New Mexico (Mr. BINGAMAN) were added as cosponsors of S. 739, a bill to amend title 38, United States Code, to improve programs for homeless veterans, and for other purposes.

S. RES. 63

At the request of Mr. CAMPBELL, the name of the Senator from Kentucky (Mr. MCCONNELL) was added as a cosponsor of S. Res. 63, a resolution commemorating and acknowledging the dedication and sacrifice made by the men and women who have lost their lives while serving as law enforcement officers.

S. RES. 68

At the request of Mr. JOHNSON, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. Res. 68, a resolution designating September 6, 2001 as ''National Crazy Horse Day.''

S. CON. RES. 28

At the request of Ms. SNOWE, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. Con. Res. 28, a concurrent resolution calling for a United States effort to end restrictions on the freedoms and human rights of the enclaved people in the occupied area of Cyprus.

## STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. GRAHAM (for himself and Mr. NELSON of Florida):

S. 771. A bill to permanently prohibit the conduct of offshore drilling on the outer Continental Shelf off the State of Florida, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. GRAHAM. Mr. President, I rise today with my colleague, Senator BILL NELSON, to introduce legislation that will protect the coast of Florida in the future from the damages of offshore drilling.

In past Congresses, I have introduced similar legislation that sought to codify the annual moratorium on leasing in the Eastern Gulf of Mexico and ensure that state's receive all environmental documentation prior to making a decision on whether to allow drilling off of their shores.

Today, I am introducing legislation that takes these steps, plus several others. The Outer Continental Shelf Protection Act will protect Florida's fragile coastline from outer continental shelf leasing and drilling in three important ways.

First, we transform the annual moratorium on leasing and preleasing activity off the coast of Florida into a permanent ban covering planning areas in the Eastern Gulf of Mexico, the Straits of Florida, and the Florida section of the South Atlantic.

Second, the Outer Continental Shelf Protection Act corrects an egregious conflict in regulatory provisions where an effected state is required to make a consistency determination for proposed oil and gas production or development under the Coastal Zone Management Act prior to receiving the Environmental Impact Statement, EIS, for them from the Mineral Management Service.

Our bill requires that the EIS is provided to affected states before they make a consistency determination, and it requires that every oil and gas development plan have an EIS completed prior to development.

Third, our bill buys back leases in the Eastern Gulf of Mexico which are an immediate threat to Florida's natural heritage and economic engine.

What does this bill mean for Florida? The elimination of preleasing activity and lease sales off the coast of Florida protects our economic and environmental future.

For years, I have taken my children and grandchildren to places like Grayton Beach so that they can appreciate the natural treasures and local cultures that are part of both their own heritage and that of the Florida Panhandle.

We have a solemn obligation to preserve these important aspects of our state's history for all of our children and grandchildren. Much of our identity as Floridians is tied to the thousands of miles of pristine coastline that surround most of our state.

The Florida coastline will not be safe if offshore oil and gas resources are developed. For example, a 1997 Environmental Protection Agency, EPA, study indicated that even in the absence of oil leakage, a typical oil rig can discharge between 6,500 and 13,000 barrels of waste per year. The same study also warned of further harmful impact on marine mammal populations, fish populations, and air quality.

In addition to leakages and waste discharges, physical disturbances caused by anchoring, pipeline placement, rig construction, and the resuspension of bottom sediments can also be destructive. Given these conclusions, Floridians are unwilling to risk the environmental havoc that oil or natural gas drilling could wreak along the sensitive Panhandle coastline.

Because the natural beauty and diverse habitats of the Gulf of Mexico, the Florida Keys, and Florida's Atlantic Coast attract visitors from all over the world and support a variety of commercial activities, an oil or natural gas accident in these areas could have a crippling effect on the economy. In 1996, the cities of Panama City, Pensacola, and Fort Walton Beach reported $1.5 billion in sales to tourists. Florida's fishing industry benefits from the fact that nearly 90 percent of reef fish caught in the Gulf of Mexico come from the West Florida continental shelf.

For the last several years, I have been working with my colleagues, former Senator Connie Mack and now Senator BILL NELSON, Congressman JOE SCARBOROUGH, and others to head off the threat of oil and natural gas drilling. In June of 1997, we introduced legislation to cancel six natural gas leases seventeen miles off of the Pensacola coast and compensate Mobil Oil Corporation for its investment. Five days after the introduction of that legislation and two months before it was scheduled to begin exploratory drilling off Florida's Panhandle, Mobil ended its operation and returned its leases to the federal government.

While that action meant that Panhandle residents faced one less economic and environmental catastrophe-in-the-making, it did not completely eliminate the threats posed by oil and natural gas drilling off Florida's Gulf Coast. Florida's Congressional representatives fight hard each year to extend the federal moratorium on new oil and natural gas leases in the Gulf of Mexico. But that solution is temporary.

Today we are introducing the Outer Continental Shelf Protection Act to make permanent our efforts to protect Florida's coastlines. I look forward to working with my colleagues on the Energy and Natural Resources Committee to move this legislation forward and protect the coast of future generations of Floridians and visitors to Florida.

By Ms. COLLINS:

S. 772. A bill to permit the reimbursement of the expenses incurred by an affected State and units of local government for security at an additional nongovernmental property to be secured by the Secret Service for protection of the President for a period of not to exceed 60 days each fiscal year; to the Committee on the Judiciary.

Ms. COLLINS. Mr. President, today I introduce a bill to provide fair reimbursement to state and local law enforcement organizations for additional costs incurred by them in providing frequent assistance to the Secret Service to protect the President of the United States.

Of course, the Secret Service has the principal responsibility for protecting our Presidents. Without the assistance of state and local law enforcement organizations, however, providing that protection would be more costly and more difficult, if not impossible. For the most part, state and local law enforcers provide this assistance with no need for or expectation of reimbursement from the Federal government. In some cases, however, reimbursement is appropriate. It is appropriate, for example, when state and local law enforcement organizations are required to incur substantial expenses on a frequent basis in localities that are small and thus does not have adequate financial bases to provide the necessary services without reimbursement.

This is not a new idea. Dating back to at least the Administration of President Jimmy Carter, the Federal government has provided reimbursement to local and sometimes state organizations where sitting Presidents maintain a principal residence. In the early 1990s, reimbursement was provided for

services provided for then-President Bush's visits to Kennebunkport, Maine. Reimbursement is similarly available now to Crawford, Texas. The bill I am introducing will extend this authority to localities and states other than the place of principal residence when the sitting President so designates.

I envision that it will help, for example, the Kennebunkport Police Department and associated law enforcement organizations in my home state. I expect that the allure of summer in Maine will draw President George W. Bush to the Bush family residence in Kennebunkport for several visits in the coming months. My bill will help ensure that the town, with a population of only 3,720, will not have to shoulder alone the substantial financial burden associated with these visits. In addition, however, I anticipate that in the future other localities will benefit, for this bill has been carefully drafted to provide reimbursement to localities and states designated by future Presidents.

This bill will not result in an unlimited ''windfall'' to local and state law enforcement organizations. It requires that the organizations requesting reimbursement first incur the expenses and therefore will likely discourage excessive expenditures. It also limits the number of days for which reimbursements may be sought to not more than 60 days per fiscal year. In addition, it provides reimbursement only for services provided in conjunction with visits to small localities with a population of no more than 7,000 residences. Finally, the total amount of reimbursement is limited to not more than $100,000 per fiscal year.

I encourage my colleagues to support this modest, yet important and equitable provision of support to local and state law enforcement organizations.

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By Mr. TORRICELLI (for himself and Mr. CORZINE):

S. 773. A bill to provide for disclosure of fire safety standards and measures with respect to campus buildings, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. TORRICELLI. Mr. President, today I rise to introduce the Campus Fire Safety Right-to-Know Act so that we can move forward in protecting our children at our colleges and universities. It is an unfortunate reality that it often takes great tragedies to highlight vulnerabilities in our laws.

On January 19, 2000, several New Jersey families experienced an unimaginable tragedy. A fire in a freshman college dormitory killed 3 students and injured 62 others. Investigations into the fire revealed that the dorm was not equipped with a sprinkler system, which could have saved lives. In addition, during that fatal evening, many students delayed leaving the building because they assumed it was a false alarm, an all too common occurrence.

On March 19, 2000, a fire broke out at a fraternity house at a Pennsylvania university, killing three students. This was not the first fire at that fraternity house, in 1994, five students were killed in a fraternity house fire.

On June 8, 2000, a student was killed in an early morning fraternity house fire at an Illinois University. Local authorities said the building was not protected with an automatic fire sprinkler system.

And, as recently as April 1, 2001, a fire in a residence hall at a New Hampshire college forced 100 students out of the building and seriously damaged at least two apartments. This was the second fire to occur at a residence hall at that college within two months.

This is a national crisis that endangers our children's lives.

Although the average number of college residence fires dropped 10 percent in the last decade, an average of 66 students still are injured in campus fires in dorms, and fraternity and sorority houses. In the 11 deadly campus fires between 1900 and 1997, an average of two people died in each.

The National Fire Protection Association reports that 72 percent of dorms, and fraternity and sorority houses that suffer fires are not equipped with life saving sprinkler systems, even though sprinklers are proven to cut by up to two-thirds the risks of death and property damage in fires.

I have a proposal that will help make university housing safer. The Campus Fire Safety Right to Know Act would highlight the issue of campus fire safety by requiring colleges and universities to provide annual reports that explains fire policies, frequency of false alarms, and whether dorms are equipped with sprinkler systems.

These reports would be straight-forward and based on the types of reporting that many campuses already do.

Colleges and universities could use these reports to highlight their successes and progress with campus fire safety. They would be, in part, a marketing tool to attract students and families.

The reports would also bring greater awareness about campus fire safety to schools that have not made progress, and encourage them to take action.

And, the reports would be a resource for students and their families, so that they know whether their dorms are fire safe and can work with their schools to improve fire safety.

My bill is supported by universities in my State, Seton Hall, Rutgers and Princeton, and is also endorsed by the National Fire Protection Association, the National Safety Council, and College Parents of America.

We need to pass this measure so that we can ensure that the tragedies in New Jersey, Illinois, and Pennsylvania are the last of their kinds.

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By Mr. BAYH (for himself and Mr. LUGAR):

S. 774. A bill to designate the Federal building and United States courthouse located at 121 West Spring Street in New Albany, Indiana, as the ''Lee H. Hamilton Federal Building and United States Courthouse''; to the Committee on Environment and Public Works.

Mr. BAYH. Mr. President, it is with great pride that I rise today to pay tribute to a good friend and a great man, former Congressman Lee Hamilton. I am honored to introduce legislation designating the Federal Building and United States Courthouse located at 121 W. Spring Street in New Albany, Indiana, as the ''Lee H. Hamilton Federal Building and U.S. Courthouse.''

Lee Hamilton was born in Daytona Beach, FL, on April 20, 1931, and raised in Evansville, IN. He attended Evansville Central High school, where he excelled both in the classroom and on the basketball court. As a senior, he led his team to the final game of the Indiana state basketball tournament, and received the prestigious Tresler award for scholarship and athletics.

After graduation, Congressman Hamilton attended Depauw University, and earned his bachelor's degree in 1952. He went on to study for one year in post-war Germany at Goethe University, before enrolling in law school at Indiana University, where he received his Doctor of Jurisprudence Degree in 1956.

In 1964, Lee Hamilton was first elected to the U.S. House of Representatives, where he went on to serve with distinction for 34 years. During his long tenure in office, he established himself as a leader in International Affairs, serving as the chairman of the House Foreign Relations committee, Intelligence Committee, and Iran-Contra committee. Mr. Hamilton was widely respected for his powerful intellect and impressive knowledge of foreign affairs, and remains unquestionably one of our nation's foremost experts on foreign policy.

In addition to his record on foreign affairs, Mr. Hamilton also played an important role in reforming the institution of Congress itself. He cochaired the Joint Committee on the Organization of Congress where he worked to reform the institution by instituting the gift-ban, tightening lobbying restrictions, and applying the laws of the workplace to Congress.

Even with all his success in Washington, however, Mr. Hamilton never forgot his Hoosier roots. He always remained down-to-earth and accessible to his Southern Indiana constituents. Over the years, he was presented with a number of opportunities to ascend to other offices, including the U.S. Senate, Secretary of State, and the Vice-Presidency of the United States. He chose instead to retain his House seat and fulfill his commitments to the people of Southern Indiana.

Today, Congressman Hamilton remains active in foreign policy and congressional reform. He currently heads the Woodrow Wilson International Center for Scholars in Washington, DC, and serves as the director of the Center on Congress at Indiana University.

Congressman Hamilton has received numerous public service awards including the Paul H. Nitze Award for Distinguished Authority on National Security Affairs, the Edmund S. Muskie Distinguished Public Service Award, the Phillip C. Habib Award for Distinguished Public Service, the Indiana Humanities Council Lifetime Achievement Award and the U.S. Association of Former Members of Congress' Statesmanship Award. It is only fitting that we recognize Congressman Hamilton's many years of service to the people of Southern Indiana by naming the New Albany Federal Building and U.S. Courthouse in his honor.

It is my hope that the Federal Building and U.S. Courthouse located at 121 W. Spring Street in New Albany will soon bear the name of my friend and fellow Hoosier, Congressman Lee Hamilton.

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By Mrs. LINCOLN (for herself and Mr. REID):

S. 775. A bill to amend title XVIII of the Social Security Act to permit expansion of medical residency training programs in geriatric medicine and to provide for reimbursement of care coordination and assessment services provided under the Medicare Program; to the Committee on Finance.

Mrs. LINCOLN. Madam President, I rise today to introduce the Geriatric Care Act of 2001, a bill to increase the number of geriatricians in our country through training incentives and Medicare reimbursement for geriatric care.

I am proud to be joined in this effort today by Senator HARRY REID of Nevada. Senator REID has been a pioneer in seeking real commonsense solutions to the health care challenges facing our Nation's seniors. In fact, he has graciously allowed me to include in this bill components of a bill he introduced during the last Congress. Moreover, he has been an invaluable resource and ally to me as I have grappled with the solutions to these challenges we are seeking.

Our country teeters on the brink of revolutionary demographic change as baby boomers begin to retire and Medicare begins to care for them. As a member of the Finance Committee and the Special Committee on Aging, I have a special interest in preparing health care providers and Medicare for the inevitable aging of America. By improving access to geriatric care, the Geriatric Care Act of 2001 takes an important first step in modernizing Medicare for the 21st century.

The 76 million baby boomers are aging and in 30 years, 70 million Americans will be 65 years and older. They will soon represent one-fifth of the U.S. population, the largest proportion of older persons in our Nation's history. Our Nation's health care system will face an unprecedented strain as our population grows older.

Our Nation is simply ill-prepared for what lies ahead. Demand for quality care will increase, and we will need physicians who understand the complex health problems that aging inevitably brings. As seniors live longer, they face much greater risk of disease and disability. Conditions such as heart disease, cancer, stroke, diabetes, and Alzheimer's disease occur more frequently as people age. The complex problems associated with aging require a supply of physicians with special training in geriatrics.

Geriatricians are physicians who are first board certified in family practice or internal medicine and then complete additional training in geriatrics. Geriatric medicine provides the most comprehensive health care for our most vulnerable seniors. Geriatrics promotes wellness and preventive care, helping to improve patients' overall quality of life by allowing them greater independence and preventing unnecessary and costly trips to the hospital or institutions.

Geriatric physicians also have a heightened awareness of the effects of prescription drugs. Given our seniors' growing dependence on prescriptions, it is increasingly important that physicians know how, when, and in what dosage to prescribe medicines for seniors. Frequently, our older patients respond to medications in very different ways from younger patients. In fact, 35 percent of Americans 65 years and older experience adverse drug reactions each year.

According to the National Center for Health Statistics, medication problems may be involved in as many as 17 percent of all hospitalizations of seniors each year. Care management provided by a geriatrician will not only provide better health care for our seniors, but it will also save costs to Medicare in the long term by eliminating the pressures on more costly medical care through hospitals and nursing homes. Quite clearly, geriatrics is a vital thread in the fabric of our health care system, especially in light of our looming demographic changes. Yet today there are fewer than 9,000 certified geriatricians in the United States. Of the approximately 98,000 medical residency and fellowship positions supported by Medicare in 1998, only 324 were in geriatric medicine and geriatric psychiatry. Only three medical schools in the country—the University of Arkansas for Medical Sciences in Little Rock being one of them—have a department of geriatrics. This is remarkable when we consider that of the 125 medical schools in our country, only 3 have areas of residency in geriatrics.

As if that were not alarming enough, the number of geriatricians is expected to decline dramatically in the next several years. In fact, most of these doctors will retire just as the baby boomer generation becomes eligible for Medicare. We must reverse this trend and provide incentives to increase the number of geriatricians in our country.

Unfortunately, there are two barriers preventing physicians from entering geriatrics: insufficient Medicare reimbursements for the provisions of geriatric care, and inadequate training dollars and positions for geriatricians. Many practicing geriatricians find it increasingly difficult to focus their practice exclusively on older patients because of insufficient Medicare reimbursement. Unlike most other medical specialties, geriatricians depend most entirely on Medicare revenues.

A recent MedPAC report identified low Medicare reimbursement levels as a major stumbling block to recruiting new geriatricians. Currently the reimbursement rate for geriatricians is the same as it is for regular physicians, but the services geriatricians provide are fundamentally different. Physicians who assess younger patients simply don't have to invest the same time that geriatricians must invest assessing the complex needs of elderly patients. Moreover, chronic illness and multiple medications make medical decisionmaking more complex and time consuming. Additionally, planning for health care needs becomes more complicated as geriatricians seek to include both patients and caregivers in the process.

We must modernize the Medicare fee schedule to acknowledge the importance of geriatric assessment and care coordination in providing health care for our seniors. Geriatric practices cannot flourish and these trends will not improve until we adjust the system to reflect the realities of senior health care.

The Geriatric Care Act I am introducing today addresses these shortfalls. This bill provides Medicare coverage for the twin foundations of geriatric practice: geriatric assessment and care coordination. The bill authorizes Medicare to cover these essential services for seniors, thereby allowing geriatricians to manage medications effectively, to work with other health care providers as a team, and to provide necessary support for caregivers.

The Geriatric Care Act also will remove the disincentive caused by the graduate medical education cap established by the 1997 Balanced Budget Act. As a result of this cap, many hospitals have eliminated or reduced their geriatric training programs. The Geriatric Care Act corrects this problem by allowing additional geriatric training slots in hospitals. By allowing hospitals to exceed the cap placed on their training slots, this bill will help increase the number of residents in geriatric training programs.

My home State of Arkansas ranks sixth in the Nation in percentage of population 65 and older. In a decade, we will rank third. In many ways, our population in Arkansas is a snapshot of what the rest of the United States will look like in the near future.

All of us today could share stories about the challenges faced by our parents, our grandparents, our families, our friends, our loved ones as they contend with the passing years. These are

the people who have raised us, who have loved us, who have worked for us, and who have fought for us. Now it is our turn to work for them, to fight for them, and this is where we must start.

I ask my colleagues to join me in support of this legislation to modernize Medicare, to support crucial geriatric services for our Nation's growing population of seniors. I also urge my colleagues to recognize that this is only the beginning of what I hope will be a grand overhaul of the way we think about and deliver care to our Nation's elderly. There are many more things to discuss and to address—adult daycare, long-term care insurance, just to name a few. But it is essential that we begin soon, that we begin now in preparing those individuals we will need 10 years from now in order to be able to care for our aging population in this Nation.

Madam President, I also want to submit three letters of support for this bill, along with a list of organizations that support this important legislation, and encourage all of my colleagues to recognize the unbelievable responsibility we have today to prepare for the seniors of tomorrow. I ask unanimous consent that the items I mentioned be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE NATIONAL COUNCIL
ON THE AGING,
*Washington, DC, April 24, 2001.*

Hon. BLANCHE L. LINCOLN,
*Dirksen Senate Office Building,*
*Washington, DC.*

DEAR SENATOR LINCOLN: On behalf of the National Council on the Aging (NCOA)—the nation's first organization formed to represent America's seniors and those who care for them—I write to express our organization's support for the Geriatric Care Act of 2001.

A major shortcoming of the Medicare program is the grossly inadequate, fragmented manner in which chronic care needs are addressed. Some of the major problems include: specific geriatric and chronic care needs are not clearly identified; services are poorly coordinated, if at all; medications are not managed properly, resulting in avoidable adverse reactions; family caregivers are excluded from the care planning process; transitions across settings are disjointed; and follow-up care and access to consultation to promote continuity are often unavailable. All of these serious problems cry out for Medicare coverage of care coordination. NCOA strongly supports your efforts to address these critical shortcomings in the Medicare program.

NCOA also supports efforts to increase the number of health care providers who have geriatric training. Given the aging of our population and the coming retirement of the baby boomers, it is important to have physicians trained to care for older patients who may be frail and suffer from multiple, chronic conditions. We applaud your efforts to meet this challenge by introducing legislation to allow for growth in geriatric residency programs above the hospital-specific cap established by the Balanced Budget Act of 1997.

We applaud your leadership on behalf of our nation's most frail, vulnerable citizens and stand ready to assist you in working to enact the Geriatric Care Act of 2001 into law this year.

Sincerely,

HOWARD BEDLIN,
*Vice President, Public Policy and Advocacy.*

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AMERICAN ASSOCIATION OF HOMES
AND SERVICES FOR THE AGING,
*Washington, DC, April 18, 2001.*

Hon. BLANCHE L. LINCOLN,
*Dirksen Senate Office Building,*
*Washington, DC.*

DEAR SENATOR LINCOLN: I understand that you are introducing legislation to provide incentives for the training of geriatricians and to require Medicare reimbursement for geriatric assessments and care management for beneficiaries with complex care needs. The American Association of Homes and Services for the Aging (AAHSA) strongly supports your proposal, which would help to alleviate the serious shortage of physicians trained to meet the special needs of older people.

AAHSA is a national non-profit organization representing more than 5,600 not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations. More than half of AAHSA's members are religiously sponsored and all have a mission to provide quality care to those in need. Every day AAHSA members serve over one million older persons across the country.

Residents of long-term care facilities rely on physician services more than the general population does. The severity of older people's medical conditions compounded by multiple co-morbidities demand more time per visit than younger or healthier people need. Many of these seniors would benefit from the services of a geriatrician, who is trained in the special medical needs of older people. Unfortunately, few physicians elect to specialize in this field. In addition, the Medicare Part B fee schedule does not recognize the specialty services of geriatricians and the time and effort they spend providing medical care of this older, more vulnerable population. Nursing facilities have a difficult time finding physicians, let alone geriatric specialists, to serve residents. Geriatric clinic practices find it difficult to provide the level of service this population requires and deserves for the payment that they receive through the Medicare fee schedule.

Your legislation would do much to address these issues, and AAHSA is anxious to work with you toward its passage. Please feel free to contact Will Bruno, our Director of Congressional Affairs.

Sincerely,

WILLIAM L. MINNIX, Jr., D. Min.
*President and CEO.*

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AMERICAN ASSOCIATION
FOR GERIATRIC PSYCHIATRY,
*Bethesda, MD, April 24, 2001.*

Hon. BLANCHE L. LINCOLN,
*U.S. Senate,*
*Washington, DC.*

DEAR SENATOR LINCOLN: On behalf of the American Association for Geriatric Psychiatry (AAGP), I would like to take this opportunity to thank you for your introduction of the ''Geriatric Care Act of 2001.''

Although geriatric psychiatry is a relatively small medical specialty, it is one for which demand is growing rapidly as the population ages and the ''baby boom'' generation nears retirement. Arbitrary, budget-driven limits on Medicare payment for graduate medical education, such as caps on the aggregate number of residents and interns at a teaching hospital, could discourage the expansion of training programs in geriatric psychiatry and other fields that are extremely relevant to the Medicare population. Your bill would help to increase the number of physicians with the specialized geriatric training that is needed to serve the growing number of elderly persons in this country.

In addition, we support the provision of your bill, which would provide Medicare reimbursement for assessment and care coordination. This will help to provide those Medicare beneficiaries with severe physical and mental disorders with the access to the appropriate and coordinated care that they deserve.

AAGP commends you for your commitment to ensuring that America's senior citizens have adequate access to effective health care, and we look forward to working with you on the ''Geriatric Care Act of 2001.''

Sincerely,

STEPHEN BARTELS, MD,
*President.*

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SUPPORTERS OF THE GERIATRIC CARE ACT OF 2001

American Association for Geriatric Psychiatrists.
Alzheimer's Association.
Alliance for Aging Research.
American Geriatrics Society.
National Chronic Care Consortium.
National Council on Aging.
National Committee to Preserve Social Security and Medicare.
American Association for Homes and Services for the Aging.
International Longevity Center.

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By Mr. BINGAMAN (for himself Mr. ENZI, Mr. BAUCUS, and Mr. WELLSTONE):

S. 776, A bill to amend title XIX of the Social Security Act to increase the floor treatment as an extremely low DSH State to 3 percent in fiscal year 2002; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, I rise today to introduce legislation with Senators ENZI, BAUCUS, and WELLSTONE, entitled the ''Medicaid Safety Net Hospital Improvement Act of 2001.'' This legislation is absolutely critical to the survival of many of our nation's safety net hospitals. It would provide additional funding to address their growing burden of providing uncompensated care to many of our nation's 42.6 million uninsured residents, including 463,000 in New Mexico, through the Medicaid disproportionate share hospital, or DSH, program.

In recognition of the burden bourne by hospitals that provide a large share of care to low-income patients, including Medicaid and the uninsured, the Congress established the Medicaid DSH program to give additional funding to support such ''disproportionate share'' hospitals. By providing financial relief to these hospitals, the Medicaid DSH program maintains hospital access for the poor. As the National Governors' Association has said, ''Medicaid DSH's funds are an important part of statewide systems of health care access for the uninsured.''

Recent reports by the Institute of Medicine entitled ''America's Health Care Safety Net: Intact But Endangered,'' the National Association of Public Hospitals entitled ''The Dependence of Safety Net Hospitals'' and the Commonwealth Fund entitled ''A Shared Responsibility: Academic

Health Centers and the Provision of Care to the Poor and Uninsured'' have all highlighted the importance of the Medicaid DSH program to our health care safety net.

As the Commonwealth Fund report, which was released just this last week, notes: ''The Medicaid DSH program has had a beneficial effect on patient access. The average payment rate for Medicaid inpatient services has increased dramatically. Medicaid payments for hospital services were only 76 percent of the cost of providing this care in 1989. By 1994, Medicaid payments had increased to 94 percent of costs.''

Unfortunately, as the Commonwealth Fund report adds, ''. . . there are large inequities in how these funds are distributed among states.'' In fact, for 15 states, including New Mexico, our federal DSH allotments are not allowed to exceed 1 percent of our state's Medicaid program costs. In comparison, the average state spends around 9 percent of its Medicaid funding on DSH. This disparity and lack of Medicaid DSH in ''extremely low-DSH states'' threatens the viability of our safety net providers. In New Mexico, these funds are critical but inadequate to hospitals all across our state, including University Hospital, Eastern New Mexico Regional Hospital, St. Vincent's Hospital, Espanola Hospital, and others.

In an analysis of the Medicaid DSH program by the Urban Institute, the total amount of federal Medicaid DSH payments in six states was less than $1 per Medicaid and uninsured individual compared to five states than had DSH spending in excess of $500 per Medicaid and uninsured individual. That figure was just $14.91 per Medicaid and uninsured person in New Mexico. Compared to the average expenditure of $218.96 across the country, such disparities cannot be sustained.

As a result, this bipartisan legislation increases the allowed federal Medicaid DSH allotment in the 15 ''extremely low-DSH states'' from 1 percent to 3 percent of Medicaid program costs, which remains far less, or just one-third, of the national average. I would add that the legislation does not impact the federal DSH allotments in other states but only seeks greater equity by raising the share of federal funds to ''extremely low-DSH states.''

Once again, the Commonwealth Fund recommends such action. As the report finds, ''States with small DSH programs are not permitted to increase the relative size of their DSH programs . . . [C]urrent policy simply rewards the programs that acted quickly and more aggressively, without regard to a state's real need of such funds.'' Therefore, the report concludes, ''. . . greater equity in the use of federal funds should be established among states.''

Again, this is achieved in our legislation by raising the limits for ''extremely low-DSH states'' from 1 percent to 3 percent and not by redistributing or taking money away from other states.

Failure to support these critical hospitals could have a devastating impact not only on the low-income and vulnerable populations who depend on them for care but also on other providers throughout the communities that rely on the safety net to care for patients whom they are unable or unwilling to serve.

As the Institute of Medicine's report entitled ''America's Health Care Safety Net: Intact But Endangered'' states, ''Until the nation addresses the underlying problems that make the health care safety net system necessary, it is essential that national, state, and local policy makers protect and perhaps enhance the ability of these institutions and providers to carry out their missions.''

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 776

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Medicaid Safety Net Improvement Act of 2001''.

**SEC. 2. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE TO 3 PERCENT IN FISCAL YEAR 2002.**

(a) INCREASE IN DSH FLOOR.—Section 1923(f)(5) of the Social Security Act (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) by striking ''fiscal year 1999'' and inserting ''fiscal year 2000'';

(2) by striking ''August 31, 2000'' and inserting ''August 31, 2001'';

(3) by striking ''1 percent'' each place it appears and inserting ''3 percent''; and

(4) by striking ''fiscal year 2001'' and inserting ''fiscal year 2002''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2001, and apply to DSH allotments under title XIX of the Social Security Act for fiscal year 2002 and each fiscal year thereafter.

## STATEMENTS ON SUBMITTED RESOLUTIONS

### SENATE RESOLUTION 73—TO COMMEND JAMES HAROLD ENGLISH FOR HIS 23 YEARS OF SERVICE TO THE UNITED STATES SENATE

Mr. BYRD (for himself, Mr. STEVENS, Mr. LEAHY, Mr. KOHL, Mr. DASCHLE, Mr. REID, Mr. WARNER, and Mr. GRAMM) submitted the following resolution; which was considered and agreed to:

S. RES. 73

Whereas James Harold English became an employee of the United States Senate in 1973, and has ably and faithfully upheld the high standards and traditions of the staff of the United States Senate;

Whereas James Harold English served as Clerk of the Transportation Appropriations Subcommittee from 1973 to 1980;

Whereas James Harold English served as the Assistant Secretary of the Senate in 1987 and 1988;

Whereas James Harold English has served as Democratic Staff Director of the Appropriations Committee of the United States Senate from 1989 to 2001;

Whereas James Harold English has faithfully discharged the difficult duties and responsibilities of Staff Director and Minority Staff Director of the Appropriations Committee of the United States Senate with great pride, energy, efficiency, dedication, integrity, and professionalism;

Whereas he has earned the respect, affection, and esteem of the United States Senate; and

Whereas James Harold English will retire from the United States Senate on April 30, 2001, with over 30 years of Government Service—23 years with the United States Senate: Now, therefore, be it

*Resolved*, That the United States Senate—

(1) Commends James Harold English for his exemplary service to the United States Senate and the Nation, and wishes to express its deep appreciation and gratitude for his long, faithful, and outstanding service.

(2) The Secretary of the Senate shall transmit a copy of this resolution to James Harold English.

### SENATE RESOLUTION 74—EXPRESSING THE SENSE OF THE SENATE REGARDING CONSIDERATION OF LEGISLATION PROVIDING MEDICARE BENEFICIARIES WITH OUTPATIENT PRESCRIPTION DRUG COVERAGE

Mr. DAYTON (for himself, Ms. STABENOW, Mr. JOHNSON, and Mr. ROCKEFELLER) submitted the following resolution; which was referred to the Committee on Finance.

S. RES. 74

*Resolved*, That it is the sense of the Senate that, by not later than June 20, 2001, the Senate should consider legislation that provides medicare beneficiaries with outpatient prescription drug coverage.

Mr. DAYTON. Mr. President, today I am introducing a resolution which expresses the sense of the Senate that the Senate will consider legislation providing prescription drug coverage for senior citizens by June 20, 2001. The resolution does not specify what form of coverage will be considered; rather, it simply commits us to scheduling consideration of this important legislation, and hopefully its passage, in the near future.

Many of us have promised the senior citizens of our states that Congress would enact this kind of program. As you know, last year the 106th Senate was unable to reach agreement on whether to provide prescription drug coverage directly through Medicare, through subsidized insurance policies, or another mechanism. While these disagreements stymied any one measure's passage, it appeared that an overwhelming majority of Senators then supported some form of coverage.

I believe it is imperative that we get a program of financial assistance for hard-pressed senior citizens quickly enacted. While I have my own preference for direct, voluntary coverage under Medicare, I am most concerned that some form of financial assistance be provided to desperate senior citizens in