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Senate

The Senate met at 9:32 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:

Almighty God, we cannot begin this day in the forward march of history without You. It is with Your permission that we are alive, by Your grace that we have been prepared for our work, by Your appointment that we are here, and by Your blessing that we are secure in Your gifts and the talents You have given us. Renew our bodies with health and strength to be the sedan chairs for our thinking brains. Open our inner eyes so that we can see things and people with Your perspective. Teach us new truth today. May we never be content with what we have learned or think we know. Set us free to soar with wings of joy and light. We trade in the spirit of self-importance for the spirit of self-sacrifice, the need to appear great for the desire to make others great, the worry over our place in history with the certainty of Your place in our hearts. Restore the continuous flow of Your spirit through us as a mighty river.

We thank You for the gift of this new day to work for Your glory and the good of America. You are our Lord and Saviour. Amen.

PLEDGE OF ALLEGIANCE

The Honorable RICK SANTORUM, a Senator from the State of Pennsylvania, led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation, under God, indivisible, with liberty and justice for all.

SCHEDULE

Mr. LOTT. Mr. President, today the Senate will be in a period of Morning Business until 11:30 a.m. Following Morning Business, the Senate will resume the final debate on the conference report to accompany H.R. 4516, the Legislative Branch Appropriations Bill. A vote on final passage of the Conference Report is expected to occur at approximately 3:30 p.m. After the vote, it is hoped that the Senate can begin consideration of the Water Resources Development Act under a time agreement. Therefore, Senators can expect votes throughout this afternoon's session.

I thank my colleagues for their attention.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER (Mr. SANTORUM). Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The PRESIDING OFFICER. Under the previous order, there will now be a period for the transaction of morning business, not to extend beyond the hour of 11:30, with Senators permitted to speak therein for up to 5 minutes.

Under the previous order, the Senator from Texas, Mr. GRAMM, is recognized to speak for up to 30 minutes.

MEDICARE

Mr. GRAMM. Mr. President, I thank the leader for allowing me the opportunity this morning to talk about Medicare and about pharmaceutical benefits.

I will talk about these issues, recognizing two things: One, that Medicare is second only to Social Security as the most important government program in operation today; and two, recognizing that in 1965, when Medicare came into existence and it was focused primarily on hospital care, physician care, and surgery, that reflected the practice of modern medicine in 1965. Today, Medicare is still focused on 1965 medicine. However, pharmaceuticals have taken the place, in many cases, of hospital stays and surgery, and yet Medicare does not pay for pharmaceuticals.

What I will address is the cold reality of where we are, what we want to do, but the dangers we face if we do it wrong. I view this as a statement on the problems we face in trying to provide pharmaceuticals in Medicare.

I hope to do this with a series of charts. I begin with the good news. The good news—the glorious news—is that 68.8 percent of all Medicare recipients already have some form of prescription drug coverage—68.8 percent. That level of coverage is a level of coverage virtually unmatched in terms of the structure of private health insurance. What it means is that almost 69 percent of people in America already have some form of pharmaceutical coverage when they are under Medicare.

Obviously, what this says is, whatever we do, we don't want to do anything that imperils the 69 percent of people who already have pharmaceutical coverage in our effort to try to provide it to the 31 percent of people who don't.

Where does this coverage come from? If we look at this chart, we can see that 44.6 percent of the people who have pharmaceutical coverage in Medicare are getting it through their employer. This is part of the benefit for which they worked a lifetime. They are getting it through an employer-sponsored program. Obviously, we don't want to do anything to induce employers to drop that coverage, nor do we want to do anything to substitute taxpayer money for the private money that is currently going into private health insurance to cover our seniors for pharmaceutical coverage.

There are 15.2 percent of those who have pharmaceutical coverage who get it from Medicaid; 11.9 percent get it from HMOs as part of Medicare; 10.6

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

percent who switched coverage during the last year and went from one form of coverage to another, so they are not counted as being in one category for the year that they had it. Then finally, 15.2 percent get pharmaceutical coverage through Medigap policies. That is the way my momma, for example, gets her pharmaceutical coverage—through a Medigap policy.

What is the point of all this? What does this mean? Why should anybody care about this?

The point is, 69 percent of Americans already have something we want to provide to 31 percent of Americans. We want to be very sure—we might even have a bipartisan agreement on this at some point—we want to be very sure we don't do anything, in trying to help the 31 percent, that could endanger, destroy, eliminate, or replace the coverage that 69 percent of those on Medicare already have.

What is it going to cost for the various plans that have been proposed? My colleagues will remember—I am sure the Presiding Officer remembers—that when Lyndon Johnson sold the Senate on passing Medicare, it was going to cost less than $1 billion a year. Medicare has now become the second largest program in America. It is on its way to becoming the most expensive program in the history of America or the history of the world. The point being, we don't always have the ability to predict what costs are going to be.

Nothing shows this more clearly than the official estimates that have been made of the Clinton-Gore drug plan. When they first introduced their plan, the Office of Management and Budget estimated that the plan would cost $118.8 billion over the first 10 years.

By April of that year, the official estimate from CBO was $149.3 billion. By May, the estimate by the Congressional Budget Office had risen to $160 billion. By July, the estimate from CBO had risen to $337.7 billion.

The point is, what happened to the program between the first estimate made when it was proposed and July? Well, the program was never implemented. What happened is—the President made some changes in it, but what really happened is people started looking deeper and deeper into the program.

The plain truth is, we don't know what the actual cost is going to be. But we know if you are going to have the federal government take over and basically federalize pharmaceuticals so that you are going to have the taxpayer paying for benefits, when currently 44.6 percent of the people who have pharmaceutical coverage are getting it from their former employer—when you have the government take it over and pay for not just the 31 percent who don't have it but for the 69 percent who do, obviously it is going to cost a lot of money.

Secondly, remember that the level of usage clearly is affected by who pays. There are many different figures you can use, but let me just use one figure. For those on Medicare who do not have third party coverage for pharmaceuticals—that is, they don't have somebody else paying their pharmaceutical bills in total or in part—they are spending, on average, less than $400 a year. But for Medicaid beneficiaries where the federal government is paying for all of their pharmaceutical bills, they are spending over $700 a year.

Now some people would say, you either need pharmaceuticals or you don't. The point is, as is true in anything, it makes a difference whether there are copayments, whether there are deductibles, and who is paying. The point this chart makes very clearly is that we have already seen, in one year, the estimated cost of the Clinton-Gore drug plan rise from $118.8 billion to $337.7 billion, and it is not implemented. The point is, we really don't have any idea about how much it is going to cost. As costs go up, what happens? As costs go up, first premiums go up, and then there is political resistance to premiums.

What happened in England with a program similar to the Clinton-Gore plan? What happened in Canada? What happened in Germany? As costs rise, with political pressure to keep premiums down, what happens? In every country in the world that has adopted a one-size-fits-all government program, one thing has happened—and it is not as if it were different in Germany from in Britain, or different in Britain from in Canada. One thing has always happened: When you have a one-size-fits-all government program and costs explode, they ration health care.

Great Britain is a good example. They delay the implementation of new drugs until the cost of those drugs comes down. That may make sense in controlling government costs, but if your mama is sick or your baby is dying, that is rationing health care. And every country in the world, to try to deal with this exact problem of exploding costs, when they have the government take over with a one-size-fits-all program, they end up rationing pharmaceuticals.

So we have people in the Senate who stand up and say that in Great Britain you can get X drug cheaper. What they don't explain is that it wasn't introduced for 2 years because of the cost, because it was rationed by the government. That is something we have to be concerned about because nobody in America wants to be in a situation where, when their mama is sick, they end up talking to some bureaucrat about cost instead of to a doctor about health care.

This is the greatest dilemma we face in doing something about pharmaceuticals. This is not a problem of anything other than arithmetic. Today, half of the people who receive Medicare spend less than $500 annually on prescription drugs. That is a fact. When people hear on television that we are debating having the government set up a program to pay for their pharmaceuticals, they think we are talking about the government paying for their pharmaceuticals. But the plain truth is—as anybody who has actually looked at the plan that has been proposed by Clinton and Gore knows—the first thing they discover is that when it is fully implemented, you are going to have to pay $662.40 in annual premiums for a plan that pays for half of your pharmaceuticals up to, ultimately, $5,000.

Here is the point. Half of all of the seniors are in the position today where their pharmaceutical bills are $500 or less. If we implement a program that has the government take over prescription drugs so that we don't have 68.8 percent of people covered by other health insurance, as we have today, but we have everybody in a government-run program, the premium cost of this is very high. And remember, this is based on a cost estimate which, if we know anything about these programs, is a gross underestimation. The annual premium cost is $662.40, and for that the government pays half of your pharmaceutical costs.

So here is the point. If the government is paying half of a Medicare beneficiaries prescription drug costs, most Medicare beneficiaries are going to get out of this program less than $250 of benefits, but they are going to pay $662.40 in premiums just to be in the program.

Now how many seniors understand that half of them are going to get $250 or less worth of benefits, but are going to end up paying $662.40 a year in premiums? What kind of bargain is it to pay $662.40 to get a benefit worth $250 or less? It is a very bad bargain, which explains why it is mandatory—why either you have to take it the first day you are eligible or you can never get into the program. They have to find ways of forcing people into this bad deal because they are not content to try to help the 31 percent of the people who don't have the insurance. They are trying to force everybody into one program run by the government, of course; and in doing so, for every one person to whom you provide new coverage, you in essence take away coverage that two people already have, which is not funded by the government.

That is why these cost estimates on a one-size-fits-all government-run program are so cataclysmic and why, if you ask people, Do you want government to provide pharmaceutical coverage in Medicare? the vast majority of people say yes. But when you explain to them that half of the people on Medicare today spend less than $500 on prescription drugs and, when the program is fully implemented, the annual premium is going to be $662.40 that will pay for only half of your pharmaceuticals up to the point you spend $5,000, people will look and see that half the people are getting $250 in benefits, and they are spending $662.40 initially when the program is fully implemented and see it isn't a good deal. But

does anybody doubt the program will be at least twice that when it is ultimately in place? I don't think so.

In this political environment we are in, people are always talking about risky schemes. We have all heard it. It is amazing to me that people will talk about spending trillions of dollars, but if you want to give half that amount in tax cuts, it is a risky scheme—spending it is not risky, but giving it back to working families is risky.

Let me talk about how risky this government takeover of the pharmaceutical benefits in America for seniors is. The Clinton-Gore plan is back-end loaded. What do I mean by that? I mean that the first year it is very cheap because it doesn't even go into effect for 2 years from now. Then it becomes very expensive. The first year of the program advertises that it will cost only $13.5 billion. When the program is fully implemented, it costs $59.7 billion, or almost $60 billion a year. When we run this out over a 10-year period and we look at the estimates that are being made when fully implemented, whereas the initial estimate by the Office of Management and Budget was the program would cost $118.8 billion, when we take its cost at full implementation and what we already know, its actual cost is $597 billion over 10 years.

How are we going to make up this difference? Britain has a government-run benefit on pharmaceuticals. Germany has one. Canada has one. How did they make it up? They made it up by raising the premiums initially, and when political resistance occurred, they start rationing health care. That is what we would be buying into here.

There is one other difference, and this is from the Congressional Budget Office ''Analysis of the Health Insurance Initiatives in the Mid-Session Review'' that they published on July 18. I urge my colleagues to look at it. They analyzed the Clinton-Gore drug plan. Most people are obviously focused on, what is it going to cost? The Congressional Budget Office, the nonpartisan budgeting arm of Congress, finds that not only is it going to cost a tremendous amount more than what is being claimed, but equally disturbing to me is this quote:

> The Congressional Budget Office estimates that after 10 years, the average price of drugs consumed by the Medicare beneficiaries would be 8 percent higher if the President's proposal was enacted.

In other words, not only will taking over pharmaceutical coverage for all Medicare beneficiaries, when only 31 percent don't have it, cost a tremendous amount of money, but it will drive up the cost of pharmaceuticals to everyone. This is not just to seniors, this is to everyone.

What is the alternative? Interestingly enough, the best alternative is a bipartisan proposal from a bipartisan commission that was led by Senator BREAUX, a Democrat, from Louisiana.

I have a very revealing chart. I will give Michael Solon on my staff credit for this. I think this is one chart that tells a very important story. Here is what it is based on. The question it asks is the following: If you left everything exactly as it is, and you held the growth of government discretionary programs to the budget, how long could the government pay Medicare and Social Security benefits as they are currently promised? In other words, when would the government run out of money to pay for Medicare and Social Security benefits under the best of circumstances?

He finds, under the current system, the federal government would run out of money in the year 2027. If we don't spend the money or use it for anything else, we keep spending in real terms where it is, and we use all the money in the budget to fund just Social Security and Medicare, the federal governments runs out of money in 2027. That means everybody 40 and over would, for all practical purposes, be covered, but everybody under 40 would be vulnerable to the federal government's inability to pay Medicare and Social Security benefits.

If you adopted the Clinton-Gore plan, what you would do is, by driving up costs, move this doomsday or day of reckoning—whatever you want to call it—from 2027 to 2022, which means that only people 44 and above would have their Medicare and Social Security benefits secured. Stated another way, 17 million people who are between 40 and 44—those 17 million middle-aged people in that 4-year bracket—would have their Medicare benefit and their Social Security benefit imperiled by the adoption of the Clinton-Gore plan.

What is the alternative? The alternative is a bipartisan proposal. The estimates that were done of the bipartisan commission—and I remind my colleagues, people were appointed by the Speaker and the minority leader, by the majority leader and by the minority leader, and by the President—they put together a proposal that a majority supported. But because all of President Clinton's appointees voted against the final package, it did not get the supermajority needed to make a formal recommendation.

However, the majority supported the Breaux proposal. The Breaux proposal basically reformed Medicare and provided pharmaceutical benefits to the 31 percent of the people, or most of them, who don't have Medicare, don't have coverage for pharmaceutical benefits. The important thing was that the reform of Medicare contained in the Breaux commission report—by reforming Medicare, extended its lifetime from 2027 to 2059, which would mean anybody over 8 years old would have their benefits guaranteed if we adopted the bipartisan Breaux commission report.

What is the point of this speech? The whole point of this is the following, and I think these points were very important and I want to just run through them real quickly. Point one, you have 69 percent of all seniors who have some pharmaceutical coverage already. Why would you want to have the government come in and pay for that, especially when 44 percent of them are having it paid for by their former employers? That doesn't make any sense.

The only case in which you would want to do that is if you had some political agenda that said we ought to have a government-run health care system. I submit, based on the record of this administration, when they tried in 1993 and 1994 to have the government take over and run the health care system, that is exactly what their agenda is. But, notice—and this is easy to explain—if you have a problem with 31 percent of the people but you have 69 percent who already have a benefit, don't tear up what they have trying to help the people who need it. That is the first point.

The second point is that when you try to have a program that covers everybody, and you start substituting government dollars, tax dollars for other health insurance that 69 percent of the people already have, you are forced into a system where most seniors will not benefit.

As I explained earlier, today over half of all Medicare beneficiaries spend less than $500 a year on prescription drugs. Yet under this one-size-fits-all, government-runs-it, government-controls-it plan that has been proposed by the President and endorsed by the Vice President, when that plan is phased in, in order to get coverage where the government will pay half of your prescription costs up to you spending $5,000, it costs you $662.40 a year in premiums. But half of all Medicare beneficiaries would only get benefits of $250 or less. Needless to say, when you say to seniors, ''We have a great deal for you, we are going to give you a benefit for $662 a year that half of you will find to be worth less than $250 in any given year,'' they are not excited about it. So how do you deal with that?

You deal with that by trying to mislead people about what it is going to cost. You don't phase in the whole program. You don't even start the program for 2 years, so, boy, it is cheap for the first 2 years because you don't have a program. Then you phase it in.

The point is, when you do that, you start out cheap—$13.5 billion. But when you get it fully phased in, even based on the estimates of the Congressional Budget Office—and we know the real costs will be higher—you are already up to about $60 billion a year when you get it fully implemented.

Obviously, anybody who is trying to be critical of what is being proposed has the obligation to propose an alternative. Fortunately, as a member of the Medicare Commission with Senator BREAUX and Senator KERREY—the two Democrat members who worked on the majority position—there was a proposal made. That proposal was a comprehensive reform of the system.

That comprehensive reform, which provided pharmaceuticals for moderate-income people but let the 69 percent of the people who already had pharmaceutical coverage keep it, didn't substitute tax dollars for General Motors' money on retirement health care. What happened was, whereas the Clinton-Gore plan would actually endanger the Medicare and Social Security benefits of people between the ages of 40 and 44 by driving up costs and by forcing those systems into insolvency or into fee increases or into tax increases sooner, the bipartisan proposal of the Breaux commission would have actually expanded the life of Medicare to 2059. That would mean everybody 8 years old and older would be protected. It would give us an opportunity to further refine the system.

I thank my colleagues for giving me this opportunity. These are important issues. They deserve prayerful consideration. I urge my colleagues to look at them before we change Medicare.

I yield the floor.

The PRESIDING OFFICER (Mr. L. CHAFEE). The Senator from Alabama.

Mr. SESSIONS. Mr. President, I thank the Senator from Texas for his insight and leadership and expertise and courage and ability to explain, in common language, some of our most complex financial issues facing this country. It is an extraordinarily valuable asset to our country, to have Senator GRAMM in this body as a trained economist. I never cease to be amazed and appreciative of what he contributes.

PROTECTING ALABAMA HOSPITALS

Mr. SESSIONS. Mr. President, today I want to talk about the situation involving hospitals in America. We passed the Balanced Budget Act in 1997. It was an agreement, not only of this Congress, but of the President. It was to be administered by the executive branch agency called HCFA. We projected a number of reductions and savings that would occur as a result of our efforts to balance the budget, to curtail double-digit increases in health care, and to make hospitals really force some cost containment in the escalating cost of health care in America.

I believe in that, and I support that. I think that, in part, it has been successful. Experts projected savings over this period of time would have been $115 billion. We now see that savings to Medicare will be closer to $250 billion. In other words, the savings that have come out of Medicare and Medicaid reimbursements to hospitals that are taking care of indigent patients whether they get paid or not have had an impact far in excess of what we anticipated when we passed the BBA.

I have traveled to about eight different hospitals in the last several months in my State. I met with groups of administrators from these hospitals. I talked to nurses, administrators, practitioners and accountants in the hospitals, and I believe that they are not crying wolf, but that their concerns are real. I believe there is a problem there.

I would like to share with the Members of this body some of my concerns about it and say we are going to need to improve and find some additional funding that will help those hospitals.

In Alabama, when we passed the Balanced Budget Act of 1997, Alabama's hospitals' bottom line already was significantly less than that of other hospitals in the country. That year, Alabama had an average operating margin of 2 percent, whereas the average operating margin for 1997 was 16 percent. Aside from lower operating margins, the State also has special health needs. When compared with other States, Alabama's health care market had a higher than average percentage of Medicare and Medicaid and uninsured residents. In 1998, the State's Medicare enrollees made up 15.4 percent of the population and Medicaid residents made up 15.3 percent, both above the national average of 14.1 percent. So when those reimbursements were reduced, Alabama felt it more severely than most States.

One significant part of the BBA that has been especially damaging to our Nation's hospitals is the lack of a market basket update. The market basket is Medicare's measure of inflation. It is an inflation index. It is essentially a cost-of-living adjustment for hospitals. Without an accurate inflationary update, or market basket update, Medicare payments for a hospital's inpatient perspective payment system—the way we pay them—are inadequate and do not reflect inflation or the increased demands of regulations, new technologies, and a growing Medicare population.

As part of the Balanced Budget Act of 1997, which was passed to address the double-digit growth in Medicare spending, updates in the market basket were frozen. But by freezing the updates, mathematically this effectively created negative update factors.

For example, in 1998, the market basket update was 0.1 percent; for 1999, it was a minus 1.9 percent; for fiscal year 2000, it was minus 1.8 percent; for 2001, it is scheduled to be minus 1.1 percent; for 2002, minus 1.1 percent. So, in effect, we not only have frozen the inflation increase over all these years, we have created mathematically a reduction in the funding.

From 1998 to 2000, hospital inflation rates rose 8.2 percent, while Medicare payments for inpatient care rose 1.6 percent. You can do that for a while. We can create some savings, but at some point you begin to cut access to essential health care, making health care in hospitals more difficult less personnel and decreased resources.

Overall, the BBA will result in a reduction of Medicare payments for hospital inpatient care by an estimated $46.3 billion over 10 years. This decrease in payments has been compounded by other increased costs such as the rapid increase in the cost of prescription drugs. We all know the rising costs of health care, particularly drug costs. Hospitals feel this crunch as well.

Cherokee Baptist Medical Center and Bessemer Northside Community Clinic in Alabama are two facilities that have been hurt. For example, Cherokee Baptist Medical Center has estimated that the 5-year impact of BBA implementation for years 1998 through 2002 will create a loss of $3.7 million for this small rural hospital. That is real money in a real community—$3.7 million. The hospital's operating margin fell from 4.5 percent in 1997 to 2.2 percent in 1999.

While Medicare inpatient admissions remain the same, the revenue they have received from them has dropped from $3.5 million to $2.9 million. That is a loss of over $600,000 for the hospital alone.

Bessemer Northside Community Clinic opened in 1997 in an attempt to deal with a specific community need. The community needed convenient care for its elder and uninsured. Bessemer opened to fill that need. But due to reductions in Medicare reimbursements, they lost approximately $3 million in 1999, and were projected to lose $4 million in 2000.

This clinic served about 2,000 low-income and elderly patients in its first year, and was expected to serve 200,000 as part of a regional health network. Now it has closed its doors.

What we need to do: Last year we passed the Balanced Budget Refinement Act. The truth is, it will really come into effect this year. The hospitals will begin to feel its impact in 2001. Some may think we did not do anything last year. We did, but it was phased in, and the real impact is just now beginning to be felt. It is a good start. But it is not enough. Now we need to deal with the market basket update reduction projection of 1.1 percent, again, for 2001 and 2002. We need to restore the full inflationary update. The Alabama Hospital Association as well as the American Hospital Association have identified this as one of their top priorities.

The American Hospital Preservation Act, which was introduced by Senator HUTCHISON and cosponsored by myself and 58 other Senators, should be included in this year's Medicare provider give-back legislation that is now being considered in this Congress.

Now I will talk about the wage index and how that affects a hospital in Stringfellow, AL. This is a chart that gives a clear indication of what this hospital receives compared to the national average.

For the national hospital average, this chart shows a per patient/diagnosis reimbursement rate for labor of $2,760; $1,128 for nonlabor reimbursements. That is what our national hospital average reimbursement rate