represents only one piece of the puzzle—parents still have to contend with music, video games, Internet sites, and movies which may be inappropriate for kids.

I think our goal should be to make available whatever information and technology is helpful to parents. Neither a rating system nor government regulations can—or should—substitute for the good judgment of parents.

TRIBUTE TO HAROLD G. HALL

HON. WILLIAM J. COYNE

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 12, 1997

Mr. COYNE. Mr. Speaker, on Wednesday, February 19, 1997, Harold G. Hall will receive the prestigious Metcalf Award at the 113th Annual Banquet of the Engineers' Society of Western Pennsylvania. The award is named for William Metcalf, ESWP's first president (1880–81) and is presented each year to an individual who has made significant lifetime contributions in the field of engineering.

Harold G. Hall was born and raised in Pittsburgh, PA. He entered Penn State University to pursue a degree in ceramic engineering, but left college to enter the U.S. Army Air Force where he became a pilot in the Alaskan theater. After 3 years in the service, he returned to Pittsburgh and earned his degree as a mechanical engineer at Carnegie Tech (now Carnegie-Mellon University).

Mr. Hall founded Hall Industries in the 1960's. His interest in manufacturing led him to help other small manufacturers who were devastated by the crash of the steel industry in Pittsburgh, and Hall Industries became a collaboration of 11 small companies which had been struggling to stay in business.

Today, Hall Industries has three facilities in western Pennsylvania and one in Greenville, SC. Its 120 employees serve national markets in the aviation and rapid transit industries, and they also produce precision industrial parts. Hall Industries has also been coordinating engineering studies by Lockheed Martin, the Pennsylvania Maglev Corp., Sargent Electric, Union Switch and Signal, P.J. Dick Corp., and Mackin Engineering that are part of an initiative to develop a magnetic levitation transportation system in Pittsburgh.

Mr. Hall continues to contribute his expertise to Hall Industries and to other companies. His next project is the evaluation of a machine facility in Beijing, China.

Harold G. Hall joins a large, distinguished group of previous Metcalf Award winners. He is an individual of gifted insight, imagination, and special abilities. He is richly deserving of this award. I commend him on the occasion of this notable achievement.

ESSENTIAL HEALTH FACILITIES INVESTMENT ACT OF 1997

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 12, 1997

Mr. STARK. Mr. Speaker, today I am introducing the Essential Health Facilities Investment Act of 1997. This legislation will provide a financial helping hand to those hospitals and health centers that are in the front lines of dealing with our national health care crisis. This legislation allows for the expansion of community health services and the capital needs of safety-net health care facilities while at the same time attempting to limit the further duplication of unnecessary high technology services.

This bill is similar to legislation that was introduced in the 103rd and 104th Congresses and which was included in the national health reform legislation that was approved by the Ways and Means Committee. It is my hope that this new Congress will work toward passage of this bill.

At a time when we are faced with continually shrinking budgets and fiscal austerity, it is more important than ever to appropriate Federal moneys in the most cost-effective manner available while providing the most benefit to all our citizens. In terms of health care, this includes establishing and expanding community health programs designed to provide low-cost primary care to underserved populations to avoid subsequent high-cost emergency room visits. In addition, we must help to support those not-for-profit and public hospitals that deal with a disproportionate number of uninsured patients. In one comparative analysis, urban public hospitals averaged over 19,000 admissions, 242,000 outpatient visits, and nearly 4,000 live births per hospital. The urban private hospitals in the same areas registered just 7,000 admissions, 50,000 outpatient visits, and 760 live births. These safety-net facilities—the public and not-for-profit hospitals that serve a disproportionate share of uninsured and low-income patients—are in essence the family doctor for many in our country. Though it would be far better to incorporate the uninsured into our national insurance pools and give them access to any health care facility they choose to visit, the stark reality is that they are dependent upon these safety-net hospitals for any and all of their health care.

But the importance and benefits associated with public hospitals do not end there. In addition to caring for our Nation's most vulnerable populations, these hospitals provide a great deal of specialty care to their communities. Services such as trauma, burn units, and neonatal intensive care units are frequently found in these hospitals. Many of these services are too costly for other hospitals to provide.

These hospitals are expected to provide quality care under extraordinary circumstances. As an example, they are frequently confronted with tragedies associated with our Nation's obsession with guns. Roughly half of all urban safety-net hospitals are equipped with a trauma center and serve as the first-line treatment facilities for victims of gun violence. The Federal Centers for Disease Control and Prevention predict that, by the year 2003, gunfire will have surpassed auto accidents as the leading cause of injury and death in the United States. Unlike victims of auto accidents who are almost always privately insured, 4 out of 5 gunshot victims are on public assistance. More than 60 urban trauma centers have already closed in the past 10 years. This means that less than one-quarter of the Nation's population resides near a trauma center. Gunshot wounds account for fewer than 1 percent of injuries in hospitals nationwide, yet account for roughly 9 percent of injury treatment costs. It is estimated that for every 1 of the 40,000 patients who die from a gunshot wound annually, 3 others suffer injuries serious enough to require hospitalization.

Serving as a safety-net hospital and community provider places public hospitals at great financial risk. With threatened cutbacks and changes in the Medicare and Medicaid programs, coupled with tightened local budgets, public hospitals face an erosion of traditional sources of funding. Additionally, changes in the health care market, particularly the evolution of managed care and increased competition among providers, have further added to the financial pressures faced by these hospitals. Managed care's ability to attract tougher competition to the health care sector has decreased the urban safety-net hospital's ability to cost-shift some of the heavy losses incurred while providing uncompensated care. As a result, according to a June 1996, Prospective Payment Assessment Commission [ProPAC] report, hospitals in urban areas with high managed care penetration saw their payment-to-cost ratio decrease by 2 percent from 1992 to 1994. Declining margins have resulted in many urban hospitals cutting their level of charity care. In fact, ProPAC found that uncompensated care fell by 4.5 percent during the same time period. This represents clear evidence that more and more of the burden for providing charity care is being shifted to the public safety-net hospitals.

As safety-net providers, public hospitals have historically provided large amounts of uncompensated care. In 1995, for instance, 67 of the member hospitals of the National Association of Public Hospitals [NAPH] provided $5.7 billion in bad debt and charity care, averaging $85,060,641 per hospital. Additionally, bad debt and charity care charges represented 25 percent of gross charges at these hospitals in the same year. According to data from the American Hospital Association [AHA], $28.1 billion in bad debt and charity care was provided nationwide. The NAPH member hospitals represent less than 2 percent of hospitals in the U.S., yet provide over 20 percent of bad debt and charity care nationally.

During the last 15 years, public hospitals have been shouldering a greater portion of the uncompensated care burden. Additionally, private hospitals have begun competing for Medicaid patients which further erodes support for the public providers. Public hospitals rely heavily on payments from Medicare and Medicaid patients to cross-subsidize care for the indigent. As dollars from these programs move from the public to the private hospitals, the ability to function as a safety-net provider is severely tested.

OUTLINE OF THE ESSENTIAL HEALTH FACILITIES INVESTMENT ACT OF 1997

In title I of this legislation, Medicare's Essential Access Community Hospital Program [EACH] would be expanded to all States and a new urban Essential Community Provider Program [ECP] would be created. Funding would be provided for the creation of hospital and community health clinic networks that improve the organization, delivery, and access to preventive, primary, and acute care services for underserved populations.

In title II, financial assistance for capital needs would be provided by the Secretary of HHS to safety-net facilities which serve a disproportionate share of uninsured and low-income patients. Funds for this legislation would

be provided by a one-half percent on hospital gross receipts tax.

In title III, financial and technical assistance would be provided to States engaged in review of capital expenditures for health care facilities and high technology equipment. Consideration of alternative, less costly, and existing services would be considered before any funds would be distributed.

REBUILDING THE URBAN SAFETY NET

Even though these essential access facilities fulfill a pivotal role in our Nation's health care system, their infrastructure suffers from gross neglect and under-investment. The buildings and systems that comprise the safety net are often antiquated. Without future reinvestment, the inequities in this system will continue to grow, causing even more of America's underprivileged population to be medically abandoned.

The average age of the physical plant of urban, public hospitals is nearly 27 years, compared to a national average for all hospitals of 7 years. The average capital expenditure for urban hospitals is $12,800 per bed compared to a national average expenditure for all hospitals of $23,700.

A national survey of the Nation's safety-net hospitals found that lack of available hospital beds is resulting in severe overcrowding. Hospital corridors surrounding emergency rooms have begun to resemble triage units seen at the height of military campaigns. A recent study showed that approximately 50 percent of the hospitals in the three most severely impacted areas, Los Angeles, Detroit, and New York were forced to restrict emergency department access over 25 percent of the time. This is occurring despite the fact that occupancy rates of all hospitals have steadily declined during the last decade and are now barely above 60 percent. The average occupancy rate for safety-net hospitals is roughly 82 percent, with some reporting 100 percent occupancy, while private urban hospitals averaged just 67 percent. At any given time, approximately one-third of America's 924,000 hospital beds are empty. Our national priorities have created an excess of beds in areas where need doesn't exist. Likewise, a severe shortage has been created in areas where demand is overwhelming. This bill attempts to address and alleviate some of the pressure built up within the safety-net system.

Historically, health care institutions have found it difficult to secure sufficient financing for capital renovation and expansion products. The financing exists within the market, yet the level of debt service required is often too burdensome for public institutions to manage. Even when revenue bonds are supported by local means, the bond ratings are frequently too low and interest rates too high. After all, these safety-net hospitals treat a high proportion of low-income patients which results in lower operating margins. These ratings have little to do with the ability of hospital administrators to manage their facilities. Rather, market analysts often consider the local appropriations sustaining these facilities to be too uncertain. Thus, the facility is simply prohibited from securing necessary capital.

For facilities facing the greatest demand in our inner-city and rural areas, the traditional method of financing through Federal funding is no longer available. Many of these facilities were originally built with grants or loans under the Hill-Burton Program. These funds have not been available for years. The lack of Federal dollars available to repair and rebuild these facilities, combined with the strain on the resources of local governments, means that the capital needs of safety-net facilities have gone unmet.

This legislation does not propose that the Federal Government take on a massive rebuilding program like the Hill-Burton Program. Nor does it propose that the Federal Government take sole responsibility to solve this problem. However, this legislation is designed to support State and local efforts to upgrade the capacity of these facilities. In drafting this bill, we recognized that the Federal Government has limited resources it can tap for this purpose. Therefore, funding for this program would be achieved through a 0.5 percent—one-half of 1 percent—tax which would be levied against the gross revenues of all hospitals. Hospital revenues received from Medicaid would be exempt from the tax.

Revenue from this relatively modest trust fund would be used by those inner-city and rural facilities across America with the greatest need for assistance. Eligible facilities would include those designated as essential access community hospitals, rural primary care hospitals, large urban hospitals, and qualified health clinics that are members of community health networks.

Assistance from the capital financing trust fund would be provided in the form of loan guarantees, interest rate subsidies, direct matching loans, and in the case of urgent life and safety needs, direct grants. The Federal assistance would be used to leverage State and local government and private sector financing. Repayment would be made back to the trust fund.

For fiscal years through 2002, $995 million will be made available each year through the capital financing trust fund for these safety-net facilities.

With relatively limited resources available to meet the significant health facility infrastructure needs across the Nation, decisions to finance the reconstruction, replacement, or acquisition of facilities and equipment must be made only after first considering whether existing service capacities could be tapped to meet the needs of the underserved more effectively. The next section of this bill is designed to ensure that the capital expenditure decisions supported by this legislation are considered within the context of the entire community's needs and capacities.

MAXIMIZING CAPITAL RESOURCES

Many communities, especially those in rural and inner-city areas, lack the facilities and equipment necessary to adequately meet the needs of their residents at the same time that other hospitals are experiencing a capital oversupply. This oversupply leads to inflationary price pressure. The Essential Health Facilities Investment Act of 1997 will expand medical services to those in need only if the planning authorities feel that the current local medical facilities are unable to meet the needs of the community. In addition, this bill specifically states that only projects that will lead to an increase in the quality of care rendered will be funded. In other words, requests for frivolous, redundant facilities will be denied funding.

One area of oversupply is hospital beds. According to the ''Dartmouth Atlas of Health Care,'' published by the Dartmouth Medical School in 1996, there were more than 827,000 acute care hospital beds in the United States in 1993. The average number of beds per thousand residents was 3.3. Following adjustments for demographic differences, the number of hospital beds per thousand persons varied by a factor of 2.8 across the Nation. The range was from fewer than 2 beds per thousand residents to more than 5 beds per resident. Some of the hospitals with this excess capacity could be closed, or at the very least, denied additional public capital improvement funds. Still, we must also make every effort to ensure that every geographic and community area receives adequate hospital services. In order to avoid exacerbating the current oversupply of hospital beds, we must establish and satisfy safeguards and criteria for the allocation of Capital Financing Trust Fund, EACH, and ECP funds.

Redundancies and inefficiencies with hospital facilities and services are well known. A study in the Annals of Internal Medicine showed that even though America had 10,000 mammography machines at the time of the report, we essentially used only 2,600 of them. This same study asserts that even if every woman in America had a mammography every time the American Cancer Association suggested it was appropriate, we would use only 5,000 of the 10,000 functioning mammography machines.

In addition to a vast waste of valuable resources, this excess capacity can be considered detrimental to the health of patients. Applying the guidelines endorsed by the American Hospital Association and the American College of Cardiologists, 35 percent of the open-heart surgery centers in California perform less than the minimum number of procedures required to achieve an acceptable level of competency and quality. We should not reward those hospitals that insist upon maintaining high cost, redundant, tertiary care services that fail to maintain a minimum level of quality. Admittedly, the availability of reliable outcome studies covering high technology procedures is limited, but there exists reputable data concerning hip replacement surgery and coronary artery bypass surgery [CABS] success factors. The October 25, 1995 issue of the Journal of the American Medical Association cites a study titled ''Regionalization of Cardiac Surgery in the United States and Canada'' which shows that:

> In California, age and sex-adjusted mortality rates in hospitals performing 500 or more CABS operations per year were 49% lower than in hospitals performing fewer than 100 CABS operations * * *
>
> Hip replacement surgery data and this coronary artery bypass surgery study effectively demonstrate a direct correlation between the volume of procedures performed and the resulting success rates.

I propose that in order to be considered for Medicare reimbursement, a coronary artery

bypass surgery hospital must meet the minimum criteria for quality outlined by the Secretary in the Medicare Centers of Excellence for CABS operations. Expanding on this idea, I suggest that any hospital wishing to improve a tertiary care service using resources in excess of $1 million from the Capital Financing Trust Fund must not only demonstrate that they are indeed a safety-net health care provider, but also meet standards of quality for that particular service outlined by the Secretary. As additional reliable outcome studies for other expensive, capital-intensive services become available, disbursement of Capital Financing Trust Funds for improvements will be dependent upon demonstration of adequate quality performance as measured by HCFA's quality outcome measurement.

EXPANDING THE EACH PROGRAM

A third provision of this legislation is designed to facilitate the organization, delivery, and access to primary, preventive, and acute care services for medically underserved populations by fostering networks of essential community providers.

The Essential Access Community Hospital Program was enacted in 1989. This Medicare initiatives provides a unique Federal-State partnership to assure the availability of primary care, emergency services, and limited acute inpatient services in rural areas. The EACH Program was created to maximize resources available to rural residents by establishing regional networks of full-service hospitals [EACH's] connected to limited-service rural primary care hospitals [RPCH's]. Since 1991, over $17 million has been awarded in seven participating States.

In a March 1993 report by the Alpha Center, the strengths of the EACH Program were clearly articulated. They stated:

The EACH Program has released an enormous amount of creative energy focused on the development of regional networks that link health care providers in remote areas with those in more densely populated communities.

A letter from the project directors of the seven EACH States contained the following comment.

We believe the EACH concept will assist policymakers, regulators and changemakers in the long process of refocusing rural health care delivery.

I am confident that the EACH Program provides a framework for greatly improving the quality and efficiency of primary care, emergency services, and acute inpatient services in rural areas across the country. As a result, this legislation contains language that would extend the EACH Program to all States.

In addition, creating a new urban Essential Community Provider Program [ECP] would carry the network concept to our Nation's inner cities. While different from the rural EACH Program, the urban ECP Program would concentrate on networking hospitals with primary care service centers, particularly federally qualified health centers. In addition, ECP networks could combine with rural networks.

A report by the General Accounting Office found that ''more than 40 percent of emergency department patients and illnesses or injuries categorized as nonurgent conditions.'' The growth in the number of patients with nonurgent conditions visiting emergency departments is greatest among patients with little or no health insurance coverage—exactly those populations served by essential community providers. Networks of essential community provider hospitals and clinics will help steer patients to more appropriate clinical settings and, as a result, maximize the resources available in both emergency and nonemergency settings.

The concept of inner-city provider networks designed to ease access and improve continuity of care is not new. Initiatives are currently being pursued in urban areas across this country to do just that. This legislation would boost these efforts through critical financial and structured technical assistance.

Funding under the ECP Program would be available for the expansion of primary care sites, development of information, billing and reporting systems, planning and needs assessment, and health promotion outreach to underserved populations in the service area. Facilities eligible to participate in the ECP networks—those designated as ''essential community providers''—include Medicare disproportionate share hospitals, rural primary care hospitals, essential access community hospitals, and federally qualified health centers [FQHC] or those clinics which otherwise fulfill the requirements for FQHC status except for board membership requirements.

In order to facilitate integration of hospitals and clinics into these community health networks, physicians at network clinic sites would be provided admitting privileges at network hospitals. In addition, the placement of residents at network-affiliated FQHC's would be counted in the total number of residency positions when determining the indirect medical education [IME] reimbursement to hospitals under Medicare. The authorized funding level for rural EACH and urban ECP would be increased tenfold, from the current level of $25 to $250 million annually.

I am introducing the Essential Health Facilities Investment Act of 1997 because I believe this legislation is an important and necessary component of the effort to reform our Nation's health care delivery system. The initiatives in this bill are essential to ensuring access to high quality and efficient services for everyone in our communities.

TRIBUTE TO THE SOUTH BRONX JOBS CORPS CENTER

HON. JOSÉ E. SERRANO

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 12, 1997

Mr. SERRANO. Mr. Speaker, recently I had the opportunity to visit the South Bronx Jobs Corps Center, which has been successful at helping disadvantaged youngsters acquire the educational and professional skills they need to succeed in the workplace.

Established 11 years ago in my South Bronx congressional district, the South Bronx Jobs Corps Center is proud of the 500 Bronx youngsters it serves annually. The center provides students with guidance and training, tailored to their individual needs. At the center, younsters have the opportunity to obtain a high school equivalency diploma and to learn a variety of trades including, office assistant with knowledge of word processing, accounting clerk, nurse assistant, and building maintenance technician.

In addition, the center encourages students to participate in community service. Every year students partake in antigraffiti campaigns and in beautifying buildings in our community. They also host meetings of Community Board No. 5 and the 46th Precinct Council, which students are encouraged to attend and participate in.

The South Bronx Jobs Corps Center fosters a family-oriented environment to help youngsters overcome their challenges. It houses 200 youngsters and provides day care services to students' children ages 3 months to 3 years. The social component of the center's training includes parenting classes for students.

In 1964, President Lyndon B. Johnson proposed the establishment of the Jobs Corps as an initiative to fight poverty. The South Bronx Jobs Corps Center is 1 of 100 centers nationwide and in Puerto Rico, serving youngsters ages 16 to 24.

Supported by President Clinton, the Jobs Corps continues to be an effective program to assist at-risk youngsters in completing their education, increasing their self-esteem, developing a sense of belonging to the community, and preparing for a productive adulthood.

This May 100 students will graduate from the South Bronx Jobs Corps Center. Seventeen of the center's 100 employees are South Bronx Jobs Corps graduates. Many others after completing the program have pursued a college education and secured part-time or full-time jobs.

The most famous graduate from one of the centers in the Nation is heavyweight champion George Foreman. Mr. Foreman, who also authored a cook book, visited the South Bronx Jobs Corps Center recently to talk about the importance that the Jobs Corps program has had in his overall career.

Mr. Speaker, I ask my colleagues to join me recognizing the staff and students of the South Bronx Jobs Corps Center for their outstanding achievements and in wishing them continued success.

TERM LIMITS

HON. LINDA SMITH

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 12, 1997

Mrs. SMITH of Washington. Mr. Chairman, today I will vote against the seven term limits amendments to the U.S. Constitution which were offered by Members of Congress who represent States which have passed term limits referendums. According to these so-called scarlet letter proposals, if a Member of Congress from one of these States failed to vote in favor of the exact term limit proposal approved in the referendum, the phrase ''violated voter instruction on term limits'' would be printed next to the Member's name on future ballots.

I am a strong supporter of term limits. I cosponsored House Joint Resolution 3 in the 104th and 105th Congress which would limit terms in the House to three terms and two terms in the Senate.

Nevertheless, I opposed the scarlet letter proposals because the way these referendums are drafted, they preclude Members of Congress in scarlet letter ballot States from voting for any other version than the one approved