr. COHEN. Mr. President, I rise in support of S. 1028, the Health Insurance Reform Act, which promises to relieve the anxiety that millions of Americans are feeling that they may lose their health care coverage if they change their jobs, lose their jobs, or become ill.

Health care reform is certainly not a new issue for any of us. In fact, I introduced my first comprehensive health care reform bill back in 1990. It was 76 pages long and it dealt with these same issues—the availability and affordability of health insurance.

Over the subsequent 6 years, we have spent countless hours studying and debating the issue. If we have learned anything, it is that the American people want health care reform, but they want something they can understand and afford, and something that builds upon rather than reinvents the current system.

The American public wisely rejected the big-government approach proposed in the last Congress by the administration—that 1,400 page proposal literally collapsed under its own weight. More Government bureaucracy is clearly not the way to lower health care costs or ensure access to care.

But rising health care costs and expanding gaps in coverage are still very much on the minds of the American people. Poll after poll continues to show that health care remains a top priority. In fact, a poll conducted late last year by Princeton Survey Research Associates found that more Americans are concerned about their own health care coverage than they are about crime, high taxes, the political system, or the economy.

Americans clearly want health care reform. But what they mean when they say that is: ''If I lose my job or get sick, I want to keep my health insurance and I don't want it to cost so

much.'' They want Congress to enact sensible, targeted reforms to make health insurance more affordable and available, and to ensure that they do not lose the coverage that they currently have.

We have that opportunity today. Despite the partisan and sometimes bitter debate over this issue in recent years, there is now broad-based, bipartisan support for this bill, which would benefit as many as 25 million Americans each year, at no additional cost to the taxpayers. The legislation currently has 65 Senate cosponsors and is supported by a wide range of diverse organizations including the National Governors' Association, the U.S. Chamber of Commerce, the American Association of Retired Persons, and the American Medical Association.

The Health Care Reform Act of 1996 builds upon and strengthens our current private insurance system to make it easier for individuals and their employers to buy and keep their health insurance. It contains a number of common sense, market-based reforms that are designed to guarantee that private health insurance coverage will be affordable, available, and portable. Most of these reforms have been included in my own health care bills over the years, and they have also been common elements of legislation introduced in past Congresses by both Republicans and Democrats.

First, the bill limits the ability of insurers and employers to restrict or exclude coverage for pre-existing health conditions like heart disease or cancer, making it easier for workers to change jobs and eliminating job lock. Insurers will also be prohibited from dropping or denying coverage for an individual when they or a family member becomes ill.

The legislation also provides a safety net for people who lose their employer-paid coverage—insurers will now be required to sell them individual policies. Some have expressed concern that this provision will cause premiums in the individual market to skyrocket. However, our experience in Maine—where insurers have been required to sell policies to any individual who applies since 1993—shows that this change should have only minimal price consequences. In fact, one Maine insurer reduced rates for its individual policies by 16 percent last year.

And finally, the bill assists employers and individuals in forming private, voluntary coalitions to purchase health insurance and negotiate with providers and health plans. These kinds of arrangements can provide small employers and individuals with the same kind of purchasing clout enjoyed by large employers, making insurance coverage more affordable.

No one pretends that the reforms contained in this bill are the answer to all of our Nation's health care woes. They are targeted and they are specific. But they will provide all Americans with what Robert Samuelson of Newsweek has termed ''a little more peace of mind.''

We should not underestimate the importance of providing this peace of mind to people like Susan Rogan, of Herndon, VA, who testified before the Labor Committee last summer.

She told the committee that the experience of obtaining health insurance after her husband's employers had gone bankrupt had been a nightmare, even though he quickly found a new job. Insurers were reluctant or unwilling to cover the family because their daughter has cerebral palsy.

She urged us to work together, saying:

> It is your responsibility, in Congress, to find a solution to the insurance problems that have caused so much heartache for so many American families. We voted for you, and we expect no less of you.

And Susan Rogan is right. She should expect no less of us. It is our responsibility to work together and take this positive step forward to tear down the barriers that millions of working Americans and their families face in obtaining and keeping essential health care coverage.

I therefore join the chairman and ranking member of the Labor Committee in urging my colleagues to resist the temptation to weigh down this important piece of legislation with highly controversial or extraneous amendments.

Some of the amendments that may be offered today are ones that I would, under other circumstances, support. For instance, I have been a long-time supporter of Senator DOMENICI's legislation to provide people with serious mental illness with health benefits and coverage that are comparable to those provided to people with physical illness.

However, this is neither the time nor the vehicle, and I intend to vote against all such extraneous amendments. We simply do not want to run the risk of having this very sensible and eminently doable package grow into yet another 1,400-page bundle of expensive mandates, more Government bureaucracy, and untested proposals.

We should not let the ghosts of health reform past destroy the promise that this important piece of legislation holds for resolving some of the most serious problems plaguing our health care system, and I urge my colleagues to join me in supporting it.

Mr. GORTON. Mr. President, let me make an important point about this bill. It is very narrow in scope, addressing portability and health coverage for preexisting conditions. It in no way resembles the expansive Clinton health care proposal this body defeated 2 years ago.

In the summer of 1994, many hundreds of Washington state citizens gathered in Westlake Mall in downtown Seattle to protest the proposed Government takeover of their health care. They were outraged by the hubris and the arrogance of that health care plan, and rightly so. The plan focused on setting up new bureaucracies, that it completely ignored the people who would have been affected by it.

This legislation takes a clear-headed approach, responding to one problem that people face regarding preexisting conditions. It follows the conclusions of the Senate health care task force, of which I am pleased to have been a member for several years. We came up with the lessons learned from the Clinton health care debacle, and topping the list was the fact that there simply cannot be a government-run health care system. Period. The only sane, responsible way to address particular problems that may arise is to take a very narrow, targeted approach. In other words, you don't solve a problem with grandiose, wholly unworkable schemes. You solve a problem with a commensurate response.

In this case, we have the problem of coverage for preexisiting conditions. The goals of this bill are strickly defined and few. They are to:

First, develop insurance reform legislation that builds upon and strengthens the current private market system;

Second, make it easier for individuals to keep and obtain private health insurance coverage, including measures to limit preexisting condition exclusions and expand portability;

Third, increase the purchasing clout of individuals and small groups.

With that said, let me enunciate what this bill will not do.

It will not require employers to offer or pay for health insurance coverage.

It will not require individuals to purchase health insurance.

It will not impose new and expensive regulatory requirements on individuals, employers, or States.

It will not create new Federal boards, commissions, or regulatory bodies.

It will not contain a standard benefit package or mandated benefits.

It will not subject ERISA plans to state regulation.

It will not impose any new taxes.

This is not ''Clinton Lite;'' this is a modest, narrow, targeted proposal. This is the way health care reform should be accomplished: not consumed with utopian visions and grand schemes of expensive government power, but realistic and down-to-earth.

I believe we have finally got it right. I know that many of my constituents in Washington State, and many Americans, are concerned any time Congress addresses the issue of health care reform. With the memory of the Clinton plan fresh in their minds, they certainly have reason to be wary. But I believe that, once they know what is in this bill, they will be pleasantly surprised. This Congress has neither the intention nor the desire to let the government take over American health care, the best health care system in the world. This Congress wants to take a very limited approach to specific problems.

The Health Insurance Reform Act is in concert with the beliefs of most

Americans, who do not want government-run health care, but who do expect Congress to address and resolve certain problems in the system. That is what this bill does, and I am glad to support it.

Mr. GLENN. Mr. President, as a cosponsor of S. 1028, the Health Insurance Reform Act, I am pleased that the Senate is considering this important legislation, and I urge its passage. I commend Senator KASSEBAUM and Senator KENNEDY for their leadership in crafting this bipartisan measure which will help many working Americans keep important health insurance protection for themselves and their families.

The purpose of the Health Insurance Reform Act is to ensure that people who have employer-provided health insurance will not lose their insurance if they change jobs, lose their jobs or become sick. This legislation makes changes in the private insurance market to protect employees, and to make insurance more affordable for small businesses and individuals.

The Health Insurance Reform Act requires insurers and health maintenance organizations to provide and renew group coverage to employers with two or more employees who want to purchase it, and this coverage must be available to all employees regardless of their health status. In addition, this legislation makes insurance portable by limiting pre-existing condition exclusions and by requiring group to individual coverage.

S. 1028 limits to 12 months exclusions for pre-existing conditions which occurred within the 6-month period prior to receiving insurance coverage. This 12-month limit will be imposed only one time for individuals who maintain continuous coverage even if they change jobs or insurance plans. Individuals who lose employer-provided health insurance will be guaranteed the opportunity to purchase an individual policy if they had continuous coverage for 18 months in a group plan, if they have exhausted their COBRA continuation coverage, and if they are not eligible for coverage under another group health plan. These provisions will go a long way toward ending the current problem of job lock, and ensuring that people who have been participating in health insurance plans do not lose protection when they change jobs or become sick.

S. 1028 is not comprehensive health care reform. It does not provide universal coverage for all Americans, and insurance costs will be unaffordable for others. However, it is a very important step forward in addressing problems in our current health insurance system, and it will provide peace of mind to many working Americans who have health insurance but fear losing it.

Mr. HATCH. Mr. President, I rise in strong support of the Health Insurance Reform Act, S. 1028. This important legislation represents a significant and reasonable step in extending health insurance coverage to a larger segment of the American population.

I am proud to serve as an original cosponsor of this bill and would like to take this opportunity to commend the distinguished chairman and ranking minority member of the Committee on Labor and Human Resources, Senator KASSEBAUM and Senator KENNEDY, for the outstanding contribution they have made in helping to provide literally millions of Americans with peace of mind that they will not lose their health coverage.

As my colleagues are aware, insurance market reform is a bipartisan issue and it is something we have been working toward for many years. I am thinking back to the Bentsen-Durenberger bill which many of us cosponsored 4 years ago.

Indeed, as most of my colleagues know, the Senate and House have spent considerable time and energy over the past 5 years debating various proposals designed to address problems with our Nation's health care system overall.

Perhaps no other issue in recent years has captured the attention and concern of the American people than the issue of health care reform and the role of the Federal Government in shaping that reform.

But I submit that today is not the time to debate measures of such tremendous scope.

Unlike the President's approach, S. 1028 is targeted and narrowly focused reform aimed at assisting nearly 25 million Americans in obtaining health insurance coverage.

Most of us in the Senate recall the innumerable hours spent considering President Clinton's legislation that was ultimately rejected by the American people and by the Congress.

One of the lessons we learned from that endeavor was the need to provide for greater access to health insurance than what is currently available.

And access to health insurance is unquestionably one of the fundamental problems facing Americans today.

The current health insurance market provides too little protection for individuals and families with significant health problems and makes it too difficult for employers—particularly small employers—to obtain coverage for their employees.

The health insurance reform bill is specifically designed to address this problem.

It will reduce many of the current barriers to obtaining health coverage by making it easier for people who change jobs or lose their jobs to maintain adequate coverage, and by providing increased purchasing power to small businesses and individuals.

The bill will not only increase access to health care coverage, but will also provide portability of insurance coverage and increase the purchasing power of individual and small employers who wish to seek to purchase insurance.

Specifically, the bill restricts the use of preexisting condition limitations by insurance carriers.

Some insurers today impose preexisting condition limitations or exclusions on individuals when they first become covered by an insurer.

These exclusions may limit coverage of a medical condition for a certain period or longer or may exclude coverage of a medical condition—forever.

Under the provisions of S. 1028, insurers, HMO's, and self-insured firms would be limited in the ability to use preexisting condition limitations to no more than 12 months after the enrollment date.

In addition, benefit limits or exclusions could not be imposed for newborns, newly adopted children, children newly placed for adoption, or for benefits for pregnancy.

Another important component of this bill is the provision regarding the guaranteed issue of health coverage benefits.

Under this provision, an insurer or health plan is required to cover any group or individual who applies, without regard to health status or claims experience. The bill would require all insurers who offer group coverage to accept coverage for all groups that apply.

Insurers would be required to offer individual coverage to all individuals moving from group coverage to individual coverage as well. However, to be eligible for this guarantee, the individual must satisfy the following four criteria:

First, the individual must have been covered under one or more group health plans for at least the past 18 months;

Second, the individual must not be eligible for group health coverage, or, if eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, or a similar State program, then they must have elected, and exhausted that coverage;

Third, the individual must apply for individual coverage not more than 30 days after the last day of coverage under the group plans, or the termination date of COBRA benefits; and

Fourth, the individual must not have lost group coverage due to nonpayment of premiums or fraud.

Accordingly, in order to be eligible for insurance coverage in the individual market, we have incorporated important benchmarks to foster individual responsibility and accountability in the purchasing or insurance plans.

We are all aware that this bill has engendered considerable debate on how it would impact existing premiums.

The American Academy of Actuaries has studied this issue in great detail and estimates that people who are newly eligible for individual coverage would pay an average of two to three times the standard-risk premium rate, unless States restrict premiums.

The Academy further states that S. 1028 will have no effect on individual insurance premiums for those currently purchasing coverage in the vast majority of States.

In States that restrict premiums, S. 1028 would lead to individual market premium increases in the range of 2 to 5 percent, spread out over a 3-year period.

Thus, I believe that fears the bill will lead to large increases in premiums are unwarranted. However, I recognize those concerns, and I will be monitoring this situation closely.

Another important provision in this legislation addresses insurance portability.

During our consideration of health care reform, it was clear that the use of preexisting condition provisions in insurance plans has contributed to a problem referred to as ''job lock''.

In effect, employees are locked into their current jobs because changing jobs might subject them to periods without health insurance coverage because of a preexisting health condition.

For an employee with a medical condition, or a dependent with a medical condition, loss of coverage during a limitation period, or worse, exclusion of coverage of the condition forever could mean significant out-of-pocket health care expenditures.

As a result, guaranteed issue and limits on the use of preexisting condition provisions by insurers provide needed portability of coverage for American workers.

It is also important to note that the legislation provides specific guidance with respect to State flexibility in compliance with this new law.

Federal provisions for group to individual portability only become effective if States do not have programs meeting Federal requirements for access.

S. 1028 will provide for state flexibility for compliance with Federal provisions.

State mechanisms could include guaranteed issue or open enrollment programs by one or more plans, a high risk pool, or mandatory conversion policies.

In my State of Utah, we have already enacted many of these reforms.

The legislation would permit a waiver from Federal law if a State could demonstrate that its law achieved the objectives of affordable individual market portability and renewability.

And finally, S. 1028 promotes group purchasing by small businesses by assisting employers and individuals in forming private, voluntary coalitions to purchase health insurance and negotiate with providers and health plans.

These coalitions will provide small employers and individuals with the kind of clout in the marketplace currently enjoyed by large employers.

It's important to note what this bill does not contain.

S. 1028 does not impose new, expensive regulatory requirements on individuals, employers or States.

S. 1028 does not create new Federal bureaucracies or agencies.

S. 1028 does not contain any new taxes, spending, or price controls.

S. 1028 does not require employes to pay for health insurance coverage.

And, S. 1028 contains no unfunded mandates on State, local, or Indian tribal governments.

In effect, this bill contains none of the onerous provisions contained in the ill-fated Clinton health care reform bill.

Mr. President, I will state in all candor that initially I had reservations about supporting this legislation.

As a general rule, I believe the Federal Government should not intervene in areas where consumer choice and natural marketplace conditions determine the level and costs of products and services.

And, indeed, in the past I have supported what I believe were true market-based reform proposals in the health care area. However, the problem of access to health insurance has long been a problem to millions of Americans.

This problem remains, and it will continue to remain until appropriate Federal action is taken.

Over the course of the past year, we have worked to develop and fine-tune the provisions embodied in S. 1028.

Most of these modifications were developed to more clearly reflect the intent of the bill.

These revisions were principally designed to provide more certainty to States and insurers as well as to respond to concerns that the Secretary of the Department of Health and Human Services was given too much discretion over alternative State programs.

I am pleased that the manager's amendment deals with concerns expressed to me from constituents in Utah over the need to revise the bill's provisions regarding conflict of interest language as it applies to purchasing cooperatives.

And, I would like to thank Senator KASSEBAUM's cooperation in resolving these issues.

This legislation will now permit insurers, agents, and brokers to serve on purchasing cooperative boards or be employed by a cooperative as long as they do not personally benefit from the sale of services or products to that cooperative.

I believe we have come as close as possible in this present political environment in developing a viable measure that will appropriately address the problem of access to health insurance for millions of Americans.

The General Accounting Office estimates that passage of S. 1028 will help at least 25 million Americans each year.

According to the GAO, an estimated 43 million Americans or 18.7 percent of the nonelderly population were without health insurance coverage for some period of time in 1995.

This bill will truly help people, and I believe it deserves our strong support.

It is clear that insurance market reform is one area which enjoys wide bipartisan support in both houses of Congress. The fact that the bill currently has 65 cosponsors and was reported unanimously by the Labor and Human Resources Committee serves as a testimonial to its strong bipartisan support in the Senate.

It is clear that this important piece of legislation with its strong bipartisan support has the potential to be signed into law by the President as he indicated in his State of the Union Address in January.

I commend Senators KASSEBAUM and KENNEDY, and all the cosponsors, and hope that we can move this key legislation forward today.

Mr. ROTH. Mr. President, I rise in support of the pending legislation. Labor and Human Resources Committee Chairman KASSEBAUM and Senator KENNEDY deserve to be commended for there efforts in crafting the bill before the Senate which assures that workers who intend to change jobs will no longer experience the fear of losing their health care coverage. Not only have Senator KASSEBAUM, other members of her committee, and their staffs labored many long hours to draft the bill, they have also successfully built a strong coalition of support. Thanks to Senator KASSEBAUM and Senator KENNEDY this bill is supported by big business, small business, a wide array of advocacy groups, many insurance companies, and many Americans.

While I do think the Kassebaum-Kennedy bill could be improved, I think it is a critical step forward. At a later time, I will join the majority leader in offering an amendment which makes health insurance more affordable.

The Kassebaum-Kennedy health insurance reform bill has an important focus. The bill will assist people who want and need to make necessary and correct decisions about their health care needs—people who work, people who join their group health care plans and have paid their premiums continuously for no less than 12 months. The bill eliminates ''job-lock'' for workers who fear they will lose their health coverage when they change jobs, and the bill eliminates the fear of losing coverage for individuals who have maintained their group coverage and have a preexisting condition.

Recently my office was contacted by a lady who has always been insured and paid her premiums. Yet she finds herself today in a situation where she is unable to obtain health care coverage because of a preexisting condition. Nancy Miller is 56 years old, after a divorce from a 27-year marriage, she was allowed access to continued group health coverage through her former spouse's employer plan at the group premium rate for 3 years. Mrs. Miller's 36 month COBRA coverage expires at the end of May. To make sure she will not have a gap in health coverage, Mrs. Miller has worked with her current insurer, called many other insurers, contacted our office, worked with an insurance broker and yet she has been rejected from every health plan she has

applied to. Mrs. Miller has a preexisting condition. She can not get health care coverage because she contracted breast cancer 2 years ago.

Mrs. Miller's situation could apply to anyone, because anyone could get sick. Mrs. Miller has not gamed the system seeking insurance only when she needed it. For years she was healthy, and for her entire life she has been insured. The letter Mrs. Miller's insurance broker recently wrote her could be a letter received by many women. The following is the letter she received from her broker:

This letter is to inform you that we have contacted all of our standard individual health insurance carriers and are unable to find one that is capable of writing a policy for you because of your pre-existing condition. We have been advised by all of the carriers that they will not consider you for insurance until you are 5 years out from your time of release from the doctor.

The Kassebaum-Kennedy bill will provide assurances to responsible Americans. In particular, the bill provides portability in two settings: When individuals change from one group health plan to another group health plan (group to group), and when individuals leave their group health plan and seek coverage as an individual policyholder in the market (group to individual).

For group to group portability, the bill establishes uniform Federal standards for insurers, health maintenance organizations [HMO's], and employers who self-fund their health plan. There is a broad consensus that these measures should be enacted, and a very broad coalition of business as well as the insurance industry and advocacy groups support these provisions. There is a need to establish uniform Federal standards for the group to group portability measures as the bulk of employer sponsored health coverage is self-funded and exempt from State regulation. Under the Employee Retirement Income Security Act [ERISA], the Federal Government regulates private self-funded employer plans. ERISA prohibits States from regulating employer sponsored self-insured plans. Therefore, States cannot achieve all the reforms needed to assure portability when workers change jobs because the Federal ERISA law prohibits States from regulating any group health plan which is self-funded.

For those individuals leaving their group health care coverage and seeking coverage in the individual market, the bill provides access to coverage to individuals. The bill also provides States with important flexibility to meet the goals of this section of the bill. While there have been concerns raised regarding the bill's provision to guarantee that insurers make health coverage available to individuals, I think this section is important if we are to truly guarantee portability and access to coverage. States currently regulate insurance provided to individuals who are not in a group plan. The Federal role in this area of the marketplace has been minimal; therefore I agree with the bill's goal to retain a strong state role in the individual market. This section of the bill provides the needed flexibility for States to be creative.

It's important to note that the bill builds on responsible behavior because it requires that individuals have previous continued group health care coverage in order to qualify for the portability provisions. This is the case with Mrs. Miller who responsibly maintained her group coverage.

The pending bill provides that health plans can not impose preexisting condition limits on individuals who had prior group coverage. In fact no preexisting condition limits can be imposed on individuals who join a group health plan if they had continuous group health coverage for the previous 12 months. For individuals leaving a group plan, they must have had 18 months of continuous coverage in order to qualify for an individual policy without any preexisting condition limits. In either case, if individuals have less than the required months of coverage, their new plan would have to credit them for the time that they were covered.

Most Americans with private health insurance receive their coverage through their employers, and the majority of the uninsured are also tied to the workplace. The Kassebaum-Kennedy bill will strengthen the employer-based health care system we now have, and it will help responsible Americans like Mrs. Miller retain their coverage. In fact, the General Accounting Office estimates that as many as 21 to 25 million people per year could be affected by Federal portability standards in all markets. This is a good first step.

Mr. KOHL. Mr. President, I rise as an enthusiastic cosponsor of the Health Insurance Reform Act of 1995 and call on my colleagues to keep this straightforward measure clear of legislative land mines.

Passing this bill will help address a problem all too common in our health care system—the fact that people can lose their insurance coverage when they get sick even if they have paid their premiums.

Mr. President, there are a number of bipartisan initiatives that can and should be passed before we adjourn this fall. Chief among these proposals is this Health Insurance Reform Act.

Under the strong bipartisan leadership of Chairman KASSEBAUM and Senator KENNEDY, the bill unanimously passed the Labor and Human Resources Committee 8 months ago. It has since languished in the confounding waste zone between full Committee endorsement and Senate floor action because some are opposed to even narrow health reform.

Last Congress the American people called for comprehensive health reform. Unfortunately, consensus could not be reached on a single plan. Instead, the country watched in disappointment as a golden opportunity for health reform fizzled out. Partisan fights and interest group influence won the day.

It will serve no good purpose to rehash the health reform battles of the past. We now have the opportunity to move beyond party squabbling. Congress can clearly demonstrate the will to enact a bipartisan health reform bill. Or we can choose to remain gridlocked and at the mercy of special interests. I believe that choice is an easy one.

Fortunately, there still is a broad consensus in this country in favor of health insurance reform. Americans want to know that they won't lose coverage if they or someone in their family gets sick. Individuals and businesses want the ability to pool resources to get the best insurance coverage possible at an affordable price.

The Health Insurance Reform Act does not seek to change our Nation's health care structure drastically. Instead, it takes a careful approach to remedy widely acknowledged problems in the health insurance market. For the first time, preexisting condition exclusions would be limited, health coverage availability and renewability would be guaranteed, and small business group purchasing would be easier. At the same time, State flexibility would be maintained.

Many States have taken the initiative and made notable progress by enacting market-related reforms. But States are unable to achieve the most effective reforms because some businesses have federally protected self-insured health plans. This bill provides continuity by applying the same standards to all employment-based plans.

The bill is also notable for what it does not do. It won't require employer mandates, limit provider choice, set up new bureaucratic health structures, or create a global health spending budget.

Many strongly believe that health care reform should go farther than this bill. In fact, many Senators, including myself, worked hard last Congress on comprehensive measures to control health costs and expand health coverage. But those efforts turned out too complex to retain broad support.

We now have a more narrow consensus measure that can pass. Yet some Senators may offer a whole host of amendments to address special concerns. A few of these are popular, others problemmatic. The sponsors of this bill have taken careful steps to ensure that the bill is narrow and bipartisan. It should remain that way. For that reason, I too will oppose controversial, special interest amendments.

As we learned from previous attempts at reform, a consensus bill may be the only way we can pass health reform this year. I urge my colleagues to refrain from condemning this bill under a weight of controversial additions.

Nonetheless, we should not hold out on improvements if they are bipartisan and avoid endangering final passage.

As a long-time supporter of health care fraud and abuse legislation, I believe it is imperative that we act to tackle rampant abuse. If strong anti-fraud provisions, such as those included in Senator COHEN's anti-fraud bill, can be added without stalling the bill, they most certainly should. Similarly, provisions helping the self-employed afford insurance and incentives for long-term care may be possible.

However, there are other compelling issues that, if attached to the Health Insurance Reform Act, may kill this bill. We should not ingore those issues. They can and should be taken up at a later date.

Mr. President, if we keep this bill clean, we will take a huge step toward addressing compelling insurance problems facing the Nation. In the process, Congress will prove that it can act in a bipartisan fashion to help hard working Americans.

There are over 40 million people without health insurance in our country. I am proud to say that Wisconsin has one of the lowest numbers of uninsured people. However, there are still too many Wisconsinites without health coverage and still too many who fear losing their coverage.

The Health Insurance Reform Act will not solve all of the problems plaguing our health care system, but it does fill a huge gap by solving job lock. Workers will no longer have to live with the fear that if they change their jobs, they may lose their health coverage.

No doubt, there is special interest opposition to this bill. It is a rare legislative initiative that doesn't have critics. But this bill is a positive first step.

The Health Insurance Reform Act does not provide a handout to the public. No one gets a free ride at the expense of insurance companies. People must maintain their payments for a full year-and-a-half before qualifying for coverage guarantees. They also must be ineligible for another group policy and exhaust their COBRA benefits. Finally, people will still have to pay the rates charged by insurance companies. These requirements were added to minimize affects on insurance premiums. However, it is important to note that States would not be prevented from going further on insurance reform.

Mr. President, you cannot satisfy everyone, but this bill comes close. While there are opponents and critics on both sides, a large majority of Americans support passage.

If Senators need more impetus to allow this bill to go forward, the General Accounting Office estimates that passing the Health Insurance Reform Act will help 25 million Americans each year obtain or retain health coverage. That evidence alone is a compelling reason to pass a clean bill.

Mr. President, Americans have had little proof this session that Congress can act to help solve problems plaguing their families. Let's give them one good reason to have greater confidence in their elected officials and this institution. We should get the job done and pass the Health Insurance Reform Act now.

Mr. BAUCUS. Mr. President, I rise in support of this bill. I am very pleased to see that today, Congress is putting aside its petty divisions and rivalries to work together on a bill that will help people. Today, when the Senate votes on the Health Insurance Reform Act, we show our support for a bipartisan effort that will address the health needs of millions of Americans and thousands of Montanans.

RECORD OF THE CONGRESS

That is a truly important step forward for this Congress, and not only on health policy. At the beginning of 1995, a lot of Montanans had high hopes for this Congress.

But those hopes have vanished in the mess of bumbling revolutionary experiments and government shutdowns which the leadership, particularly in the House has created.

Rather than make people a little more prosperous and secure, the Congress seems to have deliberately done just the opposite. It has gone from closing Yellowstone and Glacier, to a proposal to let Medicare wither on the vine, to bills that would set up a Commission on closing National Parks and dump all the public lands on the States.

The fact is, the 104th Congress has let our state down pretty badly. All too often, rather than do something good and positive for the people, it has done something irrational and destructive.

A SECOND CHANCE

But this health insurance reform is a second chance for the Congress. A sign that with some more maturity and experience, we can accomplish something good.

This bill, taken as a whole, means some more security and stability for hard-working people.

It means that if you lose your job, you won't also face the loss of your health insurance and the constant threat of lifelong debt in the case of an accident.

It means that if you own a small business, you will have more ability to buy insurance for yourselves, your family and your employees.

And it means you can upgrade your skills and change your job without being denied insurance due to health troubles.

BELINDA BYRD

Look at the case of Belinda Byrd from Great Falls, Montana.

She wrote to me last year to explain her case and that of her sister. Belinda suffers from hydrocephalus, or ''water on the brain,'' and she is about to undergo her fourth brain surgery.

She is fortunate enough to receive coverage through the Government Champus program. But she wrote to me about the problem with pre-existing conditions because of the problems her sister is having getting health insurance. Belinda's sister has the same condition and can not get affordable health insurance because of her health problem.

MONTANA AND HEALTH INSURANCE

Mr. President, that is wrong. We should not tolerate it even in one case. And the sad fact is that it is not just one case. Thousands of Montanans, and millions of Americans, have concerns just about as grave as those of the Byrd sisters.

As I have walked across the State in the past 2 years, a few subjects come up everywhere. In towns, on ranches, at small businesses, and in roadside coffee shops. The need to raise the minimum wage. The low cattle prices. And the fear of losing health insurance.

For individuals, today's bill will make a big difference. It will let self-employed people deduct most of their health insurance costs. Big businesses can already do this. Folks who are self-employed and buy their own health insurance out of pocket should be able to deduct it too. That is basic fairness and decency. With this reform, we raise the deduction from today's 30 percent of insurance costs to 80 percent. It is not all the way to 100 percent, but it is a very big step forward.

For farmers, ranchers, and small business owners, health insurance will be available and more affordable. We may have to do more down the line, but we are making a good start here.

And for people like the Byrd sisters who have pre-existing health conditions, this means justice and security. No longer will having an illness, no matter how treatable it is, mean going without affordable health insurance.

MEDICARE FRAUD AND ABUSE

Finally, we take some initial steps to fight health care fraud and abuse, particularly in Medicare and Medicaid. Today, anywhere from 5 percent to 10 percent of our Nation's entire trillion dollar health care bill goes to fraud. We need to step up our Federal efforts to fight this problem and I support efforts to do so.

However, I would caution that the savings we get from fighting fraud and abuse in Medicare or Medicaid must go to guarantee solvency for these essential programs. It should not pay for new tax breaks as last year's Medicare cuts would have done, nor to pay for untested ideas like Medical Savings Accounts.

CONCLUSION

Mr. President, I am very happy to be here supporting this bill. It is a sign that Congress is getting the message. Moving away from partisanship and revolutionary experiments. And moving toward practical, effective steps that makes life better and more secure for Montanans and all Americans.

I appreciate the work of the Labor Committee Chair, Senator NANCY KASSEBAUM and her counterpart, Senator TED KENNEDY. They have done this country a great service with their

work on crafting this bill and moving it through the legislative process. I hope it will get the Senate's support.

Mr. BRADLEY. Mr. President, I am very pleased to lend my strong support to the Kennedy-Kassebaum health insurance reform bill. At long last, we are actually moving forward on the basic reforms that will make health insurance once again serve the function of insuring and protecting American families against devastating illness or injury.

The problem of health insurance is right at the center of the economic insecurity gripping American families. The 40 million or so people who have no insurance live in fear that a headache or stomach-ache will turn out to be a costly illness. But other workers, who have health insurance, are hardly blessed with security and comfort. As the American economy changes, they know that they can lose their jobs at any moment, with no certainty of being able to find new insurance, or if they do find new insurance, it might not cover the one medical concern that is most likely to become a problem.

We have lost the idea of health insurance as real insurance, in which we all pay premiums to spread our own risks over a lifetime, and to share risks across a larger number of people. Instead, health insurance has increasingly become a short-term privilege, that comes and goes with the job, that only comes with certain kinds of jobs, and that comes with exceptions and uncertainties. When you combine that with the increasing insecurity about jobs, working families can't afford the risk. People are trapped in jobs just to keep their insurance, rather than moving on to find the job that would better use their skills, or setting out as an entrepreneur, as many dream of doing.

This bill would restore the original concept of insurance to health care. It would allow workers to change jobs without putting insurance coverage at risk, to move from group to individual plans, and to buy insurance despite a preexisting condition. It will help small businesses afford insurance, and help people who want to start their own businesses to do so without worrying about the arbitrary nature of health insurance. It will help only some of the 40 million without insurance to become insured, but it will prevent that number from continuing to increase.

Mr. President, I hope that after this legislation becomes law, we will not stop here but continue to closely watch the health insurance market and make whatever further changes need to be made to keep the focus on health and security. The first such change, which I hope will occur by Mother's Day, and perhaps even before this bill gets through conference, is to end the practice of insurance companies forcing new mothers and their infants out of the hospital within a few hours, even against the best judgment of the mother's doctor. In general, I am concerned that this bill, because it is so narrowly targeted at certain insurance practices, could have unintended consequences. I hope that if rates do increase sharply, or if insurers cut back certain areas of business, Congress should be willing to look at slightly broader solutions that would address the health care crisis without unintended consequences.

I am generally confident, however, that this legislation will serve the purpose of protecting American families from the double risk of economic and health insecurity. I hope action will be completed quickly so that the President can implement these reforms without delay.

Mrs. FEINSTEIN. Mr. President, I rise to support the Kennedy-Kassebaum legislation on health insurance reform. This legislation, while not the comprehensive health care reform called for earlier, takes an important and long overdue step in addressing the insecurity many Americans feel about their health insurance.

Americans expect their insurance to be there when they need it. That is why we buy it. And yet many Americans find that, just when they need their health insurance, it is not there, or they are denied coverage, or they can't afford the policy premiums.

This bill provides a measure of health security in a number of ways.

No arbitrary, discriminatory terminations: This bill protects employers from having their policy terminated if their employees incur large medical costs. Insurers could not impose preexisting condition limitations for more than 12 months. This means that employees could change jobs without fear of losing their insurance.

Guaranteed access: Under this bill, insurers are required to offer insurance to all groups, regardless of the health status of any member of the group.

Nongroup coverage guaranteed: It protects people who leave their job from losing access to coverage. People who have had 18 months of prior employer group coverage and have exhausted their extended coverage—through COBRA—would be guaranteed access to an individual policy.

Enlarging small groups: The bill creates incentives for small employers to form cooperatives to strengthen their bargaining power with insurance companies.

Need for the bill: The need for insurance reform is very real:

Over 41 million Americans have no insurance. That is a 4-million increase since 1993;

In California, almost 23 percent of the population is uninsured—7.4 million people. And two-thirds of these uninsured people are under the age of 34;

Twenty-three million Americans lose their insurance every year;

Eighteen million people change insurance policies annually when someone in their family changes jobs;

Employer sponsored insurance is declining, going from 61 percent of employed workers in 1986 to 54 percent in 1996;

In California, it's even worse with only about 50 percent of people covered by employer sponsored insurance in 1994; and

With California's unemployment remaining above 7 percent for the last 5 years—employer sponsored insurance is getting more scarce.

Preexisting conditions: The problem of people being denied insurance because of preexisting health conditions is one of the most serious concerns people have today about their health care.

As a matter of fact, 81 million Americans have preexisting health conditions that could affect their health insurance;

Over 9 million Americans changed jobs in 1995; and

Millions more want to change jobs. The GAO estimates that as many as 4 million employees are ''locked into'' their jobs because they fear that the insurer for the next employer would refuse to insure them because of a preexisting health condition.

Take cancer as an example:

Over 1 million people are diagnosed with cancer each year. Over 10 million Americans alive today have a history of cancer.

About 184,300 new cases of breast cancer will be diagnosed this year—the most common form of cancer among women. And, 44,300 will die of breast cancer this year.

We probably all have some condition. And yet most policies sold to individuals, and over half of all plans provided by employers, deny coverage for some period of time for the conditions most likely to require insurance.

This bill addresses this serious problem by prohibiting insurers from imposing preexisting conditions for more than 12 months.

The Problem for Small Employers: Small employers acting alone often lack the leverage to negotiate good prices and benefits that large employers can get. More than half of all uninsured employees work in small firms.

Administrative costs are higher for small groups. One survey shows that health costs for large employers declined 1.9 percent in 1994, while small employers had an increase of 6.5 percent.

This bill creates incentives for small employers to form cooperatives to strengthen their bargaining power with insurance companies.

This approach can work. In 1993, California formed a health insurance purchasing cooperative for small businesses; 2,500 small businesses joined.

One year after formation, rates were 10 percent to 15 percent lower than conventional insurance plans.

Individuals: Finally, there are 10 to 20 million individual Americans seeking to buy insurance on their own. These people, who are not part of a large pool where risk can be offset, often find themselves excluded or unable to afford the premiums.

Genetic discrimination: I especially appreciate the agreement of Senators KASSEBAUM and KENNEDY to include in the managers' amendment provisions barring genetic discrimination by employer-based plans.

The language included in this bill is similar to S. 1600, a bill I introduced with Senator MACK, to prohibit health insurers from denying health coverage based on genetic information of the insured or applicant for insurance

Last fall, as co-chairs of the Senate Cancer Coalition, Senator MACK and I held a hearing on the status and use of genetic tests. Witnesses testified about the great promise of genetic testing in predicting and managing a range of diseases, but they also cautioned about the potential for discrimination.

In the past 5 years, there has been a virtual explosion of knowledge about genes. Scientists are decoding the basic units of heredity.

We know that certain diseases have genetic links, including cancer, Alzheimer's disease, Huntington's disease, cystic fibrosis, and Lou Gehrig's disease. Altered genes play a part in heart disease, diabetes, and may other more common diseases.

These advances pose some potential problems. Witness after witness at our hearing discussed the potential and the reality of health insurance discrimination based on genetic information.

They recounted actual cases where insurers denied or refused to renew coverage based on genetic information. This type of discrimination could have a catastrophic impact if it is not addressed:

About 15 million people are affected by one or more of the over 4,000 currently identified genetic disorders; genetic disorders account for one-fifth of all adult hospital occupancy, two-thirds of childhood hospital occupancy, one-third of pregnancy loss and one-third of mental retardation; and an even larger number of people are carriers of genetic disease. The June, 1994 issue of Scientific American estimated that every person has between 5 and 10 defective genes though they often are not manifested.

Insurance companies are poised to discriminate:

In a 1992 study, the Office of Technology Assessment found that 17 of 29 insurers would not sell insurance to individuals when presymptomatic testing revealed the likelihood of a serious, chronic future disease.

Fifteen of the thirty-seven commercial insurers that cover groups said that they would decline an applicant; and

Underwriters at 11 of 25 Blue Cross-Blue Shield plans said they would turn down an applicant if presymptomatic testing revealed the likelihood of disease.

The study also found that insurers price plans higher—or even out of reach—based on genetic information.

Another study conducted by Dr. Paul Billings at the California Pacific Medical Center, reached similar conclusions.

Here are a few examples of real-life cases:

An individual with hereditary hemochromatosis—excessive iron—who runs 10K races regularly, but who had no symptoms of the disease, could not get insurance because of the disease.

An 8-year-old girl was diagnosed at 14 days of age with PKU—phenylketonuria—a rare inherited disease, which if left untreated, leads to retardation. Most States require testing for this disease at birth. Her growth and development proceeded normally and she was healthy. She was insured on her father's employment-based policy, but when he changed jobs, the insurer at the new job told him that his daughter was considered to be a high risk patient and ''uninsurable.''

The mother of an elementary school student had her son tested for a learning disability. The tests revealed that the son had Fragile X Syndrome, an inherited form of mental retardation. Her insurer dropped her son's coverage.

After searching unsuccessfully for a company that would be willing to insure her son, the mother quit her job so she could impoverish herself and become eligible for Medicaid as insurance for her son.

Another man worked as a financial officer for a large national company. His son had a genetic condition which left him severely disabled.

The father was tested and found to be an asymptomatic carrier of the gene which caused his son's illness. His wife and other sons were healthy.

His insurer initially disputed claims filed for the son's care, then paid them, but then refused to renew the employer's group coverage. The company then offered two plans. All employees except this father were offered a choice of the two. He was allowed only the managed care plan.

A woman was denied health insurance because her nephew had been diagnosed as having cystic fibrosis and she was found to carry the gene that causes the disease. The insurer told her that neither she nor any children she might have would be covered unless her husband was determined not to carry the CF gene.

These are real horror stories.

If people with genetic conditions or predispositions cannot buy health insurance on the private market, they usually have nowhere to turn. To qualify for Medicaid, the primary public health insurance program for the nonelderly, families have to ''spend down'' or impoverish themselves.

Fear of discrimination can also have adverse health effects. If people fear retaliation by their insurer, they may be less likely to provide their physician with full information. They may be reluctant to be tested. This means that physicians might not have all the information they need to make a solid diagnosis or decide a course of treatment.

This bill can help make health insurance available to many who need it and who want to buy it. It can bring peace of mind to millions of Americans. It can restore insurance to what insurance is supposed to be.

I hope my colleagues will join me today in voting for this important bill.

Ms. SNOWE. Mr. President, I rise in support of The Health Insurance Reform Act of 1995, and would like to thank the Chairwoman of the Labor and Human Resources Committee, Senator KASSEBAUM, for bringing this common sense health care reform bill to the floor. Her knowledge and efforts in the area of health care have made progress on this issue possible, and her ability to craft consensus on this complex issue deserves enormous praise from both sides of the aisle.

I would also like to compliment the ranking Member, Senator KENNEDY, and the rest of my colleagues who serve on the Labor and Human Resources Committee—the strong bipartisan vote that brought this bill out of Committee restores my hope that bipartisanship is not completely lost in this Chamber.

It has been interesting to me, having ''survived'' the health care wars of the last Congress, to read some of the things that have been written about this bill. Talk about role reversal—you now have some members on this side of the aisle complaining that S. 1028 does not go far enough, and we have members on the other side of the aisle complaining that the bill isn't small enough. What a difference a year makes!

But one thing that has not changed is the fact that the American people continue to demand changes in the health care system. This bill, while not as large or as complex as the changes we considered in 1994, would provide security to millions of Americans—25 million according to the General Accounting Office. It would reassure them that their health care coverage could not be taken from them if they changed jobs, if they became pregnant, if their family situation changed, or if they lost their jobs.

It does not solve all our Nation's health care problems—but we tried the complicated, complex, approach with a more than 1,000 page bill in 1994 and we got nowhere. So what is wrong with taking a step in the right direction? It doesn't mean that this is the only change that Congress can or should make.

It is said that every journey begins with a single step. So let us consider the Kassebaum-Kennedy bill before us today as Congress' first step on the road to overhauling our health care reform system so that all Americans will have access to affordable, quality health care by the provider of their choice that can never be taken away.

The Health Insurance Reform Act of 1995 will achieve part of that shared goal by ensuring access to health care that can not be taken away. It will ensure that workers who are offered a

new job opportunity with a different company will be able to accept it—instead of turning it down because they are afraid that a pre-existing condition will prevent them from obtaining health care coverage at their new firm.

It will ensure that workers who lose their job and have had insurance coverage for the last 18 months will be able to obtain an individual policy. They will still have a lot to worry about—but at least they will know that they can obtain insurance for their family.

And it will ensure that small businesses will no longer find themselves dropped from the insurance roles because one of their workers has medical problems.

Every Senator—every Member of Congress—has received letters or spoken with individuals who have been denied coverage or had their coverage—or their firm's coverage—dropped because of a preexisting condition. Yet these are the people who need the coverage most. It is estimated that 81 million Americans suffer from a preexisting medical condition that endangers their access to health care coverage. This bill will provide them that protection.

The Kassebaum-Kennedy bill restricts health insurance exclusions on preexisting conditions by prohibiting insurers and employers from limiting or denying coverage under group plans for more than 12 months for a medical condition that was diagnosed or treated during the previous 6 months. For example, if an individual had been covered under another employer's plan for 8 months, they would only have to work for 4 months in their new job before being covered.

The bill also prevents group health plans from excluding any employee from coverage based on health status and requires insurers to renew coverage for both groups and individuals as long as the premiums were paid.

Once an individual had been covered for 12 months, no new pre-existing condition could ever be imposed, even if they changed jobs or insurance plans.

The bill also will help make health care coverage more affordable for America's small businesses by lifting barriers to the formation of private, voluntary coalitions to purchase health insurance. For states like Maine, where small businesses are the backbone of our economy, this provision will be particularly helpful. Banding together to obtain health insurance coverage will give our small businesses the ability to spread the risk among a larger population and to use their negotiation power to get quality coverage at the best price. This bill will give employers and employees the ability to obtain quality coverage at a competitive price.

The Health Insurance Reform Act of 1995 is a commonsense approach to a serious problem in this country—access to affordable, quality health care that can never be taken away. It is not the complete answer to our health care problems, but it is a big step in the right direction and will help millions of Americans retain their health care coverage.

I would like to address one of the arguments being made against this bill. Opponents of reform have argued that while the bill ensures access, the practical problem will be that the cost of premiums will soar, making coverage unaffordable for many. The American Academy of Actuaries, however, has estimated that any premium increases would be quite small, ranging between 2 and 5 percent. In fact, this potential increase is lower than the increases we have seen in recent years: over the last 10 years the average rate paid for individual insurance premiums has increased between 8 and 15 percent annually.

And in my own State of Maine, which has had a law on the books guaranteeing issue for employers with fewer than 25 employees since 1992 and guaranteed issue for individuals since 1993, these changes have not resulted in premium increases that are outside the bounds of the normal increases in the cost of health care coverage.

By passing this bill we will be renewing our commitment to the American public that we have heard and have understood their demand that we act on health care reform. It will provide security for millions of Americans who currently fear losing their health care coverage, and will provide access to more affordable coverage for our small businesses as they band together to enhance their purchasing power. Passage of this bill will leave us with a long road ahead of us to address the outstanding issues of health care reform, but at least we will finally be on the road.

I urge my colleagues to join me in supporting passage of this bill and I yield the floor.

Mr. CONRAD. Mr. President, I want to express my strong support for S. 1028, the Health Insurance Reform Act.

Over the past several years, access to health care has been one of the most important issues facing Americans. Far too many Americans—over 40 million this year—are uninsured, and an equal number are affected each year by preexisting condition exclusions and the job lock that results when workers fear that they will lose all or part of their insurance if they change jobs.

Two year ago, I and many of my colleagues spent countless hours trying to find a compromise health care reform bill that would ensure access to health insurance and health care, maintain choice and quality for consumers, and control the skyrocketing growth in health care costs. Given the importance of this effort to millions of Americans, I was disappointed that our effort to find a moderate solution to these issues was blocked.

The bill before us today takes a modest step in the right direction. It attacks the most egregious barriers to health insurance: the use of preexisting condition exclusions to deny coverage to those who most need health insurance, and the lack of portability when workers change jobs. Addressing these issues will guarantee access to health insurance for an estimated 25 million Americans who would otherwise be subject to these barriers.

However, it is important to remember that, although this is an extremely important step, it is only a first step. It guarantees access to health insurance, but it does not guarantee that the available insurance will be affordable. And, as a representative of a rural State, I wish this bill improved access to health care services in medically underserved areas. Thus, when we complete the first step by enacting this bill, our health insurance reform journey will not be complete. There is lots of room for further progress in making health care available and affordable.

Mr. President, with that caveat, let me explain why this bill is so important. Today, millions of Americans are denied insurance because they or someone in their family have so-called preexisting conditions. This means the family of a child born with a heart murmur can't find insurance because no insurance company wants to take the risk of covering the costs of treating this heart condition. And it means that someone who has paid insurance premiums through an employer-sponsored plan but then leaves that job because she needs a major medical procedure—for example, an organ transplant—may not be able to get insurance when she tries to return to the workplace. That's just wrong. No one should be forced to stay in a job she hates because she fears she will lose her health insurance if she tries to change jobs. And no one who has paid insurance premiums faithfully for years should lose his insurance because he becomes sick and an insurance company refuses to renew his employer's policy.

This bill fixes these problems. It strictly limits preexisting condition exclusions when a person or a family applies for health insurance for the first time. It prohibits any preexisting condition exclusions for people who have faithfully paid their insurance premiums for at least 18 months and then need to get new insurance because they change jobs or lose their jobs. This means that people who change jobs can rest assured that their new insurance policy will fully cover them.

The bill also requires insurance companies to provide coverage to any employer with two or more employees. This keeps insurance companies from denying insurance to certain types of business just because the company thinks the employees are likely to get sick. It prevents the cancellation of coverage for a company just because one of its employees has gotten sick and incurred large medical costs. And it allows small businesses and other groups to band together in voluntary cooperatives to bargain as a larger

group for lower premiums and better coverage.

Finally, the bill requires individual insurance companies to provide coverage to individuals who lose their job or become self-employed and exhaust their conversion coverage under COBRA. Coming from a State with large numbers of self-employed farmers and other small business men and women, I am keenly aware of the fragility of the individual insurance market. Average premiums in this market are much higher than in the group insurance markets because of adverse selection.

Although critics of this so-called group-to-individual portability provision greatly exaggerate its likely effect on this market, their arguments are not groundless. This provision will result in more sick people entering the individual market. In order to prevent this from greatly increasing premiums for those who are already in this market, I hope States will proceed very carefully in applying rating restrictions that could inadvertently worsen the adverse selection inherent in this market. I am encouraged that the bill gives States great flexibility in designing their own approaches to meet the goals of this legislation. This allows them to develop innovative solutions tailored to the special needs of their population while ensuring that workers still have access to affordable health insurance without unreasonable preexisting condition exclusions.

Mr. President, this legislation takes a major step forward in reforming the private insurance market. It removes the biggest barriers to health insurance and will enable Americans to change jobs freely without fear of losing all or part of their insurance coverage. I urge my colleagues to reject the controversial special-interest provisions added in the House that threaten to kill this important effort, and to instead pass a bill that commands broad bipartisan support.

Mr. CAMPBELL. Mr. President, I take this opportunity to support the health insurance reform bill, offered by Senators KASSEBAUM and KENNEDY. I am pleased to be a cosponsor of this legislation.

Reforming our Nation's health care system has been a concern for many Americans. I believe the bill before us today, although limited to the health insurance industry, is a significant step toward addressing some of the issues we face with health insurance—cost, portability, and preexisting conditions. Although this legislation will not fix all of our health care problems, I think we all need to recognize that it does make some progress toward addressing these issues.

Currently, reports indicate there are an estimated 40 million uninsured Americans. This, in and of itself, highlights one of the biggest problems within the health care industry—the availability of affordable, flexible insurance policies.

All too often, people are forced into a situation where they feel they must remain in a job they would rather leave just because they have long-term health care needs and have no other source for insurance other than through their employer. This ''job lock,'' coupled with skyrocketing health care costs, makes the prospect of paying for your own medical costs without insurance, a frightening, and financially crippling situation. People simply can't afford to take this risk.

Over the past few years, my home State of Colorado has taken a very progressive approach in dealing with the issues of health insurance portability and preexisting conditions and has worked cooperatively with the health insurance industry to develop what everyone seems to recognize as a positive step forward. I have often had constituents tell me how surprised they are to learn how little other States have done in the area of health insurance reform. The Colorado State legislature was instrumental in making this law, and in conjunction with employers, have forged a partnership that seeks to cover as many Coloradans as possible in the most cost-effective manner. In fact, many of the safeguards and reforms already instituted within the State of Colorado are very similar to the Kassebaum, Kennedy bill. Currently, there are roughly 20 States that don't have this kind of insurance protection, and I believe that through this bill, we can cooperatively work to mirror at the Federal level some of the provisions the State of Colorado already enjoys.

I feel this bill will establish a much-needed standard for the health insurance industry and will work toward achieving the goal that all Americans have access to more cost-effective and affordable insurance. I don't believe anyone can deny the need for this.

Mr. President, I yield the floor.●

Mr. SARBANES. Mr. President, I rise today to express my support for S. 1028, The Health Insurance Reform Act of 1995. While S. 1028 is not the comprehensive reform of our health system which would be necessary to guarantee quality health care for all Americans, it does make important strides in reducing the barriers to coverage for over 25 million people in this Nation.

The legislation before us today, S. 1028, would attempt to make modest incremental reforms in the health insurance market by addressing only those provisions upon which there is broad bipartisan agreement. In fact, the President and over 65 of my Senate colleagues are in agreement, supporting this legislation which would have an immediate impact on the lives of over 25 million people.

For these Americans who are unable to change jobs, who cannot leave their jobs to start a new business, or who lose their jobs, S. 1028 would provide an assurance of continued access to health insurance coverage. It would end the incidence of job lock in this country by limiting the ability of health insurers to deny coverage for people with preexisting medical conditions. Once an initial exclusion period of no longer than 12 months was exhausted no preexisting condition exclusion could ever be applied to a policy holder again. It would also guarantee that a group or individual who purchased an insurance policy and faithfully paid their premiums, could never have their coverage taken away from them or canceled.

Mr. President, the health care debate is one that goes to the heart of the quality of life of all Americans. Access to quality health care is a fundamental human need and is in my view a fundamental right in a democratic society. Our challenge is to achieve a situation in which every American has access to affordable, quality health care. While there is much more that I would like to do to ensure that each and every American is guaranteed the same high quality comprehensive care, the bill before us today makes important steps toward accomplishing this goal and improving the lives of over 25 million Americans and I urge its immediate passage.

The PRESIDING OFFICER (Ms. SNOWE). The Senate majority leader.

Mr. DOLE. Madam President, I think we have partial agreement here so we can move ahead. I want to associate myself with most of the remarks, probably all of the remarks made by my colleague from Texas. We do not want to have to refight that battle again. I think he raised some excellent points. I hope in part they have been addressed in the so-called Dole-Roth amendment, that I think does improve this bill substantially.

But I ask unanimous consent that during the consideration of S. 1028, the health insurance reform bill, and following opening statements and adoption of the managers' amendment as original text, the majority leader or his designee be recognized to offer his amendment concerning tax provisions and medical savings accounts.

I further ask that during the pendency of the Dole amendment, Senator KASSEBAUM be authorized to move to strike the medical savings account provision, there be 2 hours equally divided in the usual form on the motion to strike, and that no amendments be in order to the Dole amendment or the language proposed be stricken prior to the vote on or in relation to the motion to strike.

The PRESIDING OFFICER. Is there objection?

Several Senators addressed the Chair.

Mrs. KASSEBAUM. Reserving the right to object, I would just like to ask the majority leader, when we first discussed this we had 2 hours equally divided. So much time elapsed since then, I suggest that we would like to have the vote no later than 3:45, and time then be equally divided until that time because we have already eaten up

so much. It had been my hope we could get through to some other amendments as well, since we had some considerable time, and still will, on discussing the provisions of the Finance Committee package. If that would be agreeable?

Mr. DOLE. Obviously, I would have no objection to that. I will modify the request to say the vote occur not later than 3:45 p.m., and that any time between the time we start the debate on that motion and 3:45 p.m. be equally divided.

Mr. GORTON. Madam President, reserving right to object.

The PRESIDING OFFICER. The Senator from Washington.

Mr. GORTON. Madam President, the Senator from Washington would like a clarification. I have just presented a small technical amendment to the Dole amendment to the chairman of the Finance Committee. I want that amendment to be in order.

If the understanding is that second-degree amendments would be in order if the Dole amendment is not tabled or rejected, then I will have no objection. I just want to make certain that before the Dole amendment is adopted that it is itself subject to amendment. Is that correct? Under the unanimous-consent request?

Mr. DOLE. That will be—let me just proceed with the request.

Mr. GORTON. I just want clarification my amendment will be in order some time before the adoption of the Dole amendment.

Mr. DOLE. Is it an amendment to the Dole amendment or a separate amendment?

Mr. GORTON. An amendment to the Dole amendment.

Mr. DOLE. I think the way it is going to work, it would be in order. Because I would hope to have, if the motion to strike fails, we would then get on the Dole amendment. But I could not get that agreement, so the answer would be yes.

Mr. GORTON. I have no objection.

Mrs. BOXER. Madam President, I think this could be accommodated easily. I have been waiting just to make a 3-minute statement on the overall bill. I greatly would appreciate having that opportunity before we get into the debate on the medical savings account.

Mr. DOLE. I will be happy to accommodate the Senator from California.

Mrs. BOXER. I thank the majority leader.

The PRESIDING OFFICER. Is there any objection? Without objection, it is so ordered.

Mr. DOLE. The vote will occur then. Also following that vote the Senator from North Dakota would like 15 minutes in a general statement. Prior to discussion, then, the Senator from California would have 3 minutes.

I also ask, if the Kassebaum motion to strike is agreed to, then the Dole amendment be immediately modified to reflect that chapters 2 and 3 of subtitle (f) of title IV be withdrawn.

Let me explain what that is.

In other words, they were ''pay-fors,'' and if the MSA's were stricken we will take those ''pay-fors'' out of the bill. I think it has been cleared by both Senator KASSEBAUM and Senator KENNEDY.

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

Mr. DOLE. I will send the amendment to the desk on behalf of myself, Senator ROTH, and others.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Amendment No. 3675

(Purpose: To provide for a substitute amendment)

Mrs. KASSEBAUM. Madam President, first I send to the desk a substitute amendment and ask it be considered original text for purpose of further amendment.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas [Mrs. KASSEBAUM] for herself and Mr. KENNEDY, proposes an amendment numbered 3675.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

The PRESIDING OFFICER. Under the agreement, the amendment is agreed to and is considered as original text.

The amendment (No. 3675) was agreed to.

AMENDMENT NO. 3676 TO AMENDMENT NO. 3675

(Purpose: To amend the Internal Revenue Code of 1986 to improve health and long-term care coverage in the group and individual markets by making health and long-term care insurance more accessible and affordable)

Mr. DOLE. Now I ask my amendment be called up.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas [Mr. DOLE], for himself, Mr. ROTH, Mr. NICKLES, Mr. PRESSLER, Mr. LOTT, Mr. CRAIG, Mr. MCCONNELL, Mr. COVERDELL, Mr. GRASSLEY, Mr. D'AMATO, Mr. GREGG, Mr. SANTORUM, Mr. SHELBY, and Mr. FAIRCLOTH, proposes an amendment numbered 3676 to amendment No. 3675.

Mr. DOLE. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. DOLE. Madam President, I will explain, as will the distinguished chairman of the committee, Senator ROTH, explain in some detail what this amendment does. It is a very important amendment. It is about a $10 billion amendment. It is paid for. And it does help make health care more available and more affordable. That is the thrust of this bill and that is why, even though we certainly want to accommodate Senator KASSEBAUM and Senator KENNEDY, as far as amendments are concerned, we think this amendment does improve the bill and it does provide a great deal of opportunity for many Americans who are now denied health care. Let me tell you why.

I am committed to passing this bill and the amendment is designed to help make that happen.

For many years self-employed individuals have been uncertain as to whether they could deduct their health insurance premiums. And the Democrat-controlled Congress refused to make the deduction permanent to ensure that it would apply year after year.

Last year, one of the first things Republicans did when we took control of the House and Senate was to make this deduction permanent, and to increase it to 30 percent.

But we said then and we say now that 30 percent is not enough. The amendment I now offer would raise the deduction for the self-employed to 80 percent by phasing in increases over the next 10 years.

This will provide equity and much needed tax relief to farmers, small business men and women, and other self-employed Americans.

My attempts to raise the deduction for the self-employed are not new. An amendment I offered last year passed the Senate with strong bipartisan support, but that did not stop the President from vetoing it, just as he vetoed our $500 per child tax credit.

My amendment will also provide important tax relief regarding long-term care expenses. The Internal Revenue Service has not seen the wisdom to allow taxpayers a deduction for long-term care expenses or premiums paid on long-term care policies.

So this amendment is needed to force the IRS to recognize that expenses to care for those unable to care for themselves are legitimate medical expenses that should be deductible.

It is in the best interest of the country to provide appropriate incentives for families to give proper long-term care for family members or to plan for future expenses, such as by purchasing long-term care insurance. Families want to care for their own and the IRS should not stand in the way.

This provision is particularly important for Americans who are likely to face these expenses in the near future for their parents and grandparents. Expenses to provide long-term care of a disabled or elderly relative could bankrupt a family. We cannot and will not let that happen. And neither should my Democratic friends, although they have voted against this relief in the past and the President has already vetoed this tax relief once before.

I have also included medical savings accounts in this amendment. You may have heard a lot about MSA's already. But let me tell you about them. First of all, they are hardly a radical new concept. They are being used today in 13 States and have enjoyed bipartisan support for many years.

MSA's provide individuals with choice and flexibility. If an individual

chooses to accept an MSA, the individual can tailor his or her own health care to his or her own needs. Individuals would have their own personal savings accounts dedicated to health care spending—similar to the way they have IRA's for their retirement savings.

Under the MSA proposal in this amendment, individuals could purchase a high-deductible plan and then use the money they accumulated in their savings account, up to the deductible limit, for health care expenses. They could deduct the amount they contribute to the MSA and the savings would accumulate tax free.

Who could argue against providing additional options and flexibility? The answer is the same people who thought that the best way to reform the health care system was to hand it over to the Federal Government—to impose more mandates and Government controls. The American people are thankful that the Democrat efforts to turn the health care system over to the Government failed, and they hope that Democrats will fail in their effort to block this amendment.

Let us remember that the Joint Tax Committee recently analyzed this MSA proposal and concluded that 88 percent of the MSA tax benefits would go to those making under $100,000 a year, with 78 percent of the benefits going to those making under $75,000 a year.

I urge my colleagues on both sides of the aisle to join with me in support of substantial tax relief for Americans.

Madam President, health insurance reform is, by no means, a newly debated issue in this Chamber. In fact, it predates many individuals in this town. The concern about the availability and affordability of health insurance goes back as early as the Nixon administration when President Nixon declared that the American health care system was in need of repair, particularly when it came to affordability.

Madam President, that was 25 years ago. Since then, there have been dozens of health care bills debated in this Chamber—the Bentsen bill, the Dole-Packwood bill, and others, all of which were drafted with the sole purpose of making health care more available and more affordable.

To this date, Madam President, none has been signed into law.

We now have before us a bipartisan bill that contains the kinds of commonsense insurance reforms that this Senator and many of my Republican colleagues have long advocated. I commend my colleague from Kansas, Senator KASSEBAUM, for her hard work and determination to craft a health insurance reform bill that could be supported by the vast majority—if not all Members—on both sides of the aisle.

Madam President, as I stand here, I have to say that I feel a great sense of relief—as I am sure many Americans will feel—that common sense has finally prevailed.

For nearly a decade now Republicans have been trying to pass an incremental health insurance bill that would solve many of the problems with the availability and affordability of insurance.

During the Bush administration, however, the Democrat-controlled Congress refused to give President Bush's proposal the time of day.

And then came the Clinton administration, and President Clinton's insistence that turning the American health care system over to the Federal Government was the only solution. It was a solution chock full of mandates, Government intrusion, and untold costs. And the American public took one good look at it and said, ''No thanks.''

From almost the very first day of the Clinton administration through the entire long national debate over the President's plan, I said the same thing day after day after day. And what I said was this: Fix what needs fixing, makes changes in the insurance market so that more Americans are able to obtain and afford health care, and leave the many very good parts of American health care alone.

Here we are, however, 2 years later, and still talking about insurance reforms that are still badly in need. And the tragedy of that, Mr. President, is that there are millions of Americans who could have been helped these past 2 years, had President Clinton not insisted on his plan or nothing.

Madam President, our first priority is to start with portability. This will assure that no American is denied coverage because he or she changes or loses a job. I am committed to passing that change because it will help millions of job-locked Americans with preexisting medical conditions and their families.

As I have said, eliminating job lock should have passed at least 2 years ago. Regrettably it did not.

Before we get much further into this debate, I want to underscore at the outset that it is very important that we pass a bill, once and for all, that can be signed into law. There is no hidden agenda—no surprises—no smoke and mirrors. This is serious work that we have promised to the American public for a very long time.

I also want to take a moment now, that I will elaborate on later, to describe an amendment Senator ROTH and I plan to offer to this bill. In that amendment there will be a number of tax provisions that will enhance the insurance reforms in this bill.

Again, I want to underscore, this amendment is not meant to defeat this bill or diminish its chances of being signed by the President. To the contrary, my amendment will strengthen this bill and help more people obtain affordable health insurance—all without the overdose of Government control the American people already rejected.

My amendment will include an increase in the deduction of health insurance premiums paid by the self-employed and provides deductions for long-term care expenses so that families have real incentives to plan for their later years. It also provides for tax-exempt high-risk pools, and allows for tax-free accelerated death benefits. In addition, this amendment makes medical savings accounts available to all Americans.

Medical savings accounts are not a new concept and have enjoyed bipartisan support. My view is that medical savings accounts are another choice for Americans. They may not be right for everyone. They may appeal to many others. They are included in this amendment as another option. Choice, after all, is one of the greatest virtues of American health care.

These are all provisions to help make insurance more affordable thereby increasing the number of people who are insured.

Madam President, this Congress has worked very hard to keep the promises we made to the American people when they gave us a majority. This bill represents relatively noncontroversial needed change—change we have promised for a long time. We owe it to the millions of Americans who need our help to do today what we should have done several years ago.

Passage of this bill will not only improve our health care system, it could very well restore the faith of the American public that the work for the Congress is not just a series of political stalemates. Even in an election year, we can work on a bipartisan basis to pass legislation that will improve the lives of so many Americans.

Let me indicate that the distinguished Senator from Maine, Senator COHEN, will discuss his part of this amendment, proposals to clamp down on health care fraud and abuse. Senator COHEN has been working on it for a number of years, and they save about $3 billion. They are a very important part of this overall amendment.

I will just say, as I said earlier, this is a very important piece of legislation. It is a bill that should be passed. It is a bill that can be signed into law. There is no hidden agenda, no surprises, no smoke, and no mirrors. This is a serious work product that we have promised to the American people for a long time. It seems to me we can get this done yet today. The House has passed a different version. We will go to conference. In my view, we can come up with a very reasonable proposal that I think President Clinton will sign.

We have offered what we believe will be an amendment to strengthen this bill. I happen to believe the medical savings account is another addition that will strengthen this bill. I know there is some objection to it. But all this is done without an overdose of Government control which the American people rejected just a few years ago.

For all the reasons I can think of, I urge the adoption of this amendment without anything being stricken from

it. I hope at 3:45 the motion to strike will be defeated, and then we can determine if we can vote on the Dole-Roth amendment or should there be other amendments. Maybe the Senator from Washington has other amendments or maybe other people. We can then dispose of those amendments.

I yield the floor, and I thank the Chair.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Madam President, will you tell me when my 3 minutes are up? That is all I really need.

I believe we can have a rational debate about this bill. The Senator from Texas said it is hard to be rational when you debate health care, but I think Senator KASSEBAUM is a very rational woman, and I think Senator KENNEDY is a very rational Senator. I think the two of them have come together. They have brought us a bill that I am very proud to support.

In 1993, I authored a bill that would make it unlawful to cancel or reduce an employee's benefits because the employee suffered from a particular disease or illness, and it made it unlawful for employers to impose different benefit caps for different diseases.

What happened, as we all know, is we got off track with health care reform. It was derailed, and it took us some time to mend some frayed feelings, and now we are back here in a bipartisan effort. We are on the brink of a bipartisan success to bring some fairness to this world of health insurance coverage.

Clearly, millions and millions of Americans are going to be better off as a result of the Kassebaum-Kennedy bill, because we know we will have portability now of health care coverage. Many Americans who are locked in jobs because they fear losing their insurance—and I know so many myself who are in that situation—will no longer be fearful of that.

We think that will impact 25 million Americans. This bill will prohibit group health plans from excluding any employee based on their health status. We know that we do not want to encourage people just buying insurance when they get sick, so we require a 12-month waiting period, and then they cannot be denied for a preexisting condition. We think 81 million Americans, Madam President, have conditions that could subject them to such exclusions, so we are talking about more than 100 million Americans benefiting from this, as well as small businesses.

I strongly urge us to support the Kassebaum-Kennedy bill. I think if we can support Senator KASSEBAUM's amendment to the Dole amendment, it would be far better off, because the medical savings accounts are good for some of the wealthiest and healthiest in our Nation but would be damaging to the vast majority of Americans.

So I look forward to voting for this bill. I think it will be a bright moment for this U.S. Senate.

I yield the floor, Madam President.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. Madam President, the purpose of the leadership amendment to the Kassebaum-Kennedy health insurance reform bill is to help individuals and employers purchase affordable health and long-term care insurance, and it will particularly help small business men and women go a long way toward combating fraud and abuse in the Medicare system.

Affordability of health and long-term care insurance has long been a major problem in our country, and the leadership amendment provides concrete solutions. By eliminating many of the financial barriers to affordable health and long-term care insurance, Americans will take greater responsibility for their health and long-term care needs, relying less on the Federal Government.

The leadership amendment provides affordable health and long-term care insurance and personal responsibility by increasing the health insurance deduction for self-employed individuals to 80 percent. On average, employers pay about 80 percent of their employees health insurance costs. But under current law, employers can exclude this benefit tax.

In comparison, Madam President, under current law, self-employed individuals can only deduct 30 percent of their health insurance. Raising the health insurance deduction for self-employed individuals will eliminate this inequity and will be a good first step toward putting self-employed individuals on a par with workers who receive health insurance from their employer.

But this is not all this amendment provides. It provides tax clarification for long-term care insurance. Under this amendment, long-term care insurance that meets certain consumer standards will receive the same favorable tax treatment as medical insurance. The consumer standards require insurance companies to disclose information to consumers that will aid them in buying a long-term care policy that best fits their individual needs.

Long-term care insurance tax clarification will provide the much needed incentive for Americans to buy this insurance. All too often individuals without long-term care insurance end up depleting their life savings for their care and end up on Medicaid. Long-term care insurance will give Americans with long-term care needs the dignity of providing their own care and at the same time reducing the burden on Medicaid.

Additionally, Madam President, this amendment allows tax-free benefits from the early termination of life insurance. It permits terminally and chronically ill individuals to take tax-free withdrawals from their life insurance. Many terminally and chronically ill individuals end up depleting their life savings for their care and end up on Medicaid. This provision will provide an additional source of funds for the terminally and chronically ill to attend to their health care needs and at the same time will reduce the burden on Medicaid for their care.

This amendment also includes tax-favored medical savings accounts. Our medical savings account proposal permits an individual with a high-deductible health plan to make tax-deductible contributions to an MSA. Contributions to the medical savings account are limited to $2,000 for single coverage and $4,000 for family coverage. Distribution from the medical savings account can be used for medical expenses without being taxed.

Excess funds in a medical savings account can be carried over to the next year, would be available to pay for unexpectedly high health costs, long-term care insurance, or to continue health insurance during periods of unemployment, often called COBRA coverage. Madam President, among the great freedoms that Americans cherish is the ability to make choices and decisions about how to take care of their families. Medical savings accounts will place control of America's health care back in the family. It does so in significant ways that create the right incentives for health care.

With the medical savings accounts, Americans will be able to choose their physician, their hospital, and their health care plan. Not only will Americans be allowed to go to the doctor of their choice, but to the optometrist, the dentist, or the chiropractor of their choice as well. Traditional low-deductible health insurance may not cover visits to the dentist or optometrist, but the medical savings accounts will.

In addition, Madam President, many traditional low-deductible health insurance plans do not pay for preventive care. For working poor Americans, this feature of medical health savings accounts will be especially helpful. That is because Americans with medical savings accounts will have the money to pay for preventive care for their families, whereas they may not have the money in the absence of a medical savings account.

Beyond offering patients a choice, medical savings accounts will lower health care spending by empowering people to become knowledgeable about health care costs. As a result, medical savings account users become more effective consumers of health care and reject unnecessary or duplicative treatment. Unused medical savings account funds will accumulate from year to year, providing an incentive for people to remain healthy and consume medical care wisely.

In addition, Madam President, medical savings accounts will also restore the physician-patient relationship, something that has eroded over time. Patients are finding their choice of health care providers being limited and bureaucracies are interfering with their doctor-patient relationships.

With medical savings accounts, a patient can go to any doctor, nurse, or other health care provider of their choice without worrying about whether their insurance will cover the bill.

Madam President, we already know about the success of medical savings accounts because hundreds of companies, including the United Mine Workers, are experimenting with them with great success. Companies that offer medical savings accounts have experienced significant reductions in health care spending by their employees. Most of these companies find that medical savings accounts are attractive to workers in both low- and high-income categories and workers in all health conditions. In fact, the Joint Committee on Taxation anticipates that about 78 percent of medical savings account users will have an annual income of less than $75,000.

Madam President, the problem with current medical savings accounts is that employees are treated worse under the tax laws by selecting a medical savings account and high-deductible health plan. At the end of each year the employee must include the full amount of the money deposited in his or her medical savings account as income. That is a grossly unfair result when employees with traditional low-deductible insurance do not pay tax on their employer provided insurance.

Furthermore, medical savings accounts advance an important goal of Senator KASSEBAUM's health insurance reform bill, and that is health insurance portability. Health insurance portability is something Americans have been requesting for years. The lack of health insurance portability is a problem with the current health insurance market and results in job lock for millions of Americans. Medical savings accounts will help end job lock for millions of American workers because they will be able to take their medical savings account with them when they change jobs. This would promote continuity of insurance coverage.

Another feature of a medical savings account is that it will allow a lower cost insurance alternative to millions of self-employed Americans. American farmers and small businesses will be able to buy high-deductible health insurance and fund a medical savings account to provide for their family's health care needs. This feature has the potential of removing millions of people from the ranks of the uninsured.

Madam President, it is interesting to note that 13 States and at least one city have passed medical savings account legislation and dozens more are moving to pass similar legislation. For example, Jersey City, NJ, has implemented medical savings accounts as an alternative for their city employees. Ohio is implementing a test program for State employees. Clearly, medical savings accounts offer Americans a choice about their health care that should be fundamental in a country built on free-market principles. It is the Federal Government that must now move ahead with the idea.

Madam President, strong efforts have been made to defeat medical savings account legislation by those who have a vested interest in the current health care system that is not working for millions of Americans. The real winners under medical savings accounts will be the hundreds of thousands of Americans who will grab control over their family's health care spending.

I hope the encouragement from hundreds of companies with successful medical savings account programs and the many States that are pioneering in medical savings accounts will serve as strong incentives for my fellow colleagues to join me in supporting the medical savings account provisions and the leadership amendment.

Madam President, I ask unanimous consent to have an editorial in the Wall Street Journal by Nobel Prize-winning economist Milton Friedman entitled ''A Way Out of Soviet-Style Health Care'' printed in the RECORD.

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

[From the Wall Street Journal, Apr. 17, 1996]

A WAY OUT OF SOVIET-STYLE HEALTH CARE

(By Milton Friedman)

In a chapter in his novel ''The Cancer Ward'' titled ''The Old Doctor,'' Alexander Solzhenitsyn compares ''private medical practice'' with ''universal, free, public health service'' through the words of an elderly physician whose practice predated 1918. A by-product is an eloquent statement of the major advantages of medical savings accounts for the U.S. in 1996.

Mr. Solzhenitsyn himself had no personal experience on which to base his account and yet, in what I have long regarded as a striking example of creative imagination, his character presents an accurate and moving vision. The essence of that vision is the consensual relation between the patient and the physician. The patient was free to choose his physician, and the physician free to accept or reject the patient.

In Mr. Solzhenitsyn's words, ''among all these persecutions [of the old doctor] the most persistent and stringent had been directed against the fact that Doctor Oreschenkov clung stubbornly to his right to conduct a private medical practice, although this was forbidden.''

EASIER TO FIND A WIFE

In the words of Dr. Oreschenkov in conversation with Lyudmila Afanasyevna, a longtime patient and herself a physician in the cancer ward: ''In general, the family doctor is the most comforting figure in our lives. But he has been cut down and foreshortened. * * * Sometimes it's easier to find a wife than to find a doctor nowadays who is prepared to give you as much time as you need and understands you completely, all of you.''

Lyudmila Afanasyevna: ''All right, but how many of these family doctors would be needed? They just can't be fitted into our system of universal, free, public health services.''

Dr. Oreschenkov: ''Universal and public—yes, they could. Free, no.''

Lyudmila Afanasyevna: ''But the fact that it is free is our greatest achievement.''

Dr. Oreschenkov: ''Is it such a great achievement? What do you mean by 'free'? The doctors don't work without pay. It's just that the patient doesn't pay them, they're paid out of the public budget. The public budget comes from these same patients. Treatment isn't free, it's just depersonalized. If the cost of it were left with the patient, he'd turn the ten rubles over and over in his hands. But when he really needed help he'd come to the doctor five times over. * * *

''Is it better the way it is now? You'd pay anything for careful and sympathetic attention from the doctor, but everywhere there's a schedule, a quota the doctors have to meet; next! * * * And what do patients come for? For a certificate to be absent from work, for sick leave, for certification for invalids' pensions; and the doctor's job is to catch the frauds. Doctor and patient as enemies—is that medicine?''

''Depersonalized,'' ''doctor and patient as enemies''—those are the key phrases in the growing body of complaints about health maintenance organizations and other forms of managed care. In many managed care situations, the patient no longer regards the physician who serves him as ''his'' or ''her'' physician responsible primarily to the patient; and the physician no longer regards himself as primarily responsible to the patient. His first responsibility is to the managed care entity that hires him. He is not engaged in the kind of private medical practice that Dr. Oreschenkov valued so highly.

For the first 30 years of my life, until World War II, that kind of practice was the norm. Individuals were responsible for their own medical care. They could pay for it out-of-pocket or they could buy insurance. ''Sliding scale'' fees plus professional ethics assured that the poor got care. On entry to a hospital, the first question was ''What's wrong?'' not ''What is your insurance?'' It may be that some firms provided health care as a benefit to their workers, but if so it was the exception not the rule.

The first major change in those arrangements was a byproduct of wage and price controls during World War II. Employers, pressed to find more workers under wartime boom conditions but forbidden to offer higher money wages, started adding benefits in kind to the money wage. Employer-provided medical care proved particularly popular. As something new, it was not covered by existing tax regulations, so employers treated it as exempt from withholding tax.

It took a few years before the Internal Revenue Service got around to issuing regulations requiring the cost of employer-provided medical care to be included in taxable wages. That aroused a howl of protest from employees who had come to take tax exemption for granted, and Congress responded by exempting employer-provided medical care from both the personal and the corporate income tax.

Because private expenditures on health care are not exempt from income tax, almost all employees now receive health care coverage from their employers, leading to problems of portability, third party payment and rising costs that have become increasingly serious. Of course, the cost of medical care comes out of wages, but out of before-tax rather than after-tax wages, so that the employee receives what he or she regards as a higher real wage for the same cost to the employer.

A second major change was the enactment of Medicare and Medicaid in 1965. These added another large slice of the population to those for whom medical care, though not completely ''free,'' thanks to deductibles and co-payments, was mostly paid by a third party, providing little incentive to economize on medical care. The resulting dramatic rise in expenditures on medical care

led to the imposition of controls on both patients and suppliers of medical care in a futile attempt to hold down costs, further undermining the kind of private practice that Dr. Oreschenkov ''cherished most in his work.''

The best way to restore freedom of choice to both patient and physician and to control costs would be to eliminate the tax exemption of employer-provided medical care. However, that is clearly not feasible politically. The best alternative available is to extend the tax exemption to all expenditures on medical care, whether made by the patient directly or by employers, to establish a level playing field, in terms of the currently popular cliché.

Many individuals would then find it attractive to negotiate with their employer for a higher cash wage in place of employer-financed medical care. With part or all of the higher cash wage, they could purchase an insurance policy with a very high deductible, i.e., a policy for medical catastrophes, which would be decidedly cheaper than the low-deductible policy their employer had been providing to them, and deposit all or part of the difference in a special ''medical savings account'' that could be drawn on only for medical purposes. Any amounts unused in a particular year could be allowed to accumulate without being subject to tax, or could be withdrawn with a tax penalty or for special purposes, as with current Individual Retirement Accounts—in effect, a medical IRA. Many employers would find it attractive to offer such an arrangement to their employees as an option.

Some enterprises already have managed to do so despite the tax penalty involved. MSAs have proved very popular with employees at all levels of income, and they've been cost-effective for employers. The employee has a strong incentive to economize, but also complete freedom to choose a physician, and the equivalent of first-dollar coverage. There are no out-of-pocket costs until the employee spends more than the total amount in the MSA. Such costs are then limited to the difference between the amount in the account and the deductible in the catastrophic policy. Moreover, the employee can use money in the MSA at his or her discretion for dental or vision care that is typically not covered under most health plans. No need to get ''authorization'' from a gatekeeper or an insurance company to visit a specialist or to have a medical procedure—until the catastrophic policy takes over.

LIMITING COMPETITION

The managed care industry has come to recognize that MSAs might threaten its growing control of American medicine by offering a more attractive alternative. As a result, the managed care industry has recently become a vigorous enemy of MSAs. Every believer in competition will recognize that opposition for what it is: a special interest using government to limit rather than expand competition.

Medical savings accounts are not a panacea. Many problems would remain for an industry that now absorbs about a seventh of the national product. However, I believe that they offer the closest approximation that is currently feasible to the private medical practice that Dr. Oreschenkov cherished.

Mr. ROTH. Madam President, in his editorial, Dr. Friedman recognizes medical savings accounts can be an important factor in restoring the freedom of choice for both the patient and physician and to control health care costs.

These important provisions in the leadership amendment are not all that we are offering. Our amendment also permits penalty-free withdrawals from IRA's for health and long-term care insurance. The leadership amendment encourages people to purchase health insurance by allowing penalty-free withdrawals from IRA accounts to buy health and long-term care insurance and to pay for major medical expenses.

This provision will allow unemployed workers the ability to access their IRA funds to continue their health insurance for their families.

The leadership amendment provides tax exemptions to State-sponsored, high-risk insurance pools, a provision that will encourage States to set up insurance pools from which high health risk individuals can purchase affordable insurance.

Madam President, the leadership amendment also contains new tools for law enforcement to aggressively attack fraud and abuse in health care. GAO estimates that as much as 10 percent of health spending in the United States is lost to fraud and abuse. Law enforcement officials believe that most health care fraud goes undetected.

The leadership amendment makes substantial new funds available to the Justice Department, the FBI and the IG of the Department of Health and Human Services for investigation and prosecution of health care fraud. These provisions also create for the first time a criminal statute for health care crimes, tough new penalties for fraud in Federal health programs, including Medicare and Medicaid.

Madam President, these health care fraud and abuse provisions were crafted by Senator COHEN over the past 3 years. I commend him and his staff on their tireless and important work. Madam President, the leadership amendment is actually paid for. The offsets are, first, large corporations will no longer be permitted to borrow corporate-owned life insurance and deduct the interest. The provision is a major corporate tax loophole that will be closed. The same proposal was included in the Balanced Budget Act of 1995 and is similar to the administration's proposal in its fiscal year 1997 budget.

Second, expatriates, those persons who leave the United States for tax avoidance purposes, will be subject to taxation upon exit from the United States. The proposal is similar to the expatriation provision in the Senate version of the Balanced Budget Act of 1995.

Third, starting in 1996, thrift institutions will calculate their tax deduction for bad debts the same way as banks. This provision will facilitate future legislation to harmonize the bank and thrift charters, and has widespread support. A similar proposal was included in the Balanced Budget Act of 1995 as well as an administration revenue proposal in the fiscal year 1997 budget.

Fourth, a measure to combat fraud and the earned-income credit program. This proposal is identical to the earned-income credit compliance provisions in the House health care bill.

Mr. President, I recognize that there are many other popular tax proposals championed by other Members that would likely find their way into this bill. However, this is a health insurance reform bill. The focus of this and other amendments should be on expanding the affordability of health and long-term care insurance for Americans. To stray from the purpose of this amendment may doom the entire health insurance reform effort. I suggest that no Senator wants to do that.

Mr. COATS. Madam President, the Congressional Budget Office reported that health care spending, rather than cost, is the major problem in U.S. health care. The report states that ''a major reason for high and rapidly rising health cost is the failure of the normal discipline of the marketplace to limit the quantity of services supplied.''

Today, nearly 80 percent of medical expenses are paid by somebody other than the patients themselves.

Out-of-pocket expenditures have declined from 60 percent of the Nation's total health bill in 1960 to 20 percent today. Since that time, the Government's share has doubled to 46 percent.

This means that most health care expenditures in the United States today are paid for by someone other than the consumer of health care—by the Government or by insurance carriers. Unlike any other purchase, when Americans receive medical care, they use someone else's money.

Our health care system has effectively insulated Americans from the cost of care. There is little incentive to spend wisely. There is no need to look for the best buy for the health care dollar.

Six years ago, I introduced the first MSA legislation in the Senate. My plan provides a financial incentive for Americans to choose a healthy lifestyle and to be better consumers of health care. Under my plan, employers provide an umbrella catastrophic policy and invest the rest of the money in a tax free account for each employee. I am pleased to be a cosponsor of the Finance Committee amendment which builds on these same principles.

For example, the average employer spends $4,500 on health benefits for an employee. Under the typical MSA, an employer would buy a catastrophic policy—with a $3,000 deductible—at an average cost of $1,500. The remaining $3,000 would be given to the employee to cover out-of-pocket medical expenses. Whatever is unused would be given to the employee. We would provide a financial incentive both to stay healthy and to shop for bargains in the system.

I was discussing this idea with some constituents in Indianapolis. One woman told me she knew exactly what I was driving at. She called her local hospital to inquire how much a mammogram would cost. When told $300,

she asked if they ever offered any sales. Sure enough, Mother's Day week, the screenings cost only $50. However, because her insurance covered the cost, she had no incentive to purchase the care at the reduced price.

This sounds complicated, but the effect would be simple. People would be allowed to choose their own doctors, make their own health care decisions, have a financial incentive to live a healthier life, and control medical costs through increased competition.

Medical savings accounts are working. People with these plans are looking for and finding bargains. And they are getting more preventative care from their doctors.

Listen to a letter from one woman in Indiana:

When the MSA account became an option at my company, I decided to try it with my family. For the last half of [the first year], our family will be receiving a refund for our unused portion. With five on our policy, this was a nice surprise.

''I was told I would be needing surgery performed in the near future. I have already made arrangements to pay our [catastrophic] deductible in full * * * the total surgeon's charge was $9,843. However, they have agreed to take off $3,797. With this account I have realized there is no set doctor's charge.''

This Indiana woman has become a wise consumer of health care services. She bargained and saved nearly $4,000 in surgery costs. She scrutinizes her bills and makes sure that she is getting what she pays for.

Another Hoosier had this to say:

''The MSA plan has helped me become a more frugal shopper of health care for myself and my family. I now ask the doctor for generic prescriptions when available, and try to utilize our family doctors when available, instead of the more expensive immediate care centers.''

Another Indiana resident was surprised to learn that the price of treatment does vary depending on the status of her insurance. Treatment to an ear damaged in an auto accident was $900 through insurance, but only $200 since she paid out-of-pocket.

A resident of Indianapolis writes, ''I am a single parent who receives no outside support. Therefore, it is very important for me to have insurance coverage for my 12-year-old daughter and I. I made the decision to try the medical savings account because although vision and dental expenses were not covered under the traditional plan, I would be able to use the MSA money for these expenses * * * both my daughter and I wear glasses. Both our prescriptions had changed this past year, therefore I incurred the cost of the exams along with the cost of new glasses.

''I did have necessary medical expenses last year that used all but $37 of my MSA fund. While I may have received less than others who had MSA's last year, I gained a great deal more than those who had the traditional plan. I had no out-of-pocket expenses and still had $37 come back to me. There was nothing to lose, and everything to gain.''

In addition to empowering people, medical savings accounts help control the costs of providing coverage for many companies.

In Indiana, 81 percent of employees at Golden Rule Insurance elected the medical savings account option the first year it was offered. These workers got $468,000 in reimbursements from their MSA's. Not surprisingly, the next year, 90 percent of the employees selected the MSA option. Golden Rule benefited as well—the company saw no increase in health care costs for 2 straight years, with $734,000 refunded to employees, an average of $1,000 per employee.

Dominion Resources has encouraged workers to opt for a high deductible plan and to place the monthly premium savings into a health account. Some 80 percent of Dominion's employees have selected this plan and the company has seen no increases in premiums since 1989.

Knox Semiconductor in Rockport, ME, has experienced only one rate increase in the last 4 years under its Health-Wealth Program. Its president, John Marley, claims that the program saved his company more than $100,000 in 3 years—a significant savings for a small business.

These savings are particularly impressive given the cost increases experienced by companies in conventional plans. The Clinton-Mitchell bill, for instance, claims it will achieve its major savings through encouraging HMO styled delivery of services. But even HMO costs are rising—13.6 percent a year between 1988 and 1992. In 1993, they jumped another 6.5 percent.

MSA's could potentially achieve savings in another significant way. Not only would they unleash the collective bargaining power of the American consumer, but they could significantly reduce the administrative burden on our health care system. Less than 15 percent of all Americans spend $3,000 a year on medical care, and therefore the accumulated cost of paperwork processing are for small claims. By paying these bills directly, our health care system would realize significant savings in paperwork reduction and substantially reduce the $90 billion in administrative costs we spent each year.

Forbes magazine has experimented with this concept. In order to cut down small claims, they give each employee an annual account of $1,200. For every dollar filed in medical claims, the employee loses $2 from the account. Employees can keep what is left in the account at the end of the year. This system obviously encourages employees to pay for small claims out-of-pocket. After the system was implemented, the paperwork on routine claims fell dramatically. The company's health costs fell by 17 percent in 1992 and by 12 percent the following year.

We are paying a high price for our social and behavioral attitudes, our personal lifestyle choices. The United States pays $52 billion each year on illnesses related to smoking. Unhealthy eating habits contribute directly to 5 of the 10 leading causes of death in the Nation. Two out of three deaths in the United States can be linked to tobacco use, alcohol use and abuse, controllable high blood pressure, overeating, traumatic injury, and lack of preventative care.

One man in Indiana commented, ''the plan has also given me a better outlook on staying healthy. It provides financial incentive for not over utilizing health care, but at the same time provides a way to cover the more routine expenses which one would incur at regular intervals. Getting a regular check up could help prevent more costly health care bills. Its nice to have an outlet to pay for expenses when you really should go to the doctor instead of waiting to the last minute because our deductible is not satisfied.''

The MSA is the only health reform plan that provides incentives to remain healthy. Indeed, the Kennedy bill entitles those at high risk of sexually transmitted disease more health care than it does to others not considered at risk. The Kennedy bill requires all Americans to pay for smoking cessation classes regardless of whether or not you smoke. So smokers get more care than nonsmokers under the Kennedy bill. Under the MSA, non-smokers, who likely will remain healthier than smokers, reap the rewards of their behavior.

The Wall Street Journal recently editorialized, ''Most of the health bills before Congress remind us of Henry Ford's philosophy behind the Model-T car: ''You can have any color you want as long as its black.'' [but] health care reform that includes medical savings accounts would represent real consumer sovereignty; patient self-interest would be harnessed to keep costs down, and workers would build up tax-free health care funds for when they were between jobs. Health care security would be enhanced, but not at the cost of quality or freedom of choice.''

This Congress faces a fundamental choice. We can use the lessons of our experience—Americans empowered choose wisely—competition in the free market enhances quality and drives down costs—principles which guide reform through medical savings accounts. Medical savings accounts leave health care choices where they belong—in the hands of individuals. I urge my colleagues to support real reform—and to retain medical savings accounts.

AMENDMENT NO. 3677 TO AMENDMENT NO. 3676

(Purpose: To strike medical savings accounts)

Mrs. KASSEBAUM. Madam President, I send to the desk an amendment and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas [Mrs. KASSEBAUM] proposes an amendment numbered 3677 to amendment No. 3676.

The amendment is as follows:

Strike subtitle C of title IV.

Mrs. KASSEBAUM. Madam President, the purpose of this amendment is to strike the portion of the package put forward by Senator DOLE and Senator ROTH regarding medical savings accounts. It is difficult for me to stand and do so because I think the rest of the provisions in the package that have been put forward are ones that are generally agreed to on both sides of the aisle. Senator DOLE has been a longtime leader of efforts to increase the deductibility for those who are self-employed. It is a very positive amendment. It will be a very positive part of this bill.

Also, Senator DOLE has been a longtime leader in wanting to address long-term care and to be able to provide some means of helping those who have high costs for family and long-term care. This will provide tax credits to do so.

The chairman of the Finance Committee, Senator ROTH, has also been a long-time proponent of such measures. I think the way in which the measure is crafted is a very constructive addition to the legislation before the Senate.

When the ranking member of the Labor Committee, Senator KENNEDY, and myself completed the work of the committee in a unanimous vote last August, we agreed that we would not support any additional amendments that were highly contentious. This included ones that individually we would support, as well as those that we would oppose. Cumulatively, they could cause a real collapse if they carried too much baggage, plus or minus. Therefore, we have agreed, whether we individually supported those amendments or not, to not support any amendments which were going to prove to be controversial.

I would like to speak for a moment about medical savings accounts and my own concerns regarding them. As has been pointed out, 13 States have now in place such savings accounts and I think that is going to be useful to analyze the effect of medical savings accounts. The proponents say it will bring down health care costs by encouraging consumers to shop more wisely for health care, that they will increase coverage by making health care that is affordable for individuals, and they will reduce health care spending for employers.

Nevertheless, we are not really certain, and I still believe that we need to carefully consider what medical savings accounts are about. I think it is not a question of either/or. Medical savings accounts should be considered and we should debate the merits of medical savings accounts. I strongly question whether they should be attached to this particular bill as they do not really enhance the provisions of this bill that we are debating today.

I do believe that medical savings accounts are of benefit, particularly to the healthiest and most financially secure Americans. They do not really address those with preexisting conditions, nor those with catastrophic illnesses at the time, nor those without a job or income who need coverage the most.

I think the medical savings accounts could provide a false sense of security because it does offer choices to individuals. It lends encouragement to invest wisely. It lends to a shelter in the Tax Code which would allow one to build up support that could be used at times that are important. However, it is a false sense of security, Madam President, I believe.

They are sold as giving Americans freedom to exercise choice and that people will be protected when they get catastrophic illnesses. However, as our colleague, Senator JEFFORDS knows, most so-called catastrophic policies have very low lifetime limits. He will be offering an amendment, as a matter of fact, to address that concern. So, people are not protected for truly catastrophic illnesses. Medical savings accounts are an experiment, not without merit. From the States that are already experimenting with the accounts and have passed legislation, we will be able to gather data which will be useful to us.

I suggest that Blue Cross Blue Shield of Ohio has shown that MSA's would increase, not decrease, employer costs because there would be less money in the pool to cover above average costs of high-risk individuals. There needs to be the ability to have a risk pool, to have reinsurance, so that those costs can be spread, of which all of us would have to pay. That is not going necessarily to lead to escalating premiums so much as spreading the costs across the board.

Blue Cross and Blue Shield has observed that there is a concern that MSA's will segment the market into people who are very healthy and people who are not healthy. If that happens, you lose the ability to spread the risk pool. Senator BREAUX spoke to that earlier this morning. So for all those reasons, Madam President, I have some serious reservations. Senator COHEN from Maine, as Senator ROTH pointed out, has legislation regarding fraud and abuse that helps provide savings, which has been incorporated in this amendment. I think that is a positive part of the package put forward by Senator DOLE and Senator ROTH.

But as long as medical savings accounts have such a high degree of uncertainty, I think it is a package that should be viewed with some skepticism as we regard this particular proposal before us, which has universal support and will continue to have if we give some care to the amendments that are added to it.

I have the highest regard for the efforts of the majority leader, as he has put forward what I believe are positive additions to our bill. It is my hope that those additions can be accepted and that medical savings accounts, with my motion to strike, will be defeated.

I yield the floor.

Mr. KENNEDY. Madam President, how much time does the Senator from Connecticut need?

Mr. DODD. Seven minutes.

The PRESIDING OFFICER. The Senator is recognized for 7 minutes.

Mr. DODD. Madam President, 2 years ago the 203d Congress spent a great deal of time discussing the merits of comprehensive health care reform.

The Committee on Labor and Human Resources held more than 40 hearings debating the issue.

And in the end those opponents of comprehensive reform, who said we needed to go slow, won the day.

I, for one, thank that was a mistake.

But, at the same time, I understand the apprehension of my colleagues about comprehensive reform.

Well today, the legislation before us today—the Kassebaum-Kennedy Health Insurance Reform Act—gives us the opportunity to pass sensible, incremental and common-sense health reform measures that will help millions of Americans.

This bill may not solve every problem in our health care system. But, it is good public policy.

And it will make a real difference in the lives of millions of Americans.

And if we, as a body, believe that American workers should not live in fear of losing their health care when they change their job, then we must pass these sensible reforms.

In fact, recollecting our debates from 2 years ago, it's hard to imagine that this bill would not pass on a unanimous vote.

Not once in our many committee meetings did any member argue for the preservation of exclusions based on preexisting conditions.

Not once did anybody argue against insurance portability. Even while we were debating health care reform on the Senate floor, not once did anybody raise objection to the sort of market reforms that are included in this bill.

THE HEALTH CARE PROBLEM

And, I think we all recognize the huge scope of the problem.

Almost 40 million Americans have no health care insurance.

Approximately 12 million of those uninsured are children under the age of 21.

In my State of Connecticut, 300,000 people were uninsured in 1993.

That is 12.1 percent of the population, up from 9.7 percent in 1992. That's a 25 percent increase.

In fact according to a recent poll, 22 percent of Connecticut Residents who needed health care did not go to a doctor or receive health care services because it was either too expensive or simply inaccessible.

These are unacceptable statistics, and they make clear the need for reform.

JOB LOCK

And, throughout Connecticut and the Nation as a whole, millions of others live in fear that if they change their job, they will lose their health care as well.

Various surveys have found that as many as 30 percent of Americans report that either they or a family member suffer from job lock.

Too many Americans are being forced to stay at a job because they simply can not afford to lose their health care coverage.

But if this legislation passes, the provisions in this bill would relieve as many as 3 to 4 million Americans from the burden of job lock.

KASSEBAUM-KENNEDY IS A GOOD FIRST STEP

While I think that even my colleagues Senator KENNEDY and Senator KASSEBAUM would agree that this bill will not solve every problem with America's health care system, it is a crucial step in the right direction.

The KASSEBAUM-KENNEDY would limit exclusions for pre-existing conditions.

It would allow small businesses to form purchasing alliances, which would be a difference for the 30 percent of employees at firms with 10 or less workers who do not have health insurance.

And most important it would guarantee to every American worker that if you change your job, you will not lose your health insurance.

The GAO estimates that 25 million Americans would be helped by this legislation.

These are common sense reforms and I believe that is one of the main reasons this bill is receiving huge bipartisan support.

The Kassebaum-Kennedy bill not only has more than 60 cosponsors, of which I am one, but it also passed our committee unanimously.

CLEAN BILL

With this clear level of bipartisan support it is hard for me to understand why many of my colleagues are insisting on offering amendments to this bill, that they know will make it impossible for it to pass.

Unfortunately, over the past few years it has become increasingly difficult for this body to reach compromise on any issue.

I think all my colleagues, from both sides of the aisle, bemoan this lack of bipartisan agreement.

And today we have a bill with over 60 cosponsors, with wide bipartisan support and with endorsement from much of the health insurance industry and yet several of my colleagues stubbornly insist that we allow amendments to be tacked on to this bill.

In particular, the insistence of some of my colleagues to add medical savings accounts, or MSA's, to this bill threatens the enactment of any health reform measure this year.

We all have provisions we would like to see included in this legislation. I, for one, would like to see greater health care coverage for our Nation's children.

But, this is not the time to be focusing on our individual projects, particularly at the expense of genuine reforms that we can all agree upon.

Today, we have the opportunity to help 25 million Americans with the Kassebaum-Kennedy bill and applying MSA's or any other provision to this bill will only undermine that effort.

The Kassebaum-Kennedy bill truly represents common sense, effective reform.

These are reforms that will spare millions of Americans the pain and suffering of losing their health care or being denied coverage because of preexisting conditions.

Today, we have a historic opportunity to make a real difference in the lives of millions of Americans.

As I do not need to remind most of you, cynicism toward Congress runs rampant in this Nation.

Too often the American people look to Washington and they shake their head at the partisan political games we play.

In the last two elections they have demanded that we start working together, Democrats and Republicans, and pass legislation that makes a real difference in their lives.

And I believe that if we polled the American people and asked them: Should Congress remove preexisting conditions in the health insurance industry?

Should Congress make health insurance more portable?

Should Congress guarantee that if you lose your job you do not lose your health insurance?

I think, the vast majority of the American people would respond with a resounding yes.

So today, let us uphold our responsibility to the American people and pass these sensible and commonsense reform measures.

Madam President, I ask unanimous consent to have printed in the RECORD a letter dated today from Cecil E. Roberts, international President of the United Mine Workers of America.

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

UNITED MINE WORKERS OF AMERICA,
Washington, DC, April 18, 1996.

Senator BOB DOLE,
Hart Senate Office Building, Washington, DC.

DEAR SENATOR DOLE: In recent days, certain special interest groups have wrongly portrayed members of the United Mine Workers of America as recipients of Medical Savings Account akin to those that would become more widely available under an amendment you are slated to offer to S. 1028.

The UMWA has been grossly misrepresented by these groups who have wrongly counted us as supporters in their effort to weaken the health care system through Medical Savings Accounts.

In recent collective bargaining agreements, we have negotiated a comprehensive health care plan for our members. Our members also receive a bonus and are responsible for pay equivalent deductibles under their medical plan. This plan is not an MSA.

Representing more than 200,000 working and retired coal miners and their dependents, the Mine Workers know that MSAs are not a panacea for the health care crisis. It would be unthinkable to leave such a group of people, many of whom suffer from injuries or disease brought on from working in the mines, dependent on MSAs for their health care coverage.

Sincerely,

CECIL E. ROBERTS,
International President.

Mr. DODD. Madam President, I commend our two colleagues. It has been a long ordeal, dealing with this very important piece of legislation. They deserve our universal acclaim for their efforts. It was a very good process in our committee. As the chairman of the committee, Senator KASSEBAUM, pointed out, this particular proposal was unanimously voted out of committee. To the credit of all of our members on the committee, Republicans and Democrats alike, we all have ideas that we would have liked to have incorporated in this legislation. But the agreement was that we would try and limit the bill to those areas where there was consensus, so that we could deal with the problems that 25 million Americans face today. With the passage of this legislation, and a Presidential signature, we would solve the problems immediately for 25 million Americans. It would immediately solve the problems they face with portability and preexisting conditions—not to mention some of the proposals in the leadership amendment, which the Senator from Kansas pointed out we all agree with and go back many years supporting.

We have a wonderful opportunity here. It has been almost since last August that this bill came out of committee. We are almost in May now, and the weeks are rolling by. Here is a chance to do something for 25 million Americans, without getting into a real disagreement and argument over a controversial proposal—the medical savings accounts.

Madam President, I would like to spend a few minutes on that particular subject matter. I will leave the remarks I have inserted in the RECORD that go to the general provisions in the bill, which have been discussed today at some length. I compliment my colleague from Kansas and my colleague from Massachusetts for doing a remarkably fine job in putting those provisions together.

I have inserted the letter from the United Mine Workers because there has been some discussion here on the floor that this was one organization that has a medical savings account. Without reading the entire letter, let me read paragraphs 2, 3, and 4 of the letter:

> The UMWA has been grossly misrepresented by these groups who have wrongly counted us as supporters in their effort to waken the health care system through Medical Savings Accounts.
>
> In recent collective bargaining agreements, we have negotiated a comprehensive health care plan for our members. Our members also receive a bonus and are responsible for paying equivalent deductibles under their medical plan. This plan is not an MSA.

Representing more than 200,000 working and retired coal miners and their dependents, the Mine Workers know that MSAs are not a panacea for the health care crisis. It would be unthinkable to leave such a group of people, many of whom suffer from injuries or disease brought on from working in the mines, dependent on MSAs for their health care coverage.

I think that is important, since their names have been used as an example of an organization with an MSA, and by implicit suggestion that they are supporters of MSA's. I voted twice for medical savings accounts, back when we considered the larger health care package. I am proud of those votes. I have no inherent objection to the idea of a medical savings account. But they need to be, as the Senator from Kansas suggested, in the context of a larger discussion of health care.

Whether you agreed or disagreed with the large health care proposal of a year or so ago, in that context, medical savings accounts make sense. In the absence of it, you are running the risk of leaving people aside who cannot afford to get into these programs.

It is very controversial, too. As many have pointed out, the major insurance groups and consumer groups, which rarely agree on these matters, all agree on this point—that this could create some real problems. They all agree that this would segment and undermine the insurance market. They would divide the health care system and cater to the healthier and wealthier people at the expense of those with financial constraints, leaving those in traditional plans to pay a higher price tag on health care costs, as their risk pool shrinks and as the percentage of individuals with serious health conditions increases.

They point out that according to the Joint Committee on Taxation, it would cost taxpayers about $1.8 billion.

Again, I am not talking about one group versus another. The insurance industry, consumer groups, the Blues, are not saying that they are totally opposed to this, but that in this context, it does not make a great deal of sense.

I also point out there have been some studies done on the medical savings accounts. According to the Congressional Budget Office, medical savings accounts could threaten the existence of standard health insurance, placing a far greater burden on lower-income patients, individuals with chronic ailments, and patients with disabilities, who have larger out-of-pocket expenses. The Blue Cross Blue Shield of Ohio, as the Senator from Kansas pointed out, says, ''MSA's would bankrupt our current system of financing health care and significantly add to the cost of medical care.'' That is their language, not mine.

The American Academy of Actuaries said, ''Less healthy individuals will likely pay more for their coverage, since the most healthy and highest persons in the group are likely to select MSA programs.'' That is not the Senator from Connecticut, or the Senator from Massachusetts, or the Senator from Kansas. That is the American Academy of Actuaries speaking.

We have a wonderful opportunity to deal with something we all agree on, in a bipartisan way. The current bill is bipartisan, as we have some 60 cosponsors. Why take on an MSA issue that is highly controversial with major private sector groups and consumer groups that are saying, ''Please do not do this''? This is not the right suggestion at this hour. It jeopardizes what we could do for 25 million Americans, by eliminating the problem of portability and preexisting conditions, issues that we all agree on.

I do not know of anybody who stood up and suggested that we ought not to make those changes. We have the chance to do that in a bipartisan way. If you add the MSA's, given all the arguments raised by the private sector, consumer groups, and others, including the American Academy of Actuaries, and the Blues, who have looked at this issue carefully, then you do great damage and jeopardize what we can accomplish this afternoon by passing a good bill and showing the American public we care about their concerns and we are determined to see to it that they are addressed.

I strongly urge the adoption of the Kassebaum amendment to strike the MSA provisions, adopt the other provisions, and then adopt this overall piece of legislation.

I yield the floor.

Mr. KENNEDY. Mr. President, how much time remains?

The PRESIDING OFFICER (Mr. KEMPTHORNE). The Senator has 24½ minutes.

Mr. KENNEDY. I yield myself 10 minutes of our time.

Mr. President, our distinguished colleague and friend, Senator KASSEBAUM, has outlined, I think very effectively, the reasons why we should reject the part of Senator DOLE's proposal that deals with medical savings accounts. Senator KASSEBAUM has outlined the principal issues which are at stake—both the cost and the health implications of MSAs, and I am in total agreement. My friend and colleague from Connecticut has expanded on those thoughts in a very effective way.

I think many of the provisions that the majority leader has introduced are useful and, by and large, helpful. He brings focus on the need for long-term health care for the American people. If there is a part of our Social Security system that has been really left out over the period of the recent years, it has been the failure to deal effectively with long-term care for our parents, for neighbors, for friends, for communities, and for the American people. We are blessed and fortunate to have people living longer lives and more productive lives. That is an increasing phenomenon. The fragile elderly increasingly are an important concern before us. To be able to attend to their particular needs in a thoughtful way either through long-term care, through nursing homes, or through home care is immensely important. The idea that we have long-term care insurance included in this legislation, I think, is commendable.

The leader as well has identified additional areas—providing the deduction for the self-employed; the small businesses around this country, in rural towns and in cities as well, have a particular disadvantage in terms of the cost of health care for their employees. And certainly there is a strong justification for that provision.

I believe the provisions which apply as well in terms of terminal illnesses, to help those that have terminal illness, to give them at least some assistance in terms of the tax system, again, to give them some tax relief, is a commendable system.

So I hope at the time we have an opportunity to address those particular issues that we will find broad bipartisan support throughout the Senate on those measures. There may be a feature or two that we might discuss, but I commend the leader for bringing attention to that and for adding that particular measure.

Mr. President, I agree that those issues have been debated and discussed. There is broad understanding of them and broad support for them, and we are certainly justified in accepting those. But the issue in terms of the medical savings account is another matter entirely.

For the reasons that have been outlined, the overall Kassebaum/Kennedy legislation has broad support. Senator KASSEBAUM and I are in agreement that we will resist amendments that do not have the overwhelming support of the Members. There are many different provisions that I would like to see which I think have been tried and tested and for which there is a very important need.

My good friend from Vermont has talked about lifting the lifetime limits in terms of health insurance because many of those that have serious disabilities run up against the top limits in their health insurance. I would like to support that measure. Senator JEFFORDS spoke passionately about it, and he believes in it, and I look forward to working very closely with him on a different health care proposal. I am convinced that we will pass that proposal here in the U.S. Senate and the House of Representatives.

I agree with my friend, Senator DOMENICI from New Mexico, who is one of the real leaders in this body in terms of mental health issues. During the course of the debate the last time we addressed the comprehensive issues of health reform, one of the real important features that we effectively worked out was that we were going to consider the challenges of mental illness as well as physical illness similarly and treat them equitably. They are not treated equally under current law. I have supported that. We debated

it. There is broad support for it. It is justified as a health improvement measure.

I support mandatory preventive services for children. That has been an issue where there has been broad support. It passed overwhelmingly in the Finance Committee as part of our previous discussions. There is strong justification for providing the range of services—immunizations, preventive, screening, and attention for children in our society. It is not costly. We have the expenditures for that proposal. Out of the list that is included in here, we certainly could have worked on that measure. There is broad support. But we have resisted that. Why? Because, as has been pointed out before, the range of different supporters that we have been able to gather for this measure—we have said that on this issue, on this bill, we will not accept provisions which are going to be untested, untried, and controversial in terms of their health implications and their cost implications.

There is not a lot of difference in this body—Republican and Democrat—about providing preventive health care services for children. There is not a lot of difference in this body in trying to equate mental health with other physical challenges. There is not a lot of difference I say in raising lifetime limits.

Those are measures that I feel strongly about and that I would like to support, but we do not have those measures up here. The reason we do not have them up here is because we have an understanding; we have an agreement that we are going to keep this legislation as close to the target as we possibly can in trying to deal with the problems of preexisting conditions so that individuals who are working and are playing by the rules of the game and are paying their premiums are going to be able, if they lose their job or change their job, to take their insurance with them. We are going to provide the incentives in terms of small business so that they can pull together and develop the economic advantages that the major corporations have. We have agreed to move in that area.

Now we have medical savings accounts. I have myself serious problems with that issue. Others have expressed support. The question should not be so much how we stand on these particular issues, but I want to just express very briefly my very serious concerns about it. But, nonetheless, it is highly divisive, highly controversial, and highly unacceptable. I think all of us understand that if this measure is included in the proposal, school is out—school is out in terms of amendments; school is out in terms of what may be added or what may be subtracted; school is out in terms of the focus and attention on a very important proposal that has the broad support and the unanimous support of Republicans and Democrats out of our committee.

So I hope that the proposal of Senator KASSEBAUM to strike this provision will be acceptable.

Let me mention briefly why I am opposed and others are opposed to medical savings accounts. First of all, over 10 years this is $3.2 billion. It is going to cost $3.2 billion. The fact of the matter is, we have to ask ourselves: Are we going to raise the deficit by $3.2 billion when many of us were around here trying to increase education programs, trying to even increase the various programs on Head Start? We were told we did not have the money when we tried to expand support for education on the Goals 2000, increasing academic achievement. We do not have that money. When we were out here trying to do something about increasing child care, we did not have the money. Now suddenly we have $3.2 billion. That is the cost, $3.2 billion.

So we have to ask ourselves: Well, $3.2 billion, who is going to benefit from the $3.2 billion? Is this going to be something that is going to be across the board in terms of beneficiaries? We can start right out and say, as the Joint Tax Committee has pointed out, no one whose income is below $20,000 will benefit one nickel—not one. Only one percent of all the benefits from the MSA proposal, will go to individuals who earn less than $30,000—only 1 percent of the benefits. Ninety-seven percent of the benefits will go only to people above the median family income in this country—only 3 percent of the benefits from MSAs will go to those below the median family income.

Who benefits from this? Who benefits are the wealthiest individuals. Sound familiar? Sound familiar? The higher income individuals are the ones that will be participating in this program.

So we ask ourselves at the beginning: Can we afford the $3.2 billion? If we get it, not according to my estimates, not by the various actuary and other groups, but by the Joint Tax Committee, Republican and Democrat alike, it has been pointed out that the great majority of Americans will not be eligible.

And why? It is quite understandable. They do not have the income to pay the deductibles for the MSA's. So therefore it does not do them any good. In order to be able to benefit from an MSA, an individual has to be able to afford the deductibles, and ordinary working Americans simply will not be able to do that; they won't be making enough money.

Secondly, we can ask, what is going to be the impact on our whole health care system? Well, the various reports that we have received—and we will have a chance perhaps to get into them in greater detail—demonstrate that what is going to happen in this situation is that the younger people and the wealthier people are going to take this opportunity to participate in the MSA's. They are going to take the opportunity. Why? Because they know they are not going to need to spend up to $3,000 for a sickness over the period of that next year. That is the deductible, $3,000. They know that by and large they are not going to get sick during that period of time. So they are not really at risk. They know they only need help if something serious is going to happen to them.

So the healthy and the individuals who have the resources are going to be the ones who use those MSA's. What about everyone else? Are they going to use it? Probably not. Because they know they are going to have deductibles and they know that they are going to have particular health care needs like every family has.

And the health implications of this are profound. It means that the general insurance pools are going to continue to include the sicker people, and the premiums are going to go up for everyone because they are going to have the sicker Americans and they are going to have the working Americans who can't afford the MSA's. And what is going to happen, the premiums are going to go up and therefore workers are going to begin to disband their commitment to health care for themselves because the costs are going up.

We have to ask ourselves: Does this really have an advantage in terms of savings? Is this a new process of delivering health care that many of us had hoped the HMO's would be? We hoped that by having the payment for health care at the beginning of the year and the incentives on the various kinds of HMO's to develop preventive programs that they would keep people healthier so they save money through prevention. But with MSA's, this won't happen.

To the contrary, every time a woman goes and gets a mammography test, they are going to have to pay out. Is that covered by your health insurance? No. Because you are not up to $3,000. Every time a woman gets a pap smear, she has to pay out. Is that going to be offset by health insurance? Absolutely not. They are going to have to pay out. All the screening for children, for the sons and daughters of working families, are they going to be encouraged to go to preventive health care? Absolutely not, because they are going to have to pay out.

Finally, make no mistakes—medical savings accounts are also part of the long-term Republican anti-Medicare agenda. Every senior citizen and every Senator who cares about Medicare should be aware of this Trojan horse. The special interests who are urging this provision now are part of the ongoing effort to undermine Medicare by turning it over to the private insurance industry. If we open the door to medical savings accounts for the non-elderly today, we will be opening the door to medical savings accounts for the elderly tomorrow and that is not a step Congress should take.

So, Mr. President, in summary, this proposal is skewed financially. The financial benefit goes to the wealthiest

individuals and to the healthiest people. It is poor health policy because it is going to disadvantage the incentives in the areas where you can provide true savings on health care, and that is going about the business of providing preventive health care.

One of the extraordinary ironies in terms of our budget policy here is you do not get any credit in terms of CBO when you move towards preventive care. Even though you save the Government millions and millions of dollars over the period of years, you cannot get credit for any kind of preventive care. That is where savings come about—when you immunize children, when you give well-baby care, when you give an expectant mother good kinds of care and nutrition so the child is going to be healthy rather than have medical complications at birth.

This vote is not just about medical savings accounts. It is also about whether Americans will get the genuine health insurance reform they deserve. Senator KASSEBAUM and I have pledged that we will resist controversial amendments, because they will kill this bill. We intend to vote against even controversial amendments that we support. Many other Senators on both sides of the aisle have made the same pledge. This vote is the test. If Senators insist on their narrow agenda, this health reform will die.

This is an unwise, untested, unjustified measure. It is effectively a poison pill. There are many other, more deserving health care issues that we ought to be accepting or addressing ourselves to that are a lot less costly than this particular measure, and I hope that Senator KASSEBAUM's amendment is accepted.

I would be glad to yield 12 minutes——

Mr. NICKLES addressed the Chair.

Mr. KENNEDY. Twelve minutes to the Senator, 12 minutes to the Senator from West Virginia.

The PRESIDING OFFICER. The Senator from Massachusetts controls 10 minutes.

Mr. KENNEDY. Twelve minutes to the Senator from West Virginia.

The PRESIDING OFFICER. Does the Senator from Oklahoma have an inquiry?

Mr. NICKLES. Mr. President, I believe that both the Senator from Delaware and the Senator from Massachusetts have control of the time, and I also think the Chair has usually recognized Senators seeking recognition, and then the Senators delegate how they allocate that time, I think is the normal procedure.

Mrs. KASSEBAUM. Mr. President, not to intervene here, but I would suggest that I think the Senator from Oklahoma has been waiting quite some time to speak. And while I am not in charge of the time at this point, it would seem to me best to let that back-and-forth proceed.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. I yield 10 minutes of the leader's time to the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized for up to 10 minutes.

Mr. NICKLES. Mr. President, I thank you. I thank my colleague from West Virginia. I will be happy to accommodate my friend as well. I think it would be better if we go back and forth a little bit, if that is possible. I say to my colleague from Massachusetts, that was my interest because my colleague from Massachusetts has generated a little interest in me to respond.

I also compliment the Senator from Massachusetts and the Senator from Kansas for their work, but particularly I wish to compliment the Senator from Delaware and the Senator from Kansas, the majority leader, for this amendment. This amendment is probably the most significant health care provision that the Senate has considered in a long time.

I have heard a lot of people say we want to make insurance more portable; we want to make insurance more affordable. If you do, then we need to support Senator DOLE and Senator ROTH's amendment. That would include some tax equalization. The Tax Code is really skewed. It is really inequitable. It is not fair.

Let me just give you a couple of examples. The amendment that we have dealing both with the medical savings account and deductibility for self-insured help fix the problem—not totally, but they certainly improve it.

The Tax Code right now discriminates against people who do not work for generous employers. If you work for a generous employer, they can pay for your health care benefits and the individual can receive that tax free benefit, does not have to pay anything for it. It is nice. If you work for General Motors, they can deduct 100 percent for health care costs.

What if you do not work for a generous employer? What if you work for an employer who maybe cannot afford it or does not subsidize your health care? Then as an individual you have to pay for your health care with after-tax dollars. That is not fair.

What if you are self-employed? Right now, if you pay for your health care, you get a 30-percent deduction. Let me make sure everybody understands that. If you work for General Motors or a generous corporation, they get a 100-percent deduction, the company does. If you are self-employed, you get a 30-percent deduction.

That is not right. I used to run a manufacturing company, and at one time we paid 100 percent of health care costs. It was all deductible, a tax-free benefit for employees. I also used to be self-employed. Right now, they get 30 percent. I used to have a janitor service when I was self-employed. They only get 30 percent. But a big manufacturing company or a little manufacturing company, a corporation, they get 100 percent.

Now, what is right about that? That makes no sense, no sense whatsoever. This bill is going to help fix this.

What about an individual who maybe does not work, is unemployed. They need health care just as much as anybody else. This bill helps fix that. And the Senator from Massachusetts does not want to allow it to happen. He said, well, school is out if we allow medical savings accounts. Medical savings accounts are the only thing, the only thing, that will benefit somebody who does not have a job and wants to get health care. We do not help them in other areas. We are going to help them. We are going to say, yes, you can get health care; you can have your medical savings account; it is yours; it is portable; you do not have to have a job; it goes with you. It is not contingent on a job.

We use the Tax Code to encourage homeownership and so we say, you are entitled to an interest deduction on your home. And we do not say you have to have a job to get the interest deduction; it is yours; you designed the house, or you can buy the house. That is your decision, and it is your deduction. We do the same thing for other things. You make that decision. But we do not do it on health care. We say, well, you have to work for a generous employer. You get a real nice benefit. You work for yourself, you only get a third as much. You get a 30-percent deduction.

This bill takes it up to 80 percent for self-employed. And that is about what the average of a lot of companies is. So that is pretty equitable. It takes some time to get there, I might mention. We do not do it overnight. But at least it gets it up to 80 percent. That is a good move.

I compliment Senator DOLE. When we passed this originally in the Balanced Budget Act, it only went to 50 percent and Senator DOLE said, ''Let's make it 80 percent.'' He was right. That is equitable, and that means that Don NICKLES' janitor service gets just about as good a deal as a manufacturing company in 7 years.

That is a good provision. It needs to pass. But equally as important is that individual who does not have a job or that individual who is unemployed or that individual who works for an employer that does not give anything to their health care. Right now, they have to buy their health care with after-tax dollars. And they need health care as much as somebody working for any company in America. Let us help them. Medical savings accounts will help them, and they are not something untested and untried, as my colleague from Massachusetts said. We have something like 3,000 firms right now offering those.

Seventeen States now have MSA laws, an additional 11 States have called on Congress to enact MSA legislation. We ought to do it. Everybody ought to have the opportunity to have this choice. We are not mandating it on

anybody, but it should be a choice. They should have the opportunity.

What is the choice? Yes, they can buy insurance, I think pretty good insurance. They can buy insurance that is for the catastrophic illness. We say a medical savings account is very comparable to an Individual Retirement Account. Individuals can put in $2,000, families or couples can put in $4,000, and then use it for medical expenses. They have to buy at least catastrophic coverage, to cover the really expensive care. That makes sense.

We are encouraging this with medical savings accounts. A lot of the private sector is doing the same thing. In our company we used to ensure the first dollar coverage on anything. That is very expensive and it is not what insurance is for. When you buy car insurance you do not buy car insurance to fill the car up with gasoline or fill it up with oil. You buy car insurance for collision or something that is really expensive that you need insurance for. That also makes sense in the medical field, to let people use their own dollars for the small things, the routine things, the doctor's office visit. And they will use their own money. If they do not use it they can save it. It is not use it or lose it. They can save it, accumulate it. We encourage savings and they can use that money later for something that really is serious, that is problematic. Or they can use it for long-term health care.

This is a good provision. This will help countless middle-income families. Mr. President, 88 percent of the benefit falls to individuals who make less than $100,000. It is not for wealthy people, it is for American families and it will help people who get no help whatsoever from the present Tax Code. If we want to eliminate a lot of this tax inequity, medical savings accounts will go a long way to doing that. Let us give them some benefit. Right now they get zero. An individual who is unemployed, an individual who works for a corporation that does not subsidize his or her health care, they get zero tax benefits. Finally, if we pass this they will get something and to me that is a very positive contribution.

So I urge my colleagues, let us not make this a partisan issue. I know Senator BREAUX introduced a MSA bill in 1992. Senator DASCHLE, Senator NUNN, Senator BOREN, Senator Dixon—they cosponsored the bill. Representative GEPHARDT, in 1994—almost all Members but one of the Democrat Party on Ways and Means supported Mr. GEPHARDT's provision that had medical savings accounts. So why all of a sudden are we being partisan? This is a good provision. It is a bipartisan provision. It should be passed.

We should help individuals. We are not helping individuals. We should make insurance truly portable and we do that with medical savings accounts. It is not contingent on a job. If they lose their jobs they still have their medical savings account. It is portable. It stays with them. It is not contingent on employment. It is a good provision. So I am very disappointed in some of the comments that have been made.

This is a good provision. It will make health care more portable. It is the most portable health care plan you can have. It goes with the individuals. It is theirs. If they save the money and they do not spend it, it grows, it accumulates. They can use it for later times.

Also, it makes it more affordable. People are a lot more frugal with their own money than they are with employer money or than they are with Government money.

Mr. President, I urge my colleagues to pass the medical savings account provision, to vote against the amendment to delete this provision, and then also to pass the underlying Dole-Roth amendment. It is an excellent amendment that will help expand coverage to countless Americans that right now, because of inequities in the Tax Code, really come up short.

Again, I thank my colleague from Delaware for his leadership. And also Senator DOLE for proposing this amendment. I hope my colleagues will agree to it.

Mr. ROTH. Before we conclude action on the measure before us, I want to specially commend the Senator from Kentucky, Senator MCCONNELL, for his invaluable contribution to this effort. His introduction of S. 1658, the Family Choice in Long-Term Care Act, along with his behind-the-scenes advocacy on this issue, has made the difference in getting long-term care on the must-do list of health care reforms. Senator MCCONNELL has shown tremendous concern for the long-term care needs of elderly Americans and their families, and he has played a key role in proposing common sense and compassionate solutions to the problem. We all know how some people just talk about an issue; the junior Senator from Kentucky works issues, and the legislation before us reflects the work that Senator MCCONNELL has devoted to this crucial health care concern.

Mr. MCCONNELL. Let me thank the chairman for his generous remarks and for his tremendous work on this legislation. The need to provide meaningful long-term care coverage cannot be overstated. It is estimated that at least 40 percent of those aged 65 and over will require nursing home care at some point, costing an average of $38,000 per year. As the chairman knows, this poses a terrible Hobson's choice for most seniors and their families. Many seniors are forced to liquidate their life savings and sell off family heirlooms just to pay for this expensive care, and only when they have depleted nearly all of their assets will Medicaid pick up the tab. Because of the massive costs involved, private insurance has thus far played a negligible role in the financing of long-term care, accounting for less than 2 percent of long-term care payouts. The dearth of private planning options for long-term care is also having a devastating impact on strained State Medicaid budgets. Long-term care costs are draining away Medicaid resources that are needed to provide health care for indigent and disabled Americans. We cannot continue to rob Peter to pay Paul much longer. America's elderly population is expected to increase by almost 25 percent between 1993 and 2011, and this will place an unbearable burden on the Medicaid Program unless decisive action is taken. This bill provides essential private financing options for long-term care, and takes a positive step toward meeting the long-term care needs of future generations of Americans. Again, I want to thank the chairman for addressing this issue in his amendment, and look forward to having it signed into law.

Mr. SANTORUM. Mr. President, I wanted to take some time to discuss a specific provision included in the majority leader's amendment.

I have had the pleasure of working with the long term care industry in Pennsylvania during my service in Congress. I am extremely pleased that the leadership amendment included long-term-care provisions which will fill a void in the security of older Americans. I wrote my Senate colleagues this past week as well as the majority leader directly urging the inclusion of the long-term-care language. The long-term-care section will improve this bill by giving long-term-care insurance the same Federal tax treatment as health insurance and by establishing Federal long-term-care insurance standards and consumer protections.

The cost of long-term care is easily the biggest financial threat facing elderly Americans. The average cost of nursing home care has risen to $38,000 per year. We also know that more than 40 percent of those who turn 65 this year will require nursing facility care at some point in their lives. Medicaid does pay for nursing home care, but only after the costs of long-term care makes the recipient destitute. Basically, people in need of long-term-care services must pay for the care out of pocket until they spend down all their assets to the point of poverty. Then and only then do they qualify for Medicaid.

The real crime here is that people do not know that they will have to lose all their assets to obtain long-term-care services. They think Medicare covers it.

Even after 30 years of Medicare, many Americans remain confused regarding what Medicare does and does not cover—particularly regarding long-term care. Year after year, public surveys show that nearly half of Americans believe that Medicare covers long-term care. Because of this misconception, many Americans come to a rude awakening when they need long-term care for which they have not prepared. Helping individuals and families understand the limits on Government long-

term-care assistance and giving them incentive to prepare for their needs will encourage more Americans to plan for, save for, and insure against the costs of long-term care.

We currently allow acute health care expenses and insurance premiums to be deducted. State laws require car insurance, home or flood insurance, and other protections for individuals and families. Yet we do not require, much less encourage, people to plan for something that more than likely will impact them—the need for long-term-care services.

The language in the leadership amendment would correct this. Specifically, the provisions will give long-term-care insurance the same Federal tax treatment as health insurance and link tax provisions to Federal long-term-care insurance consumer protections. This second part is so important because it ensures that policies offer value to consumers and pay appropriately and adequately for quality long-term care when needed.

Not only would greater use of long-term-care insurance help protect individuals and families from impoverishment due to long-term-care costs, but it would also help control Medicaid costs. Mr. President, in the long run this will save money for the Medicaid program.

In a 1994 article in Health Affairs, Marc Cohen, Nanda Kumar, and Stanley Wallack estimated that having a long-term-care insurance policy reduces the probability of spending down to Medicaid eligibility levels by some 39 percent. The authors estimate that, in the aggregate, Medicaid expenditures would be reduced by $8,000 to $15,000 for every nursing home entrant who had a long-term-care insurance policy. According to the analysis, this translates into cutting what Medicaid pays per nursing home entrant in half for long-term-care policy purchasers. It is in our best interest to encourage people who can meet their long-term-care needs to do so. Medicaid will then take care of truly needy individuals.

The majority leader's amendment assists America's elderly and their families with long-term care by putting policies in place that help assure the affordability and value of long-term-care insurance. Giving Americans tax incentives to insure against the potential costs of long-term care will also save Medicaid dollars in the long run. Since we cannot continue to rely so heavily on scarce Government dollars to pay for long-term care, individuals and families should be encouraged to plan for, save for, and insure against the potential long-term-care costs. I urge my colleagues to vote for this amendment and to support this specific language.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that there be 10 additional minutes for debate, equally divided in the usual form.

The PRESIDING OFFICER. Without objection, it is so ordered. Who yields time?

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

Mr. ROTH. I am sorry, I did not hear.

Mrs. KASSEBAUM. There will be 10 additional minutes added, equally divided.

Mr. ROTH. I ask whether, because we agreed to a very brief time, whether at least on our side we could have another 10 minutes, total of 15 minutes.

Mr. KENNEDY. I will give you my 5.

Mrs. KASSEBAUM. That gives you 10 minutes additional.

Mr. ROTH. Can I have 15?

Mrs. KASSEBAUM. I think maybe you better take it. A bird in the hand is worth two in the bush.

The PRESIDING OFFICER. Who yields time? The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, how much time do we have remaining?

The PRESIDING OFFICER. The Senator from Massachusetts has 14 minutes and 55 seconds.

Mr. KENNEDY. I yield 10 minutes to the Senator from West Virginia.

The PRESIDING OFFICER. The Senator from West Virginia is recognized for up to 10 minutes.

Mr. ROCKEFELLER. Mr. President, I agree with the Senator from Oklahoma that this could be the most significant health care legislation that we have passed in a long time, which is why I think it is terribly important that we pass it. What has been made very clear, very distinct throughout this discussion, is that we are in an argument now on MSA. We have not been in an argument on anything else. We are in an argument on MSA. The agreement, from the very beginning, was to take the controversial stuff out; leave that for now, and do it later. It will probably pass on its own, but now is not the time.

To back that up, I have a letter from the NFIB. This NFIB letter, signed by Dan Danner, says, ''The NFIB opposes the adoption of any amendment to S. 1028 which would draw a Presidential veto or cause the bill to be defeated in the Senate.''

I repeat the statement of administration policy from the White House, in which they indicated, as their first priority, that for the bill to include medical savings accounts would, as they say, ''create grave risks to the passage and enactment of this bipartisan legislation.'' I think those who are pushing the MSA, for whatever the various interesting reasons that have floated around here for the past several days, ought to bear very carefully in mind that they are putting the entire bill in jeopardy. If the amendment passes with MSA's, as the Senator from Massachusetts said, ''school is out.'' Everything else comes in. The bill is down. The bill is gone. An opportunity is finished.

I hope people will take moral responsibility in considering the decision which they are making. In fact, every single serious health policy analyst—and you can laugh at them, except when you realize they are just about the whole gamut—they all say that giving a tax break for medical savings accounts is a very bad idea. I repeat—it is a very bad idea. Medical savings accounts, they say, would cherry pick the healthy people —yes—and drive up health care costs for the sick—yes. Medical savings accounts would further destabilize an already seriously fragmented insurance risk pool. And of course we understand what that means.

The insurance risk pool gets fragmented when companies self-insure; many big companies do that now. They did not 25 years ago. That puts more pressure on the small business market where you have individual insurance. It is a very, very risky business in any event, without thrusting MSA into it.

Another thought worries me. The Republicans put MSA's into reconciliation, with respect to Medicare. CBO has determined that only about 1 or 2 percent of Medicare beneficiaries would, in fact, select a medical savings account. But let there be no doubt in the mind of anyone here that what is hoped is that the MSA's would spread, indeed, to the whole concept of Medicare. This should represent to every one of my colleagues a very severe threat to the future of Medicare. That, I think, is what is in mind here. Furthermore, CBO concluded that healthy seniors would opt in and out of traditional Medicare based on whether they thought they would be using health services in that particular year. In other words, there would be no predictable pattern.

Lewin-VHI, a well respected consulting firm, concluded that ''An optional health coverage program that promises potential cash benefits to persons who are able to keep their health spending low will experience extreme selection bias.''

The American Academy of Actuaries has also been quoted. This is an interesting quote from them. ''Those who have little or no health care expenditures. . .would save money on MSA's. The greatest losses will be for those employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women.

A report from the Congressional Research Office, written by the nonpartisan folks there says, ''If MSA's only attracted the healthy, the cost of insurance for everyone else would increase due to adverse selection.''

The Kaiser Family Foundation has concluded that, ''Enrollees who leave the traditional Medicare plan would be healthier on average than those who remain in the traditional plan.''

Again, notice that threat—the Medicare beneficiaries lost to MSA's would

be healthier on average than those who remain in the traditional plan.''

That foreshadows an ominous future for Medicare. And you have this broad, broad coalition that is saying exactly the same thing.

Mr. President, I do not think it is any secret that there have been special interests working very hard on this in the last several days, and those who are in the process of making up their mind at this point, I think, might consider that there is really one group that is especially interested in this particular medical savings account activity. Their president was working the entire Capitol yesterday and saw a number of people. In exchange, they are hoping to win approval of a special tax break that they hope will throw millions of dollars in new insurance business their way. Is that a crude thing to say? I do not know. I think it is a major part of this debate, and I think it is a major part of the reason that we are in a debate we should not be in at all. Debate on this bill was to be based on the clear premise that we agree that controversial stuff should be left out—so we can take, as the Senator from Oklahoma said, 25 million kids and adults and improve their lives substantially, in terms of health care.

This is a bill which enjoys strong bipartisan support. MSA's do not enjoy strong bipartisan support. I have to conclude that the vote on this will be very close, and I hope as people vote, they will consider the pressures which have been brought, particularly by one single company, on Members on both sides of the House and the Senate.

Are we really going to do their bidding, or are we going to help 25 million people in this country when we have a historic chance to do it? I think the answer is easy. I hope my colleagues will move to strike the MSA provision. I thank the Presiding Officer.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield 4 minutes to Senator FAIRCLOTH.

The PRESIDING OFFICER. The Senator from North Carolina is recognized for up to 4 minutes.

Mr. FAIRCLOTH. Thank you, Mr. President.

Mr. President, what a difference 2 years makes. All of us remember that at this time 2 years ago, the Clinton administration was struggling to keep afloat their Health Security Act—the Clinton plan for a nationalized health care system.

In case anyone's memory needs refreshing, I have reproduced the chart that Senator SPECTER used to illustrate the workings of the Clinton plan. Once Members of Congress and the American people saw what was behind the President's rhetoric, nothing could save the Clinton plan. Once the American people realized that the Clinton plan was a big-government power grab on the most enormous scale ever attempted in this country, they rejected it.

Mr. President, in contrast, the general philosophy of Republicans in Congress supports health care reform that benefits and empowers Americans and their families on an individual scale. As these charts illustrate, this philosophy is about improvements for individuals, not big government.

On my chart, I have included four principles: affordability, availability, flexibility, and portability. In the bill we are now debating, Senator KASSEBAUM has done a fine job of addressing two of these principles. In the provisions for insurance reform and for insurance purchasing pools, Senator KASSEBAUM'S bill takes important steps to improve the availability and portability of health care coverage.

It is my strong and sincere hope that we can further improve this legislation by amending it to include provisions that enhance the flexibility and affordability of health care coverage for all Americans on an individual basis. The provisions I have in mind include those that I have placed on my chart: medical malpractice reform, increased deductibility of insurance for self-employed individuals, and medical savings accounts.

The majority of uninsured Americans are adults who work full-time jobs, usually in small businesses. Measures like more favorable rules for the formation of voluntary purchasing pools, increased deductions for health care expenses, medical malpractice reform, and medical savings accounts would give small employers more options at lower costs to help them offer the health coverage they currently cannot afford. Under these proposals the decisionmaking will remain where it belongs, with individuals and their employers.

To reduce the number of uninsured Americans, President Clinton proposed an employer mandate that would have required all businesses to cover their employees with a Cadillac plan designed in Washington. The result of this policy would have been hundreds of thousands of lost jobs, and hundreds of billions of dollars in increased costs for businesses.

President Clinton also proposed that his nationalized health care system would have been run by a system of health alliances. Through a complex system of cost controls and rationing, the bureaucrats who ran these alliances would have decided what Americans spent health care dollars on, and how much they spent individually and collectively. If medical savings accounts were available to Americans, any individuals who chose them would gain full control of their own health care decisions.

As chairman of the Labor Committee, Senator KASSEBAUM has done a commendable job of advancing the difficult issue of health insurance reform within the jurisdiction of her committee. But, medical savings accounts fall within the jurisdiction of the Finance Committee.

Mr. President, the rules of the Senate should not deprive the American people of the most meaningful free-market health care reform measure that we could give them.

Perhaps the most important debate that we can have is a debate on medical savings accounts. It is unfortunate that the administration has already tried to poison this debate by threatening to veto a health care reform bill that contains them. Their accusation is that anyone who wants to include medical savings accounts wants to kill the Kassebaum bill. That simply is not true. The truth is the President knows that if medical savings accounts become law, they will drive the final nails in the coffin of the Clinton plan, and bury his dream of nationalized health care.

Once individual Americans have the power to control how their own health care dollars are spent, they will never allow the Government to take that power back.

In his last State of the Union Address the President stated that ''the era of big-government is over.'' I wonder if he really meant it, or if he was just echoing a decision already made by the voters in the last elections. Regardless, the decision has been made. We should pass health care reform that ensures that the power to make health care decisions is placed in the hands of individual Americans, not big-government. That means health care reform that includes medical savings accounts.

I applaud the decision of Chairman ROTH and the majority leader to bring an amendment to the floor that contains medical savings accounts. Just as he has done so many times in the past Senator DOLE has shown the leadership necessary to make the difficult decisions, and push aside the administration's rhetoric.

Mr. President, there are very different goals involved in this debate. Our goal should be health care reform based on improvements for individuals, not health care reform based on big-government solutions.

I plan to strongly support the Dole-Roth amendment, and I urge my colleagues to do the same.

Thank you Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. FAIRCLOTH. I plan to support the Dole amendment and urge my colleagues to do the same.

Mr. ROTH. I yield 5 minutes to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized for 5 minutes.

Mr. SANTORUM. Thank you, Mr. President. I appreciate that.

As I always like to say, I was one of the first Members of Congress in either the House or Senate to introduce a medical savings account bill. I introduced a bill with JOHN KASICH, TOM DELAY and John Miller, a former Member from Washington, back in January

1992. I have followed it for a long, long time prior to corporate lobbyists being up here on the Hill, and I believe very strongly in its concept.

Let me explain. I guess we had a lot of talk about what is going on here with this specific MSA bill. Let me explain the concept behind medical savings accounts and the fear many of us have with, the best way I can put it, the ''corporatization'' of the health care field and how we see medical savings account as, really, the last chance for patient choice and for compassion in an industry that is becoming more and more regulated by third parties in the fundamental relationship between doctors and patients.

If I can, let me just walk back to the system we had before managed care came into place. What we had was a doctor/patient relationship. That was the problem. There was nobody in this relationship who had any incentive to control costs. As a rule, costs escalated out of control. Why?

If you were the patient and had first-dollar coverage, who asked how much things cost? Who asked whether you needed one or two or five of these? You took whatever the doctor suggested and you did not pay for it, so why did you care?

So, on the other side is the doctor, and what is the doctor's incentive in this doctor/patient transaction? The more the doctor does, the more money he gets paid. The more the doctor does, the less chance the doctor gets sued. So you have a doctor who gets more money, with less chance of being sued, and you have a patient who does not pay for anything.

Then we sat back and wondered several years ago, gee, why are health care costs going up? It was very simple. There was nobody with any incentive to control costs. We understood that and companies understood that and insurance companies understood that, and they did a very logical thing. They brought someone in to control costs, the gatekeeper, the insurance company, who came in; and now they are governing the relationship between the doctor and patient. If you want something done, you go through the insurance company. You get approval, and it can be done. That is now the governor, the one who is in charge of this relationship.

What many of us believe is that that is not the most compassionate, and some would suggest that it may not result in the best quality of care. It certainly does not result in the maximization of patient choice. So what we have put forward is a concept called medical savings. I think it is really misnamed. I think we should call it ''patient choice accounts,'' because that is what is left. If we do not do medical savings accounts, if we do not do patient choice accounts, the doctor-patient relationship which we know will disappear in America. It will disappear. It is disappearing, has disappeared, in a lot of communities already in this country.

We hear so much from so many people on both sides of the aisle about being compassionate, about caring for people, about doing things to give people choices and to give people the ability to do what is best for them and their families. What we have here is a situation going on in the private sector in America where that choice is going away. Private practice is almost a thing of the past in many communities and is growing more apparent in all States across this country.

What medical savings accounts do is provide a chance, an opportunity, for the traditional doctor-patient relationship to be restored where now the incentive is on the patient to be cost conscious. How? Because, instead of the old system where you had first-dollar coverage and the insurance company pays for everything, we are going to say, look, we are going to take a higher deductible policy like an auto insurance policy—we do not pay, as Senator NICKLES said, for gasoline or oil changes—but you pay for the incidental costs of health care, the day-to-day costs, and we insure you for the catastrophic illness or for a year where you had a lot of serious problems.

So you take a high-deductible policy and you pay for the out-of-pocket expense and you afford that because, when you take a higher deductible policy, the cost of that policy is less.

Senator CRAIG gave an example earlier where a policy with a $250 deductible and a $500 cap and a 20-percent copay cost $458 a month for a family. A $3,000 deductible policy, same coverages, no copay, costs two-thirds less, costs under $200 a month. Where did that savings go between the $200 and $450? It went into the pocket of the person who had the medical savings account.

It would go, under this bill, tax free into an account you set up at your bank. You get a little debit card. You could then use it to purchase health care. You could use it to make choices about what doctor you wanted to go to, what hospital, and how much you wanted to spend.

I always ask people, ''Who are the lowest paid doctors in this country?'' Well, they are pediatricians and family practitioners and dentists because they are not covered under insurance. Why? They have to charge people who pay out of pocket, so they have to keep their costs down. Just imagine if we did that to most of the health care sector in this country. It would be an enormous contraction, I believe, in costs in our society. It would not lead to higher costs in other areas, in other insurance pools. I think this is a dramatic step forward. This is the reason that I applaud Senator DOLE for fighting to the end because this is the kind of dramatic reform that this country needs to preserve freedom of choice for patients.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. Mr. President, I yield 2 minutes to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas is recognized for up to 2 minutes.

Mrs. HUTCHISON. Thank you, Mr. President.

I appreciate the chairman's generosity in letting me talk on this very important issue. I wanted to speak on two points on the amendment. First, the deductibility for the self-employed is such an important step forward that the people who are self-employed will be encouraged to get health care coverage for themselves, and that is what we are trying to do here. It is what we have been trying to do for 2 years. To increase the tax deductibility for them to 80 percent from 30 percent is a big step in the right direction to encourage more people to get health care coverage.

The issue of medical savings accounts—''patient choice accounts'' is a great name for it because it really will make a difference for so many people and so many small businesses in this country, giving them an opportunity they would not have had.

Senator KENNEDY's bill in 1994 had language saying that they hoped there would be medical savings accounts included in the health reform bill passed by the Senate. This is not a partisan issue. Congressman JACOBS and Congressman TORRICELLI today wrote the President of the United States asking him to support MSA's.

Let me give you some examples of companies that have benefited from MSA's, medical savings accounts, patient choice accounts.

Dominion Resources in Richmond, VA. Since 1989, the company's health care costs have risen less than 1 percent a year while other health care costs all over this country have risen over 10 percent. Here we are at 1 percent a year. Not only have their costs come down, but their employees are happy because they have had improved and expanded medical benefits under their medical savings accounts.

Knox Semiconductor in Rockport, ME. Their president says they have saved the company $100,000 over 3 years. That is with just 42 employees.

The National Center for Policy Analysis in Dallas, TX, has been on the leading edge of giving their employees the choices. They have been able to contain their health care costs, and their employees are happier with their coverage.

Mr. President, medical savings accounts are a key part of the reform that is necessary to give more health care coverage to more people, more working people, in our country. That is why it is important to keep this amendment, the medical savings account, in the bill. Thank you, Mr. President. I thank the chairman.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield 4 minutes to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Delaware controls 2 minutes 30 seconds.

Mr. ROTH. With 1½ minutes of leader time, we have a total of 4 minutes.

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

The Senator from Iowa is recognized for 4 minutes.

Mr. GRASSLEY. Mr. President, the best thing we can do for health care reform is to let the marketplace operate to a greater extent in the delivery of health care. This issue is the most important one that faces us today. You know how strong our argument is from the weakness of the argument made by those on the other side of this question.

The other side's argument is that we should leave this medical savings account provision out of this bill because it happens to be controversial. Well, that is the strength of their argument: it is controversial in Washington, DC; that is, inside the beltway. Well, Mr. President, medical savings accounts are not controversial outside of Washington, DC.

The people who oppose this amendment are some of the same people who believe that Washington knows best, that Washington knows how to dictate the delivery of health care better than the people themselves do, particularly people at the grassroots. It seems to me a weak argument when the strongest argument against this legislation is that it is controversial. Since when is giving people more choice in health care controversial? That is what people want. That is what people know will work better. This is the usual big Government argument against any changes.

It is the argument in favor of big government versus letting the free marketplace work. It is the old in favor of big government making decisions for people, as opposed to letting people themselves make decisions.

Medical savings accounts give people choice. It is letting people control their resources for health care. Quite frankly, it is going to save us a lot of money and reduce health care costs.

I am very happy that the leadership puts forth this amendment, because allowing medical savings accounts is a step in the right direction. They are basically like IRA's, giving people an opportunity to save for their retirement. Medical savings accounts are giving people an opportunity to save for themselves and to control their resources for their own medical expenses.

There is a widespread use of medical savings accounts already in this country that speaks better than any of us can to their legitimacy and to their hope for success. They should reduce health care costs. Administrative costs are lower. Consumers with MSA's should use health care services in a more discriminating manner. Consumers with MSA's should be more selective in choosing providers. This should cause those providers to lower their prices to attract medical savings account holders as patients. Medical savings accounts can also help to put the patient back into the health care equation.

Patients should make more cost-conscious choices about routine health care. Patients with medical savings accounts would have complete choice of providers. Medical savings accounts should make health care coverage more dependable. Medical savings accounts are completely portable. Medical savings accounts are still the property of the individual, even if they can change jobs.

Hence, for those reasons, I support medical savings accounts. I very much thank the leadership for providing this amendment. I yield the floor.

Mr. DASCHLE. Mr. President, I know that we want to have a vote by 4 o'clock so I will divide the time remaining with the distinguished Senator from Delaware.

How much time remains?

The PRESIDING OFFICER. Six minutes and twenty-two seconds.

Mr. DASCHLE. I yield 3 minutes to our side and leave the Senator from Delaware the final 3 minutes.

Mr. President, given the very short period of time we have remaining, and the fact that all of the arguments have been made, let me simply summarize the case against including MSA's on this bill.

Two years ago we all agreed that comprehensive health care reform would not pass. In the last year and a half we have all agreed that we can only pass something which enjoys broad bipartisan support. It was with that understanding and with the remarkable leadership of the Chair of the Labor Committee, the distinguished Senator from Kansas, and the Senator from Massachusetts, we now have a bill that we all agree is the only health reform legislation that can pass this Congress with broad, bipartisan support. This narrowly drafted bill some of the most pressing health problems facing Americans.

Portability and coverage for preexisting conditions are two of the most important issues we face. So let there be no mistake, we have an opportunity today to pass something, but we also have an opportunity to kill that very bill with this MSA provision in this amendment. The NFIB clearly stated in a letter dated today, and they have said very clearly, ''We oppose any amendment which will bring about a defeat of the legislation before us.''

They recognize the importance of this moment. They recognize what an opportunity we have before us. We should not blow it. We should not kill this bill. Let us recognize there will be another day to have yet another debate about many other health care issues. But let us not destroy the golden opportunity we have today to pass meaningful legislation, by adding something as controversial as MSA's. We can do better than that. We will do better than that if we can, on a bipartisan basis, strike the MSA portion of the Dole amendment and pass this bill intact, as we know we can.

If we do that we can look back on this Congress with some satisfaction that we have done our best under these circumstances to address some of the real health care problems working Americans face.

I yield the floor.

Mr. ROTH. Mr. President, medical savings accounts are among the most important steps that must be taken to address this country's health care needs, particularly the need for portability. MSA's are of such importance in our effort to address our health concerns that on September 8, 1992, several of my distinguished colleagues signed a letter calling for the introduction of MSA's as part of their bill.

Let me quote a portion of that letter:

> Unlike many standard third-party health care coverage plans, Medical Care Savings Accounts would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their ''own'' money. . . Once a Medical Savings Account is established for an employee, it is fully portable. Money in the account can be used to continue insurance while an employee is between jobs or on strike. Recent studies show that at least 50 percent of the uninsured are uninsured for four months or less. . . . Today, even commonly required small dollar deductibles (typically $250 to $500) create a hardship for the financially stressed individual or family seeking regular, preventative care services. With Medical Savings Accounts, however, that same individual or family would have this critical money in their account to pay for the needed services.

Mr. President, these are important arguments that were made for MSA's over 3 years ago. They are equally, if not more, important today. That letter was signed by Senators BREAUX, BOREN, DASCHLE, LUGAR, COATS, and NUNN, a formidable bipartisan coalition of Senators taking a necessary stand on a critical issue.

Mr. President, I have a copy of a letter received from the Vice President of the NFIB that makes it clear that they are supporting the MSA. This letter, dated today, April 18, 1996, to the Honorable DON NICKLES says, ''Overall, NFIB members need health care reform. It has been a top priority for years. MSA's are among the provisions we have consistently supported. These also include portability, no preexisting condition exclusion, deductibility, and small business purchasing groups. We will continue to fight for all these provisions of importance to small business.''

For these reasons, Mr. President, I urge my colleagues on both sides of the aisle to vote against the motion to strike. I yield the floor.

The PRESIDING OFFICER. All time has expired. The question is on agreeing to the KASSEBAUM amendment No. 3677.

Mr. KENNEDY. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk called the roll.

Mr. LOTT. I announce that the Senator from Florida [Mr. MACK] and the Senator from Colorado [Mr. CAMPBELL] are necessarily absent.

The VICE PRESIDENT. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 52, nays 46, as follows:

[Roll Call Vote No. 72 Leg.]

YEAS—52

Akaka	Feinstein	Levin
Baucus	Ford	Lieberman
Biden	Glenn	Mikulski
Bingaman	Gorton	Moseley-Braun
Bond	Graham	Moynihan
Boxer	Harkin	Murray
Bradley	Hatfield	Nunn
Breaux	Heflin	Pell
Bryan	Hollings	Pryor
Bumpers	Inouye	Reid
Byrd	Johnston	Robb
Chafee	Kassebaum	Rockefeller
Conrad	Kennedy	Sarbanes
Daschle	Kerrey	Simon
Dodd	Kerry	Wellstone
Dorgan	Kohl	Wyden
Exon	Lautenberg	
Feingold	Leahy	

NAYS—46

Abraham	Gramm	Nickles
Ashcroft	Grams	Pressler
Bennett	Grassley	Roth
Brown	Gregg	Santorum
Burns	Hatch	Shelby
Coats	Helms	Simpson
Cochran	Hutchison	Smith
Cohen	Inhofe	Snowe
Coverdell	Jeffords	Specter
Craig	Kempthorne	Stevens
D'Amato	Kyl	Thomas
DeWine	Lott	Thompson
Dole	Lugar	Thurmond
Domenici	McCain	Warner
Faircloth	McConnell	
Frist	Murkowski	

NOT VOTING—2

Campbell	Mack

So the amendment (No. 3677) was agreed to.

Mrs. KASSEBAUM. Mr. President, I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

Mr. DOLE. Mr. President, I suggest the absence of a quorum.

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

The assistant legislative clerk proceeded to call the roll.

Mr. DOLE. 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. DOLE. Mr. President, we had hoped that we might have a vote on the Dole amendment, a rollcall vote here. I need to check with one Senator on this side. Is there any objection on the other side to having a vote at this time or not? Are you prepared?

Mr. DASCHLE. Yes.

Mr. DOLE. I would say with reference to the last vote, I think it was a close vote. As one of the conferees on the tax side, I think there will still be opportunities in conference. We wanted as many votes as we could have. We have one absentee so I think we have about 47 or 48 votes, which puts us in a strong position in the conference.

But, in any event, the outcome here may permit us to conclude action on this bill today, hopefully. I trust that is what the managers have in mind.

So, perhaps maybe Senator DORGAN might proceed at this time so we would not lose any time, if he wants to take his 15 minutes now while we are checking to see if we can go ahead and have the vote?

Mr. DORGAN. I say to the majority leader, if the majority leader wishes to proceed I will defer my time until after the vote. I do not need to intervene at this point. All I want to do is get the appropriate time following the vote.

Mr. BUMPERS. Will the majority leader yield for a question?

The PRESIDING OFFICER. The Senate is not in order.

Mr. DOLE. I will be happy to yield to the Senator.

Mr. BUMPERS. Mr. President, I wonder if it is too early for the majority leader to tell us if plans have been made for a session tomorrow and, if so, will votes be included tomorrow?

Mr. DOLE. If we can complete action on this bill tonight I do not anticipate any votes tomorrow. We will probably move to term limits, unless we could have some agreement. There would not be any votes.

I do not believe there are that many amendments left on this bill. So, as soon as I check with the Senator from Texas, we will be able to proceed.

Mr. COHEN. Will the Senator yield? I inquire whether or not he included the antifraud provision in his amendment?

Mr. DOLE. We included the Cohen antifraud provision, which I think will save $3 billion.

Mr. COHEN. According to the CBO, they scored a $3 billion savings. I want to commend Senators DOLE and ROTH for including it in the package. We are losing roughly $18 billion a year just out of the Medicare Program itself, and we are losing about $100 billion itself throughout the health care system. It works out to about $275 million a day, $11.5 million an hour. I would also like to thank Mary Gerwin, Helen Albert, and Priscilla Hanley from the Aging Committee for all their hard work on the fraud legislation.

Mr. President, last spring the Medicare trustees, on a bipartisan basis, issued an urgent warning that the Medicare hospital trust fund will go broke by the year 2002, unless major changes are made to protect the system. Since that alarm was sounded, the Congress has been wrestling with ways to bring Medicare spending under control, in order to forestall impending bankruptcy and to strengthen Medicare for both current and future beneficiaries.

The debate over how—and how much—to control the unsustainable growth of Medicare spending was part of the budget reconciliation process which now remains stalled.

A major step we can and must take toward Medicare reform is to crack down on the fraud and abuse that drives up the costs of health care for senior citizens and taxpayers. Estimates are that Medicare loses over $18 billion each year to fraud and abuse, and that fraudulent schemes cost the entire health care system and our economy over $100 billion each year.

The investigation of the Senate Special Committee on Aging, which I chair, has revealed that it is shockingly simple to commit health care fraud, and that the size, complexity, and splintering of the current health care system creates an environment ripe for abuse.

Health care fraud is equal opportunity employer that does not discriminate against any part of the system. All Government health care programs—Medicare, Medicaid, CHAMPUS, and other Federal and State health plans, as well as private sector health plans, are ravaged by fraud and abuse.

Similarly, no one type of health care provider or provider group corners the market on health care fraud. Scams against the system run the gamut from small companies or practitioners who occasionally pad their Medicare billings because they know they'll never get caught, to large criminal organizations that systematically steal millions of dollars from Medicare, Medicaid, and other insurers. According to the FBI, health care fraud is growing much faster than law enforcement ever anticipated, and even cocaine distributions are switching from drug dealing to health care fraud schemes because the chances of being caught are so small—and the profits so big.

Of particular concern is the growing evidence that health care fraud has infiltrated the health care industries providing services to our nation's elderly and disabled Americans, and in turn, contributing to the runaway costs of these entitlement programs.

The Inspector General of the Department of Health and Human Services, for example, has cited problems in home health care, nursing home, and medical supplier industries as significant trends in Medicare and Medicaid fraud and abuse. Padding claims and cost reports, charging the government and patients outrageous prices for unbundled services, and billing Medicare for costs that have nothing to do with patient care are just a few of the schemes that are occurring in these industries.

Unscrupulous providers are enjoying a feeding frenzy on Medicare and Medicaid, while taxpayers are picking up the tab for their feast.

It is time that we crack down—and shut down—these schemes that are bilking billions of dollars from Medicare and other health care programs. If we have asked honest health care providers to take cuts in reimbursement and asked Medicare and Medicaid recipients to pay more out-of-pocket costs to bring spending under control,

we have an absolute duty to ensure the American public that their health care dollars are not lining the pockets of criminals and greedy providers who are manipulating the system through fraud and abuse.

I was very pleased that the budget reconciliation bill includes anti-fraud legislation that I introduced last year as a result of an investigation of the Special Committee on Aging and I am pleased that my legislation is included in the leadership amendment on the Kassebaum bill.

Specifically, the proposal creates tough new criminal statutes to help prosecutors pursue health care fraud more swiftly and efficiently, increases fines and penalties for billing Medicare and Medicaid for unnecessary services, overbilling, and for other frauds against these and all Federal health care programs, and makes it easier to kick fraudulent providers out of the Medicare and Medicaid Program, so they do not continue to rip off the system.

Most importantly, the bill establishes an antifraud and abuse program to coordinate Federal and State efforts against health care fraud, and substantially increases funding for investigative efforts, auditors, and prosecutors.

According to the Congressional Budget Office, these provisions will yield over $3 billion in scorable savings to Medicare—without costing a penny to senior citizens. I am convinced that the long-term savings are much greater, and that billions more will be saved once dishonest providers realize that we are cracking down on fraud, and that they can no longer get away with illegally padding their bills to pad their own pockets.

The legislation has received the support of the FBI Director, the Attorney General, the HHS' Secretary, and the Congress, which passed it as part of Budget Reconciliation. We should not let an opportunity to pass this bill go by. We lose as much as $275 million per day or as much as $11.5 million per hour to health care fraud and abuse. Every day we wait, will be a victory to those unscrupulous providers who are bankrupting our public health programs.

I urge my colleagues to support this important endeavor and I would like to thank Senators ROTH and DOLE for including this proposal as part of the leadership amendment.

Mr. HATCH. If my colleague would yield for a moment, I would like to take this opportunity to discuss some concerns I have with the section which pertains to establishment of a new health care fraud and abuse data collection program.

Mr. COHEN. I would be glad to yield to my colleague.

Mr. HATCH. As you may be aware, the alternative medicine community has expressed concerns about this provision. I have received communications from, for example, the American Preventive Medical Association and the National Nutritional Foods Association. In general their concerns—which I share—focus on the potential abuse of the fraud provisions we are passing today. I am sure my colleague is aware, for I know he shares my strong support for alternative medicine, that providers of alternative medical treatments sometimes find themselves in the cross hairs of the more traditional medical establishment. Personally, I believe that both alternative and traditional medicine are important and that both can benefit patients. But, this cooperative coexistence has not been fully realized it seems.

While we are all supportive of strong efforts to weed out health care fraud and abuse, I hope the Senator from Maine will agree that we do not want to create an opportunity for those who might want to eliminate or discourage such alternative treatments by threatening fraud actions under the new language we are considering today.

Mr. COHEN. My colleague is correct. I have long been interested in promoting alternative medical treatments and I do not have any desire to enact a new law which might treat such providers unfairly. Could the Senator from Utah share with me specific concerns?

Mr. HATCH. I would be glad to. I have concerns in four specific areas. First of all, would the Senator agree that the mere practice of unconventional or non-standard therapies would not fall within the definition of fraud? I am not asking you to amend the bill here, but rather to give me your assurances and the implementing agencies your guidance that such is the case.

Mr. COHEN. I agree with my colleague that the practice of alternative medicine in itself would not constitute fraud.

Mr. HATCH. Thank you. My next concern relates to creation of the health care fraud and abuse data collection program. As you know, some people are concerned about the very establishment at the Federal level of this new program. I understand those concerns, but I also am very sympathetic to my colleague's argument that this would be a strong weapon in our Federal arsenal to fight the fraud and abuse which are costing our health care system so many billions of dollars each year and robbing us of valuable resources which would be better used for patient care.

The specific concern I want to raise now is that the program not duplicate existing data bases which already collect information about credentialing, licensing, and malpractice violations against providers. Is that the Senator's intent?

Mr. COHEN. My language does not cover malpractice at all. Further, it is my intent that the new data collection system be coordinated with existing data bases, so that there is no costly and burdensome duplication of effort. I have revised the language to reflect my colleague's concerns in this area. The new language makes it clear that there should be coordination with existing databases.

Mr. HATCH. I appreciate my colleague's actions to accommodate my concerns here. Turning to another concern I have with respect to reporting action on licensing and certification of health care providers, suppliers and licensed health care practitioners, I understand that the Senator intends that the actions to be reported are final actions, after completion of due process. Is my understanding correct?

Mr. COHEN. That is correct. I would want to make certain that participants in the system can avail themselves of due process guarantees, and that only final actions be included in the new database.

Mr. HATCH. The last issue I wish to raise is with respect to a data base requirement of reporting providers, suppliers, and licensed health care practitioners who are excluded from participation in Federal or State health care programs. This is my concern. Increasingly, managed care organizations are excluding providers from participation solely because of economic concerns, not because of any wrong-doing or program violations. For example, a physician could be excluded from a managed care organization certified by the State to care for the Medicaid population solely because that provider may have ordered more services than the managed care plan allows. If a provider were excluded from participation in such a plan because of such ''economic decredentialing,'' could that provider be reported to the data base?

Mr. COHEN. That is certainly not my intent. I have revised the language in the bill to state specifically that only exclusions for program violations are to be reported.

Mr. HATCH. I thank Senator COHEN very much for his work in this area, and specifically for his efforts to clarify the bill with respect to the treatment of alternative medical providers. I think that his changes have improved the bill greatly. I appreciate his efforts in this regard.

Mr. PELL. Mr. President, I ask unanimous consent to speak as in morning business for 4 or 5 minutes.

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

THE TRAGEDY IN LEBANON

Mr. PELL. Mr. president, I am deeply upset by this morning's news from Lebanon. As many of my colleagues have heard, Israeli shells hit a United Nations base in the village of Cana near the city of Tyre, within which approximately 500 Lebanese civilians had taken refuge from the recent fighting between Israel and Hezbollah. According to early press reports, the shelling caused the death of at least 75 Lebanese refugees—and perhaps many more than that—including men, women, children, and the elderly. At least 120 have been wounded, and two Fijian peacekeepers were killed.