L. Johnson, 33, Memphis, TN; Rickey D. Johnson, 36, Memphis, TN; Willie Johnson, 20, Miami, FL; Roberto E. Moody, 30, Seattle, WA; Donald Morrison, 20, San Antonio, TX; Deric Parks, 23, Washington, DC; Harry R. Penninger, 69, Memphis, TN; Albert Perry, 31, Detroit, MI; Artemio Raygoza, 22, San Antonio, TX; Douglas M. Stanton, 33, Chicago, IL; Rodrick Swain, 24, Houston, TX; Ramon Vasquez-Ponti, 56, Miami, FL; Damon Williams, 21, Kansas City, MO; Derrion Wilson, 19, Memphis, TN; Margaret Wilson, 52, Dallas, TX; Dwayne Wright, 28, Detroit, MI; Unidentified Male, 18, Norfolk, VA.

One of the gun violence victims I mentioned, 20-year-old Donald Morrison of San Antonio, was shot and killed one year ago today when an irritated driver followed Donald into a convenience store parking lot and shot him in the head.

Another victim, 33-year-old Greta Johnson of Memphis, was shot and killed one year ago today by her husband before he turned the gun on himself.

We cannot sit back and allow such senseless gun violence to continue. The deaths of these people are a reminder to all of us that we need to enact sensible gun legislation now.

HEALTH CARE SAFETY NET OVERSIGHT ACT OF 2000

Mr. HATCH. Mr. President, I am pleased to cosponsor the Health Care Safety Net Oversight Act of 2000, which is an important step toward addressing a critical issue facing our country: the fact that over 40 million Americans lack health insurance.

While it is natural to question the need for any new commission, I believe this legislation is more than warranted given the fact that there is such a substantial number of Americans who are uninsured and there is to date no comprehensive solution to this problem.

Despite the hard work of Community Health Centers in Utah and throughout the Nation, and despite the many, many efforts of others who are working to improve health care delivery in hospitals, emergency rooms and clinics, two facts remain. First, it is deplorable that in a Nation as great as the United States, we still have so many people who lack basic health care services. And second, there is no national consensus on how this problem should be addressed by the public and private sectors.

It is obvious that we need to begin the process toward developing that necessary consensus, and I believe the Health Care Safety Net Oversight Commission's work will help us meet that goal.

I commend Senator BAUCUS and my colleagues for their work which has led to introduction of our bipartisan bill tonight. As the legislation progresses, I do want to work with them to improve a limited number of provisions in the bill, including the funding source for the Commission.

THE MEDICARE BENEFICIARIES' CHOICE STABILIZATION ACT

Mr. SANTORUM. Mr. President, I rise today to address a matter of critical importance to our Nation's 39 million Medicare beneficiaries, 2 million of whom live in Pennsylvania alone. I speak of the current erosion of the Medicare+Choice program, a situation which demands attention by Congress and this administration.

Currently, more than 6.2 million Medicare beneficiaries are enrolled in the Medicare+Choice program, receiving high quality, affordable health care services through HMOs and other private sector health plans. Beneficiaries are choosing these plans because they typically provide a more comprehensive package of benefits (including coverage of prescription drugs), lower out-of-pocket costs, and a stronger emphasis on preventive health care services than the old Medicare fee-for-service system.

As my colleagues well know, for more than ten years Medicare beneficiaries have had access to this array of enhanced health benefits and options through the Medicare's risk contract program, and the success of this program was evidenced by the fact that beneficiaries signed up for Medicare HMO coverage in large numbers. From December 1993 through December 1997, enrollment in Medicare HMOs increased at an average annual rate of 30 percent. In states such as Louisiana, Pennsylvania, Ohio, and Texas, enrollment in Medicare HMOs increased even more rapidly. In December 1997, shortly after the enactment of the BBA, Medicare HMO enrollment stood at 5.2 million, accounting for 14 percent of the total Medicare population—up from just 1.3 million enrollees and 3 percent of the Medicare population in December 1990.

The success of the Medicare HMO program inspired Congress to establish the Medicare+Choice program in 1997 through the enactment of the Balanced Budget Act (BBA). In establishing the Medicare+Choice program, Congress had three goals in mind: (1) to build on the success of the Medicare HMO program; (2) to give seniors and persons with disabilities the same health care choices available to Americans who obtain their health coverage through the private sector; and (3) to further expand beneficiaries' health care choices by establishing an even wider range of health plan options and by making such options available in areas where Medicare HMOs were not yet available. Three years later, however, the Medicare+Choice program has not fulfilled its promise of expanding health care choices for Medicare beneficiaries. Instead, a large number of beneficiaries have lost their Medicare+Choice plans or experienced an increase in out-of-pocket costs or a reduction in benefits.

This disturbing trend is especially harmful to low-income beneficiaries, who are almost twice as likely to enroll in Medicare HMOs as are other Medicare beneficiaries. For many seniors and persons with disabilities who live on fixed incomes, having access to a Medicare HMO means that they can spend their limited resources on groceries and other daily essentials. Beneficiaries also like Medicare HMOs because they provide coordinated care and place a strong emphasis on preventive services that help them to stay healthy and avoid preventable diseases.

Mr. President, when Congress enacted BBA in 1997, plans were still joining the Medicare+Choice program and 74 percent of beneficiaries had access to at least one plan. But today, access dropped to 69 percent, with 2 million fewer beneficiaries having access to a plan. Next year, 711,000 Medicare beneficiaries will lose access to health benefits and choices as a result of Congressional underpayment and burdensome HCFA regulations.

In addition, many Medicare HMOs have curtailed benefits, increased cost-sharing and raised premiums. Average premiums have increased $11 per month in 2000.

Two major problems are responsible for this outcome: (1) the Medicare+Choice program is significantly underfunded; and (2) the Health Care Financing Administration (HCFA) has imposed excessive regulatory burdens on health plans participating in the program. The funding problem has been caused by the unintended consequences of the Medicare+Choice payment formula that was established by the BBA, as well as the Administration's decision to implement risk adjustment of Medicare+Choice payments on a non-budget neutral basis. Under this formula, the vast majority of health plans have been receiving annual payment updates of only 2 percent in recent years—while the cost of caring for Medicare beneficiaries has been increasing at a much higher rate.

When plans withdraw from communities, beneficiaries are forced to switch plans, or in some cases revert back to the traditional Medicare program, which does not cover additional benefits like eye and dental care, or, more importantly, prescription drugs.

It is in response to this crisis in the Medicare+Choice program that I am pleased to be introducing The Medicare Beneficiaries' Choice Stabilization Act. This legislation will make numerous changes to the way Medicare+Choice rates are calculated and will seek to sensitize the funding mechanisms in the current Medicare system to the difficulties of health care delivery in all communities, and particularly in rural areas.

As the costs of providing care in some areas can be higher than the payments from Medicare, The Medicare Beneficiaries' Choice Stabilization Act will also give plans the opportunity to negotiate for higher payment rates based on local costs.

Realizing the importance of assuring that the benefits of programmatic regulations outweigh their costs, my legislation will also provide Medicare+Choice providers regulatory relief from overreaching HCFA dictates. Rather than devoting substantial human and financial resources toward compliance activities, which leaves fewer resources available for paying for health care services provided to beneficiaries, Medicare+Choice plans ought to be left to the fullest extent possible to the business they know best: providing high quality and cost effective health care to our Medicare beneficiaries.

Congress must devote more adequate funding to the Medicare+Choice program, and work to ensure that resources are allocated in such a way as to assure that the Medicare+Choice program is viable in areas where beneficiaries have already selected health plan options and that the program can expand in areas where such options are not yet widely available. I am sponsoring Beneficiaries' Choice Stabilization Act with just these goals in mind, and I hope my colleagues will join me in a bipartisan effort to save and strengthen the Medicare+Choice program and the valuable health benefits it provides for our Medicare population which relies on them.

DEPARTMENT OF JUSTICE REPORT OF RACE AND GEOGRAPHIC DISPARITIES IN FEDERAL CAPITAL PROSECUTIONS

Mr. FEINGOLD. Mr. President, in recent months, our Nation has begun to question the fairness of the death penalty with greater urgency. Now, with details of the Justice Department report being released, we have learned that just as we feared, the same serious flaws in the administration of the death penalty that have plagued the states also afflict the federal death penalty. The report documents apparent racial and regional disparities in the administration of the federal death penalty. All Americans agree that whether you die for committing a federal crime should not depend arbitrarily on the color of your skin or randomly on where you live. When 5 of our 93 United States Attorneys account for 40 percent of the cases where the death penalty is sought; when 75 percent of federal death penalty cases involve a minority defendant, something may be awry and it's time to stop and take a sober look at the system that imposes the ultimate punishment in our names.

I first urged the President to suspend federal executions to allow time for a thorough review of the death penalty on February 2 of this year. I repeat that request today, more strongly than ever. While I understand the Attorney General plans further studies of some of the issues raised by the report, additional internal reviews alone will not satisfy public concern about our system. With the solemn responsibility that our government has to the American people to ensure the utmost fairness and justice in the administration of the ultimate punishment, and with the first federal execution since 1963 scheduled to take place before the end of the year, a credible, comprehensive review can be conducted only by an independent commission.

This is what Governor Ryan decided in Illinois. He created an independent, blue ribbon commission to review the criminal justice system in his state, while suspending executions. The wisdom of that bold stroke by Governor Ryan is clear, both to supporters and opponents of capital punishment. The federal government must do the same. The President should appoint a blue ribbon federal commission of prosecutors, judges, law enforcement officials, and other distinguished Americans to address the questions that are raised by the Justice Department report and propose solutions that will ensure fairness in the administration of the federal death penalty.

I urge the President to suspend all federal executions while an independent commission undertakes a thorough review. That is the right thing to do, given the troubling racial and regional disparities in the administration of the federal death penalty. Indeed, it is the only fair and rational response to these disturbing questions. Let's take the time to be sure we are being fair. Let's temporarily suspend federal executions and let a thoughtfully chosen commission examine the system. American ideals of justice demand that much.

CABIN USER FEE FAIRNESS ACT OF 1999

Mr. CRAIG. Mr. President, soon the Senate will take up S. 1938, the Cabin User Fee Fairness Act of 1999. It is designed to set a new course for the Forest Service in determining fees for forest lots on which families and individuals have been authorized to build cabins for seasonal recreation since the early part of this century.

In 1915, under the Term Permit Act, Congress set up a program to give families the opportunity to recreate on our public lands through the so-called recreation residence program. Today, 15,000 of these forest cabins remain, providing generation after generation of families and their friends a respite from urban living and an opportunity to use our public lands.

These cabins stand in sharp contrast to many aspects of modern outdoor recreation, yet are an important aspect of the mix of recreation opportunities for the American public. While many of us enjoy fast, off-road machines and watercraft or hiking to the backcountry with high-tech gear, others enjoy a relaxing weekend at their cabin in the woods with their family and friends.

The recreation residence programs allows families all across the country an opportunity to use our national forests. This quiet, somewhat uneventful program continues to produce close bonds and remarkable memories for hundreds of thousands of Americans, but in order to secure the future of the cabin program, this Congress needs to reexamine the basis on which fees are now being determined.

Roughly twenty years ago, the Forest Service saw the need to modernize the regulations under which the cabin program is administered. Acknowledging that the competition for access and use of forest resources has increased dramatically since 1915, both the cabin owners and the agency wanted a formal understanding about the rights and obligations of using and maintaining these structures.

New rules that resulted nearly a decade later reaffirmed the cabins as a valid recreational use of forest land. At the same time, the new policy reflected numerous limitations on use that are felt to be appropriate in order keep areas of the forest where cabins are located open for recreational use by other forest visitors. Commercial use of the cabins is prohibited, as is year-round occupancy by the owner. Owners are restricted in the size, shape, paint color and presence of other structures or installations on the cabin lot. The only portion of a lot that is controlled by the cabin owner is that portion of the lot that directly underlies the footprint of the cabin itself.

At some locations, the agency has determined a need to remove cabins for a variety of reasons related to ''higher public purposes,'' and cabin owners wanted to be certain in the writing of new regulations that a fair process would guide any future decisions about cabin removal. At other locations, some cabins have been destroyed by fire, avalanche or falling trees, and a more reliable process of determining whether such cabins might be rebuilt or relocated was needed. It was determined, therefore, that this recreational program would be tied more closely to the forest planning process.

The question of an appropriate fee to be paid for the opportunity of constructing and maintaining a cabin in the woods was also addressed at that time. Although the agency's policies for administration of the cabin program have, overall, held up well over time, the portion dealing with periodic redetermination of fees proved in the last few years to be a failure.

A base fee was determined twenty years ago by an appraisal of sales of ''comparable'' undeveloped lots in the real estate market adjacent to the national forest where a cabin was located. The new policy called for reappraisal of the value of the lot twenty years later—a trigger that led to initiation of the reappraisal process in 1995.

In the meantime, according to the policy, annual adjustments to the base fee would be tracked by the Implicit Price Deflator (IPD), which proved to be a faulty mechanism for this purpose.