and therefore, higher peak rates drive up the average costs. Less efficient equipment operating at peak times drives up the cost of electricity for all customers, including those of low income, who are less likely to have central air conditioning. According to 1997 Residential Energy Consumption Survey (RECS) microdata (the same data set used by DOE in their analysis), of the total 101 million households represented, approximately 46% have central air conditioning, but among poor households, only 25% have central air conditioning; just half the rate of presence among non-poor households (See Exhibit 2).

Also related to distributional equities and according to the RECS data, among households below the poverty level, about 60% rent their housing units. This is in contrast to 27% of above poverty level households that rent (See Exhibit 2). Therefore, low-income consumers, or those defined as ''poor'' in TSD Table 10.1, are not the ones to buy a central A/C or heat pump product, but they would be the one to pay the utility bill (or likely face increased rents if utilities were included in their rent) for the use of that product. Instituting a higher minimum efficiency standard will actually ensure that low-income consumers have lower utility bills, providing a benefit to this population.

MISINFORMATION ON PRODUCT AVAILABILITY

DOE justifies a lower SEER rule because the higher efficiency levels would put manufacturers out of business. However, according to the Air Conditioning and Refrigeration Institute (ARI) database of model combinations, many manufacturers already produce models that meet the 13 SEER requirements. This technology has been available for many years to large and small manufacturers alike. Although confidential ARI shipment information may not reflect large sales of high efficiency equipment, the publicly accessible ARI database of models shows extensive product availability. Over 7,000 air source heat pump model combinations and over 14,000 central air conditioner model combinations currently meet or exceed the 13 SEER level as listed by ARI.

The TSD (TSD page 8–2) describes a group of manufacturers that ''offer more substantial customer and dealer support and more advance products. To cover these higher operating expenses, this group attempts to ''sell-up'' to more efficient products or products with features that consumers and dealers value.'' With a higher standard, these manufacturers would not go out of business, but would rather continue to sell-up, to even higher efficiency levels or additional valued features.

Furthermore, results and upcoming plans for utility programs around the country also document the availability of 13 SEER and above products, as well as the demand for such products. Austin Energy's Residential Efficiency Program 2000–2001 gave rebates to single family existing homes for installation of split systems and heat pumps with efficiencies of 12 SEER and above. Rebates were staged: $150 for 12.0–12.9 SEER; $250 for 13.0–13.9 SEER; $400 for 14.0–14.9 SEER; and $500 for 15.0 and above. In total, 4,000 rebates averaging $312 were given to consumers. These numbers illustrate that a significant portion of the rebates given were for 13 SEER and above units.

In New Jersey, a 3-year rebate structure began in 2000 with a $370 rebate given for the installation of 13.0 SEER equipment and a $550 rebate given for 14.0 SEER equipment. A total of 14,000 rebates were given in the year 2000. As of August 2001, 8,000 rebates were given out with approximately 6,000 of these units at the 14.0 SEER level. Overall results in New Jersey show that 27% of the market (1998–2000) are 13 SEER or higher with 60% of those being at the 14 SEER or higher levels.

The Long Island Power Authority (LIPA) instituted a program similar to the one in New Jersey offering rebates for installation of 13.0 and 14.0 SEER equipment. Results to date show that LIPA is on target to reach their goal of approximately 3,500 rebates for 13 SEER equipment. Approximately 80% of these rebates are for SEER 14 equipment. LIPA is expecting to ramp up to 5,000 rebates in 2002. Overall, 17% of LIPA's market in 2000 is at 13 SEER or higher, with the market share for existing homes even higher at 22%.

Program plans for 2002 in Texas and California are geared toward equipment at 13 SEER and above. Reliant Energy in Southeast Texas is planning an incentive program to target 13 SEER and above matched systems. California's two large municipal utilities (Sacramento Municipal Utility District and Los Angeles Department of Water and Power) and four investor owned utilities (San Diego Gas and Electric, Southern California Gas, Southern California Edison, and Pacific Gas and Electric), serving over 30,000,000 consumers, are planning rebate programs to assure California residents receive energy efficient equipment, measures, and practices that provide maximum benefit for the cost. These programs all revolve around 13 SEER equipment or higher. Actual incentive amounts are not yet available.

RECORD CLARIFICATION

Mr. BINGAMAN. Mr. President, I have a clarification for the RECORD. Amendment No. 2018 is an Inhofe amendment and not a Chafee amendment.

The ACTING PRESIDENT pro tempore. The RECORD will so reflect.

ORDER FOR RECESS

Mr. BINGAMAN. Mr. President, on behalf of the majority leader, I ask unanimous consent that the Senate recess today from 12:30 p.m. until 2:15 p.m.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BINGAMAN. Mr. President, I yield the floor, and I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2002

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will now resume consideration of H.R. 3061, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3061) making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2002, and for other purposes.

Pending:

Dorgan amendment No. 2024, to provide for mandatory advanced electronic information for air cargo and passengers entering the United States.

The ACTING PRESIDENT pro tempore. The Senator from Oregon.

Mr. WYDEN. Mr. President, first I salute Chairman HARKIN and Senator SPECTER for doing, in my view, a superb job with respect to this bill. They have really set a special standard in terms of trying to work on important issues in a bipartisan way. The chairman has left the Chamber, but I want him to know how much I appreciate the good work he and his staff are doing on this issue.

This morning I wish to talk about a health and a scientific issue of extraordinary importance, and that is the vacancies that now exist at the National Institutes of Health, the Food and Drug Administration, and the National Cancer Institute. At a time when the public is focused on public health because of bioterrorism, there are many reasons we should be concerned about the work of these agencies and get these positions filled.

I want to talk for a few moments about why I am so troubled by the vacancies we are seeing at these agencies today. This has been, as all of us know, a decade of remarkable scientific progress in the health care field. It has really been something of a scientific and health care renaissance with extraordinary amounts of information learned about cells, about cancers, about what has come to be known as biological detectors that are important as we deal with anthrax and smallpox, and various other serious health concerns that Americans are focused on today.

This scientific progress has been bipartisan. Democrats and Republicans alike have joined to support funding for these very key public health agencies, and we have worked together to ensure these programs are properly funded.

I am convinced if those vacancies are not promptly filled, if we do not soon get a head of the National Institutes of Health and the Food and Drug Administration and the National Cancer Institute—if those positions are not soon filled—it threatens to unravel some of the important progress that has been made in this country over the last decade.

Suffice it to say, if those positions are not filled, a message is sent to the young scientists, to the young future leaders of this country in the health care field, that the Federal Government does not think this is particularly important. It takes years for

companies to get products developed and approved, and this is especially true of the new products created by biotechnology. It is important that we have scientific leadership throughout this process—at the companies developing these products and at every level of these two important agencies—NIH and the FDA. Without these scientists throughout the process, in the companies, and at the Federal level, biotech companies lose the incentive to invest in what might be the next medical breakthrough.

I spoke to a group of students on a college campus just a few days ago. A young woman came up to me and only half jokingly said: ''I am ready to be the head of the National Institutes of Health. I have focused on these issues. I have studied the questions for some time. Why in the world can the Federal Government not get somebody to head the National Institutes of Health right now?''

I have focused on health care and technology questions over the last few years in Congress, and the business community is especially alarmed that these vacancies are open. They want to work with leaders at the Federal level to expedite the development of drugs, vaccines, and therapies. One of these business leaders told me recently what concerns him is that at a time when the public is focused on public health, on the question of how to deal with anthrax and smallpox and bioterrorism, there is not anybody home in the Federal Government.

I think it is extraordinarily important that the Congress work with the President to get the officials we need sent up for review by the key committees. The National Institutes of Health has now been without a leader for almost two years.

The National Institutes of Health is now hemorrhaging the key people they need to be effective advocates for the public health. Recently, there was another vacancy at the National Institutes on Mental Health, and there is a vacancy at the National Cancer Institute. There has been a substantial period of time where we have not had anybody heading up the Food and Drug Administration.

If we want to attract the stellar scientists whom I know Democrats and Republicans both are so interested in supporting, we are not going to be able to do it, and we are going to lose very talented people who are in these agencies now.

We are already seeing a real brain drain in these essential agencies. What we need to do, and the Congress is prepared to do, and what the chairman and Senator SPECTER have made it very clear that they are willing to do, is make sure these agencies are properly funded. What we need now especially are scientifically sound programs to take on anthrax, smallpox, and ensure we can allow our scientists to work on what are known as biological detectors so we can move more rapidly and readily to recognize the agents in the field. We can more precisely describe the various strains of these bacteria and diseases. We will have a chance to learn more about their genomic sequence and develop creative strategies for public health that could pay very significant benefits for this country. Certainly the potential benefits to this country can be extraordinary.

I am very interested in working with the President on filling these positions. Biomedicine research and science policy has long been bipartisan. Senator Mack, for example, from Florida, did yeoman work for years and years with Senator SPECTER, Senator HARKIN, myself, and others. That is the kind of progress, it seems to me, that is in danger of being lost at this time.

The President of the United States certainly has lots on his agenda right now. All of it is extremely important as we deal with the question of fighting terrorism. I come to the Chamber today to say it is of extraordinary importance these positions at the National Institutes of Health and the Food and Drug Administration move to the top of the President's agenda, move to the top of the congressional agenda, and we work together in a bipartisan way, as we have done on a variety of subjects in recent weeks, to get the key officials in these agencies in place.

To make progress in the area of biomedical research and science, we need a public-private partnership, one where the Federal Government is involved in ensuring our laboratories are helping address issues that involve coming up with the basic knowledge that companies and scientists can then take to develop the cures and therapies that will improve the quality of life for the public.

I want to work with the President of the United States to get the biosciences back on track. I want to make sure we don't step back from this golden age of scientific progress, when we had an administration committed to ensuring we moved forward with this important research, and Congress backed it up on a bipartisan basis. The Congress has the power to advise and consent, and it is important that the Congress and the President work together to fill the positions at the Food and Drug Administration, the National Institutes of Health, and the National Cancer Institute.

We are not dealing just with bioterrorism although that is obviously very much on our mind this morning—but the entire public health system. We are seeing, obviously, when we open our morning newspaper, there are gaps that we need to address. We can best address this if officials in these key agencies are in a position to advise the Congress.

It has been too long that we have gone without a leader at the National Institutes of Health. It has been too long that we have gone without a leader at the Food and Drug Administration. The Senate will meet the President of the United States more than halfway. He can speak for himself. He has been extraordinarily eloquent on biomedical research over the years. Senator KENNEDY, who I have discussed this with, has made it very clear as chairman of the committee that focuses on these issues, he is very anxious to get these officials confirmed.

I hope this message this morning, at a time when we are working on this important bill that funds so many key health agencies, can help spark a new effort to speed up getting these key positions filled. I, and I believe every Member of the Senate, wants to work with the President to get these positions filled. Even though there are so many important issues the President has to deal with, this issue of the vacancies at the National Institutes of Health, the Food and Drug Administration, and the National Cancer Institute has become so serious, it needs to be a priority matter that Congress moves quickly to deal with. We ought to move quickly to deal with it before we adjourn for the year.

I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, we urge our colleagues to come to the Chamber to offer amendments. There was a long list filed yesterday where we have a unanimous consent agreement limiting amendments to those which have been listed. Many of them are obviously placeholder amendments. We need to move ahead with this bill. We have been on this bill now into our second day. We have had only one amendment offered so far. We urge our colleagues to come to the Chamber and identify what amendments they intend to offer and to be in a position to move forward to proceed with the disposition of this bill.

Mr. REID. Will the Senator yield?

Mr. SPECTER. I yield.

Mr. REID. We have an amendment pending, the Dorgan amendment. Has there been a decision made whether that would be accepted or do you want a vote on it?

It is my understanding now that staff is still working on that.

Senator STEVENS wanted to alternate back and forth, and I said that was fine, but if we could get all Democrats to offer their amendments and all Republicans, one after the other—we are so desperate to have amendments, we don't care where they come from.

Mr. SPECTER. If I may respond, I don't think we have a problem on alternating. We have a problem finding amendments. If a series of amendments from your side of the aisle come forward, we will take them; and if a series of amendments from our side of the aisle come forward, we will take them. If there is a complication, we will alternate. We are now in search of amendments.

The Senator from Alabama is prepared to offer an amendment. I ask

unanimous consent the pending amendment be set aside so we may proceed to the amendment of the Senator from Alabama.

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

AMENDMENT NO. 2042

Mr. SESSIONS. I thank Senator SPECTER for his leadership and courtesy in allowing me to present this amendment which I believe is exceedingly important to health care in America. It is a problem with which we simply have to deal. It affects hospitals all over America, causing the richer hospitals to get richer and the poorer hospitals to get poorer.

The problem is the wage index. I offer the Wage Index Fairness Act, and I send the amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Alabama [Mr. SESSIONS] proposes an amendment numbered 2042.

Mr. SESSIONS. Mr. President, I ask unanimous consent reading of the amendment be dispensed.

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

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to establish a floor on area wage adjustment factors used under the medicare prospective payment system for inpatient and outpatient hospital services)

On page 54, between lines 15 and 16, insert the following:

SEC. ____. (a) FLOOR ON AREA WAGE ADJUSTMENT FACTORS USED UNDER MEDICARE PPS FOR INPATIENT HOSPITAL SERVICES.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by inserting ''(i) IN GENERAL.—'' before ''The Secretary'', and adjusting the margin two ems to the right;

(2) by striking ''The Secretary'' and inserting ''Subject to clause (ii), the Secretary''; and

(3) by adding at the end the following new clause:

''(ii) FLOOR ON AREA WAGE ADJUSTMENT FACTOR.—Notwithstanding clause (i), in determining payments under this subsection for discharges occurring on or after October 1, 2001, the Secretary shall substitute a factor of .925 for any factor that would otherwise apply under such clause that is less than .925. Nothing in this clause shall be construed as authorizing—

''(I) the application of the last sentence of clause (i) to any substitution made pursuant to this clause, or

''(II) the application of the preceding sentence of this clause to adjustments for area wage levels made under other payment systems established under this title (other than the payment system under section 1833(t)) to which the factors established under clause (i) apply.''.

(b) FLOOR ON AREA WAGE ADJUSTMENT FACTORS USED UNDER MEDICARE PPS FOR OUTPATIENT HOSPITAL SERVICES.—Section 1833(t)(2) of the Social Security Act (42 U.S.C. 1395l(t)(2)) is amended by adding at the end the following: ''For purposes of subparagraph (D) for items and services furnished on or after October 1, 2001, if the factors established under clause (i) of section 1886(d)(3)(E) are used to adjust for relative differences in labor and labor-related costs under the payment system established under this subsection, the provisions of clause (ii) of such section (relating to a floor on area wage adjustment factor) shall apply to such factors, as used in this subsection, in the same manner and to the same extent (including waiving the applicability of the requirement for such floor to be applied in a budget neutral manner) as they apply to factors under section 1886.''.

Mr. HARKIN. Will the Senator yield?

Mr. SESSIONS. I yield.

Mr. HARKIN. Which amendment?

Mr. SESSIONS. The Wage Fairness Index Act.

Mr. HARKIN. I thank you.

Mr. SESSIONS. I note that Iowa is also adversely impacted by this wage index formula.

I introduced this amendment as a bill earlier this year with my colleagues, Senator SHELBY and Senator HUTCHINSON. We have a terrible inequity in the system and in the index formula. This amendment will establish a floor on the area wage index adjustment factors that are utilized under the Medicare prospective payment system for inpatient and outpatient hospital services. I believe this is the best way to do that.

Several other Members have other proposals to help fix this problem. This is a solution I believe would be most effective. Over the past several years, I visited a number of hospitals, 15 or more, in the State of Alabama. In every one, hospital administrators and staff have urged me to do something about the wage index. Time after time it has been cited to me in personal and confidential discussions, just heart to heart, as we discussed the frustrations and problems they face in hospitals, and in particular rural hospitals. It has been raised to me as a No. 1 issue facing hospitals in Alabama.

The Alabama Hospital Association and its members have helped craft a plan. They consider it an emergency problem and a priority for them. The National Hospital Association has recognized this as a problem, and they support reform.

A complicated and a mostly arbitrary formula, the wage index, is part of the hospital prospective payment system which was created just in the early 1990s, about 10 years ago. We are just now beginning to feel how it plays out in real life. It was an effort to cut Medicare spending. It established a base rate for Medicare reimbursement based on two components—the labor component and the nonlabor-related costs. That is how a hospital is paid for Medicare services they render to a person who is not otherwise paying. This could be the elderly on Medicare and they come in and the hospital provides services. All they get for that service is what the Federal Government pays them under the Medicare Act.

So everyone knows that basically hospitals are not making any money. In fact, they lose money, often, on Medicare patients. It is the individuals who pay their way or have insurance to pay their way who help them be a success. The hospitals that have larger numbers of Medicare patients who serve a poorer population are more critically impacted by this problem. Once again, the wage index is falling particularly hard on hospitals that serve a disproportionately high number of Medicare patients and poor patients—Medicaid also.

It established a base rate for paying Medicare costs. They decide how much we are going to pay for a gall bladder operation, how much we will pay for pneumonia and other things, and that is what the hospital gets. They factor that on labor and nonlabor costs.

Nonlabor costs—that is the material and all—are similar nationwide, and the factors come out the same. But labor-related costs must be adjusted to regional differences in wage costs. This adjustment is made according to the wage index. The wage index, by the way, is a larger component of the cost of hospital care than the other factors. It is the biggest component. I believe about 60 percent of the reimbursed rate is based on the wage rate.

Rural areas such as Alabama and other States have lower wage costs, which is not a good thing. We don't like it that our nurses and support personnel aren't paid the same wages as in other States. But it is true we have some lower wage rates. Therefore, the Medicare reimbursement cost for health care in Alabama and many other States and rural areas even within larger States is much lower. Actually, Alabama has the lowest average wage index in the country and Montgomery, AL, the capital—a good, strong city, not some small rural town—has the lowest wage rate in the State. In fact, the wage index for all Alabama hospitals is between .74 and .89, well below the national average of 1.0.

In other words, where the national average is hospitals are reimbursed at the rate of $1, they are reimbursed at the rate of maybe 78 cents in Alabama, many of them at 74 cents. Some hospitals in the country that have somehow, some way, under this formula found their costs higher, they get as much as $1.50. So it is twice as much, 74 cents to $1.50, on 60 percent of the formula on the payment for health care. This is too big a gap. This is more than we ought to accept. For person in Iowa, a person in Alabama, their health care is just as valuable and as important as the health care of someone in New York or California.

To further exacerbate the problem, Alabama has to compete for nurses and hospital personnel with nearby urban areas such as Atlanta. To recruit these highly qualified health care professionals, Alabama hospitals must compete with urban wages. This has become a bidding war and has really impacted adversely the bottom line of hospitals in the State. Until we fix this problem, Alabama hospitals and hospitals all over the country will continue to lose millions of dollars each year. Unfortunately, it is falling hardest, and the losses fall most often, on

hospitals in poorer areas, the ones that are actually doing the care and the good deed of treating people who otherwise would not have health care. They are already forced to make the most of limited resources and to continue to provide care for the State's uninsured.

These hospitals will face tough decisions regarding health care services. They will continue to postpone important projects and the purchasing of much needed equipment. The rich are getting richer and the poor are getting poorer.

In fact, what happens is, when your wage index is low and you talk with your nurses about what kind of raises they might expect, or how many RNs and how many LPNs and how many less skilled personnel you have because you are not being reimbursed at the national rate but maybe 75 percent of the national rate, you end up cutting those salaries even more, so you have more LPNs rather than RNs, you have more support personnel than nursing personnel to try to get by, and what happens then? Your wage index goes down even further. They come in and say: Look, your wage index isn't that high. You don't get reimbursed as much. So your formula can even go down worse.

The Center for Medicare and Medicaid Services, CMS, the Medicare Payment Advisory Commission, and the MedPAC have recognized the problem, and they have even made recommendations to improve the wage index.

In addition to these recommendations, several pieces of legislation have been introduced in this Congress to address the wage index. Five bills have been introduced so far this year to address the wage index. Forty-five Senators from twenty-nine States have either sponsored or cosponsored wage index legislation.

Eight members of the Senate Finance Committee, including the ranking member, Senator GRASSLEY, agree something must be done. Unfortunately, although many have recognized the problem with the wage index, we have not been able to do anything to fix it.

So I raise this issue today to call attention to what is a critical problem in health care in America. Particularly in light of September 11, we know we are going to have to be sure we have a healthy health care system to deal with crises with which we may be faced at any time. If we allow an unfair reimbursement system to continue, then we will allow our hospitals to weaken and eventually close.

This is a matter of serious import. The wage index is irrational. It is not working correctly. It is ratcheting down wages on poorer hospitals in rural areas. When the hospitals cut and reduce and cut and reduce, then the next year the wage index formula people come in and say your wages are lower, and your index drops even further, and you go down even more.

This is something we have to confront. I will share this specific example from my hometown of Mobile, AL. The wage index dropped from .81 to .77, whereas 50 miles away in Pensacola, FL, it is maybe .87; it is in the high .80s in Pascagoula, MS, an hour's drive either way from the city. That means millions of dollars of reimbursement for those people. Montgomery, our capital, has the lowest rate in the Nation. Its hospitals are hurting as a result.

Mr. President, this is an important issue. The time has come to address it. Although this is a Health and Human Services bill that deals with health care issues, I recognize that this amendment is not appropriately favored to be offered here—although we could offer it with a point of order. I hope we can begin to draw some attention to an issue that is getting out of control. The gap is simply too large. We cannot accept it. We cannot allow it to continue. We have to do something to fix this problem.

My bill will bring everybody up to 92 percent. It would not bring down anybody. It would at least bring those 74-cents-on-the-dollar hospitals up to 92 cents on the dollar. They would still be well below the national average—and well below the people who are above the national average—but it would at least bring them out of poverty and allow them to provide the kind of quality health care we need.

Mr. President, I appreciate the opportunity to make these remarks. I yield the floor and suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. EDWARDS). Without objection, it is so ordered.

Mr. DAYTON. Mr. President, I ask unanimous consent that I be permitted to speak as in morning business for 5 minutes.

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

(The remarks of Mr. DAYTON pertaining to the introduction of S. 1600 are printed in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Mr. DAYTON. Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. BAYH). Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, I will just follow up on the remarks I made previously concerning the wage index and share with our fellow Members some of the information I have concerning this issue.

I have a letter from the Mobile/Baldwin County area hospitals. It was sent to me, Senator SHELBY, and Congressman Callahan. I will share some of the things that are in it supporting the legislation I have offered. They note this:

> Because of the huge discrepancy in the Area Wage Index which applies in Mobile and Baldwin Counties, Alabama as compared to our neighboring areas of Pascagoula, Mississippi and Pensacola, Florida, not to mention the even greater discrepancy with other parts of the country, we are beginning to face a critical shortage of skilled registered nurses with which to staff our hospitals. In the last three months alone we have lost at least 87 registered nurses from our area labor pool to traveling nurse agencies and to facilities in adjacent states. Collectively, we have over 200 registered nurse vacancies in the hospitals of Mobile and Baldwin Counties. . . .
>
> We are literally unable to compete with the salaries that are being offered these individuals because of the very low (.80) Medicare Area Wage Index under which we must now labor.
>
> Already our ability to handle the volume of patients being seen in our emergency rooms has been hampered and the waiting time has increased significantly. Already this summer we have had occasions where one or more of our hospitals have had to declare a ''Code Red'' status, meaning that they could not accept any more patients in their facility that would require intensive care due to a lack of staffed intensive care beds.

As a matter of fact, this weekend I was in an airport and talked to an administrator at one of our area hospitals. He told me for the first time in years, they cannot accept more patients. This is a great hospital. My mother has been there a number of times; other relatives, including my father, have been hospitalized there. I said: You mean you don't have beds or you don't have nurses?

He said: We don't have nurses. We have the beds. We don't have nurses.

This index situation is working in a perverse way so that when you economize, when you reduce your cost and cut your salary and negotiate toughly with nurses and pay them the most minimum salary you can get away with paying them, then they come back the next year and rate your wage costs lower. Then they want you to cut it again next year. This thing is getting out of sync.

We have nurses in Alabama—and I have heard this all over the State in talking to administrators—who go off for a week or two. They work long hours at nearly twice the salaries they make in the State of Alabama. Then they quit working at the local hospitals where they have worked before. This is done because the majority of health care in hospitals in most areas of the country is Medicare/Medicaid work. So if you are not paying a living wage, if you are not paying a basic amount for those Medicare payments—this is our elderly who are most often hospitalized—then the net result of all that is the hospital gets squeezed badly.

Last year, we made a good step in increasing the overall inflation index for

hospitals. We had reduced that substantially as part of the Balanced Budget Act of 1997. It helped us create a surplus in this country, but we realized that it was beginning to cut deeper and deeper and deeper into hospitals. So this helped hospitals across the board.

I know the hospitals in more rural areas are at a double disadvantage because 60 percent of their reimbursement cost is based on the wage index.

Again, in Mobile, one of the larger cities in the State, a city on the coast, Mobile's wage index is 80. They get 80 cents on the dollar. The average in America is $1. Some hospitals in America are being reimbursed at $1.50. So this is really a huge difference. That is almost twice.

In Montgomery, another sizable city in the State of Alabama—Alabama is a State of 4 million people, an almost average State in America—it is being reimbursed at 74 cents on the dollar. That is half what you are getting reimbursed in some other areas of this country.

It is draining our qualified nursing personnel and endangering health care, causing the poor to be poorer and the rich, in a way, to get richer. At least the poor will get poorer. Nobody is getting rich on Medicare reimbursement today.

I will share one more letter from the Baptist Health Care System of the State of Alabama. I talked with Dennis Hall a number of times. I have visited in several of his hospitals around the State of Alabama. He is passionately of the belief that the wage index is devastating their health care system. He said:

> The national crisis is affecting hospitals in Alabama in dramatic ways. Most of the hospitals in Alabama, including the very strong Baptist Health System, are losing money on operations. We have counted on interest earnings on reserves to offset losses. However, most institutions are now facing losses on their reserves also.
>
> Our total losses in operations for our year ended June 30, 2001 will be in excess of $21 million. Charity, Medicaid and Medicare played a big role in causing these losses. We simply cannot continue to sustain these operating losses. We certainly cannot be adequately prepared to respond to bio-terrorism should it strike one of our hospitals where we serve.

Mr. President, I have also a letter from the Coffee Health Group. I visited the Coffee Health Group. It is in Florence, AL, the Quad Cities area. There are a number of people in this area, a series of smaller communities in a fairly sizable metropolitan area.

This is what Carl Bailey writes me:

> The wage index is a complicated issue that I truly believe few understand. Nevertheless, you have asked us to help you get some grasp of the problem by describing the impact of the recruitment of a registered nurse from one of our Alabama hospitals (''Hospital A'') to another institution (''Hospital B'') that is already receiving higher Medicare payment due to higher wage index.
>
> Hospital B will pay the travel, lodging, and higher wages to recruit the RNs. This additional cost to Hospital B actually increases the wage index for Hospital B.
>
> The hospital that is hiring a person at a higher wage and paying all these costs then bills that to create a higher wage index.
>
> This increase can only be paid from other areas because of budget neutrality.
>
> Get that? This increase for Hospital B that is paying a higher wage can only be paid from taking money from the other areas because of budget neutrality. We only have a certain pot of money.
>
> Therefore, Hospital A must share in the cost of paying for the increased wages of Hospital B. Since Hospital A cannot replace this RN, Hospital A's average wage decreases due to the loss of an employee with a higher than average hourly rate.
>
> You get that? Hospital A's, the losing hospital's wage index goes down because their wage rate goes down because they lost one of their higher paid people and one of their better people.
>
> This lowers the wage index for Hospital A and because of budget neutrality further increases the wage index gain for Hospital B. To respond to the shortage of staff, Hospital A then hires two or three nursing assistants to share the workload, reducing the number of nurses. This creates an even lower wage index for Hospital A which decreases the wage index even more. It also decreases the quality of care in Hospital A. Again, because of budget neutrality, the decrease in reimbursement to Hospital A is passed on as a higher wage index to Hospital B. Hospital B is now in a better financial position to hire additional employees from Hospital A than they were before, and the cycle continues.
>
> Although this scenario takes three years to play out, the mechanics are very real. We in Alabama have been living with similar recruitment strategies and subsequent negative reimbursement impact that has occurred in the past. Our loss in the past cannot be recruited, but we must stop the flow of Medicare funds from the ''have-nots'' to the ''haves.''

Mr. President, those are the points we are making. This affects hospitals all over America, States such as New York. Both Senators from New York support wage index reform because their State has large numbers of hospitals that are being adversely affected. It is not just what State or what area of the State you are from; the gap has grown too great, and the gap is widening and accelerating. It is not good for quality of health care in America. We have to do something about it.

Perhaps this is not the best bill to fix it, but I hope we can bring some increased attention to it. I look forward to working on it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I thank the Senator from Alabama for raising this very important issue. It is also an important issue to our providers in my State also, I might add. According to the Iowa Hospital Association, providers in Iowa would get about an additional $25 million a year under this amendment. To put it simply, we are being discriminated against in our State and in a lot of rural areas, as I am sure Alabama is.

This critical issue is at the center of States' like Iowa that are trying in vain to recruit and retain an adequate number of providers in rural areas. This is something of which I am very supportive. This is a point in time where I wish I were chair of the Finance Committee and we had a finance bill on the floor and we could take care of it right now.

The Senator raised this issue in good faith. He is right on the mark. We have to change this wage index floor. We have to raise that floor. Also, I say to my friend from Alabama, since we are now talking about this issue, I ask him to look at another piece of legislation that I and others have introduced called the FAIR Act. The difference in States between Medicare reimbursement for Medicare patients on a per patient basis vary widely. Some States are as low as about $3,000 per beneficiary per year; some States are as high as $7,000 per beneficiary per year. In other words, if you are on Medicare in one State, the reimbursement rate for your State might be as high as $7,000; in another State, it may be less than half that amount. In Iowa, we are No. 50 out of the 50 States. I think Alabama is down pretty low with us. We need to close that gap. My bill would do just that as well as address the wage index floor problem this amendment seeks to address.

My bill would take the national average and you say that no State can go over 105 percent and no State can go under 95 percent. You would leave some leeway for different problems, but no State could go over 105 percent and no State could go below 95 percent of the average. I ask the Senator to take a look at that because that is something that would even out some of the problems we have in Medicare reimbursements. But the bottom line is simple. Any Medicare reform bill, whether it is attached to an appropriations bill or goes on its own, has to include a provision to level the playing field and fix a system that is currently unfair and inequitable. Again, I would like like to accept the Senator's amendment and include it in this bill, but the Chair and Ranking Member of the Senate Finance Committee have made it clear that they will oppose any attempt to attach amendments that fall under the jurisdiction of the Finance Committee—including this amendment—to this appropriations bill.

I wanted to mention that, and I thank the Senator for raising this issue. Count me on board to work with him to see what we can do.

Mr. SESSIONS. I think it would take a point of order to do this. I wanted to

raise this issue, and maybe others would like to speak on it. I would like to go on to another issue. I have had my say at this point. Perhaps a vote would not be necessary on this amendment or on a point of order. It is a health care bill.

It is time to talk about one of the biggest problems we have in health care, which I believe is the wage index. I have been to hospitals and talked to administrators and CFOs, the people writing the checks, and the heads of nursing, and they see people leave, driving up the wage index at another hospital and reducing theirs even further. We have to fix this.

Mr. HARKIN. The Senator is right on target on this issue.

Mr. SESSIONS. I thank the Senator for his interest and leadership.

I yield the floor.

Mr. SPECTER. Mr. President, I commend my distinguished colleague from Alabama for raising this important issue. I believe it has national implications. There is certainly a problem in my state of Pennsylvania.

For those who are watching on C–SPAN II and don't understand the procedures, it might be worth a word or two of explanation. This is a matter for the Finance Committee, and they have the jurisdiction over this matter and have lodged an objection to having it taken up on this bill.

So what we have to do is look for an opportunity to raise it in a context where there is a Finance Committee bill on the floor. At that time, I think the Senator from Alabama will have a lot of support. I thank him for raising the issue at this time.

Mr. President, in the absence of any Senator seeking recognition to introduce an amendment, I ask our colleagues to come forward. We have 29 amendments on the list on one side and 32 on the other, for a total of 61. We need to proceed to conclude this bill. The conference is going to be very lengthy. If we are to have the appropriations for the National Institutes of Health, and the education bill, and the other matters, we are going to have to move ahead and not have this folded into a continuing resolution. I urge colleagues to come forward.

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. DASCHLE. Mr. President, I ask unanimous consent the order for the quorum call be dispensed with.

The PRESIDING OFFICER (Mr. CARPER). Without objection, it is so ordered.

AMENDMENT NO. 2044

Mr. DASCHLE. Mr. President, I ask unanimous consent the pending amendments be set aside and that an amendment I have just sent to the desk be considered.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

The Senator from South Dakota [Mr. DASCHLE] proposes an amendment numbered 2044.

Mr. DASCHLE. I ask unanimous consent the reading of the amendment be dispensed with.

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

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. DASCHLE. Mr. President, I rarely come to the floor to offer amendments on appropriations because, I have to say, especially in this case, the chair and ranking member have done a phenomenal job under very difficult circumstances to get us to this point. I admire their work and their leadership and appreciate very much their extraordinary efforts as we have attempted to accelerate consideration of the appropriations bills.

I come to the floor to offer this amendment in part because I believe this provides perhaps the only vehicle we will have to consider legislation that I believe ought to have the opportunity to be considered before the end of this year. I offer the amendment on this bill in part because of the importance I think this legislation holds, not only for firefighters but for the country as a whole.

When the planes crashed into the World Trade Center on September 11, the shift had just changed at fire houses all across the country. In New York, firefighters who had just worked through the night could have gone home, but they didn't. Without a moment's hesitation, they rushed to what we now call Ground Zero to try to save lives.

They climbed on the first pumper or ladder truck they saw. One group of firefighters even commandeered a city bus to get to the World Trade Center as quickly as they could. Retired firefighters who heard what had happened rushed from their homes. Within hours, we now know, 343 New York City firefighters had lost their lives in the greatest terrorist attack in our Nation's history.

More than 7 weeks later, other firefighters, police, and rescue workers continue to comb through the still smoldering pile at Ground Zero, still risking their lives.

We have heard many words of praise for these heroes, and for their extraordinary efforts and for their first responders who risked their lives at the Pentagon, and in western Pennsylvania. They deserve every word of that praise, and far more.

As we honor them, it is important to remember that they are not alone.

Every day, in every State in America, firefighters, police officers and other emergency workers risk their lives to protect our safety. But in 18 States, they don't have the legal right to sit down with their employers and talk about their own health and safety.

That is wrong, and I believe the time has come for those circumstances to change.

That is why Senators DODD and GREGG, and I are offering this bipartisan amendment today: the Public Safety Employer-Employee Cooperation amendment.

Our amendment extends the basic right of collective bargaining to firefighters, police officers, paramedics, and emergency medical technicians.

It guarantees public safety officers the right to form and join a union, and the right to bargain collectively over hours, wages, and conditions of employment.

That is it.

There are things this amendment does not do, and I want to clarify and emphasize that.

It expressly forbids strikes or ''lockouts'' by public safety workers. It exempts all States with State bargaining laws for public safety workers that are equal to or greater than this proposal. And it preserves all management rights.

We know the essential role firefighters, police and other first responders played on September 11.

We know the role Capitol Police played on October 15. When a member of my staff opened a letter containing anthrax, Capitol police officers were immediately notified and were there immediately as well. They risked their lives to protect us. As a result, six law enforcement officers were exposed to the deadly bacteria. Today, every one of them is on the job.

Capitol Police are all working 12-hour, 14-hour days, 6 days a week, to protect us all; and they are all union members.

People who say that protecting public safety workers' basic rights will somehow jeopardize the public safety simply do not understand the dedication of the men and women who take these jobs.

We owe them our thanks. We owe them the basic right to collective bargaining. We owe them this opportunity to look out for themselves in the best way they know how, in their health, in their work, and in their lives.

So, Mr. President, I hope that our colleagues will look favorably on this amendment. I commend the extra effort made by Senators KENNEDY and DODD in particular, and Senator GREGG, who has been an outspoken advocate and proponent of this legislation. I am grateful to them. I am especially grateful for the opportunity this afternoon to offer this amendment with their support.

Mr. KENNEDY. Mr. President, I thank our leader, Senator DASCHLE, for the introduction of amendment No. 2044 to this Health and Human Services appropriations. I welcome the opportunity to cosponsor this with him.

So much of the Labor, HHR appropriations bill addresses the well being of our Nation's workers. We must meet the needs of all our workers, including our public safety workers, who do so much for us. The firefighters tell us that this amendment is their highest

priority. This amendment is the least we can do for them, in light of the sacrifices they have made for our country.

This amendment is an important bipartisan effort to help protect our Nation's public safety officers on the job. I have been pleased to work with my Republican cosponsors, Senator GREGG, Senator DEWINE, and Senator SNOWE. This amendment will measurably add to the caliber of our defense against threats to the security of our communities. It will also further this country's historic commitment to collective bargaining. I can point out to the Senate the substance of this amendment, in legislation, passed overwhelmingly from our Senate Labor and Human Resource Committee.

I know that no one in this room needs to be reminded of the heroic efforts made by the country's public safety officers in the last 10 days. The pictures of tired, dust covered firefighters confronting unimaginable horror are permanently emblazoned in our minds.

The courage and dedication of those who died—including Peter Ganci, the chief of the New York Fire Department; William Feehan, the first deputy commissioner; and Mychal Judge, the chaplain of the Department—set a shining example for all of us. There were 344 firefighters and paramedics who died in the World Trade Center rescue effort. They were members of locals 94 and 854 of the International Association of Firefighters. And, just miles from the Capitol, hundreds of firefighters risked their lives in the rescue efforts at the Pentagon. America needs these men and women, now more than ever, and it is no exaggeration to say that we owe our lives to them.

This amendment will ensure that firefighters, police officers, correctional officers, and emergency medical personnel will be afforded the fundamental right to bargain collectively with their employers. The amendment guarantees the basic rights that are necessary to meet that goal—to form and join a union; to bargain over hours, wages, and working conditions; to sign legally enforceable contracts; and to deal with an impasse in negotiations.

This proposal follows in the honorable traditions of our country's labor laws, by recognizing the importance of collective bargaining to improve job conditions, increasing worker safety, and improving productivity. Most importantly, this amendment will lead to safer working conditions for public safety officers and to enhanced safety for the public that they serve.

As we now know all too well, firefighters, police officers, and emergency medical personnel serve in some of the country's most dangerous, strenuous, and stressful jobs. They are frequently asked to risk—and sometimes give—their lives to protect the safety of others. We have a moral obligation to do whatever we can to increase the safety of these critical jobs—and thereby to add to the Nation's defense against threats to the public's health and safety.

It is clear that this amendment will help us to meet these goals. The men and women who serve on the front lines in providing firefighting services, law enforcement services, and emergency medical services know what it takes to create safer working conditions. Ensuring that these professionals have a right to collective bargaining will give them a voice in decisions that can literally make a life-or-death difference on the job. Making such a difference for our country's public safety officers will, by definition, improve our collective safety.

Available data prove that collective bargaining enhances safety. These data show that States that lack collective bargaining laws have death rates for firefighters that are nearly double that of States in which bargaining takes place.

In States with collective bargaining, there were 1.5 firefighters killed in the line of duty for every 10 thousand firefighters. In States without collective bargaining, 2.5 out of every 10 thousand firefighters were killed on the job. Similarly, in 1993, firefighters in 9 of the 10 States with the highest firefighters death rate lacked collective bargaining protection.

This amendment will also save money for States and local communities. A study by the International Association of Fire Fighters shows that States and municipalities that give firefighters the right to discuss workplace issues have lower fire department budgets than States without such laws.

When workers who actually do the job are able to provide advice on their work conditions, there are fewer injuries, better morale, better information on new technologies, and more efficient ways to provide the services.

The amendment also accomplishes its goals in a reasonable and moderate way. The amendment requires that public safety officers be given the opportunity to bargain collectively; it does not require that employers adopt agreements.

Nor does it regulate the content of any agreements that are reached. Where States have collective bargaining laws that substantially provide for the modest minimum standards set forth in the bill—as a majority of States already do—moreover, those States will be unaffected by the legislation.

Where States do not have such laws, they may choose to enact them or to allow the Federal Labor Relations Authority to establish procedures for bargaining between public safety officers and their employers. This approach respects existing State law and gives each State the authority to choose the way in which it will comply with the requirements set by this amendment. States will have full discretion to make decisions regarding their implementation and enforcement of the basic rights set forth in this proposal.

This approach respects existing State law and gives each State the authority to choose the way in which it will comply with the requirements of this proposal. States will have full discretion to make decisions regarding the implementation and enforcement of the basic rights in this amendment.

This amendment will not supersede State laws which already adequately provide for the exercise of—or are more protective of—collective bargaining rights by public safety officers. This amendment is intended to ensure that public safety officers have a role in addressing their wages, hours, and terms and conditions of employment; and to improve the safety and welfare of public safety officers and the communities they serve.

It is a matter of basic fairness to give these courageous men and women the same rights that have long been enjoyed by other workers. They put their lives on the line to protect us every day. They deserve to have an effective voice on the job, and improvements in their work conditions will benefit their entire community.

I commend my cosponsors for their leadership on this important proposal, and I urge the Senate to approve it.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

(The remarks of Mr. HOLLINGS are printed in Today's record under ''Morning Business.'')

Mr. HOLLINGS. I yield the floor.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:29 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. CORZINE).

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2002—Continued

The PRESIDING OFFICER. The Senator from New Hampshire.

AMENDMENT NO. 2044

Mr. GREGG. Mr. President, I rise in support of the amendment offered by Senator DASCHLE which deals with the rights of police officers and firefighters—especially—firefighters to have the opportunity to organize in collective bargaining agreements.

This amendment is timely in light of what we have seen relative to the commitment of our firefighters across the