

formulating amendments. It was a great disappointment to see this effort unravel over partisan politics. We may have a second chance this week. Let's not squander the opportunity. We can and should work together to pass this bill.

We were elected to his body to pass legislation not to bicker. Let's do what the people sent us here to do.

I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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 Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. GRAHAM. Madam President, I ask that we return to morning business for a period of 30 minutes for remarks on the Labor-HHS conference report.

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

D.C./LABOR-HHS APPROPRIATIONS

Mr. GRAHAM. Madam President, the business before the Senate will soon be the conference report on Labor Department and Health and Human Services and Education appropriations bill. We are now considering various trade measures. Since we will be taking up the D.C./Labor-HHS conference report tomorrow, I appreciate the Presiding Officer's generosity in allowing me to discuss this very important piece of legislation.

I think it is fair to describe that one night within the last few weeks, through back-door negotiations, various members of the Senate and House of Representatives Appropriations Committees crafted the conference reports that we have before us today. The end result was that a very large elephant, weighing \$313.6 billion, The Labor/HHS conference report, being placed upon the back of a relatively small and not particularly compliant ant weighing \$429 million, the District of Columbia's Appropriations bill.

Out of that marriage of elephant and ant, we now have before the Senate the conference report on the District of Columbia with the enormous addition of a \$313 billion of Labor-HHS "rider".

Unfortunately, when these bizarre marriages occur, the public interest is not necessarily served. This parliamentary tactic has stolen from Members of the Senate the right to offer motions instructing the conferees on how we believe they should proceed in conference. We have also lost the right to challenge the existence of authorizing legislation on an appropriations bill during the process of negotiation between the two Houses. There will be no opportunity for Congress or the President to independently consider the

Labor, Health and Human Services and Education Appropriations bill. While one is an elephant and one is an ant, they are both important and deserve separate and distinct consideration.

There is not the opportunity to protest the inclusion of items which were not included in either the Senate or the House bill, or were so altered as to be unrecognizable. This bill is purely the creation of that late-night negotiation. This lack of democracy has allowed the will of a small minority to triumph on a variety of provisions of great importance. I will take the opportunity this afternoon to focus on only two of the issues that are a part of this marriage of elephant and ant: First, the proposal to terminate competitive bidding for Medicare's payment of health maintenance organizations' reimbursement; and, second, preventing the Congress from fully funding the Social Service Block Grant Program.

Let me begin the discussion with the absconding of funds from two congressionally authorized competitive pricing demonstrations. This takes us back 2 years to 1997 during the consideration of the Balanced Budget Act. Both Houses of Congress voted to create demonstration projects based upon community participation in an attempt to learn more about how HMOs, which provided services to Medicare beneficiaries, could be priced; that is, how the amount of that reimbursement from the Federal Government could be determined by competitive bidding.

In order to understand what this issue is about, I am afraid some discussion of how HMOs currently are priced when they provide services for a Medicare beneficiary is required. In a simplified form, the way in which an HMO receives reimbursement when it provides funds to a Medicare beneficiary is a function of how much is paid within that county for fee-for-service payments. While there are some modifications to this overly broad statement, basically if, let us say, in a particular county the average payment for a fee-for-service Medicare patient is \$5,000, then the HMO is reimbursed at, more or less, 95 percent of that level, or \$4,500. There is some blending of the national fee-for-service rate and the local fee-for-service rate, but as of today, and in the past and in the immediate future, the description I have given is essentially an accurate representation.

What has been the result of this reliance on a percentage of fee-for-service within a narrow, local area on the amount that HMOs are reimbursed? It has resulted the fact that in many areas of your State and mine, where fee-for-service charges are relatively low—that is particularly true in rural areas—there are no HMOs. Why? Because HMOs cannot economically justify operating with the reimbursement

levels they would get based on 95 percent of those relatively low fees for service.

On the other hand, in some areas which have very high fees for service—for instance, an area that has a large tertiary hospital, particularly one associated with a medical school where costs tend to be very high because of the nature of the service they provide—that community will have a high fee-for-service rate. Therefore, 95 percent of that high level will result in high reimbursement levels for HMOs. So, you have not just one HMO, but typically many HMOs that want to compete to get that fixed-formula-based percentage of fee-for-service reimbursement.

The purpose of the 1997 action of the Congress was to try a different model; to not rely on this central planning use of fee-for-service but rather go out and test the marketplace. What will the market in a rural area say is called for to engage managed care as an option for Medicare beneficiaries? What is the appropriate level of HMO reimbursement in a large urban area with high fee-for-service costs? That was the purpose of this competitive bidding demonstration project.

The Balanced Budget Act, in conjunction with the Health Care Financing Agency, set up a structure which included area advisory committees. These committees consisted of health plans, providers, and beneficiary representatives. It was decided the two communities in which demonstrations would take place were Kansas City and Phoenix. The function of the area advisory committees was to recommend how to best implement the competitive pricing demonstrations in these two communities.

Unfortunately, in the bill that will be before us tomorrow, the bill that the conference has reported as the funding for Departments of Labor, HHS, and the District of Columbia, all funding for these two demonstrations in Kansas City and Phoenix has been removed, removed by those who do not want to find out if there is a means to use the competitiveness of the marketplace to arrive at what should be the appropriate reimbursement level for health maintenance organizations.

Experience has shown us in other areas of the Medicare system that there is the potential for preserving high levels of quality and saving money by using the dynamism of the marketplace as determined by competitive bidding. Let me use an example from my own State. One of the other provisions in that 1997 Balanced Budget Act was to set up competitive bidding on the Part B, or hospital component of Medicare, as it related to a variety of items, including durable medical equipment. The demonstration for durable medical equipment was settled to be in Lakeland, FL.

In its first year, this project has substantially reduced the amount Medicare pays for the five products that were included in the demonstration, and in that one community has saved Medicare approximately \$1 million.

What are the areas that are being competitively bid? Let me say that these products, durable medical equipment, for most of America today are the subject of a price list. It would be as if you suddenly needed, let's say, a wheelchair—you had broken your leg and you had to have a wheelchair for temporary use—and the way you would pay for that wheelchair, or decide what was the appropriate rental for the wheelchair, was to have Government give you a price list and say this is what thou shalt pay to purchase or lease that wheelchair. That is exactly what Medicare does today for a list of hundreds of durable medical equipment items. So we are going to find out, was there a different way to establish what those prices should be? Was there a means by which we could use the marketplace to set the price? That was the purpose of the demonstration in Lakeland, FL.

What results? Competitive pricing has reduced the price of oxygen supplies and equipment by 17.5 percent over what was on that price list, for exactly the same oxygen supplies and equipment. Competitive bidding for hospital beds and ancillary hospital items has been reduced by 29.8 percent by competitive bidding as opposed to the price list. For enteral nutrition, where a person is taking his or her nutrition through intravenous means rather than more normal oral means, the price of that has been reduced by 29.2 percent as a result of competition, rather than using the price list. Surgical dressings have been reduced by 12.9 percent, and urological supplies by 20 percent. All of these savings were accomplished by the use of competitive bidding as opposed to relying on almost a Soviet system of a prescribed price list.

It is estimated, if this Lakeland demonstration were to be applied on a nationwide basis and applied to a broader range of items that are just as susceptible to competitive bidding as the five which were selected for the demonstration in Lakeland, we could save the Medicare programs over \$100 million a year. The Medicare program is a big program, but even for that big program, even for the Federal Government, saving \$100 million a year is an important achievement.

It is interesting that, while we are about to take a vote on whether we should terminate even a demonstration on competitive bidding to establish the appropriate price for HMO reimbursement, we are applying competitive bidding in other areas. We are using the competitive marketplace, rather than centralized planning, to determine what is a fair price.

For example: In 1998, Congress reformed the means by which national parks reimbursed their concessionaires. To put it more accurately, the concessionaires paid for the privilege of operating within one of our national parks. Previously, prior to 1998, concessionaires had a preferential right of renewal allowing them to match any other offers, thus eliminating competition.

You can imagine if, Madam President, there were a firm which had a concession in a national park in your beautiful State of Maine and they knew that in order to keep that concession, all they had to do was match any other competitor who would deign to try to take the concession. That would not encourage very many people to go to the effort of offering a competitive bid because they knew all the incumbent concessionaire had to do was just match their best price and they would continue to have the concession.

In 1998, we changed the system. We said we would go to an open, competitive bidding process and let those who could offer the highest quality and the best return to the park system be the concessionaires.

Yesterday, I had the privilege of visiting Bandelier National Monument in New Mexico. It exemplified the concession's contract law's positive effect on the national parks system. The new concessionaire improved the quality of products and provided such things as handicapped access to facilities that had not been available previously.

We can anticipate that the rates of return to the Government at Bandelier and other national parks will increase because we have a good example at Yosemite National Park. At Yosemite, the application of competitive bidding resulted in almost a 15-percent increase in the rate of return to the Government of the lease of their various concession facilities.

I commend Senator CRAIG THOMAS, our colleague, who was the leader in assuring this movement towards a fair price and quality goods and services for the users of our national parks. Unfortunately, the zeroing out of funds for competitive bidding demonstrations in Phoenix and Kansas City, as this conference report on the Labor-HHS/District of Columbia appropriations will do—it ensures that we will never know if we can achieve similar savings in the Medicare+Choice Program; that is, we can never know there will be a better, fairer way of reimbursing health maintenance organizations, which provide services to Medicare beneficiaries than what we are getting today through this percentage of fee-for-service formula.

Here is a riddle for the Senate to answer: Why would the appropriators eliminate funding for a program that saves money without harming quality, that gives us the opportunity to learn if there is a free-enterprise approach to

reimbursing HMOs as opposed to a socialist approach?

Madam President, it does not take a Sherlock Holmes to solve this mystery.

Chapter 1 of our mystery: It is July, 1999. The United States spends a full week debating managed care reform. The end result of this debate is vapid, weak legislation that impacts less than one-third of all Americans whose health care is covered by HMOs. It has weak standards on issues such as emergency room, access to specialists, a woman's right to use an OB/GYN as a primary physician, the right to continue to use a doctor if an HMO changes its plan. The legislation the Senate passed earlier this summer also had very limited enforcement and no right to sue.

It is interesting that the House of Representatives has written a different chapter with a much stronger and more effective bill of patients' rights when they are members of a health maintenance organization.

We have a second chapter in our book. The Senate is about to eliminate two demonstration projects that will allow us learn whether the marketplace might be an appropriate determinant of how Medicare HMOs should be reimbursed. Chapter 2 continues with the Senate Finance Committee designing a bill to give funds back to providers who have made the case they have been negatively, excessively impacted by the Balanced Budget Act of 1997. It is the same Balanced Budget Act that weaves its way through this whole volume.

What does the Senate Finance Committee decide to do? Nearly one-third of the money that will be provided back to physicians, hospitals, home health care agencies, skilled nursing facilities—a whole variety of medical providers—nearly one-third of the total money goes to the health maintenance organizations that provide services under the Medicare+Choice Program.

The irony is that only about 15 percent of the beneficiaries of Medicare receive their health care through a health maintenance organization. The remaining 85 percent of Medicare beneficiaries get their Medicare through the traditional fee-for-service system; that is, they make an unrestrained choice as to what doctor they want to see and then receive the services of that physician, and they, along with Medicare, then reimburse that physician.

The 85 percent of Medicare beneficiaries who use fee for service get only two-thirds of the additional payback money. Clearly, there is something fishy about the way these critical funds, intended to allow for the providers of health care to Medicare beneficiaries avoid draconian cuts in their service levels, were divided. Clearly, there is something amiss when one-third of the money in the Balanced

Budget Act "add back" measure goes to one-sixth of the Medicare beneficiaries.

Adding to this peculiar situation is the Congressional Budget Office's estimate that up until the end of this decade, the number of Medicare beneficiaries receiving their reimbursement through an HMO will still be less than the one-third of the total Medicare population. Yet, one-third of the money in the Balanced Budget Act "add back" bill is allocated to Medicare HMOs.

Chapter 3: A Republican Member of the House of Representatives introduces a bill to give doctors the right to collectively bargain with HMOs. The chairman of the Judiciary Committee brings this bill up before his committee for consideration. What happens? Let me read from the Daily Monitor of Wednesday, October 27. I ask unanimous consent that this article be printed in the RECORD immediately after my remarks.

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

(Exhibit 1.)

Mr. GRAHAM. Under the headline "GOP Leaders Order Hyde To Kill Bill On Doctor Bargaining":

Managed care lobby pushed to halt measure allowing doctors to negotiate with health plans.

After an intense lobbying campaign by managed care plans, House GOP leaders have killed for this year—at least—a bill that would allow doctors to bargain collectively with health plans.

The bill (H.R. 1304), sponsored by Tom Campbell, R-Calif., had been scheduled for a markup in the House Judiciary Committee Tuesday. But Speaker J. Dennis Hastert, R-Ill., on Monday asked committee Chairman Henry J. Hyde, R-Ill., to yank it.

"It won't be dealt with this year," Hyde said. "The leadership decided that they were involved with other health care issues and this was the...one that broke the camel's back. It's extra weight on a complicated issue. They felt it was another area of focus they don't need right now."

On Oct. 7, after months of heated negotiations and debate, the House passed a broad patients' rights measure (H.R. 2723, later H.R. 2990) after voting down a much narrower package backed by Hastert. The issue has long been a thorn in the side of the GOP leadership, which favors allowing the marketplace—rather than government—to regulate managed care.

The Campbell bill would for the first time allow independent doctors who contract with health plans to bargain collectively on everything from fees to who determines the treatment a patient receives. Health insurance groups strongly oppose the bill, arguing that doctors would be able to fix prices and drive up health insurance premiums. Doctors, led by the American Medical Association, backed the measure. They say health plans are beginning to monopolize the patient market, and that doctors often have no choice but to sign restrictive contracts in order to stay in business.

Hyde said that, along with Hastert, rank-and-file members who had been contacted by the health insurance industry asked him to pull the bill.

The chairman said he still wants to pursue the issue in the future but could not say if he would ever mark up the Campbell bill. "I don't know," he said. "I'm interested in doing something with the difficult relationship between doctors, HMOs and insurers. I don't think the problem will go away, nor will our responsibility [to address it]."

We have had the HMO industry delude, almost to total lack of effectiveness, the Patients' Bill of Rights in the Senate. We have had the industry increase its reimbursement at twice the rate that fee-for-service medicine is having its reimbursement increased as a part of the Balanced Budget Act "add-backs" legislation that we will soon be considering. We have had the House kill a bill to allow doctors to collectively bargain when they negotiate with HMOs. And now, after the HMOs have said what they want is to have the marketplace, not Government, run their business, they seem to have said they do not want to participate in the competitive bidding process to determine their levels of reimbursement. It appears that they would rather rely on the socialist-based theory of percentage of fee-for-service cost.

The managed care industry has successfully used its influence to move forward one of its key policy objectives: To strengthen Medicare managed care at the expense of Medicare fee for service. You might think that my statement is extreme, but I assure you it is accurate.

The policy objective is very clear. Using the words of the former Speaker of the House, Speaker Newt Gingrich, which he used to describe his view of Medicare reform, I quote from an Associated Press article of July 30, 1996, in a speech given to the Health Insurance Association of America. This is what the Speaker said:

We don't get rid of it [Medicare] in round one because we don't think that's politically smart, and we don't think that's the right way to go through a transition. But we believe it [traditional Medicare] is going to wither on the vine.

"Wither on the vine."

If you had to have a series of events that all had as their common objective diverting energy, resources, and attention away from the program where 85 percent of the Medicare beneficiaries receive their health care services towards the program where 15 percent receive their health care services—and nobody is estimating that within the next 10 years any more than 30 percent of the Medicare beneficiaries will receive their health care through HMOs—you couldn't have had a better strategy than the chapters that we have either written or are in the process of writing in the Congress in 1999.

On behalf of the 39 million Medicare beneficiaries in America today, and the millions more who will rely on the program tomorrow, I pledge to make certain that when Congress embarks upon true Medicare reform it will be focused

on what is best for all beneficiaries, both fee-for-service and Medicare+Choice participants alike.

We must reverse the course of this Congress. This Congress has shielded HMOs from patient protections, balanced negotiations with physicians, and competition in pricing. This Congress has rewarded HMOs with one-third of the additional money for one-sixth of the Medicare beneficiaries. And this Congress has refused to enhance the fee-for-service programs for 85 percent of the Medicare beneficiaries.

This Congress can begin to reverse this record by sustaining the President's veto of the outrage which describes itself as the Labor-HHS/District of Columbia appropriations bill. I am confident that the President will reject this legislation. We will have our next opportunity when we sustain his veto.

Madam President, having talked about just one of the outrages in this bill, let me turn to a second. That is the funding of the social services block grant.

On September 30, by a 57-39 vote, the Senate placed its strong bipartisan support behind the continued funding of the Social Services Block Grant Program at its authorized level of \$2.38 billion.

The Social Services Block Grant allocates funds to States, enabling them to provide services to vulnerable, low-income children and elderly, disabled people. The Social Services Block Grant is a mandatory program established under Title XX of the Social Security Act.

The purpose of Title XX is to intervene with vulnerable populations before they reach the point of disability or other condition that might make them eligible for a Social Security entitlement program.

In 1996, the Senate Finance Committee joined the House Ways and Means Committee, and then the full Chambers, in promising that this program of social services block grants would be funded at the authorized level of \$2.38 billion for the fiscal year 2000. In fact, we made a commitment to the States that the social services block grant would be guaranteed at the \$2.38 billion annual level until welfare reform was fully completed in the year 2002.

When this commitment was recommended to be breached by the Senate version of the Labor-HHS appropriations bill, on September 30, the Senate stood up, and by that vote of 57-39 voted to restore full funding to comply with our commitment to our constituents and to the States.

Once again, the appropriators have nullified our vote. They have voided our promise to the States. In the conference report that will be before us, the Labor-HHS/District of Columbia appropriations bill, the Social Services

Block Grant Program will be recommended for funding at \$1.7 billion—over a half billion dollars below what is our authorized level, what is our commitment to the States. This figure is below what was approved by the Senate. This figure is also below the \$1.9 billion that the House Labor, Health and Human Services and Education Appropriations Subcommittee approved for this program.

The raiding of the Title XX program should serve as an example of what can happen when a program is block granted. Our experience with the social services block grant should serve as a red flag as we structure other social services funding.

Those, for instance, who might succumb to the siren call of block grants for education should take note. A Federal program which serves a largely politically voiceless group of Americans, as Hubert Humphrey described, those who live in the dawn of life, our children, those who live in the twilight of life, our elderly, and those who live in the shadows of life, the disabled, these are the Americans who will be at risk, just as they are at risk today with the slashing of funding of the social services block grant. They will be at risk if we move towards the same pattern of funding for important national programs such as education. Because they will not have the HMOs' lobbyists, they will not have the PACs to represent their interests, to ensure they get their share when the Federal largess is divided, they are likely to get the scraps that are left over.

I urge the President of the United States to veto this legislative elephant which is squashing the ant. I urge that he veto the legislation that would fund the Departments of Labor and HHS, and the District of Columbia because we, the Congress, can do better. We need to be given the opportunity and the challenge to do so.

EXHIBIT 1

[From the CQ Daily Monitor, Oct. 27, 1999]
GOP LEADERS ORDER HYDE TO KILL BILL ON
DOCTOR BARGAINING

(By Karen Foerstel)

After an intense lobbying campaign by managed care plans, House GOP leaders have killed for the year—at least—a bill that would allow doctors to bargain collectively with health plans.

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package backed by Hastert. The issue has long been a thorn in the side of the GOP leadership, which favors allowing the market place—rather than government—to regulate managed care.

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Mr. GRAHAM. I thank the Chair and suggest the absence of a quorum.

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

The legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. FITZGERALD. Mr. President, I ask unanimous consent that the Senate now proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

RALPH TASKER "A COACHING LEGEND"

Mr. LOTT. Mr. President, I rise today to honor a man who touched the lives of each person he came into contact with throughout his teaching and coaching career. Coach Ralph Tasker was a respected person, and a perfect gentleman. He always looked for the good in people and had that rare ability to bring out the best in others.

Born and raised in Moundville, West Virginia, Coach Tasker took up basketball when he was five years old. This was his common bond with most of his friends. In Moundville, nearly everyone worked in coal mines except for Tasker's parents, who owned and operated a grocery store. He played basketball in high school, earning all-state honors in his junior and senior campaigns. From there he played four years at Alderson-Broadus College, and this is where he met his wife, Mar-

garet Elizabeth Marple. The two were married and devoted to each other for nearly fifty years until Margaret passed away in 1991.

Tasker began his coaching career straight out of college at Sulphur Springs High School in Sulphur Springs, Ohio, in 1941. He spent less than a year at Sulphur Springs, but even then made an impact on his students and players. Tasker went beyond the role of coach and teacher, as he was always a friend to his students and players. From his first year in coaching, his students considered Coach Tasker a father figure. Those who knew Coach Tasker describe him as dedicated, sincere, and loyal to his players and community.

After leaving Sulphur Springs, Coach Tasker served our country for three years in the U.S. Air Corps. He then accepted another coaching position in New Mexico at Lovington High School. After three years and one state championship with Lovington, Coach Tasker moved twenty miles south to Hobbs High School, where he would remain for the rest of his coaching career. Forty-nine years, eleven state championships, two perfect seasons, and two National High School Coach of the Year awards later, Coach Tasker decided to retire. In fifty-three years of coaching, Tasker had a remarkable collection of achievements. He finished with 1,122 wins and 291 losses, which ranks him as the third place coach in total number of wins in high school boys' basketball history. Among many honors, he was elected to four different halls of fame, won twelve state championships, and in 1991 was named the National Athletic Coach of the Year in the prestigious Walt Disney National Teacher Awards Program.

Coach Tasker was slow to take credit, but quick to praise. He often said, "When you've got players like I've got, they make a great coach out of you." He was uncomfortable in the limelight, and even chose to put his awards away in drawers, preferring to display artwork by his grandchildren. Coach Tasker always sought to uplift his children, grandchildren, students, and players.

Mr. President, Coach Ralph Tasker passed away on Monday, July 19, 1999, after a brief bout with cancer. I trust the Senate will join me in honoring one of the greatest men in the sports history of New Mexico and this country. He will be missed by everyone. I believe my friend Senator DOMENICI put it best when he said, "The passing of Ralph Tasker marks the loss of an institution in Hobbs and in New Mexico."

CONGRATULATIONS TO THE GARRETSON, SD, CHAPTER OF THE FUTURE FARMERS OF AMERICA

Mr. DASCHLE. Mr. President, I have spoken many times to my colleagues in