confounding NATO's attempts to gain the freedom for low-level attacks to whittle down field units. Yugoslav units also have shown considerable resourcefulness, reconstituting damaged communication links and finding alternative routes around destroyed bridges, roads and rail links.

''They've employed a rope-a-dope strategy,'' said Barry Posen, a political science professor at the Massachusetts Institute of Technology. ''Conserve assets, hang back, take the punches and hope over time that NATO makes some kind of mistake that can be exploited.''

Hawley disputed suggestions that the assault on Yugoslavia has represented an air power failure, saying the full potential of airstrikes has been constrained by political limits on targeting.

''In our Air Force doctrine, air power works best when it is used decisively,'' the general said. ''Clearly, because of the constraints, we haven't been able to see that at this point.''

NATO's decision not to employ ground forces, he added, also has served to undercut the air campaign. He noted that combat planes such as the A–10 Warthog tank killer often rely on forward ground controllers to call in strikes.

''When you don't have that synergy, things take longer and they're harder, and that's what you're seeing in this conflict,'' the general said.

At the same time, Hawley, who is due to retire in June, insisted the course of the battle so far has not prompted any rethinking about U.S. military doctrine or tactics, nor has it caused any second thoughts about plans for the costly development of two new fighter jets, the F–22 and Joint Strike Fighter. Despite the apparent success U.S. planes have demonstrated in overcoming Yugoslavia's air defense network, Hawley said the next generation of warplanes is necessary because future adversaries would be equipped with more advanced anti-aircraft missiles and combat aircraft than the Yugoslavs.

If the air operation has highlighted any weaknesses in U.S. combat strength, Hawley said, it has been in what he termed a desperate shortage of aircraft for intelligence-gathering, radar suppression and search-and-rescue missions. While additional planes and unmanned aircraft to meet this shortfall are on order or under development, Hawley said it will take ''a long time'' to field them.

In the meantime, he argued, the United States must start reducing overseas military commitments. He suggested some foreign operations have been allowed to go on too long, noting that the U.S. military presence in Korea has lasted more than 50 years, and U.S. warplanes have remained stationed in Saudi Arabia and Turkey, flying patrols over Iraq, for more than eight years.

''I would argue we cannot continue to accumulate contingencies,'' he said. ''At some point you've got to figure out how to get out of something.''

The Air Force blames a four-fold jump in overseas operations this decade, coming after years of budget cuts and troop reductions, for contributing to an erosion of military morale, equipment and training. The Air Force has tried various fixes in recent years to stanch an exodus of pilots and other airmen in some critical specialties.

It has boosted bonuses, cut back on time-consuming training exercises and tried to limit deployment periods. It also has requested and received hundreds of millions of dollars in extra funds for spare parts.

Additionally, it announced plans last August to reorganize more than 2,000 warplanes and support aircraft into 10 ''expeditionary'' groups that would rotate responsibility for deployments to such longstanding trouble zones as Iraq and Bosnia.

But Hawley's remarks suggested that the growing scale and uncertain duration of the air operation against Yugoslavia threaten to undo whatever progress the Air Force has made in shoring up readiness. Whenever the airstrikes end, he said, the Air Force will require ''a reconstitution period'' to put many of its units back in order.

''We are going to be in desperate need, in my command, of a significant retrenchment in commitments for a significant period of time,'' he said. ''I think we have a real problem facing us three, four, five months down the road in the readiness of the stateside units.''

MEDICARE MUST NOT BE PRIVATIZED

The SPEAKER pro tempore (Mr. ISAKSON). Under the Speaker's announced policy of January 6, 1999, the gentleman from Ohio (Mr. BROWN) is recognized for 60 minutes as the designee of the minority leader.

Mr. BROWN of Ohio. Mr. Speaker, I am joined tonight by my friends, the gentleman from Florida (Mr. DEUTSCH), the gentleman from Texas (Mr. GREEN), the gentleman from New Jersey (Mr. PALLONE).

For the next hour we are going to talk about efforts that the majority party has tried to improve Medicare in this system, perhaps the single best government program of our lifetime, that has brought half the population in this country, really has provided health care for half the senior population.

In 1965 when Medicare was created, only about half of America's elderly had health insurance. Today 99-plus percent of America's elderly do.

Mr. Speaker, many in Congress have been on a campaign to scare America's seniors into believing that Medicare is going bankrupt. They say that Medicare must be improved in order to save it. Once again, Medicare privatizers are wrong. The Trustees of the Medicare Trust Fund have just reported that Medicare will remain solvent through the year 2015, up from its earlier projection just a year ago of 2008.

Republicans in Congress, the Washington, D.C. think tanks, and their media supporters who want to privatize Medicare are wringing their hands over the Trustees' latest report. They believe these new projections will lead Congress to do nothing toward reforming social security and Medicare. With the programs projected to last longer, they tell us we cannot rest on our laurels.

The real threat to Medicare, however, is not its alleged pending bankruptcy. The real threat is a proposal just rejected by the National Medicare Commission to privatize Medicare and to deliver it to the private insurance market.

Under a proposal soon to be introduced called premium support, Medicare would no longer pay directly for health care services. Instead, it would provide each senior with a voucher good for part of the premium for health care, for private health care coverage. Medicare beneficiaries could use this voucher to buy into the fee-for-service plan sponsored by the Federal Government, or could join a private plan.

To encourage consumer price sensitivity, the voucher would track to the lowest cost private plan. Ostensibly, seniors would shop for the plan that best suits their needs, paying the balance of the premium or paying extra if they want higher quality. The proposal would create a system of health coverage, but it would abandon Medicare's fundamental principle, its fundamental principle of egalitarianism.

Today the Medicare program is income-blind. All seniors have access to the same level of care. The idea that vouchers would empower seniors to choose a health plan that best suits their needs is simply a myth. The reality is that seniors will be forced to accept whatever plan they can afford.

The goal of the Medicare Commission was to ensure the program's long-term solvency. The premium support proposal will not do that. Supporters of the voucher plan say it could shave 1 percent per year from the Medicare budget over the next few decades. That is still not enough to prevent insolvency, and it is surely based on much too optimistic projections of private sector performance.

Bruce Vladeck, a former administrator of the Medicare program and the Medicare Commission, a bipartisan Commission Member, doubted the Commission plan would save the Federal Government $1. That same proposal under a legislative plan, under a legislative title, will not succeed, either.

Efforts to privatize Medicare are, of course, nothing new. Medicare beneficiaries have long been able to enroll in private managed care plans. Their experience, however, does not bode well for a full-fledged privatization effort. These managed care plans are already calling for higher government payments. They are dropping out of unprofitable markets, and they are cutting back on benefits to senior citizens.

Managed care plans obviously are profit-driven, and they simply do not tough it out when those profits are not realized. We learned this the hard way last year when 96 Medicare HMOs unceremoniously dropped 400,000 Medicare beneficiaries because the HMOs did not meet their profit objectives.

Before the Medicare program was launched in 1965, more than one-half of the Nation's seniors were uninsured. Private insurance was the only option for the elderly. But these insurers did not want senior citizens to join their plans because they knew that seniors use their coverage. The private insurance market surely has changed considerably since then, but it still avoids high-risk enrollees and, whenever possible, dodges the bill for high-cost medical services.

The problem is not necessarily malice or greed, it is the expectation that

private insurers can serve two masters, the bottom line and the common good. Logically, looking at the bottom line, our system leaves 43 million people without health insurance, 11 million of whom are children. Only Medicare can insure the elderly and disabled population because the private market had failed to do so.

If we privatize Medicare, we are telling America that not all seniors deserve the same level of health care. We are betting on a private insurance system that puts its own interests ahead of health care quality and a balanced Federal budget.

Look at efforts to privatize in other parts of government, efforts to privatize our public pension system. The mission of a private pension system is to make a profit. The mission of a public pension system, like social security, is to provide a decent amount of money, a decent standard of living, for people as they are older.

The mission of a private prison is the bottom line, to make a profit. The mission of a public prison is public safety, punishment, and rehabilitation.

The mission of a privatized national park system, as many Republicans in this body have proposed, is to make a profit in commercialization. The purpose of a public national park system is to provide green space, to provide entertainment, to provide places for Americans to go and enjoy life with their families in secluded areas in national parks.

The point is, privatization of the greatest part of our health care system, Medicare, the mission of privatization for insurance companies is the bottom line, is to make a profit. But the purpose of our public health care system, our Medicare system, is to provide a decent amount of health care so that older people can live their lives more productively, can live their lives longer, can live their lives in a more healthy sort of way.

Mr. Speaker, Republicans earlier this evening, two of my friends from Arizona, talked about choice and how the great thing about privatization of Medicare is choice. The fact is, under Medicare fee-for-service, people have choice in this system. They can choose their doctor, they can choose their hospital. Managed care privatization of Medicare is taking away that choice, and ultimately it will reduce quality.

The goal is simple: Let us keep Medicare the successful public program that it always has been.

Mr. Speaker, I yield to my friend, the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. First of all, Mr. Speaker, I want to thank my colleague, the gentleman from Ohio (Mr. BROWN) for organizing this special order. It goes without saying that along with social security, the Medicare program is the cornerstone of the Federal government's commitment to America's seniors, and the importance of the program to the millions who are covered by it cannot be overstated. I do not think there is any question that we in Congress have to continue to search for ways to strengthen Medicare.

I just wanted to say a few words today to agree with my colleague, the gentleman from Ohio (Mr. BROWN) about the proposal put forward by the cochairs of the recently disbanded Bipartisan Commission on Medicare. The cochairs' proposal fortunately did not pass the Commission because it did not achieve the required majority in the voting process, and I am glad that it did not, because I think that the cochairs' proposal of this Commission would drastically change Medicare as we know it.

The problem is that there is really nothing we can do to stop the proponents of this proposal from introducing the bill in Congress. Here on the House side, the gentleman from California (Mr. BILL THOMAS), who was one of the principal authors of that proposal that failed in the Medicare Commission, has vowed to move forward and pass this ill-conceived scheme.

The centerpiece of this scheme is changing Medicare from a program with a guaranteed benefits package to a program without a guaranteed benefits package.

Proponents of this plan would do this by converting Medicare into what they call a premium support program. I would caution, and I know my colleague from Ohio said, that seniors should beware of this proposal. Premium support is just a fancy phrase that the plan's supporters like to use to hide the fact that they want to turn Medicare into a voucher program. It is nothing more than a voucher program.

Under this proposal, the Federal Government would pay a set amount towards the cost of a beneficiary's health care. Any expense that exceeded what the Federal Government contributes would have to be paid by the beneficiary. Seniors may still choose fee-for-service under this scheme, but their premiums will be more expensive.

I think this was designed deliberately. The goal of the proponents of this proposal is to eliminate fee-for-service as we know it and basically replace it with a managed care-dominated system.

Ironically, the voucher plan's proponents want to put seniors out of fee-for-service into managed care because they think the competition between managed care plans will drive health care costs down. But the information we have on the cost of health care in recent years indicates that the Federal Government is doing a better job of controlling health care costs than the private sector.

The figures we have, for example, for the first 6 months of fiscal year 1999 indicate that this trend is continuing. Medicare funding has actually declined by $2.6 billion, compared to the first 6 months of last year.

What I am basically putting forward is that under this voucher plan, the costs of fee-for-service would see a sharp increase. According to an independent Medicare actuary, the voucher proposal would be an 18 to 30 percent increase in the cost of the traditional fee-for-service program.

So there should not be any doubt here, the price increase would bully seniors into managed care programs, and then we have a track, essentially, for our seniors. Once seniors make the switch to managed care, they will not only lose their freedom to choose their doctor, they will also lose the guaranteed benefits package today's Medicare beneficiaries enjoy. A voucher system is simply not going to provide the guarantee.

What we are seeing essentially with this proposal that has been put forward by the Medicare Commission, and I stress again, it failed the Medicare Commission, is that we are going to see increasing costs, out-of-pocket expenses for seniors. We are going to see them pushed out of fee-for-service and into a managed care plan.

The problem is that if we look at what has been happening across the country in terms of managed care plans, we know that many people are not satisfied with their managed care plans, even when they are available, and that many seniors, after a few months or a few years in the managed care plan, find that the HMOs drop them because they claim that they cannot afford to continue with the seniors in the managed care plan. So we have seen cases and cases across the country, particularly in my home State of New Jersey, where seniors have simply been dropped from HMOs or managed care plans.

Why in the world do we want to push more and more American seniors into the managed care plans when people have not been happy with many of them, they have not had adequate protections, and, in many cases, they have simply been dropped?

I am very concerned that what we are doing with this voucher plan that is being proposed is simply changing Medicare to the point where it will not be the type of quality program that we have had in the past.

The other thing I wanted to mention, and then I would yield back to my colleague, is that the other aspect of this voucher plan that disturbs me a great deal is this idea of increasing the age of eligibility for Medicare from 65 to 67.

We know there has been a steady increase in the number of uninsured Americans. That is probably the greatest threat we see today is the number of people who are uninsured. The most rapidly growing group of the uninsured are people between the ages of 55 to 65. If we raise the eligibility, we are only exacerbating this problem and denying even more people coverage at a time when they most need it.

If I could just say, in conclusion, the fact of the matter is that the Medicare program has been enormously successful and does not need to be changed in

the manner suggested by this voucher proposal. The voucher proposal is a solution in search of a problem, and it ignores six key principles that most Democrats on the Medicare Commission supported, that I support, and I think must be protected as Congress and the President consider ways to improve and strengthen the current Medicare program. I just want to list them briefly, if I could.

First, any revision of Medicare must protect the right of individuals to choose their doctor by continuing the traditional fee-for-service program.

Second, any revision of Medicare should not increase the number of uninsured or reduce access to health insurance.

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Third, any revision of Medicare must not increase burdens on beneficiaries and should do more to help low-income beneficiaries.

Fourth, Medicare must always cover a well-defined set of benefits that cannot be reduced or eliminated.

Fifth, Medicare must provide comprehensive prescription drug coverage for all its enrollees; and

Sixth, 15 percent of the budget surplus should be set aside to extend the life of the Part A Hospital Trust Fund to 2020 and to combine the Part A and Part B Trust Funds to eliminate solvency as an issue in Medicare.

I am afraid, I say to my colleague from Ohio and my other colleagues here on the Committee on Commerce, that if we look at this voucher proposal that is being put forth by the cochairs of this Medicare Commission, it does not satisfy these different enumerated guarantees or principles that we should be aspiring to. These principles will ensure Medicare is preserved and protected for the current and future generations.

I know my fellow Democrats want to accomplish that goal, and hopefully we will be able to withstand some of the efforts that are being put forward, primarily by the other side of the aisle, to change Medicare—from to what it has traditionally been: a good program, a quality program that covers all seniors.

Mr. BROWN of Ohio. I thank the gentleman from New Jersey. I want to add that the leadership of the gentleman from New Jersey (Mr. PALLONE), especially in his efforts to fight Republican efforts to privatize Medicare, have been very, very important in our so far successful efforts to do that.

One point, before calling on the gentleman from Florida (Mr. DEUTSCH), and that is that the gentleman from New Jersey (Mr. PALLONE) repeatedly has talked about the success of Medicare; that it is a program that almost no one in this country, except for some insurance company executives, some Wall Street analysts, and some Washington political pundits and their representatives in the Republican Party say that that Medicare is that broke. There are not huge demands from across the country in any of our districts clamoring for Medicare to be so radically changed.

Sure, it needs some changes; sure, it needs some fixes; but it is not a broken program. It is serving people in this country very well. And this kind of radical surgery proposed by Republicans is dead wrong.

Mr. PALLONE. If the gentleman will yield, I would like to say one more thing before he yields to another colleague.

This Sunday coming up is Mother's Day. A few years ago I was on the floor talking about Medicare at the time when there was an effort by the Republicans on the other side to try to cut back significantly on the funding. And one of my colleagues on the Republican side was talking about how his mother was frustrated and did not need Medicare because it was not a good program.

And I was shocked because, as the gentleman said, everyone that I talk to, including my own mother who is on Medicare, tells me just the opposite. They think Medicare is very valuable. What they would like to see is maybe expanded coverage.

I sort of thought it was ironic that it was close to Mother's Day, as it is again today, and we had these opposite points of view about the Medicare program. But, frankly, I get no one who suggests to me that they want to see a radical overhaul of Medicare.

One of the things I want to talk about later, after my other colleagues have spoken, is a report that just came out by OWL, I guess the Older Women's League, that talks about Medicare and women, and this was in preparation for Mother's Day. It has some significant insights into the problems that elderly women face.

Mr. BROWN of Ohio. I thank the gentleman from New Jersey, and now I want to yield to my friend, the gentleman from Florida (Mr. DEUTSCH), a prominent member of the Subcommittee on Health and Environment of the Committee on Commerce, and thank him for his help.

Mr. DEUTSCH. Mr. Speaker, I appreciate the opportunity to be here this evening and really focus in on Medicare and what it faces in the future and, in a sense, what it has done in its past.

Medicare's creation is not ancient history. We are talking about a program in effect for less than 30 years at this point in time. And the bad old days, which many people still remember, not in terms of reading about but hearing about, it almost seems like ancient history to us, of America prior to Medicare; of seniors literally across the country not having health care coverage, period. In a sense, effectively dying by not having health care coverage. That does not happen today.

In fact, Medicare, as a government program, is really government at its best; government coming in and dealing with incredibly serious problems on a societal level, on a community level in the United States of America and changing the world. That in fact is what Medicare as a program has done. Over 30 million people are presently on Medicare. It is the largest health care system in the world, and it has changed the world.

One of the things I think is interesting to reflect on, just as we are talking about this issue, is does anyone seriously believe that Medicare would have been created if my Republican colleagues were in the majority of the United States Congress? I do not think that is a serious question because I think we know the answer to it.

And, in fact, the reality of what is occurring, and we have talked about some of the battles that we have shared in fighting to save Medicare over the last several years, is that Medicare really has been and continues to be attacked. In fact, literally there is an attempt to destroy it on a continual basis.

That is what this whole voucher concept is about. And hopefully we will have a chance to really discuss it at some length this evening, but the voucher concept is an attempt to destroy Medicare. It would destroy the Medicare system because it would fundamentally alter the Medicare system.

That is the intention of the proponents of the voucher system. They are not going to come flat out and say we are proposing vouchers to destroy Medicare, but the reality of what their proposal will do is, in fact, destroy the Medicare system.

Again, I think we really need to talk about it in a detailed way so people understand what really the Republicans, in general, are talking about as their solution to destroying Medicare.

Medicare is presently a defined benefit plan. The statute specifically delineates what benefits a beneficiary, those 30 million people, get under Medicare. They get 80 percent of reasonable cost. Under Part B they get hospitalization coverage with a deductible; under Part A they get certain home health care benefits, nursing home benefits, specific benefits that are delineated under the Medicare statute.

And, in fact, we have added, occasionally. Just in the last Congress we have added some preventive coverage, and we have pushed and we have pushed. And, in fact, if anything, what we ought to be talking about is adding additional benefits. One of the issues that this Congress should address is the issue of prescription drug medication being covered under Medicare. That is a critical issue for us to pass in this Congress. It is a gap in the Medicare system that we do not provide coverage. In fact, I think we can make a very strong case that providing coverage will have a positive cost effect in terms of the Medicare Trust Fund.

But that is the present Medicare system. In fact, the way it is set up, regardless of how much hospitalization

costs, that is the coverage that a Medicare beneficiary gets. Obviously, people also have the option, in most communities in the country, most urban centers in the country, of choosing Medicare HMOs, if those are available to them.

But what is the voucher system? The voucher system is a totally different concept. It says we believe that each person should get X dollars, whatever that X dollars is, for their health care coverage under Medicare. Theoretically, someone can then take that voucher and go shopping in the private sector for health care coverage. The theory of our colleagues is that the private sector is going to do better than this present system and they are going to provide individuals with more coverage.

Do not be fooled. Because the whole concept of the voucher system, the way it has been proposed continuously, is a set amount of dollars. Now, from a strict budgeting point of view, if our only concern was outlays of dollars, then we could see supporting the voucher system. But if our concern is really impact on people's lives, we just cannot be.

But once that voucher system is set up and we pick that dollar amount, and today it might be a good dollar amount, and we can really debate that dollar amount, but what about tomorrow, and what about the next day, and what about the day after that? And the reality is that no matter what the dollar amount in the voucher is, there will be a health care provider who will bid for that service.

So the voucher today is $4,000. Next year it might be $3,500, or even next year it might be $4,000. It will be below the average cost of Medicare beneficiaries today. And there will always be a private-for-profit provider of care who will bid for that. But what we are saying, effectively, is that we are creating a two-tier health care system, because the wealthiest of the wealthy in America will not have to opt into that type of process.

What will happen is the voucher system, inevitably, from a policy perspective, will force the vast majority of Medicare beneficiaries into substandard HMOs. That is the result of the voucher system that is proposed. And that is not Medicare. That is minimalist health care. That is a tragedy of monumental proportions for this country.

I know the four of my colleagues here, and really almost everyone on our side of the aisle, will fight with our last ounce of strength, and I know the President is committed, to prevent that from happening. And I look forward to really entering into a dialogue with those of us who are here this evening and really defining this a little bit more.

I yield back to my colleague from Ohio.

Mr. BROWN of Ohio. Mr. Speaker, I want to thank my colleague from Florida, and I want to now introduce another good friend, the gentleman from Texas (Mr. GENE GREEN), who has been a member of the Subcommittee on Health and Environment for 3 years now and has done a good job.

Mr. GREEN of Texas. Mr. Speaker, I want to thank my colleague for requesting this special order. I think it is so important that we recognize the Medicare issue.

Here we have a Member from Ohio, our ranking member on our Subcommittee on Health and Environment who requested this hour, a Member from Florida, a Member from New Jersey, and myself, I am from Texas, and it shows how it is not just a regional problem.

The Medicare program has been so important since 1965, and I am glad we are taking time out at the end of the day to talk about it and to hopefully raise the level of intensity for not only senior citizens who are now Medicare beneficiaries but those of us who will grow into being Medicare beneficiaries over the next few years and realize the benefits of the current program.

My colleague, the gentleman from Florida (Mr. PETER DEUTSCH), mentioned that Medicare does not pay for everything. In fact, it does pay for 80 percent. There are a lot of things Medicare should not pay for, but it does not pay for all the things that maybe health care should. One in particular, prescription medication, has risen now to a new level of importance, because prescriptions in 1999 are such that we do provide delivery. It saves ultimately on going to the doctor or the hospital, whereas in 1965 or 1975, some of the advances in medications were not there.

So perhaps we should reflect and say, okay, let us do what we can do on prescription medications and provide some type of copay for Medicare beneficiaries and not necessarily force seniors into managed care, an HMO, simply because they are paying $300 or $400 a month for prescriptions.

In some cases in my own district I have seniors who are paying that much, and their minimum benefits on Social Security are just a little bit less than that. So thank goodness the family is still together, the husband and the wife, and maybe the wife is the minimum beneficiary and they are paying her whole Social Security check just for their prescription medication.

Medicare is such an important program. Again, it started in 1965, and I was proud that in 1965 it was Lyndon Johnson from Texas who originally proposed it, although it was not a new program. It had frankly been around since the depression, but it was enacted in 1965 as a national health care insurance program for people over 65. It was expanded in 1972 under a Republican administration to cover the disabled and the need for continuing dialysis, for permanent kidney failure, or a received kidney transplant. So over the years Medicare has been expanded to include disabilities.

The United States public and private spending on health care far exceeds that of other industrialized nations by roughly a trillion dollars. Medicare comprised 11 percent, more than $200 billion of our Federal spending, and is funded by a combination of both general funds and payroll taxes. Current workers are taxed 1.45 percent of their earnings and our employers are taxed 1.45, where the self-employed are at 2.9 percent. This tax makes up 89 percent of the income for the Medicare Trust Fund Part A. And I would challenge any other Federal program to have that kind of taxpayer supported program.

We will talk tomorrow about the supplemental defense spending, what is going on in Kosovo. I always like to give the example that if we did not appropriate $1 for the Pentagon tomorrow, we would not be able to handle our commitments to NATO or buy another missile or another tank or pay another service personnel, but the hospital portion of Medicare Part A, 89 percent is funded by the taxpayers directly.

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It does not come out of necessarily general revenue. It is for the trust fund. Medicare Part B is a split between 75 percent and 25 percent, general fund 75 percent and 25 percent from the beneficiaries. So we see that Medicare is not just general funds, it is a tax support. And that was created in the late 1980s and 1990s.

The deductible for Medicare Part A is $768 per patient for Medicare Part A. That is a deductible. So it does not pay for everything. Medicare Part B, the premium that seniors pay is $45 a month, with a $100 a year deductible. Actually, beneficiaries pay a co-pay of 20 percent of the approved amount because Medicare pays for 80 percent and that 20 percent is the responsibility of the senior citizen. They can buy them a Medigap coverage that is regulated by State insurance commissions or they can pay that 20 percent themselves.

The reason I think we are here tonight, and I do look forward to the dialogue that we have, and I could talk all evening about the benefits of the current program in the fee-for-service program, but the Medicare Commission I think had a great many shortcomings.

I do not want to take anything away from Senator BREAUX and his efforts to try and come up with a compromise. But the concern I had was the premium support proposal that they did come up with. That is not something I could vote for on the floor of this House. And I was glad that the Medicare Commission failed to get the number of votes that they needed to. It would increase premiums for millions of beneficiaries. It would cause the traditional program to rise, the premium, from 18 percent to 30 percent.

In rural districts, of course my district is very urban, but in rural areas

Medicare beneficiaries would pay differential premiums for the same traditional Medicare for the first time. And also, the premium support system, with what has happened with the managed care proposal issue now, we have managed care companies withdrawing from rural areas predominantly, so we could even see that as not as an option for rural areas in our country.

It was a lose-lose situation for urban beneficiaries because urban beneficiaries who generally have access to managed care would not be protected against the higher traditional program premiums. They would also likely pay more for private plans, such as plans that would raise premiums for beneficiaries to compensate for Government payments that do not cover the local cost.

And an unclear commitment on defined benefits. Again, we have a defined benefit program instead of a defined premium program. And again, the concern that we also hear is unfunded mandates for the States. Traditional Medicare premiums would rise under this proposal, and Medicaid cost for some States would actually go up for the low-income beneficiaries.

So that is the concern. And again, I know the Commission worked long and hard. Both Members of the House and Senate were on it, along with private citizens. But I was glad they were not able to come up with a plan because the plan they ultimately came close to was one that we would be fighting here every day to try to keep from happening.

Again, I thank the gentleman for asking for this time. Medicare is so important to not only my district and our Nation but to all our districts that we need to again continue this dialogue and raise the intensity so people know Medicare is challenged. It is in good shape until 2015 now. But it is still something we have to guard against every day to see that the reforms do not literally do what we in Texas call throw the baby out with the bath water.

Sure, we can have some reforms. But let us not lose the traditional support that Medicare has for senior citizens.

Mr. BROWN of Ohio. Mr. Speaker, I think that both the gentleman from Texas (Mr. GREEN) and the gentleman from Florida (Mr. DEUTSCH) both touched on the history of Medicare and who really was responsible for this program, and I think it begs the question of whom do we trust to make changes in Medicare?

In 1965, Medicare, with an overwhelming Democratic majority in Congress, the Congress passed the program setting up Medicare. Many Republicans opposed it. In fact, Bob Dole, who was then the leader of the other body and later was the Republican nominee for President in 1996, was in 1995 bragging to a conservative group on whom he counted for the Republican nomination for President, bragging about who he was one fighting against Medicare against its creation in 1965 as a Member of the House of Representatives at that point because he knew it would not work and he wanted to defeat it.

Literally the same day, then Speaker Gingrich said he wanted to see Medicare wither on the vine. It is the same group of people that opposed Medicare in 1965. The conservative wing of the Republican party which now dominates the Republican party are the people that really do not like Medicare.

In 1993, when Medicare was in some trouble, this Congress and I know the four of us all supported the efforts of this Congress to make some relatively minor changes in Medicare, some cuts to some providers that were probably making too much money at the time and some minor changes in the program of some significance but, by and large, did not affect Medicare beneficiaries particularly but made the program a good deal fiscally stronger in 1993. Again, every Republican in this institution voted against it then.

Then, 2 years later, Republicans tried to cut Medicare $270 billion. At the same time, they were giving a tax break mostly to wealthy taxpayers of roughly the same number of dollars and it was another assault on Medicare. And every time we turn our backs or we forget to watch or we are not vigilant, we see the conservative wing, not all Republicans, but the conservative wing of the Republican party which dominates that party in the 1990's go after Medicare.

And before we think about radical surgery on this program, the program of Medicare, we need to think whom do we trust? Do we trust the people that never liked Medicare to begin with, the far right of the Republican party? Do we trust them to make changes, the voucher program that the gentleman from Florida (Mr. DEUTSCH) talked about? Or do we trust people who supported this program, people like us that have supported it all along, mainstream Democrats, the President who supports it? Do we trust this group of people to make some minor changes to continue to keep Medicare strong?

Mr. DEUTSCH. Mr. Speaker, if the gentleman would yield, it really is a philosophical chasm between us and them in a sense, or at least part of them and most of us, that we really believe that Government can be a useful vehicle to help solve problems, to change the world; and I think, philosophically, probably maybe a majority of my colleagues on the other side of the aisle believe that Government would mess up a two-car funeral and Government should not be involved.

We can create a voucher system where effectively Government is not involved in this process even though Government is paying the money. But it is a totally different concept of the role of Government. I think none of us believe that Government can solve every problem. But I think what we do believe is that Government can be a force to literally make people's lives better.

I think part of this history discussion, for people who are watching us this evening, and if they do not know it themselves, talk to their parents or their grandparents and ask them about the time, it is only 30 years ago or a little bit over 30 years ago when Medicare did not exist in America.

I tell my colleagues, there is an analogy of it as well if we go back of when Social Security did not exist in America. I mean, it is not an accident that Social Security was created under a Democratic administration of Franklin Roosevelt.

I mean, do any of my colleagues really believe that, philosophically, that would have occurred in a Republican administration? And there is a real parallel I think in terms of that. And it is not ancient history before Social Security existed in America.

Mr. PALLONE. Mr. Speaker, will the gentleman yield?

Mr. BROWN of Ohio. I yield to the gentleman from New Jersey.

Mr. PALLONE. Mr. Speaker, I just wanted to say, I mean, I totally agree with what the gentleman from Florida (Mr. DEUTSCH) said and my colleague from Ohio (Mr. BROWN).

I think that the problem that we face with this Breaux-Thomas voucher proposal is the following: Right now, because Medicare applies to everyone over 65 and is a program that most people can rely on and is a quality program, there is substantial support for it, I think, all over the country. But, as my colleague from Ohio points out, the Republicans traditionally were not very supportive of Medicare from the beginning.

And that statement about Medicare withering on the vine that Speaker Gingrich made I think is exactly what would happen with this Breaux-Thomas voucher plan, it would wither on the vine. Because once this voucher plan went into effect, people would be paying more and getting less.

So they are going to be paying more out of pocket because they are just going to get a set amount of money which is not going to cover a lot of expenses. And as they pay more out of pocket and find that the benefits of the program, which are very vague under Breaux-Thomas so it is not clear what kind of benefits they are going to get, as they find that they are going to pay more and get less in terms of benefits or alternatively and at the same time be pushed into managed care, which they do not like or where they cannot choose their doctor or they end up getting dropped, because, as my colleagues know, in many States managed care has dropped seniors after a bit of time, they are going to become very dissatisfied with the Medicare program.

And the kind of consensus that we have now that says that this is a good quality program will disappear. And then we are going to have a race, if you will, to see what is going to replace it. And I think it, essentially, destroys the program so that people will not

have faith in it anymore. They will be looking for an alternative.

I do not want to be so cynical, because maybe I am being a little too cynical. But if we look at that whole philosophy of withering on the vine, that is essentially what would happen to this program.

The irony of it is that Breaux-Thomas does nothing to solve the long-term solvency of Medicare. I think the information we have is that it extends Medicare for 1 or 2 years, at the most.

President Clinton and the Democrats have said, we want at least 15 percent of the budget surplus to go towards extending the life of the Medicare program. The Republican leadership has refused to do that. They are not really interested in extending the life of the program. They just want to change it radically with this voucher system. And I think ultimately it would wither on the vine.

Mr. BROWN of Ohio. Mr. Speaker, I yield to my colleague from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I want to agree with my colleagues from New Jersey and from Florida.

Medicare was originally created because of the failure of the free enterprize system for insurance. If I owned an insurance company, I would not want to sell insurance to someone over 65, although we do have some who only want to take the healthiest, as we know, because we cannot afford the premiums.

Any actuary will tell us what is the quote of a premium for someone over 65, $1,500 a month, $2,000 a month, because they are ill. That is why Government had to step in, free enterprise could not take up the need for some type of health care for senior citizens.

In fact, under the current system, almost half of all seniors have an income of below $15,000 a year. Approximately 10 million widows have an income of less than $8,000 a year. So this is not a program for the rich, as we sometimes hear we have all these rich seniors.

Despite all the out-of-pocket costs that seniors already have to pay, 52 percent of Medicare's costs now go to 5 percent of the most sickest senior citizens. So we are not talking about a program for the wealthy. We are talking about a program for seniors who make less than or earn $15,000 a year under their pension plans or Social Security.

Let me talk a little bit about raising the age to 67. That may be something that the actuaries can say, well, we are living longer. I do not know if we are living that necessarily healthier longer. Because I can tell my colleagues, in my own district, again, maybe it is the difference between someone who is predominantly a white-collar worker and somebody who is a blue-collar worker, I have a very industrialized district. They load the airplanes at Intercontinental Airport. They load the ships at the Port of Houston. They work in the petrochemical facilities. Those folks cannot wait, they are just barely waiting now until they are 65 so they can get Medicare.

And also private business. If they have an early retirement and they have some type of retiree health plan, let us see what some of our large employers are going to do in the country by saying, by the way, their collective bargaining agreement is going to have to last 2 more years because once they become 65 their retiree health plan goes into Medicare.

So raising it to 67 may be great for some folks. But if my colleagues have a district where people literally work with their hands, they are not necessarily getting healthier.

Again, following my colleague from New Jersey when he said the proposed Commission plan only extended the life, at the maximum, of 2 years.

Mr. DEUTSCH. Mr. Speaker, if the gentleman would continue to yield, it is really interesting also just talking about the present situation of Medicare. I think we would agree that this is another area where benefits really should be expanded, not cut back.

I think what we really should be doing, and we have been involved in supporting legislation to this effect, although it has not passed, is giving options to buy into Medicare for that age group that my colleague from New Jersey talked about as people who retire early.

We have a phenomenon in America now that, yes, people are living longer and some working longer. But some are not working longer. And really the worst situation to be in is either by choice or by forced circumstances, maybe by health, of retiring early and not having retirement benefit of health care coverage and trying to buy private coverage in that 60-to-65 age group, where private coverage could literally be potentially 50 percent of someone's income.

□ 2145

It is an incredible box that we are in. Previously we have tried to expand that coverage, because that is another area where appropriately from what Medicare should be doing, we should be expanding the coverage to people who retire before 65, and not talking about raising the eligibility to 67.

Mr. BROWN of Ohio. If I could reclaim my time for a moment, following up on what you are saying and what the gentleman from Texas (Mr. GREEN) said about people that work with their hands, that start working, a neighbor of mine is a carpenter. He started working when he was about 18, he is about my age, in his mid 40's. He cannot quite lift as much as he used to be able to.

If we let Republicans raise the Medicare age to 67, then they will look at the actuarial tables and they will say the average person is living another year longer and raise it to 68. It is simply not fair to the large number of people in this country who do not dress like this when they come to work, whose bodies really do not allow them to work until they are 67 or 68. It really shows how out of touch people are in this institution and in this city, and especially on that side of the aisle that really do think, well, because people are living longer, we will raise the Social Security age, the Medicare age, because people are living to be 80 and they can take care of themselves.

The fact is, as the gentleman from Florida (Mr. DEUTSCH) is implying, people between the ages of 55 and 64, the age that we want to move Medicare coverage and include them, those in that age group, there are so many people in that age group that are losing their health care coverage because they are getting laid off, their company is downsizing, their company is moving to Mexico or somewhere else.

There are people that have many more health demands, many more health needs as they are 60 years old compared to when they are 50 years old. They are getting their health care cut off from their employer when they lose their job or when their employer cuts benefits when they are 59 years old, right at the time they most begin to need their health care.

For this body to endorse moving the age up to 67 is absolutely absurd. We should be thinking of moving the opposite direction, especially since the President's plan and the plan that all of us have worked on actually pays for itself in the cost of the premium between the ages of 55 and 64. It is no giveaway program, as Medicare is not, anyway. But particularly this part of it, expanding it to 55 to 64, voluntarily pays for itself and will make a difference in the lives of literally hundreds of thousands if not millions of Americans in that age group who no longer have the health insurance coverage they figured that they would have from their employer until their 65th birthday, until they could move into Medicare.

Mr. PALLONE. I totally agree with the gentleman. I think you were hinting earlier about the fact that really what this is is like a social contract. In other words, people were told when they started out working at 18 that when they got to be the age of 65, that Medicare would be there. I think it is grossly unfair after they have depended upon that to say all of a sudden now the age is going to be higher. Because we know that in fact what is happening is that many people in that near elderly group, as you mentioned, are the very ones that do not have any health care coverage.

In the beginning I talked about women, because this Older Women's League put out this report in conjunction with Mother's Day coming up this Sunday. A lot of the people that are in that near-elderly category that do not have health care coverage or insurance are women, because what happens a lot of times is that the spouse who is not

working, for example, is not covered when there is a buyout or somebody gets laid off at that age, and there is a tremendous amount of people that are in that category that are women.

The other thing I just wanted to say very briefly is that instead of worrying about the aspect of this that how we are going to make benefits less for people, as the gentleman from Florida (Mr. DEUTSCH) said, we do not want to do that. What we want to do is look at the gaps that exist in Medicare and try to fill them.

We know that when Medicare started in the 1960s, at least this is what I have been told historically, that prescription drug coverage was not that important because people did not rely on prescription drugs that much. The preventive care that comes with prescription drugs really was not available all that much. Also the long-term care, adult day care, which is another gap that Medicare does not pay for, that did not exist then because people did not live as long or they had a situation where they maybe were at home and the family would take care of them.

The reality is that the gaps in Medicare have resulted because of the changes in life-style, of people living longer. It is absurd to suggest that in order to accomplish and deal with that, you should simply raise the age. You should try to cover those gaps by providing prescription drugs, providing for long-term care, providing for adult day care.

It is particularly important for women. I do not mean to keep stressing that, but I keep thinking about the fact that Mother's Day is coming up. I think about my own mother, and the fact that there are so many women that particularly benefit from Medicare and that these gaps are particularly important to them, and raising the age even makes it worse for them.

Mr. DEUTSCH. I could not agree with the gentleman more, literally listing some of the areas where we ought to legislatively increase benefits. That is really what the debate should be about. I think this year our focus, and I think really the President's focus is really trying to get that prescription drug coverage which is a necessary component of Medicare. That is our number one priority.

I could add and agree with the gentleman on five other things that are probably just as high but I think the focus this year is trying to get that additional coverage. I think some of the things that the gentleman also mentioned, this is sort of a high class problem we have.

First of all, we have dealt with the actuarial issues and it is a good thing people are living longer. That is a high class problem that we have in America. We can deal with it, we have dealt with it, in some of the changes that we talked about in 1994. I keep thinking as we are talking, particularly in that pre-65 age group, where if we went from 65 to 67.

One of the things about health insurance is statistically people who do not have health insurance actually get sick at a higher rate than people who do have health insurance. In effect, whether you have health insurance or not, statistically you have got a chance of getting sick.

What is going to happen when you do not have health insurance? What happens in America today? What happens to real people in that category, 65, younger than 65, retired, for whatever reason, as you said, without health insurance in America? What is happening to those people? The reality is not a lot of good things, things that we know for a fact we can do better as a country.

We have made changes where we can do things. It is going to be an approach of saying, hey, here is a problem, how are we dealing with it? As my colleague from Ohio mentioned, there is a plan out there, there is legislation out there to do that without costing the system any money. That is an actuarially based system, which I think is something that people again need to hear and really need to understand.

Medicare is not welfare for health. Medicare is not a giveaway program. Medicare is a forced retirement system. It is Social Security for health. Every working American is paying into the Medicare Trust Fund today, this week, in their paycheck, a certain amount of money that is going into a trust fund that is Social Security for health.

That is what we are getting back. It is not an entitlement, it is an insurance plan. That is a big difference. It is a forced insurance plan, yes. You do not have a choice in our salaries, or working people in America in their salaries, whether to choose to pay the Medicare payroll tax or not. You have got to pay that payroll tax. But that is going into a plan that we as Americans control, this body, this Chamber and our colleagues on the other side of this building control.

I think also, just as we are coming to the close of this hour, to reiterate, is people out there in the real world, in America, who live with Medicare understand the system. With all of its faults and foibles, it is a darn good system. It is not Cadillac coverage but it is a darn good Chevy. It has worked really well for over 30 million people in this country.

It is an incredibly successful system. It has done innovative things over the last 10 years to make itself even more successful. We could talk about some of the specific changes, probably not this evening but another night, that we have done in terms of whether it is DRGs or whether it is issues regarding that which have really saved the system incredibly, tens of billions of dollars to make it even better, to provide more benefits for people.

Mr. BROWN of Ohio. The comments of the gentleman from Florida about people without insurance actually are sicker, get sicker is particularly applicable to prescription drugs. We all have heard stories in our district similar to the one in the city of Elyria in my district, a woman who is paying $400 for her prescription drugs, her Social Security is about $800 a month, she has no prescription drug coverage. What she does with her prescriptions is she typically takes half the dosage that she needs. If she is supposed to take four pills a day, she will take two or take four half pills a day so her prescription will last twice as long. She is more likely to get sick and end up back in the hospital, more likely to suffer and more likely to cost the Medicare system more money because the system is not paying for prescription drugs and not dealing with some of the preventive care and wellness care and less expensive care, like prescription drugs, than emergency room or hospital stays. That is one reason, putting even the humanitarian element aside, looking at the importance of taking care of this woman and hundreds of thousands like her around the country. The health of the Medicare system long-term will be in better fiscal shape if we can do some of these things like prescription drugs, put a better system out there for America's elderly and make it more fiscally sound at the same time.

Mr. GREEN of Texas. I know we are getting close to the end of the hour, and there are things that can be done with modernizing and making Medicare more efficient. Of course we talk about prescription medication. It can save ultimately people from going to the hospital if they can take the full dosage instead of trying to self-diagnose and lower their amount. The President's plan of dedicating 15 percent of the surplus to Medicare. Let me say, and I know the dollars and the numbers are on our side, but let us realize the humanity of it. I use this example at my town hall meetings in Houston. My dad will be 84 years old this year. I did not know his father. His father died before I was born. He is part of the success of Medicare. If we can talk about our constituents, talk about our family, and instead of looking at what we can do to say, well, how do we need to save money in Medicare, let us also look at what impact that will have on our own constituents, on our own family. By living to 84 years, that is successful. He is a product of the benefits of our system, Medicare. His father did not have Medicare when he passed away in the late 1940s. We need to remember that. The better quality of life for our senior citizens, they have paid their dues, the World War II generation that my dad is part of. Let us remember those folks, that they are the ones that this was created for. It was created for that. Let us not forget those folks that are still providing for our country, that we want to make sure that they will have Medicare and a good Medicare program when they retire.

Mr. PALLONE. I just wanted to follow up on what my colleague from

Florida said also about low-income people, low-income seniors not being aware and therefore not applying for some of the low-income protection programs like the QMB or the SLMB programs that we have. Under Medicare and Medicaid, if you are below a certain income, you can apply through Medicaid so that you actually get certain prescription drugs covered and certain other benefits covered. But one of the things that is in this Older Women's League report that I mentioned for Mother's Day is that half the elderly women who are eligible for those low-income protection programs never apply for them because they are not aware of them. And also because they do not want to go to the welfare offices where they have to go from what I understand in order to get them because they do not want to be part of a welfare program. One of the reforms that was suggested by OWL is that individuals be able to apply directly through Medicare or Social Security for those low-income protection benefits. Again that is a kind of reform that we should be looking at, something that is going to help people with prescription drugs and some of these other protections rather than worrying about how we are going to save money by raising the age of eligibility.

Mr. DEUTSCH. I just want to quickly mention, because I think what the gentleman said is really important, sort of almost as a public service announcement for whoever is watching us this evening, that there are benefits in Medicare that unfortunately not enough people take advantage of. We have put into Medicare some preventive coverage. Mammogram screening. Right now less than 50 percent of Medicare beneficiaries who are eligible for it take advantage of it. It is free, with no copayment, no deductible. We really need to push that, because that also has its positive humanitarian, human side, preventing one but also the monetary side as well.

Mr. BROWN of Ohio. Preventive care for prostate cancer, for breast cancer, for osteoporosis, for diabetes, a whole host of new preventive care programs paid for by Medicare all in the last 2 or 3 years. That is something people should certainly take advantage of.

Mr. PALLONE. Those were put in as a result or with the balanced budget process.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. OSE). The Chair would remind the Members to direct their comments to the chair and not to the members or viewing audience outside the Chamber.

Mr. BROWN of Ohio. In closing, I think, Mr. Speaker, the commitment for all of us, all four of us that have been here tonight, the gentleman from Florida (Mr. DEUTSCH), the gentleman from Texas (Mr. GREEN), the gentleman from New Jersey (Mr. PALLONE) is start with the 15 percent budget surplus, put it in Medicare, put those over the next half dozen, dozen years, hundreds of billions of dollars into Medicare. The trust fund already is solid until 2015.

□ 2200

We can even do better than that. Make sure the preventive care is explained as well as the gentleman from Florida (Mr. DEUTSCH) did, and we continue to talk about that, and expand Medicare 55 to 64, and especially programs like prescription drugs.

I thank my colleagues for joining us tonight.

DISCUSSION ON KOSOVO

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from Colorado (Mr. MCINNIS) is recognized for 60 minutes.

Mr. MCINNIS. Mr. Speaker, I would note that I will be happy to yield to the gentlewoman from the Committee on Rules when the time is appropriate.

Mr. Speaker, good evening.

I am pleased that I have an opportunity to visit with all of my colleagues this evening about an issue that is very dear to my heart, an issue that I am going to spend the next, say, 45 or 50 minutes talking to you on several different areas that I think we should review, an issue that is not only dear to my heart but dear to everybody's heart that is sitting on this floor.

As my colleagues know, I have never been at a stage in life where I had children that were of the age that could now serve in the military. My wife, Lori, and I are very privileged to have three children: Daxon, Daxon is 22 years old; Tessa, who is 21 years old; and Andrea, who is 17 years old. As my colleagues can guess, my concern today is about the military action that is being taken in that land far away called Kosovo or Yugoslavia.

I thought we would start out by covering several points. I want to give you just somewhat of a brief history, talk about what are the real interests of the United States.

At this point in time, Mr. Speaker, I would be happy, so that we could go ahead and take care of the rule, to yield to the gentlewoman for the rule.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 1664, KOSOVO AND SOUTHWEST ASIA EMERGENCY SUPPLEMENTAL APPROPRIATIONS ACT, 1999

Mrs. MYRICK, from the Committee on Rules, submitted a privileged report (Rept. No. 106–127) on the resolution (H. Res. 159) providing for consideration of the bill (H.R. 1664) making emergency supplemental appropriations for military operations, refugee relief, and humanitarian assistance relating to the conflict in Kosovo, and for military operations in Southwest Asia for the fiscal year ending September 30, 1999, and for other purposes, which was referred to the House Calendar and ordered to be printed.

Mr. MCINNIS. MR. SPEAKER, WELL, WE WILL GO BACK TO THE KOSOVO DISCUSSION, BUT I DO, FIRST OF ALL, WANT TO ACKNOWLEDGE THE COMMITTEE ON RULES.

As my colleagues can see, it is after 10 o'clock at night back here in the East, and that Committee on Rules is still working hard. They put in a lot of late hours, and I know they are appreciated by the Members on this floor.

Let us go back to my outline about what I am going to discuss this evening on Kosovo and Yugoslavia.

First of all, we are going to talk a little on the brief history, just give you summary.

I am not a historian, I am not a teacher or a professor, so I am not going to go into great detail, but I do want to summarize kind of the scenario or the historical perspective that I think is important for me to get to the other points of this speech. We are going to talk about what are the interests of the United States.

As my colleagues know, before the United States enters any type of military action, we need to define, we need to have a clear interpretation and a clear definition of why it is that we are doing what we are doing, what is it about the authority. Do you have the authority to invade the sovereign territory of another country? Under what conditions does that authority exist, and do we meet those conditions?

Talk about what the European responsibility is in this situation, what the cost is to the American taxpayers, and I think you will be surprised by the numbers that I give you this evening as to what it is going to cost the American taxpayers to complete this action over the next 2 to 3 years.

We should talk about the humanitarian effort. Clearly, no matter where you fall on the side of the policy that is now being followed by this country in regards to Kosovo, we can all agree on one thing, and that is that there is a just cause for a humanitarian effort. We will talk a little bit about the humanitarian effort.

We will also talk about the deployment of ground troops. I have read the press lately, I have read and been briefed and so on that there is an urge to put ground troops in over there. Let us talk a little about that this evening.

What are the logistics involved? What do ground troops really mean? What kind of numbers of ground troops are we going to have to have to go into this situation, not just to keep the peace, but do we ever stand a chance of making the peace? And tonight my colleagues will see that I distinguish between keeping the peace and making the peace.

We will talk a little bit about NATO, what the military facts are of NATO,