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

looks like for per patient diagnoses for inpatient care, totaling $3,888.

But Medicare/Medicaid reimbursements for Stringfellow Memorial Hospital in Anniston, Alabama—because of lower labor costs and a higher percentage of non-labor costs are calculated by HCFA with a complicated formula that does it—is only reimbursed $2,042 for labor. This means that this rural Alabama hospital is being reimbursed $718 less per patient diagnosis. That is money not going to Stringfellow Hospital. That is money not going to that hospital. And the nonlabor costs are the same. So they are feeling a loss of $718 out of the $3,888 average cost for care compared to the national average.

Make no mistake, there are other hospitals well above the national average. Where rural Alabama hospitals lose $718 per patient, these hospitals may make $1,500 per patient diagnosis.

The nonlabor-labor split also assumes that hospitals purchase outside services from within their region, when in fact, most rural hospitals must purchase services from urban areas—which have must higher wages. In rural Alabama, much of a hospital's services often have to come from Birmingham, the University of Alabama Medical Center, and all the first-rate quality care there. It may have to be transported out to the local hospitals at greater cost than it would be in Birmingham or any other regional medical center.

According to a recent study by Deloitte Consulting, approximately 70 percent of Alabama's hospitals will be operating in the red in 2000 and as many as 14 are likely to close—unless something is done.

The reductions which have resulted from HCFA's implementation of the BBA, have affected Alabama hospitals in many ways. The reductions have hurt hospitals, both big and small, urban and rural. They have been forced to limit access, cut off services, downsize, and in some instances, close their doors.

Shelby Baptist Medical Center in Alabaster, Alabama was forced to close its inmate/juvenile detention medical clinic, close their occupational medicine clinic, close a pediatric clinic, downsize psychiatric services, close physician services to new patients, and decrease the number of health screenings for early detection of disease. They have had to place a hold on all capital projects including a women's services clinic, an additional lab, and the expansion of diagnostic services to the surrounding communities. They have also had to end the development of an ''Open Access Clinic'' to help deal with the area's numerous uninsured and under-insured patients.

Likewise, the net income of Coffee Health Group in Lauderdale, Colbert and Franklin Counties in Alabama dropped from $38.3 million in 1997 to a projected negative $13.6 million in 2000. The hospitals' operating margin—the pre-tax profits which are the major source of a hospital's cash flow—dropped from $19.6 million in 1997 to a projected negative $21.5 million in 2000.

Market basket update: One significant part of the BBA that has been especially detrimental to our nation's hospitals is the lack of a Market Basket Update. The Market Basket is Medicare's measure of inflation. 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 are inadequate and do not reflect 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 a looming health care crisis: double-digit growth in Medicare spending, updates in the Market Basket were frozen. By freezing the updates, the BBA effectively created negative update factors: For fiscal year 1998, the market basket update was −0.1 percent, for fiscal year 1999, the update was −1.9 percent, for fiscal year 2000, the update was −1.8 percent, for fiscal year 2001, the update is scheduled to be −1.1 percent, and for fiscal year 2002, the update is scheduled to be −1.1 percent.

Between 1998 and 2000 hospital inflation rates rose 8.2 percent while Medicare payments for hospital inpatient care rose 1.6 percent. 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 a rapid increase in the cost of prescription drugs and the price of blood and blood products. We all know of the rising costs of health care—most especially in drug costs. Hospitals feel this crunch as well. While the average costs of ''existing drugs'' or those that came to the market before 1992, is $30.47, the average price of new prescription drugs is $71.49—more than twice that of existing drugs.

Cherokee Baptist Medical Center and Bessemer Northside Community Clinic in Alabama are 2 facilities that have been affected by the BBA and provide disheartening real-life examples.

Cherokee Baptist Medical Center has estimated that the five-year impact of BBA implementation for fiscal years 1998 through 2002 will create a loss of $3.7 million. The hospital's operating margin fell from 4.5 percent in 1997 to 2.2 percent in 1999. And while Medicare inpatient admissions remained the same, the revenue dropped from $3,512,910 to $2,909,666. That's a loss of over $600,000 for this hospital alone.

Bessemer Northside Community Clinic opened in October of 1997 (about the same time the BBA was passed) in coordination with the community and in response to a specific need. The community needed convenient care for its elderly and uninsured. Bessemer opened to fill that need, but due to reductions in Medicare reimbursement that came as a result of the implementation of the BBA, Bessemer lost approximately $3 million in 1999 and was projected to lose about $4 million in 2000. This clinic served about 2,000 low income and elderly patients its first year and was expected to serve over 200,000 as part of a regional health network. It provided more than $4 million in free medical care to Northside residents since the clinic opened. Now, due to the drastic reductions in reimbursement, Bessemer has closed its doors, leaving the community's elderly to travel long distances for care, or in many cases to go without.

Last year Congress passed the Balanced Budget Refinement Act (BBRA) in 1999 to address some of the concerns we had about the affects of the implementation of the BBA. One provision in this legislation allows Sole Community Hospitals—those hospitals that are the only access to health care in an area—to receive a full Market Basket Update in fiscal year 2001. That's a good start, but it's not enough. Now we need to strike the BBA-mandated Market Basket reduction of 1.1 percent for fiscal year 2001 and 2002 and restore a full inflationary update. The Alabama Hospital Association as well as the American Hospital Association have identified this as one of their top priorities, and it is what the American Hospital Preservation Act of 1999 does. This bill which was introduced by my colleague Senator HUTCHISON and cosponsored by myself and 58 other Senators, should be included in this year's Medicare provider give-back legislation to address the continuing needs of our Medicare providers.

Wage index: Mr. President, another Medicare reimbursement issue which needs to be addressed in any upcoming Medicare provider give-back legislation is a needed adjustment to the Wage Index.

Medicare reimbursement for hospital inpatient care is based on a Perspective Payment System (PPS) which was created in the early 1990's to cut Medicare spending. A formula within the PPS is used to adjust Medicare payments to a hospital based on a Wage Index—or the average wage for a particular area. The formula is based on 2 components: labor-related and non labor-related costs. While non labor-related costs are the same nationwide—these are costs for supplies, pharmaceuticals, equipment, etc—labor-related costs differ from region to region and there are large discrepancies between the labor costs in urban and rural areas. The cost of living is lower in rural areas, so they pay, on average, lower wages. The adjustment made for these regional differences is made according to the Wage Index.

The national wage index is 1, but most rural hospitals have a wage index of 0.74 and most hospitals in Alabama have a wage index between 0.74 and 0.89, which is 0.11 to 0.26 below the national average. This index which is used to calculate the base rate for

Medicare reimbursement, has several inequities:

For example:

Adding additional lower paid employees lowers your wage index.

Hiring 2 lower paid employees to do the job of one higher paid employee lowers your wage index.

Increasing wages has no impact on the wage index for 3 years.

Having no corporate overhead from a large proprietary entity lowers your wage index.

When developing the Wage Index mechanism, HCFA decided that 71 percent of a hospital's costs were labor related. This rate also includes a predominant shift to labor-related costs due to purchases of outside services which incorrectly assumes that hospitals purchase services only from within their region and thus pay similar wages for these outside services. In reality, rural hospitals usually purchase services from urban areas and must pay urban wages for these services. However, the purchase of outside services from urban areas which may have a greater labor cost is not reconciled with the prevailing wage rate within the rural area. Hence, rural hospitals are paying urban rates for those services but are not being reimbursed at their urban wage rate. The average percentage of hospital expenditures in Alabama that are labor related is 51 percent—far from the 71 percent used by HCFA. And the annual impact of these formula problems result in a reduction of Alabama hospital payments by HCFA by between 5.5 and 6.5 percent or close to $46 million a year.

To illustrate the unfairness of the Wage Index formula, you must see the differences in the calculation of the base rate for reimbursement using the Wage Index for both the national average and for a typical Alabama hospital.

National Average:

Take the initial national base rate for a per patient diagnosis of $3,888.

Multiply it by the national average for percentage of wages to all other costs (71 percent) = $2760.

Remaining $1128 is non-labor costs.

Apply National Average Wage Index (1) to wage cost of $2760 = $2760.

Add $2760 to the non-labor portion, $1128, to get a total payment of $3888. This is the base rate for Medicare reimbursement per Medicare patient diagnosis.

Compare that to: Stringfellow Memorial Hospital in Anniston, AL:

Take the initial national base rate for a per patient diagnosis of $3,888.

Multiply it by the national average for percentage of wages to all other costs (71 percent) = $2760.

Remaining $1128 is non-labor costs.

Now here's the problem. Instead of applying the national average wage index of 1, for this Alabama hospital, we would use the Montgomery wage index of 0.74.

So, apply the local wage index of (0.74) to wage cost of $2760 = $2042.

Add $2042 to the non-labor portion, $1128, to get a total payment of $3170.

Therefore the base rate for per patient diagnosis at Stringfellow Memorial Hospital is $718 less than the national average. That's nearly 20 percent below the national average.

HCFA has recognized the problem and has addressed it in other areas. In developing the formula for the new Outpatient Perspective Payment System (PPS), which was required by the BBA of 1997, HCFA set the labor component of hospital costs at 60 percent (as compared to the 71 percent in the Inpatient PPS). According to HCFA, in the development of this new Outpatient formula, 60 percent represents the average split of labor and non labor-related costs.

Why then has HCFA not changed the Inpatient PPS formula? Why do we have to do it legislatively?

Senator GRASSLEY has proposed legislation that would correct the faulty wage index formula. His plan would mandate that HCFA apply the wage index adjustment only to each hospital's actual labor costs. This proposal, though it has not been scored, would cost approximately $230 million the first year.

While I support this proposal, I am also sympathetic to my colleagues whose states are not detrimentally affected by the wage index. For that reason, I would also support other possible solutions to the Wage Index issue.

There are 2 possible options:

(1) We can develop a Wage Index ''Floor,'' possibly set at 0.85 or 0.9. Thus there would be no effect (positive or negative) on hospitals with Wage Indeces above that level.

(2) We can establish a hold-harmless provision and apply the Wage Index adjustment to the share of hospital costs that are actually wage related (51 percent for Alabama), but only for hospitals with a Wage Index below 1.

The bottom line is that something must be done before the reductions in the BBA threaten the access to and quality of health care for our nation's seniors and uninsured. This government must not create a situation in which many of these needed hospitals have to close. We must act quickly or closures will occur.

I would like to thank the Chairman of the Senate Finance Committee, Chairman ROTH, for his efforts to address these concerns, and I look forward to working with him and the members of the Senate Finance Committee as well as the Senate Leadership to get this done.

It is time for this Congress to deal with the unfair wage index and improve it and take a step in the right direction. It is hurting our hospitals in rural America. It is really hurting them in Alabama where 70 percent are operating in the red and as many as 14 might close.

MARSHALL SPACE FLIGHT CENTER'S 40TH ANNIVERSARY

Mr. SESSIONS. Mr. President, today we are celebrating the accomplishments of the men and women of the Marshall Space Flight Center in Huntsville, AL, on the occasion of their 40th anniversary which will be celebrated tomorrow.

In September of 1960, President Dwight Eisenhower dedicated the Marshall Space Flight Center, which soon began making history under the leadership of Dr. Wernher von Braun. From the Mercury-Redstone vehicle that placed America's first astronaut, Alan Shepard, into suborbital space in 1961, to the mammoth Saturn V rocket that launched humans to the moon in 1969, Marshall and its industry partners have successfully engineered history making projects that gave, and continue to give, America the world's premier space program.

We are fortunate to have these dedicated men and women in Huntsville. I will be offering some remarks and hope to speak on the floor again later today. I take this opportunity to express my compliments and those of the American people to the men and women at Marshall Space Flight Center, which began 40 years ago, sent men to the moon, and now is working steadfastly to create a cost-efficient, effective way to send people into space routinely, almost as easily as we fly now across the Atlantic Ocean.

ENERGY

Mr. SESSION. Mr. President, I see the Senator from Alaska is here. I will just say this: Senator MURKOWSKI understands the failure of this administration's energy policy. He understands their desperate attempt to blame it on everyone but themselves.

The plain fact is, for almost 8 years, this administration has, through a myriad of ways—the chairman of the Committee on Energy and Natural Resources well knows—reduced American production of energy, leaving us more and more dependent on foreign oil. Now they have gotten together, created their cartel strength again and driven up the price of a barrel of oil in a matter of months from $13 a barrel to over $30, maybe $35. We are feeling it in every aspect of the American Government. It was done not on the basis of a free market supply and demand but because of the political acts of the OPEC nations. This administration needs to do something about it.

I am glad to see Chairman MURKOWSKI here this morning. I know he will be speaking about this important issue.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. MURKOWSKI. Mr. President, may I ask how much time I am allotted under the standing order?

The PRESIDING OFFICER. The Senator may have 13 minutes of the time remaining of the Senator from Alabama.

Mr. MURKOWSKI. I thank the Chair, and I thank my good friend from Alabama.