

not have the opportunity to pay respect to my friend and the much-celebrated life of his father. It is for this purpose that I rise today.

It has been said that, "the worst sin against our fellow creatures is not to hate them, but to be indifferent to them; that is the essence of inhumanity." George Durenberger, the parent, the teacher, the coach, must have been acutely aware of this because there was not indifference in him. He saw worth in every person he met and rewarded them with a first chance, a second, and a third.

In short, George Durenberger never gave up on anyone. Beyond all his other contributions, George Durenberger will be most remembered for his abiding faith in people.

According to newspaper accounts, George Durenberger was one of the "best known and most well-liked men in Central Minnesota." By the same accounts, "Big George" as he was often called, was "a legend."

Coming to St. John's Abbey and University in Collegeville, MN in 1924 as a student, George Durenberger obtained hero status as the star offensive center on the football team, the first three time All-Minnesota Intercollegiate Athletic Conference award winner, and also the captain of not only the football team but the basketball team as well.

Upon graduation in 1928, Durenberger became a professor and coach at St. John's and, over the course of 44 years, served as head coach of the football, basketball, and baseball teams—and sometimes all at once.

Durenberger served as athletic director for both St. John's University and St. John's preparatory school athletics for all but 2 of his 44 years at St. John's.

Many Minnesotans still recall that it was George Durenberger who started the round robin system of intercollegiate competition in the Minnesota Intercollegiate Athletic Conference. And, some still remember the national recognition he gained through his ace athletic program to condition the 87th Airborne Detachment for World War II.

Perhaps, these accomplishments figured into St. John's decision to name the college's athletic field complex, the "George Durenberger Field." But, I believe that what contributed most to his Herculean stature can be best expressed in George Durenberger's own words:

A coach should be judged not only on his ability to produce winning teams, but also on whether or not he has made a positive contribution to the moral, mental, social and emotional growth of his students.

George Durenberger was the epitome of a teacher. He knew and loved people. He saw the good in them—even when they could not see it in themselves.

"The young men who came to St. John's in the early forties from the small towns of Minnesota and North Dakota were very much in need of a role model," recalls former Minnesota

Supreme Court Justice John Simonett. "Then we met 'Big George'. And we looked up to him—both literally and figuratively."

George Durenberger lifted spirits, recalled another St. John's alumnus, "I always left George feeling better about myself." George Durenberger "was the first person I met as a student at St. John's in 1924," remembered Fred Hughes, a St. Cloud attorney and former University of Minnesota Regent, "and to this day, he remains the best."

And, consider what the Hill newspaper's Al Eisele, who attended St. John's, had to say. Mr. Eisele said, "George Durenberger was as much a part of the modern history of St. John's University as the Benedictine monks who founded it 150 years ago."

Durenberger, "a physically imposing man with a booming voice and outgoing personality," as described by Eisele, "helped shape the lives of thousands of young men." As athletic director, Durenberger was such a forceful man, noted Eisele, that he even got the monks to exercise.

In closing, Eisele remarked that Durenberger and his wife Isabelle were "surrogate parents to many * * * and an inspiration to all."

George Durenberger never left St. John's until he died. He loved the institution and all the people and memories that came with it. However, this love was not connected to stubborn consistency but to confection. George Durenberger, said one friend, "was driven by a vision of a 'better city'," something akin to the city referred to in the book of Hebrews.

Another book in Scriptures, Proverbs, states, "Train up a child in the way he should go: and when he is old, he will not depart from it." According to George Durenberger's eldest son, my friend and former colleague, "All my desire for public service and for making the world a better place than I found it, came from him." That was Dave Durenberger.

In this way, and in so many others, George Durenberger made a very profound and lasting contribution to the world. All he withheld from the world was indifference.

Mr. President, I offer George Durenberger's wife, Isabelle; his daughters, Constance and Mary; his sons, George Mark and Thomas; his nine grandchildren and two great grandchildren; and most especially I offer his eldest son, my dear friend, David Durenberger, my most heartfelt sympathy.

Thank you very much, Mr. President. I yield back the remaining part of my time and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

MEDICARE REFORM

Mr. WYDEN. Mr. President, I have come to the floor each day this week to talk about what I think is the critical need for the Senate to develop a bipartisan plan to reform Medicare. Medicare is a lifeline for millions and millions of American families, and I think it is understood by every Member of this body that this is a program that faces financial crisis as we look to the next century.

Today, as part of the effort to build support for a bipartisan Medicare reform effort I will look specifically at the Medicare reimbursement formula. I think it is important to take this subject up because I believe today's Medicare reimbursement system in many instances overcharges taxpayers on costs and shortchanges older people who need and deserve good quality care.

Now, Mr. President, as we all know, there are essentially two major types of health care in America. There is traditional health care, what is known as fee-for-service. It means just what it sounds like. Providers get paid on the basis of the number of services that they render. This, unfortunately, can encourage waste. If, for example, an older person in traditional health care receives 10 medical tests and 4 would have been sufficient, under traditional health care the provider gets paid for 10. The other type of health care is what is known as managed care or health maintenance organizations. This is essentially a prepaid kind of arrangement. It creates incentives to hold down costs. But as we know, in some instances, tragically, it has also been used as a tool to hold back on needed health care that older people depend on.

The Federal Government, looking to the great demographic changes, the demographic earthquake that our country will face in the next century, has sought to try to change this system of reimbursement and, in particular, try to encourage the availability of good quality—I want to emphasize that, good quality—managed care or health maintenance organizations.

They set up a plan for reimbursing these organizations known as the average adjusted per capita cost, or AAPCC. Now, I am the first to admit that discussion of this topic is pretty much a sleep-inducing, eye-glazing issue, but certainly for folks in rural Wyoming, rural Oregon and across this country, the low-cost areas, it has great implications, but also it has great implications for the system as a whole.

I believe that the Federal Government has botched the job of handling this reimbursement system, and it is time to make some fundamental changes. Under this reimbursement system, Medicare pays health maintenance organizations 95 percent of the estimated cost of treating a patient under fee-for-service plans in a particular county. What this very often means

is that in an area where there has not been an effort to inject competition, where there has not been an effort to drive out waste, you have wasteful, inefficient fee-for-service health care being offered, and it is being used, essentially, as a path to guide reimbursement for the HMO's, the health maintenance organizations.

I brought a couple of charts to the floor today. The first is one that shows that many, many of our counties across this country that have tried to hold down costs are reimbursed for health maintenance organizations, or the competitive part of the Medicare system, in a way that is below the national average. Certainly, Mr. President, you and others like myself who represent rural areas see how critical this issue is because our providers have difficulty providing the defined benefits under Medicare, let alone some of the extras such as reduced drugs, eyeglasses and hearing aids that are available in many of the high-cost areas.

For example, as my next chart illustrates, in 1997, one of the very high-cost reimbursement areas was in Florida, in Dade City, FL, with \$748 a month received there, whereas in Arthur, NE, they receive \$221 per month. So the question, essentially, is to our colleagues, again, on a bipartisan basis, our colleagues from Nebraska, Senator KERREY and Senator HAGEL: Is it true that a typical 72-year-old Nebraskan is that much healthier than a typical New Yorker of the same age? Well, Medicare thinks so. That is how the Federal Government does business. The Federal Government conducts its affairs that way. I think it is wrong. It is that way not just for folks in Nebraska but many other parts of the country like ours that, again, we share on a bipartisan basis, and as a result our seniors get a much thinner Medicare benefit package than they would if they were in an area that was much more costly.

For example, in my home community of Portland, OR, we have the highest concentration of HMO's in the country, the highest level of penetration of HMO's in the United States, just about 60 percent, and we are reimbursed at a level significantly below the national average of \$467. We get reimbursed at a \$387-per-month level. What happens is a senior who lives in Dade City, FL, or in southern California or parts of New York State calls seniors I represent in Oregon and asks them how Medicare is going, and seniors in the high-cost areas say, "It's going great because we can get prescription drugs, eye glasses and hearing aids all at essentially little or no cost," and seniors in Oregon get none of those things, and, in fact, many of their providers in rural parts of our State have difficulty providing basic services.

So the question then becomes, what are some of the fundamental ways in which to change this system which so often rewards waste, penalizes the frugal and, in effect, creates an incentive

for various parts of the country to do business as usual, even though the General Accounting Office and other bodies are saying that business as usual will be bad news for both seniors and for taxpayers. Several practical suggestions are at hand, Mr. President, and suggestions that I believe ought to be adopted on a bipartisan basis. I think for the long term, it is time to separate out, to literally cut off the link between HMO's, the managed care, and fee-for-service, because I think what we are having today is a situation that literally creates incentives for wasteful health care.

Second, it seems to me there ought to be a new minimum payment floor that brings up all the counties that have been low cost, and especially those in rural areas, and certainly the President of the Senate, just as I see in rural Oregon, understands the importance of that.

Third, it seems to me that the Senate, on a bipartisan basis, ought to begin a gradual effort to move to a national reimbursement level, a blended kind of level, and do it gradually so that areas that have been more inefficient are not going to face all of the changes overnight, but are going to understand very clearly that with an effort to move to a blended or national reimbursement rate, Congress is not going to tolerate what we have today, which is a system that rewards waste.

Finally, Mr. President, it seems to me that the Federal Government should be trying to promote competition, serious competition, as the private sector does, in areas of high-cost managed care or significant penetration of health maintenance organizations. There is no question in my mind that some HMO's are overpaid. We do need to produce competition in those areas. I believe that that can be carefully targeted. That, in my view, is the guts of reimbursement reform, Mr. President.

I would like to conclude my remarks today by saying that going to the next level of Medicare reform after we take care of the reimbursement issue is a logical step because it flows from what needs to be done with the reimbursement formula. By getting good data and more logical data about the various counties, the Health Care Financing Administration will be in a position to make information available to older people and their families across this country about how to make better choices with respect to their health care. Today, what we have is a situation where many older people get no choices at all. We see that in many rural parts of our country because of the reimbursement formula. The reimbursement formula is so low that many plans won't come in, so seniors in those areas get few choices. In the high-cost areas, the Federal Government has put out a mishmash of information which makes it impossible to choose between the various services that are available to them, and that is absolutely key be-

cause in those high-cost areas we have exactly the places where it is most important to get competition.

Yesterday, I brought to the floor—I am going to blow it up in the days ahead so that it's possible for the Senate to see it in more detail—an example of what it is like for an older person in Los Angeles to try to navigate through the various health choices available to her. In fact, it takes one full wall, in a picture that the General Accounting Office took, just to put the various pieces of information that that senior would have to wade through. So I want to see us now have the Federal Government look to what the private sector is doing to empower seniors and their families to get understandable, clear information about Medicare so that they can make appropriate choices. This involves details on the way different Medicare choices and plans work, data on the experience of seniors with similar health and income backgrounds, the methods and the decision steps used by plans to pay participating practitioners and health care facilities and providers. And, Mr. President, certainly, Members of this body should understand that this is doable because this is largely the kind of information that is available to Members of the Senate and other Federal employees who participate in the Federal employee health plan.

So in ensuring that seniors can receive a full list of plans available to them, enrollment fairs are an approach that has been looked at in the past, and there may be other ways to do that, such as publishing appropriate performance data on plans. These kinds of steps are approaches that the Federal Government has pursued and have related to Senators and members of the Federal service. It seems to me that there is no reason to further delay making this kind of information available to those who depend on Medicare. Older people ought to be in a position to enroll and disenroll from a plan at any time.

Certainly, this kind of approach will encourage competition. Perhaps at some point there ought to be incentives to try to keep people in plans that are cost effective, and I think that the Federal Government can look to this kind of approach. But, certainly, significant rights of older people to enroll and disenroll in plans is critical.

So these kinds of rights, like appeal rights when you have been denied benefits, a good grievance procedure—in effect, a patients' bill of rights—is what is fundamental to making sure that older people are in a position to get the kind of information they need in order to make choices about their health care and, at the same time, inject competition into this system.

We have made many of these decisions already as it relates to Federal employees and Senators. We have made them as it relates to the private sector and, in fact, we have even made them in areas that have parallels to this program—for example, in the Medigap

Program. I and others were involved in this to try to make sure that seniors who purchased supplemental coverage would be in a position to make sure they could get full value and have a place to turn to for their questions. We can take a lesson from the Medigap Program, and the Federal Government ought to make available troubleshooters to answer questions from older people as we move to competition.

So, Mr. President, let me conclude by saying that I think every Member of this body understands that business as usual with respect to Medicare is unacceptable. I will tell you, if you don't like the program, if you really dislike Medicare, keep it the way it is, because the way it is is going to be a path that will cause, in my view, great calamity for families and seniors. If you believe Medicare is a program that has made an enormous difference in the lives of older people, I think that is the best argument for a bipartisan Medicare reform effort, a bipartisan Medicare reform effort that would ensure that seniors got guaranteed, secure benefits, not some check or some sort of voucher that just said, well, maybe this will be enough for your care and maybe it won't.

Seniors deserve guaranteed, secure benefits. Many of my colleagues on the other side of the aisle have been absolutely right in saying that much of Medicare across this country is an outdated tin lizzy kind of program, a program that the private sector consigned to the attic years ago. So let us try to bring the parties together around the proposition that there ought to be defined, secure, guaranteed benefits, around the proposition that it is time to bring the revolution in the private sector to Medicare, and do it in a way that protects patients' rights—no gag clauses or limitations on what older people can know about plans, grievance procedures, appeal rights. Those are the kinds of issues I think that both parties can agree on.

I intend to come to the floor day after day to bring the issues of Medicare reform to the attention of the Senate and to the attention of the public, because I believe this is going to be the issue that is going to dominate the debate about our priorities, particularly our domestic priorities, for the next 15 to 20 years.

I believe that every Member of this body in the next century is going to be asked: What did you do in 1997 to get Medicare on track?

I believe there are opportunities now, as we move to the budget, as we move to efforts to have a bipartisan balanced budget, to start the changes that will put Medicare on track for older people and taxpayers.

Senator WYDEN. Mr. President, to reiterate, the heart of the Medicare Program is the 38 million beneficiaries now dependent on this health care system as an essential social lifeline.

Any changes we make to Medicare must, first and foremost, consider the

likely effects those reforms will have on these beneficiaries, many of whom are frail, infirm, and low-income.

As I've said every day on the floor of the Senate this week, I'm going to be talking today about the choices and access those beneficiaries ought to have, but who in too many parts of the country have no choices and poor access to health care.

I'm also going to be talking about the window of opportunity we have in this Congress to enact significant changes in the program to cure the half-trillion-dollar shortfall we can expect in this program by the end of the coming decade, and to bring new choices, new access and new efficiencies necessary to save Medicare for not just the next 5 years, but into 2010, 2020, and 2030.

As I said yesterday, Medicare is a 1965-model tin-Lizzy health care program showing little resemblance to the rest of American health care. Various out-dated, out-moded and bureaucratic features of Medicare practically encourage practitioners in the greater part of the Medicare system to drive up unnecessary care and resulting over-billing—actions which over-charge the Government on costs, but short-change beneficiaries on good health care.

Beginning in the last decade, the Government's partial solution to this was to institute coordinated care in Medicare. We encouraged health insurers to begin offering plans that managed service Medicare beneficiaries received, and we offered encouragement to beneficiaries to participate in the form of lower out-of-pocket costs and, we anticipated, a broader package of goods and services.

And we would determine how each plan, in each city, would be paid for each beneficiary in the plan according to an arcane formula called the average adjusted per capita cost—or the AAPCC.

Now, before your eyes glaze over, let me give you a very simplistic idea of how the local AAPCC payment rate is determined, and how this formulation really penalizes beneficiaries living in places where medical costs are relatively low.

The AAPCC is any given county is formulated on the cost of providing medicine, per beneficiary, in the most costly portion of Medicare—the traditional sector known as fee-for-service. This is the portion of the program where beneficiary can elect to see just about any doctor they want, whenever they want, and the individual care providers in those situations can be reimbursed for just about any services they deem necessary for that beneficiary.

No questions asked. No oversight.

This may sound like a pretty good deal for the beneficiaries. But it doesn't always mean they get the care they need or require. For example, there's nothing to stop an individual provider in fee-for-service for ordering up 10 or 12 tests for a beneficiary, when only 3 or 4 really are required.

This is one of the reasons why fee-for-service Medicare is growing at a much more rapid rate than the rest of the program—and it's one of the reasons we find ourselves in such a deep financial hole.

It is also clear that the rapid growth of fee-for-service Medicare seems endemic to certain large metropolitan regions of the county.

As my colleagues may be able to see, the areas in blue and white represent portions of the country where the AAPCC rate is below the national average.

The areas in red and orange represents areas where the payments are above the average.

And just for the record, the variation is huge. The 1997 high-reimbursement county is Richmond County, up in New York, at \$767 per month, per beneficiary, while the lowest paid county was over here in Arthur County, Nebraska, at \$221 per month.

Now, I'd ask my colleagues BOB KERREY and CHUCK HAGEL whether they think a typical 72-year-old Nebraskan is that much healthier than a typical New Yorker of the same age?

Medicare seems to think so, and I think they're wrong.

And unfortunately for folks in Nebraska and other low pay States—my home State of Oregon is certainly one of them—the difference is that they get a much thinner Medicare benefit package in coordinated care plans, if they have access to such plans at all because their monthly reimbursement rate is so abysmally low.

Let's talk about some examples of how this hurts beneficiaries in cost-efficient counties where the reimbursement rate is particularly screwy.

In Mankato, MN, where the average payment is \$300 per month, beneficiaries in coordinated plans get their basic managed care coverage under Medicare rules—but nothing else. No discounts on prescription drug purchases, no additional preventative care, no hearing aid discounts, no coverage for eyeglasses.

In Portland, OR, my home town, the rate is a little better at \$387 per month, but that's still well below the \$467 national average. That means the best additional benefit received by these folks, who have the highest managed care penetration rate in the country at about 60 percent, is a 30 percent discount on prescriptions up to a \$50 maximum.

Now, let's go up to the high end of this wacky AAPCC payment system. In Miami, FL, where the payment rate is all the way up to \$748 per month, seniors in these programs get unlimited prescription drug reimbursements, a \$700 credit for hearing aids, and dental coverage—all add-ons that are virtually unheard of in most of the rest of the country.

Mr. President, I wish I could say that this is the kind of cost-accounting that's going to add stability and integrity to the Medicare Program into the

next century. Unfortunately, all this payment formula accomplishes is: First, huge overpayments in some counties, with resulting extravagant profits to insurance companies, and second, payments to other counties which are obviously too low, and which result in either no coordinated care offerings to beneficiaries in those communities or bare-bones plans that for millions of beneficiaries to incur higher out-of-pocket costs purely as a matter of geographic accident.

I believe we can transform Medicare from an aging dinosaur insurance program into a comprehensive seniors health care system while maintaining our historic commitment to a basic package of benefits for every beneficiary, no matter their health or income status.

But that transformation necessarily will involve providing seniors with many more choices with regard to their health plan selection.

The current formula used for paying Medicare in rural counties and in other places where communities have worked hard to reduce general health care costs is precisely antagonistic to that purpose.

This system denies folks choice because it necessarily results in poor quality health plans, high out-of-pocket expenses, or no managed care choices—or a combination of all three—for vast numbers of beneficiaries.

And again, an accident of geography seems to be the deciding factor in the current state of affairs.

I believe Medicare reform has to include remedies for these problems.

This is not just a matter of increasing the benefit package for folks in low pay counties. More fundamentally, this is an issue of providing more choices, to encouraging the entry of more plans, into large areas of this country where the current AAPCC formula creates reimbursement rates which are so low—which are so nonsensical—as to completely discourage anything but fee-for-service Medicare in those communities.

I believe reimbursement reform include several important features:

A new minimum payment floor that brings all counties up to 80 percent of the national average, immediately.

A new annualized reimbursement increase formula that shifts adjustments away from localized fee-for-service medicine costs, and toward actual cost increases in coordinated care.

A systematic imposition of financial controls reimbursement growth in high-reimbursement counties in order to squeeze out what have to be monumental over-payments to plans in those communities, and huge losses to the Medicare Program.

Mr. President, reforming Medicare isn't just about reforming payment systems, however.

It's also about helping beneficiaries to become smarter shoppers in a new Medicare environment that we hope

will offer many of them many more choices and options for care.

Therefore, it is critical that we change the program in way that will empower seniors to make the appropriate choices.

At the bottom, this means developing and executing a much better system of informing beneficiaries about their rights in managed care, and about the most important provisions of the health plans available to them. This information must be given to seniors as "news they can use"—data that is in clear and accurate layman's language, and which conforms to standardized reporting practices so that consumers can compare one plan against another in a traditional kitchen-table-assessment.

Indeed, these tools if we had them would be useful, today, with 80,000 beneficiaries per month choosing to leave fee-for-service Medicare for Medicare managed care organizations.

According to Stanley Jones, chairman of the National Institute of Medicine's committee on choice and managed care:

Many elderly are making these new choices without enough information to judge which option is best for them, what the plan they choose will actually cover, or how the plan will operate.

Jones said that many seniors misunderstand the basic structure of HMO payment and care practices. He criticized Medicare managers for providing information to beneficiaries about differences in available health plans that "appears primitive" compared with what's available from private purchasers.

Mr. President, last year I asked the General Accounting Office to look into this problem, and the GAO auditors came to similar conclusions:

Though Medicare is the nation's largest purchaser of managed care services, it lags other large purchasers in helping beneficiaries choose among plans. The Health Care Financing Administration (HCFA) has responsibility for protecting beneficiaries' rights and obtaining and disseminating information from Medicare HMOs to beneficiaries. HCFA has not yet, however, provided information to beneficiaries on individual HMOs. It has announced several efforts to develop HMO health care quality indicators. HCFA has, however, the capability to provide Medicare beneficiaries useful, comparative information now, using the administrative data it already collects.

The kind of data HCFA collects, now, of use to beneficiaries includes performance indicators such as: First, annual disenrollment rates, second, cancellation rates, third, so-called rapid disenrollment rates—the percentage of enrollees who disenroll within 12 months of signing up, fourth, rate of return to fee-for-service Medicare from the plan, and fifth, disenrollments tied specifically to sales agent abuses involving, among other things, marketers who mislead enrollees about what a plan may cover.

I think we can go beyond these quality indicators. The Federal Employees

Health Benefits Program [FEHBP], for example, includes a graded system of reports on the quality of key services in federal employee health plans. There is no reason why Medicare beneficiaries, who must make these decisions on their own without benefit of employers or corporate benefit managers, shouldn't have at least the kind of qualitative analysis available to members of Congress who are covered by FEHBP plans.

Mr. President, I am heartened by the announcement earlier this year by HCFA Administrator Bruce Vladeck that the program would begin offering beneficiaries some qualitative information on managed care plans through the Internet. I think that's great for seniors that use the Internet in their homes or have access to that technology somewhere else.

I think it's clear, however, that we need to step up efforts going beyond the limited information that eventually would be made available at a HCFA website.

Here's the bare minimum of information that seniors need in a revamped Medicare program which empowers them to make appropriate choices:

Details on the way different Medicare choices and plans work.

Data on the experience of seniors of similar health and income background in those plans.

The methods and the decision steps used by plans to pay participating practitioners and health care facilities and service providers.

And here are the steps we need to take to insure seniors receive that information and the other tools they need to prevail in an increasingly more complex and choice-intensive Medicare marketplace:

First, Medicare managers must ensure that every senior, in every county, receive a full list of plans available to him, with a detailed description of what each plan offers. These submissions must be written in a way that allows a consumer to make easy comparisons between plans.

HCFA should require annual "enrollment fairs," giving seniors a chance to review all plan materials at least once a year in order to determine if alternative Medicare offerings might be more suitable to the individual enrollee.

Second, Medicare must collect, evaluate and publish appropriate performance data on every plan. Using independent quality review organizations like the National Council of Quality Assessment, Medicare must devise and publish qualitative analysis—consumer report cards—on each Medicare plan, further enabling seniors to make appropriate choices among offerings.

Third, consumers must be allowed to enroll and disenroll from plans at any time during their first 12 months in a plan. After the first year of enrollment, disenrollment with guaranteed enrollment in a new plan would be limited to a first opportunity after six months in the second year.

We would make it somewhat tougher to disenroll after the first year because we would expect plans to make investments of preventative health services for new enrollees in the initial few months of their enrollment.

Fourth, health plan enrollees need a patient bill of rights that by Federal statute protects certain baseline issues fundamental to their good health. At the top of this list would be a Federal statute absolutely protecting the free and unfettered communication between patient and doctor on that enrollee's health condition and any appropriate services and procedures necessary to treat the patient.

Fifth, give Medicare beneficiaries a certain and sure grievance and appeals process, and the information they need to use it. Medicare must streamline the current process, allowing beneficiaries to by-pass certain bureaucratic roadblocks in the present system—most especially those that force time-delaying procedural exercises when the outcomes already are known. On an initial enrollment, and at any time a beneficiary changes plans, an explanation of new or amended appeals procedures must be part of the enrollment exercise.

And as with Medigap insurance, HCFA should hire and train ombudsmen and trouble-shooters tell help beneficiaries both understand provisions in plans, generally, and appeals and grievance procedures specifically.

Sixth, every Medicare risk provider should offer at least one plan in his portfolio that includes a point-of-service provision, so that those seniors who would try plans if they could keep going to a particular practitioner would be allowed to do so.

Mr. President, I have spent quite a number of years talking with seniors about their health care. Before I was elected to the House of Representatives in 1980, I was cochairman of the Oregon Gray Panthers. I know that seniors are deeply suspicious of any changes to Medicare, in particular, and many of them view the current debate over the shape and direction of the program with a good deal of alarm.

But many more who I've talked to recognize the need for changes and, indeed, want to see this debate begin.

And on the basis of those conversations I am convinced that seniors will feel a lot better about anything we do if we give them more decision-making power to fashion the health care they receive through the program.

Fundamental to that is making sure they have the information and tools to make the right decision, at the front end, and to protect themselves in the case of disputed decisions while they are enrolled in plans. These changes would go a long way toward providing seniors with that kind of empowerment, and in the long run strengthening and improving Medicare as a critical government program.

Mr. President, I yield the floor.

Mr. FAIRCLOTH addressed the Chair.

The PRESIDING OFFICER. The Senator from North Carolina [Mr. FAIRCLOTH], is recognized.

Mr. FAIRCLOTH. Mr. President, I ask unanimous consent to be recognized for 10 minutes in morning business.

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

PITIFUL STATE OF OUR LEGAL SYSTEM

Mr. FAIRCLOTH. Mr. President, I take the floor today to discuss an issue that is serious and becoming more serious every year, and that is the pitiful state of our legal system. It is becoming harder and harder and harder to convict anybody of anything. You can catch them on tape, film them committing the crime, and then you will probably lose it; they will be found not guilty. No amount of evidence seems to be sufficient anymore. I think we have reached this sorry and pitiful state because we have basically let the system be controlled by lawyers. When you control the legal system by lawyers, you are simply asking a thermostat to set itself. Defense lawyers are twisting and bending common sense to let the guilty go free, and they are aided by judges—in many cases, hand-picked by the trial lawyers. The lawyers pick the judges.

At every turn, you have lawyers controlling a system that makes no common sense, except to serve one purpose, which is for their benefit.

The most recent example I can think of is the glaring stupidity involving the Oklahoma bombing case. First, it has taken 2 years to bring it to court when the man was caught the day after he did it. Now, many taxpayers are appalled by the very fact that they are paying for McVeigh's defense—they are paying for it. They think that is reprehensible. But they don't realize how much they are paying. If they did, they would rise up and revolt. It is not just the defense of McVeigh; it is gold-plated from one end to the other. He has 14—14—expensive lawyers defending him that the working people of this country are paying for—14 of them. His chief lawyer, Mr. Jones, says that it will cost \$50 million to defend him. That is his estimate. Now, anybody that has ever had a lawyer knows they never come in with a low estimate. They are estimating \$50 million to defend him. This is absolutely offensive to every taxpayer in this country, and it should be. But this is a typical example of a legal system that is out of control.

Now, to defend Mr. McVeigh because he blew up the building in Oklahoma City, his lawyers have traveled literally all over the world. They have been from Kansas, where he rented the truck, to Jericho. I don't know why he would have been there. They have been to the Philippines. These lawyers are traveling at taxpayers' expense. They have been all over Italy. They have

covered every country in Europe and gone to the West Bank. Nobody knows what they are searching for—maybe for the real killer, or maybe just enjoying travel at taxpayers' expense. While they have the killer, they are always looking for another one. The taxpayers have paid for a TV and VCR for Mr. McVeigh so he can review the evidence.

Mr. President, to add insult to injury and outrage to outrage, they moved the trial. So now we, the working people of this country, are paying \$50,000 a week—\$50,000 a week—for the living expenses of his lawyers. When you start talking about the working people, \$50,000 every week for the living expenses of his lawyers—they spent \$0.5 million to remodel the courtroom in Denver for his trial. They couldn't try him at home. They had to move it to Denver and we spent \$0.5 million getting the courtroom ready for him.

The victims of his crime have had to travel hundreds of miles from Oklahoma to Denver in hopes that they see that he gets justice. They are paying for the defense of the man that killed their children. They are also having to pay for their own room, board and lodging in Denver. Plus they are paying \$50,000 for his lawyers' lodging and board in Denver. There is no end to it.

How many times do the victims of this crime, or any crime, have to be made victims again by the very judicial system that they are paying for? We will be paying for McVeigh's trial long from now in the form of interest on the debt and the money we borrow to give him \$50 million for his lawyers.

It would be my thought that if McVeigh didn't have the money for his gold-plated defense, he should not have blown up the building in the first place.

Mr. President, I suggest that there are a number of things we could do, and we need to start fixing a system that is broke. And it is broken bad. We need to change the law that allows criminals to get the best defense that taxpayers can pay for. That is exactly what they are getting. I am going to propose legislation putting a cap on the Federal Defender Program.

I would like to cap what McVeigh is getting right now. But that will be appealed for years and years. As long as we pay the lawyers, they will keep appealing for Mr. McVeigh. So he will be out there far into the future with the people's money. The \$50 million figure will run into \$75 million before we get through hearing about him. We need a comprehensive overhaul of the legal system, and it needs to be done by non-lawyers. We need to overhaul the legal system and not let a single lawyer be involved in the overhaul. We need a national commission composed of non-lawyers to review the judicial system and provide some commonsense solutions to the problem, and it needs to be made up of homemakers, regular people, business people, truck drivers, and people who would bring some practicality to it and not lawyers who would continue to feather their own nest.