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House of Representatives

The House was not in session today. Its next meeting will be held on Monday, June 17, 2002, at 12:30 p.m.

Senate

FRIDAY, JUNE 14, 2002

The Senate met at 9 a.m. and was called to order by the Honorable BLANCHE L. LINCOLN, a Senator from the State of Arkansas.

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

Almighty God, Sovereign of this Nation and Lord of our lives, we thank You for the outward symbols of inner meaning that remind us of Your blessings. The sight of our flag stirs patriotism and dedication. It reminds us of Your providential care through the years, of our blessed history as a people, of our role in the unfolding of Your American dream, and of the privilege we share living in this land.

Today, as we celebrate Flag Day, we repledge allegiance to our flag and recommit ourselves to the awesome responsibilities that You have entrusted to us. May the flag that waves above this Capitol remind us that this is Your land.

Thank You, Lord, that our flag also gives us a bracing affirmation of the unique role of the Senate in our democracy. In each age, You have called truly great men and women to serve as leaders. May these contemporary patriots experience fresh strength and vision, as You renew the drumbeat of Your Spirit, calling them to march to the cadence of Your righteousness. In the Name of our Lord and Saviour. Amen.

PLEDGE OF ALLEGIANCE

The Honorable BLANCHE L. LINCOLN led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, June 14, 2002.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable BLANCHE L. LINCOLN, a Senator from the State of Arkansas, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. LINCOLN thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The Senator from Nevada is recognized.

SCHEDULE

Mr. REID. Mr. President, we are going to be in a period of morning business until 9:35 a.m. Senator MURRAY has the first 20 minutes. The remaining time will be under the control of the Republican leader or his designee. At 9:35, we are going to have two votes. Following that, the main reason for me appearing this morning is to tell Members S. 2600 will be open for amendment. We hope people will come over today. There will only be two votes.

We didn't have a good day yesterday. We had a couple of amendments, but the rest was not very serious business related to the extremely important antiterrorism insurance legislation.

We hope people will begin to move forward on this legislation. The majority leader indicated we are going to pass this legislation. It is just a question of whether we are going to do it with or without cloture.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 9:35, with 20 minutes being under the control of the Senator from Washington.

The Senator from Washington is recognized.

HEALTH CARE CHALLENGES IN THE STATE OF WASHINGTON

Mrs. MURRAY. Madam President, seniors in Washington State cannot get

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

the medical care they need, and I have come to the floor today to explain the problem and to offer a solution that has the support of doctors, nurses, hospitals, and patients throughout Washington State.

While many States are facing challenges in health care, the problems are especially severe in my home State, where providers are struggling to care for patients in a system that is falling down around them. There are many reasons for this crisis, but one of the most fundamental is the unfair way in which Medicare reimburses doctors and providers.

Just look at what happens to the seniors I represent. They have spent their lives working hard, raising their families, and paying into the Medicare system. In fact, they have paid the same percentage of their income into Medicare as Americans from every State. But when they retire, they find that their access to health care depends upon where they happen to live. If they live in Washington State, they can expect far less access and far fewer benefits than seniors in other States. That is because Medicare reimbursement rates vary State by State.

Today, those reimbursement rates don't reflect the true cost of providing care, and they are penalizing patients and providers throughout Washington.

Madam President, in recent years, we have lost many physicians and clinics, especially in our rural areas. These unfair Medicare rates are making the problem even worse by encouraging doctors to retire early, to move, or to stop seeing Medicare patients altogether.

At the same time, these rates make it even harder for us to attract the new doctors, nurses, and health care professionals that we need to fill the growing void. As a result, seniors have to spend all day long on the phone trying to find a doctor who will see them. More often than not, they are told the doctor is not accepting any new Medicare patients.

Today, I want to explain the problem, show the impact it is having on the people of my State, and talk about a legislative proposal that Senator CANTWELL and I have introduced to give Medicare patients the equity they deserve.

For years, the health care challenges of Washington State have been getting worse, just like in the Presiding Officer's State. More and more patients don't have insurance and families don't have enough insurance. There is a shortage of health care professionals. That is causing problems, especially in our rural areas. There are many reasons for these difficulties, including our growing retired population, the rising cost of medical care and prescription drugs, as we all know, and paperwork and insurance.

In January, Medicare payments to doctors were slashed by 5.4 percent nationwide. Because many private insurers base their rates on Medicare payments, providers cannot shift the costs as they could in the past. In addition, Washington State is facing a budget shortfall and that has affected funding for Medicaid.

As we in Washington State try to address those national challenges, we are starting out several steps behind. That is because Washington State receives far below the national average in Medicare payments per patient. As this chart behind me shows, Medicare rates vary by State. Shown here are the average Medicare payments per beneficiary. These figures come from the Federal agency that manages the program—the Centers for Medicare and Medicaid Services, known as CMS. These figures are for fiscal year 2000. I would love to show more recent numbers, but I understand CMS has decided they are no longer going to calculate or distribute these figures.

Looking at this chart, you can see that these figures vary dramatically between States. At the top is Louisiana. They get, on average, $7,336 per Medicare patient. At the bottom is Iowa, which receives less than half that, just $3,053. When you include the District of Columbia, Washington State, my State, ranks 42nd in the Nation in Medicare reimbursement beneficiary. The Presiding Officer's State of Arkansas ranks right here at about 28th in the Nation. It is well below the average of what most States get. The national average is $5,490. Washington State, my State, receives $3,921 per patient.

In fact, in New York, a doctor can be reimbursed at twice the rate as Washington State for some procedures. That affects the stability of our doctors, hospitals, clinics, and home health care providers. Over the lifetime of a Medicare beneficiary, it can mean thousands of dollars less spent on their care in Washington.

These regional inequities have resulted in vastly different levels of care and access to care. For example, in Florida, up here at the top of the chart, a lot of Medicare beneficiaries have access to prescription drugs and prescription eyeglasses in their Medicare Plus Choice program.

In Washington State, while there may be some willing providers, there are no open plans available that offer prescription drug coverage, much less eyeglasses, because of our low reimbursements.

Overall, this is about fairness and access to health care. So I want to point out four reasons this morning why this system is unfair to patients in my State and the other States that rank at the bottom in reimbursements.

First, Washington State seniors pay the same rate into Medicare as everyone else. During their working years, every American pays the same percent of their income into the Medicare system, no matter where they live.

During retirement, every American pays the exact same dollar amount in part B premiums, no matter which State they live in. Washington seniors pay the same, but they do not get the same access to care, and that is not fair.

Second, the reimbursement rates do not reflect the true costs of providing care. The cost of treating a patient does not magically drop when you cross the border into my home State of Washington. The health care pressures we are facing do not stop at the State line, but payments do, and that is forcing doctors to choose between helping patients and staying in business. That is not fair.

Third, health care today is affected by national trends that require more equal reimbursement rates throughout the country. Two of those trends are the shrinking pool of available doctors and the growing need for expensive medical equipment.

There are a limited number of medical professionals, and every State is now competing to attract them. Because Medicare rates are so much lower in my State, we cannot offer the same salaries or the same recruitment incentives.

Hospitals face this challenge when it comes to medical technology. Today, health care relies increasingly on sophisticated expensive technology. An MRI machine costs the same amount for a hospital in Florida as a hospital in Washington State, but the only difference is the hospital in Washington State receives far less money from Medicare to pay for it. Overall, that means our State cannot attract the providers or buy the equipment that other States can, and that is not fair.

I recently heard from doctors with Olympia Radiation Oncology in Olympia, WA, and they said:

> While the cost of state-of-the-art equipment and personnel remains the same from state to state, the reimbursement is allowing appropriately reimbursed states to maintain a higher quality of care, while Washington State is struggling to deliver basic care. . . . If this problem is not addressed in a timely manner, we will continue to have a migration of young people and businesses out of our state, and we will be left with an aging population with suboptimal care.

My State is being penalized for doing the right things in health care, and that is not fair. Washington State has a long tradition of providing high-quality, low-cost health care, but today that innovative tradition is being used against us by the Medicare system. Other States spend more than twice what we spend and end up with less healthy outcomes while we are being punished for providing excellent care at low costs, and that is not fair.

This is an issue of fairness. Our seniors pay the same into the system and pay the same Part B premiums, but we do not get the same access or benefits. Our doctors have to choose between staying in business or accepting Medicare patients because Medicare payments do not reflect the true costs.

Our State is competing with every other State to attract doctors and to buy medical equipment, but we do not

have the same resources as Medicare provides to other States.

Finally, our State is being penalized for providing highly efficient, high-quality health care at low costs. Any way we look at it, the system is not fair to the people I represent.

This difference in reimbursement rates would not be a big deal if it were just a bureaucratic formula on a piece of paper, but we are talking about whether or not people can see a doctor, and I can tell you, unfair Medicare rates are hurting patients in Washington State in several ways. Many doctors are leaving our State, retiring early, or even refusing to accept Medicare patients. Nationwide a study by the American Academy of Family Physicians found that 17 percent of family doctors are not accepting new Medicare patients. The problem is even more severe in my State. The Washington State Medical Association conducted a survey last November and found that 57 percent of physicians who responded said they are either limiting their Medicare patients or dropping all Medicare patients from their practice.

Many experts believe that study does not even show the full extent of the problem. Other doctors are just leaving our State altogether. Since 1998, the number of Washington State Medical Association members leaving our State has increased by 31 percent.

To illustrate this problem, the Washington State Medical Association took out print advertisements in Washington State newspapers. And they say: Eastern Washington, my State, has a thriving medical community. You will find them in places like Boise, ID and Eugene, OR.

It's getting to the point where Washington doctors can't afford to stay in Washington. Administrative costs are out of control, reimbursement rates don't cover services, medical practices are shutting down. The fact is Medicaid and Medicare are grossly underfunded and private payers are setting their rates according to public programs. Now what does this mean to the patient? It means that even if you have great health insurance, the underfunding of public programs puts your personal physician's practice in jeopardy. So in other words, all the insurance in the world isn't going to help when your family doctor packs up and leaves the State.

This is a pretty good description of what is happening in my State. When doctors leave our State or retire early, their patients have to look for a new doctor who will accept Medicare, and according to my State's medical association, each time one physician leaves the Medicare Program, 2,000 patients have to find a new caregiver.

Across Washington State, seniors are experiencing the frustration of spending all day on the phone and still not being able to find a doctor who will accept them just because they are on Medicare.

Many articles have been published in my State detailing the trouble our seniors are having finding a doctor, and I have included many of these articles on my Web site. But I want to share one example with my colleagues.

A few months ago in Sequim, WA, a small, rural community, an older woman came up to me in a parking lot with a cast on her arm. She told me when she broke her arm, she went to the doctor. He put her cast on and told her to come back in 4 weeks. In the interim, her doctor determined he could no longer take Medicare patients. So when she went back 4 weeks later, she found out her doctor would not see her because he was not accepting Medicare patients.

There she was in this parking lot, standing there asking me how she was supposed to get her cast off. That is how bad it has gotten.

These terrible examples are becoming more common every day in my State because unfair Medicare rates are encouraging doctors to leave my State or close their practices to Medicare patients. But it is not just a problem for people on Medicare. It ends up having an impact on everyone.

When a patient cannot find a doctor, a patient ends up in the emergency room. The ER is really the only place where a patient cannot be turned away. Unfortunately, by the time they make it to the ER, their symptoms, which could have been addressed easily, have now developed into more serious medical problems.

James Newman is an emergency room doctor in Kennewick, WA. He is the chairman of education for the Benton-Franklin County Medical Society. Dr. Newman has seen patients go into cardiac arrest in the emergency room because they did not get care early enough. Often those patients had symptoms for weeks, but they could not find a primary care doctor, so they end up going into cardiac arrest in the emergency room, and that is outrageous.

Dr. Newman says that once a patient is ready to leave the ER, he cannot find a doctor who will continue to care for them. So Dr. Newman, who is board certified in emergency medicine and has been practicing for 10 years, spends much of his time trying to find doctors for his patients, sometimes begging and borrowing favors just to get his patients the care they need, and he ends up having to practice beyond the normal scope of his job.

For example, he might give a patient an 8-month prescription for hypertension medicine because he knows that patient will not be able to find a primary care doctor to refill a shorter prescription. Even worse, Dr. Newman ends up seeing the same patients again and again in his emergency room because they cannot find a doctor to care for them. That is how bad things have gotten in my State.

Remember, the cost of providing care in emergency rooms is much higher than preventing those problems in the first place. This problem impacts everyone who needs emergency care. Our emergency rooms are overcrowded. According to a recent study by the Washington chapter of the American College of Emergency Room Physicians, 91 percent of small hospitals and 100 percent of large hospitals reported overcrowding.

In addition, 76 percent of large hospitals reported overcrowding 2 to 3 times a week or more often.

In addition to problems in the emergency room, these unfair rates also make it hard for us to recruit the new physicians we need to replace those who are moving and retiring early.

I want to share with the Senate what Mike Glenn, the CEO of Olympic Medical Center in Port Angles, WA had to say on recruitment.

As he tries to attract doctors, he is finding that hospitals in other States are offering twice the salaries he can offer.

He says:

Doctors in nearly every field are either fleeing our state to earn higher salaries, or staying but with growing levels of dissatisfaction and resentment.

Physician headhunter firms have targeted our state as fertile ground to find doctors willing to pack up and leave for positions in states benefitting from more Medicare dollars.

If this situation is not quickly remedied, many Washington communities will face critical shortages of physicians.

Imagine a trip to a hospital Emergency Room without qualified ER doctors to provide life saving treatment, or without anesthesiologists to staff the Operating Room.

This is not a doomsday scenario, but a logical consequence of the current Medicare reimbursement system.

There is no denying that unfair Medicare rates are hurting patients and providers in Washington State.

Doctors are leaving our State or refusing to see new Medicare patients.

As a result, seniors cannot find doctors who will accept them.

Too often, those seniors end up in the emergency room in much worse condition.

We cannot even dig ourselves out of this hole because the low reimbursement rates make it hard for us to recruit new doctors to Washington State

It is going to get worse.

As I mentioned earlier, in January, Medicare payments to doctors were cut by more than 5 percent.

They are expected to continue to decline in the next 3 years for a total decrease of 17 percent by 2005.

That is untenable. We need to do something about it.

Unfortunately, the Bush Administration does not acknowledge the severity of the problem.

In April, Tom Scully, the administrator of CMS, told Washington seniors that ''access was not yet a serious problem.''

On Wednesday, I asked him about it at a hearing, and he said basically the same thing: That it will be a problem, but it is not a serious problem today.

They do not get it.

CMS is not going to fix this.

The White House is not going to fix this.

The Office of Management and Budget is not going to fix this.

If we are going to fix this problem, we are going to have to do it right in the Senate.

That is why Senator CANTWELL and I have introduced S. 2568, the MediFair Act.

The MediFair Act is designed to restore access and fairness to Medicare, and—in the process—help seniors, the disabled and all of our citizens.

This proposal is based on what I have heard from doctors, nurses, hospitals and patients over the past year.

Our bill has been endorsed by the Washington State Medical Association, the Washington State Hospital Association, and the Washington Nurses Association.

On the House side, companion legislation has been introduced.

It has the support of lead sponsor ADAM SMITH along with Representatives DICKS, MCDERMOTT, BAIRD, INSLEE, and LARSEN.

The MediFair Act is a starting point for eliminating the regional inequities in Medicare.

The bill will make the system more fair.

It will ensure that seniors are not penalized when they choose to retire in the State of Washington.

It will encourage more doctors to accept Medicare patients.

It will make it easier for us to recruit new doctors to our State.

And it will help our hospitals and home health agencies get the resources they need to care for our patients.

Let me explain my bill. The MediFair Act works to bring States up from the bottom of the reimbursement list.

The legislation would ensure that every State receives at least the national average of per-patient spending.

The bill does not affect States that currently receive the national average or just above the national average.

Further, our bill promotes efficient health care and healthy outcomes.

This is an area where we really need to correct the incentives.

Here is how Mike Glenn of the Olympic Medical Center put it:

The concern is not over 42 states receiving better Medicare reimbursement than Washington, but over what is rewarded and what is not.

Washington hospitals and physicians are proud of our record of pioneering high quality, cost effective medicine. And we do so by focusing on treatments that can help, while avoiding overuse of treatments that cannot.

This style of medicine yields equal if not better patient outcomes. Our reward for this is to be paid a fraction of our actual costs.

To make matters worse, states who do not embrace our style of cost effective care continue to demand and receive twice as much funding from Medicare for no discernable difference in patient outcomes.

The gap between the ''haves'' and the ''have-not States'' is growing.

If Medicare does not change this—through action like the MediFair bill—Washington hospitals in Medicare dependent areas will enter into a death spiral until they are forced to close their doors.

So our bill promotes the right things: efficient healthcare and healthy outcomes. It will force States that receive inordinately high payments to improve the quality of their healthcare.

Payments would be reduced to those States, which do not realize healthy outcomes—such as extending life expectancy or reducing rates of diabetes or heart disease.

Simply put, our bill finally holds states accountable for the health care they provide with Medicare dollars.

Before I close, I want to answer just a few questions about my bill.

Some are concerned about the possible cost of fixing the inequities in Medicare.

I am, too.

But I also know that there is a high cost to doing nothing as seniors lose their doctors and their access to healthcare.

There is a cost to the community when seniors end up in-and-out of the emergency room on a regular basis.

And of course, there is a human cost to the patients and their families.

Another question I have heard is:

How will this bill attract support from Senators from high reimbursement states?

First, States that are using Medicare dollars efficiently and effectively don't need to be concerned.

Either way, I recognize that not everyone will embrace this specific legislative proposal.

I want to find a solution that will help seniors get the care they need, and I recognize that there may be different ways to approach the problem.

This MediFair bill is a starting point. It's a way to draw attention to the problem and get folks to look at various solutions.

What matters is fixing the problem, so I welcome ideas and suggestions from anyone who wants to help us solve this problem.

Finally, some of my colleagues may wonder how this bill fits into our efforts to provide a Medicare prescription drug benefit, which is something I have worked to pass for several years.

We have introduced the ''Medicare Outpatient Prescription Drug Act of 2002,'' of which I am a cosponsor.

Our work on prescription drugs should not keep us from fixing this fundamental problem.

After all, a prescription drug benefit isn't worth anything if there aren't any doctors to write out a prescription. So both issues are critical, and we need to move forward on both of them.

We need to fix these problems now—before another senior in my State loses her doctor—before another patient goes into cardiac arrest in the emergency room because he could not find a doctor when his symptoms first appeared.

The system is unfair, and as Dr. Sam Cullison said, ''Sadly, it is the Medicare patients themselves who are paying the price for this inequity.''

We can restore fairness to Medicare.

We can help patients get the medical access they need, and the MediFair Act is part of that process.

I invite my colleagues to talk with Senator CANTWELL and me about how we can move this or any other proposal forward.

I conclude by saying that this is a matter of critical national attention, and I am going to work every single day to educate our fellow Senators, who are also impacted. We have to do something about this.

I ask unanimous consent that several articles be printed in the RECORD.

There being no objection, the articles were ordered to be printed in the RECORD, as follows:

[From the Everett Herald, June 4, 2002]

MURRAY'S MEDICARE PLAN A STEP IN RIGHT DIRECTION

Sen. Patty Murray has the right intention. She wants to make Medicare work better for patients and health care providers alike in this state.

Murray and the rest of the state's congressional Democrats have united around a plan that would raise Medicare reimbursements to health care providers in states where payments are below the national average. Washington is among the 10 lowest states in reimbursement rates, which actually punish areas with relatively efficient health care systems.

Murray's Medi-Fair Act would remedy the inequity by raising all payment rates to at least the national average and over time, forcing improvements elsewhere. It's a good plan, but one that is more likely to raise much-needed discussions rather than solve the problem immediately.

The short-term political reality is that the potential solutions run into a double-whammy. On one side, the Bush administration appears determined to avoid domestic spending increases—unless there is a high enough political gain, such as with the farm bill. On the other side, major states—including California, New York and Florida—aren't about to help others address the equity issue unless their higher Medicare reimbursements can be protected.

The best hope is that Murray and potential allies in both parties, including Republican Sen. Charles Grassley of Iowa (where reimbursement rates are the lowest of all), can raise the level of discussion to the point that a solution becomes politically necessary.

Certainly, for Medicare patients and aging baby-boomers who will soon use the system, the need for action is becoming increasingly serious. The inequities have been around for years, but their effects have become more severe. In this state, many doctors are now refusing to take new Medicare patients because the reimbursements don't cover physicians' costs. The problems extend beyond doctors, though, to other providers.

For the entire health care system, the paper work accompanying Medicare is also a serious issue. It aggravates the low reimbursements here by running up the expenses in medical offices. There is a need for a system that simplifies administration, just as there is a need for a health care system that provides broader access for all people, regardless of age and income.

Action on reforming Medicare's inequities should not be made to wait for such larger solutions. Medicare is America's most significant achievement in assuring health care access. Its erosion cannot be tolerated. Whatever the politics obstacles to immediate action, the Murray initiative helps bring forward the issue of massive inequities in reimbursements. That's a step in the right direction.

[From the Bellingham Herald, June 12, 2002]

''MEDIFAIR'' IS WORKABLE ANSWER

Our nation's Medicare system is so fraught with problems that there is no single cure for what ails it. Recovery will require multiple remedies over time. Still, U.S. Sen. Patty Murray, D–Wash., took a healthy step toward a solution in announcing her ''Medifair'' legislation last month.

Much lip service has been paid to addressing Medicare issues, but Murray's bill, still in draft form, advances the fight.

It's no secret that Washington state is at the low end of the scale for reimbursements. That's more than evident in Whatcom County, where the Family Care Network and Madrona Medical groups have had to stop taking new Medicare patients because they can't afford to treat them.

Despite the fact that everyone pays into the system at equal rates, the doctors who treat them are not reimbursed at the same rates. States like California and Florida receive far higher payments than Washington, which is being penalized for trying to contain medical costs. The current formula is unfair to both the patients who pay into it and to the health-care providers who treat them.

Murray's bill would require that every state receive at least the national average for per-patient spending, which was $5,490 in 2000. Washington received about $3,900 per beneficiary in 2000, making it 42nd among the states in per capita spending.

Under Murray's proposal, states that receive 105 percent of the average could see cuts.

In reality, the bill will face very strong opposition and will be difficult to pass. Big states will fight hard not to have their reimbursements cut, and the formula could require new revenue that won't be readily available.

The important thing is that Murray is getting the system on the table for examination.

While Washington ranks near the bottom in reimbursements, it ranks closer to the top in numbers of Medicare clients. The federal plan covers about 750,000 seniors and disabled people in this state, making it 18th in the nation in client base, according to 1999 figures.

U.S. Rep. Rick Larsen, D-Arlington, has already announced he's behind Murray's idea.

It's time for Washington's other members of Congress, on both sides of the aisle, to join this fight and help Washington be a leader in Medicare reform.

[From the Spokesman-Review, June 5, 2002]

MURRAY'S BILL RIGHTS MEDICARE INEQUITY

(By John Webster)

Unveiling a Medicare-enhancement bill the other day, U.S. Sen. Patty Murray told an unsettling story: An elderly constituent wearing a cast on her arm came up to Murray and said that when the time came to get her cast removed, her physician refused to see her because he recently had stopped accepting Medicare patients.

Why would any member of the healing profession want to shun Medicare, a major source of patients? Because, in Washington state, Medicare's reimbursement rates are lousy and getting worse.

That's why Murray introduced S. 2568, the MediFair Act of 2002. The bill would compel Medicare officials to correct a reimbursement inequity.

The state medical association says this inequity has created such financial difficulty that a growing number of older physicians are throwing in the towel and retiring; young physicians are moving to states other than Washington; and, some Washington state physicians are deciding to stop taking Medicare patients.

These are alarming trends for the residents of our state. The problem is particularly troubling for Spokane. Here, there is a sizable population of low-income and elderly people who depend on Medicare. In addition, Spokane is a regional center for advanced medical services—one of the strongest sectors in our economy. Medicare is a leading source of the health care industry's income; if it fails to cover costs, that's a serious problem.

The reimbursement inequity has existed for years, but it is getting progressively worse. When Medicare set its reimbursement rates years ago, it built them on the status quo, state by state. Medical care was more cost-efficient here than in some states, so reimbursement rates here were set at a lower level.

But as years went by, physicians have faced a accelerating need to invest in high-tech equipment, which costs the same everywhere. Medicare's rates left Washington's clinics with less money to buy that technology, than doctors had in other states.

On top of that, in 1997 Congress approved a series of cuts in Medicare, to balance the federal budget. Ever since, Medicare has been cutting physicians' reimbursement rates. Doctors in less-efficient states with higher reimbursement rates had leeway to adopt efficiencies and adjust. Not so, in Washington, where rates are lower. By 2005, that 1997 budget deal is scheduled to have cut reimbursement rates by 17 percent.

As of 2000, Sen. Murray says, Medicare spent an average of $3,921 on each Medicare beneficiary in Washington state. In New York it spent $6,924. The national average was $5,490. Washington's rate ranked 42nd in the nation.

This makes it tough for Washington to keep or recruit physicians.

According to a survey by the Washington State Medical Association, 57 percent of physicians are limiting or dropping Medicare patients from their practice.

Murray's bill would require Social Security to correct the inequity; in states such as Washington, Medicare would have to raise reimbursement rates to the national average.

The proposal has the support of associations representing the state's doctors, hospitals and nurses. Good for Sen. Murray, for seeking a solution. The elderly depend on Medicare, and they are counting on Congress to fix Medicare's many ailments—including this one, which threatens the stability of medical clinics as well as access to the physicians that elderly people need.

Mrs. MURRAY. I yield the floor.

The ACTING PRESIDENT pro tempore. Under the previous order, the remaining time shall be under the control of the Republican leader or his designee.

The Senator from Virginia

UNANIMOUS CONSENT AGREEMENT—S. 2600

Mr. ALLEN. Madam President, I ask unanimous consent that amendment 3838, which will be the second vote today, be referred to as the Harkin-Allen amendment in recognition of the tireless efforts and leadership of our colleague from Iowa on this important issue.

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

TERRORISM RISK INSURANCE

Mr. ALLEN. In support of the Harkin-Allen amendment No. 3838, I do want to say that our friend and colleague from Iowa, Senator HARKIN, and I, introduced the measure to allow victims of terrorist acts to seek judgments in our Federal courts with due process and, if accorded a judgment, be able to try to get that judgment satisfied from assets of those terrorist organizations or terrorist assets which have been seized or frozen by the Federal Government.

This measure allows those people from all across the country, including Iowa, Virginia, and other States, to get satisfaction for compensatory damages that they have been awarded. I want to again thank our colleague from Iowa, Senator HARKIN, for his great leadership and his great efforts in this regard.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

ENERGY POLICY

Mr. THOMAS. Madam President, I will make a few remarks this morning in our remaining time regarding one of the issues before us. We, of course, have spent a good deal of time on emergencies over the last number of months, and properly so. We have had emergencies. Obviously, the most compelling one has been terrorism and homeland defense.

In addition to that, we have talked about a number of other things. We have had fires; agriculture, which we felt is something of an emergency; as well as health care, which the Senator from Washington talked about. Indeed, most legislation that comes up is sort of deemed an emergency, at least in the view of the sponsor.

There is one thing which I think pretty clearly should be one of the most important, something that will affect us over time and one that we can avoid, which is the energy problem in our country. Probably nothing touches more Americans than energy, whether it be electric energy or gasoline for one's automobile.

Finally, after a considerable amount of effort in both Houses, we do have an energy bill that has passed both Houses. It is designed to give us an energy policy which we have not had for a very long time. Obviously, there are differences between the House-passed bill and the Senate-passed bill. Both of them have many of the components that were put forth by the President and the Vice President early last year in terms of an energy policy. Yesterday, we had the appointment of a conference committee named by the House, and I am pleased with that because we will be able now to go forward in putting together these two bills and coming out with an energy policy for the United States.

I want to emphasize how important that is. We have seen some problems