Estimated impact on state, local, and tribal governments: JCT has determined that the revenue provisions of S. 1971 contain no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

CBO reviewed the non-revenue provisions of S. 1971 and has determined that they contain no intergovernmental mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimated impact on the private sector: With only limited exceptions, private employers who provide pension plans for their workers must follow rules specified in ERISA. Therefore, CBO considers changes in ERISA that expand those rules to be private-sector mandates under UMRA. The nonrevenue provisions of S. 1971 would make several such changes to ERISA that would affect sponsors, administrators, and fiduciaries of pension plans. CBO estimates that the direct cost to affected entities of the new requirements in the bill would exceed the annual threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation). JCT has determined that the revenue provisions of S. 1971 do not contain any private-sector mandates.

Title I of the bill would impose restrictions on individual-account (that is, defined contribution) plans regarding assets held in the plans in the form of securities issued by the plan's sponsor. The bill would require affected plans to allow participants to immediately sell those securities that have been acquired through the employee's contributions, and to allow participants to sell certain securities acquired through the employer's contributions after three years of service with the firm. The latter requirement would be phased in over three years. CBO estimates that the added administrative and record-keeping costs of this provision would be approximately $20 million annually, with larger amounts in the first year.

Title I also would require plans to offer a range of investment options. This requirements would add little to plans' costs because many plans now abide by a safe harbor provision in ERISA that has similar requirements.

Title II of the bill would impose restrictions on plan administrators during transaction suspension periods. (Transaction suspension periods are periods of time when participants are unable to direct the investment of assets in their accounts—for example, when a plan is changing recordkeepers.) To avoid financial liability during those time periods, fiduciaries would be required to abide by certain conditions. The bill also would increase the maximum bond required to be held by fiduciaries from $500,000 to $1 million. CBO estimates that the direct cost of these provisions to plan sponsors and fiduciaries would be small.

Title III of the bill would impose a number of requirements on plans regarding information they must provide to their participants. Administrators of defined contribution plans would be required to provide quarterly statements to participants. Those statements would have to contain several items, including the amount of accrued benefits and bested accrued benefits, the value of investments held in the form of securities of the employing firm, and an explanation of any limitations or restrictions on the right of the individual to direct the investments. Currently, plans must provide more limited statements to participants upon request. CBO estimates that, while many plans now provide pension statements on a quarterly basis, about 30 million participants would begin to receive quarterly statements as a result of this bill. The added cost of this requirement would be about $100 million annually.

Title III also would require administrators of private defined-benefit pension plans to provide vested participants currently employed by the sponsor with a benefit statement at least once every three years, or to provide notice to participants of the availability of benefit statements on an annual basis. CBO estimates that the cost of this provision would be less than $5 million annually.

In addition, Title III would require plans to provide participants with basic investment guidelines and information on option forms of benefits, as well as information that plan sponsors must provide to other investors under securities laws. Plans also would have to make available on a web site any disclosures required of officers and directors of the plan's sponsor by the Securities and Exchange Commission. CBO estimates that the cost of these provisions would exceed $25 million annually.

Previous CBO estimates: CBO has prepared cost estimates for three other bills that contain provisions similar to those in S. 1971. These are:

H.R. 3669, the Employee Retirement Savings Bill of Rights, as reported by the House Committee on Ways and Means on March 14, 2002 (CBO estimate dated March 20, 2002),

H.R. 3762, the Pension Security Act of 2002, as ordered reported by the House Committee on Education and the Workforce on March 20, 2002 (CBO estimate dated April 4, 2002), and

S. 1992, the Protecting America's Pensions Act of 2002, as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on March 21, 2002 (CBO estimate dated May 7, 2002).

The major budgetary effects of H.R. 3669, like S. 1971, pertain to revenue provisions that relate to pension plan funding. (H.R. 3669 also included a provision excluding certain stock options from wages.) H.R. 3669's provisions affecting pension would produce an estimated revenue loss of $1.2 billion over the 2002–2012 period, compared with the $277 million revenue loss projected for the pension provisions of S. 1971 over the 2003–2012 period.

Like S. 1971, both H.R. 3669 and H.R. 3762 would make several changes to ERISA affecting premiums collected by the PBGC. CBO estimated that H.R. 3669 would increase direct spending by $104 million over from 2003–2012 and H.R. 3762 would increase direct spending by $185 million over the same period. Unlike S. 1971, H.R. 3762 included a provision amending the underlying formula used to determine variable rate-premiums for plan-year 2003. Also, one of the changes made by H.R. 3762 would first apply to plan-year 2002, while that provision in S. 1971 would start with plan-year 2003. Both bills also contained somewhat different language than S. 1971 affecting the interest rates used to calculate variable-rate premiums in the plan-year 2001.

S. 1992 did not have any estimated impact on either revenues or direct spending.

Estimate prepared by: Federal revenues: Annie Bartsch; Federal spending: Geoff Gerhardt; impact on state, local and tribal governments: Leo Lex; impact on the private sector: Bruce Vavrichek.

Estimate approved by: Robert A. Sunshine, Assistant Director for Budget Analysis; G. Thomas Woodward, Assistant Director for Tax Analysis.

LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Mr. President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of last year. The Local Law Enforcement Act of 2001 would add new categories to current hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred March 26, 2002 in Denver, CO. A lesbian, April Mora, 17, was brutally attacked by three men. The attackers punched and kicked her in the stomach, then held her down and carved the words ''dyke'' and ''RIP'' into her flesh with a razor.

I believe that government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act of 2001 is now a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

CHALLENGES IN RURAL HEALTH CARE

• Mr. DORGAN. Mr. President, I wanted to take a few minutes to describe some of the challenges facing rural health care systems and why I feel it is critical for the Senate to act now to reduce the inequities in Medicare funding between rural and urban providers.

Rural America depends on its small town hospitals, physicians and nurses, nursing homes, those who provide emergency ambulance services, and other members of our rural health care system. And because of past and proposed cuts in Medicare reimbursement, plus historical unfairness in Medicare payments, these vital services are in jeopardy.

Like most of my Senate colleagues, I supported the Balanced Budget Act, BBA, of 1997 when it was enacted by Congress with strong bipartisan support. Prior to the passage of this law, Medicare was projected to be insolvent by 2001, so it was imperative that we took action to extend Medicare's financial health and to constrain its rate of growth to a more sustainable level.

We later found that the Balanced Budget Act worked to reduce Medicare program costs, but many health care providers were adversely affected by payment reductions that were larger than intended. To address these concerns, Congress in 1999 made adjustments in the Balanced Budget Refinement Act, BBRA, followed in 2000 by the Medicare Beneficiary Improvement and Protection Act, BIPA. Without these needed changes, frankly, as many as a dozen of North Dakota's hospitals might be closed today.

But, additional legislation is still needed to improve Medicare reimbursement for health care providers in order to stabilize the Medicare program and ensure that beneficiaries, especially in rural areas, will continue to have access to their local hospitals, physicians, nursing homes, home health, and other services. Many small rural hospitals in particular serve as the anchor

for the full range of health care services in their communities, from ambulatory to long-term care. Medicare is the single most significant payer for services at these hospitals, and as such, it has an impact on the whole community.

Part of the problem in North Dakota is simply demographics: North Dakota's population is the second oldest in the Nation, and our population is shrinking daily. In fact, in 13 of North Dakota's counties, there were 20 or fewer births for the entire county last year. Admissions to rural hospitals have dropped by a drastic 60 percent in the last two decades, and those patients who do remain tend to be older, poorer, and sicker. This means that rural hospitals tend to be disproportionately dependent upon Medicare reimbursement, to the extent that Medicare accounts for 85 percent of their revenue. Obviously, given this reality, changes in Medicare reimbursement have a major impact on the financial health of rural hospitals.

Another part of the problem is that Medicare has historically reimbursed urban health care providers at a much higher rate than their rural counterparts. Of course, some of this difference can be explained by regional differences in the cost of health care and variations in the health status of older Americans. But this is not the whole explanation. Even after adjusting for these factors, a recent report by health care economists found that, for example, Medicare's per beneficiary spending was about $8,000 in Miami, but only $3,500 in Minneapolis. When average Medicare payments for the same procedure are compared, the disparities in payment in different areas of the country are dramatic. The table below compares payments for two of the most common procedures in North Dakota: hospitalization for heart failure and shock, and hospitalization for treatment of pneumonia.

Location in U.S.	Heart Failure and Shock	Simple pneumonia
North Dakota	$3,079	$3,383
California	4,774	5,153
New York	4,471	5,237
District of Columbia	6,168	6,588

As you can see, the average payment for these same hospital procedures, in larger and more urbanized States like New York and California, is 150 percent of the Medicare payment for the same procedure in North Dakota. The average Medicare payment for these same procedures is twice as high in the District of Columbia. In my opinion, the difference is largely explained by a Medicare reimbursement system that is skewed in favor of urban area, and past legislation has done little to address that concern, despite efforts by some of us to do so.

I have cosponsored legislation in the Senate, the Area Wage and Base Payment Improvement Act, S. 885, that would address the rural inequity in Medicare reimbursement in two ways. First, this bill would equalize the ''standardized payment'' which forms the basis for Medicare's reimbursement to hospitals. You would think something called the ''standardized payment'' would already be standard, but the fact is that hospitals in rural and small urban areas, including all of North Dakota, receive a smaller standardized payment than large urban hospitals. This bill would raise all hospitals up to the same standardized payment.

Second, S. 885 would increase the wage index for most of North Dakota's hospitals. This is a major area of concern that I hear about from North Dakota hospital administrators. The current wage index, which is an important factor in a hospital's total Medicare reimbursement, is based on an antiquated theory that it costs more to hire hospital staff in urban areas than it does in rural areas. That may have been true once, but it is no longer true today. Today, hospitals in North Dakota are competing with hospitals in Minnesota, Chicago and elsewhere for the same doctors and nurses, and they have to pay competitive wages in order to recruit staff.

I am also a cosponsor of the Rural Health Care Improvement Act of 2001, S. 1030. This legislation introduced by Senator Conrad would, among other things, provide for a new ''low volume'' adjustment payment for hospitals with a smaller number of patients and establish a revolving loan fund to help rural health care facilities make much-needed capital improvements.

I also want to mention a positive impact of the Balanced Budget Act of 1997. That legislation created the Critical Access Hospital program, which has proven to be critically important to the survival of North Dakota's smallest and most rural hospitals. Twenty-eight of North Dakota's rural hospitals, serving about 181,000 North Dakotans, have now converted to Critical Access Hospital status, which allows them to receive cost-based reimbursement from Medicare. I strongly support continuing this program and making some modest changes to strengthen the program. We also need to reauthorize the Rural Hospital Flexibility program, which provides grants to states to assist small rural hospitals in making the switch to Critical Access Hospitals.

In addition, Congress also must make some other changes to Medicare reimbursement to head off some upcoming reductions in payments. For instance, Medicare reimbursement to physicians and allied health providers is scheduled to be reduced by 12 percent over the next three years because of problems with the payment formula. In addition, reimbursement to home health agencies is scheduled to be cut by 15 percent on October 1, and a 10 percent payment boost for rural home health agencies expires at the end of this year. And skilled nursing homes will be facing a 10 percent reduction in their Medicare payment rates in 2003 and a 19 percent cut in 2004 unless Congress acts to avert this ''cliff'' in funding. I support making changes in all of these areas to help address these concerns.

In closing, I think we as a Nation need to acknowledge that a strong health care system is an important part of our rural infrastructure. Over the years, we have determined that rural electric service, rural telephone service, an interstate highway system through rural areas, and rural mail delivery, to name a few services, make us a better, more unified Nation. We need to make the same determination in support of our rural health care system, and I will be fighting for policies that reflect rural health care as a strong national priority.●

ON CONSTITUTION DAY, THE WORK OF THE SENATE, AND BALANCING THE BUDGET

Mr. CRAIG. Mr. President, I rise to note an interesting coincidence of things that are happening, and not happening, today.

Many Americans are celebrating today as Constitution Day. At 4 p.m. eastern time, on September 17, 1787, the Framers of the U.S. Constitution adjourned the Constitutional Convention in Philadelphia. The Constitution they proposed, after deep debates and tortured compromise, was then submitted to the several States for ratification, and for the judgment of history.

According to the nonpartisan, nonprofit organization, Constitution Day, Inc., at 4 p.m. today, ''schools across America will be led in the recitation of the Preamble to the US Constitution on a national teleconferencing call conducted by Sprint . . . churches across America will be led in the ringing of their bells to honor the First Amendment, Freedom of Religion . . .'' and there will be commemorations from Valley Forge, PA, to a replica of Independence Hall at Knott's Berry Farm, CA.

Little can be said, that has not been said before, about the profound wisdom, foresight, and faith that the Framers of our Constitution brought to constructing the foundational document of our Nation's system of government and laws.

President Coolidge said of the Constitution, in 1929, ''The more I study it, the more I have come to admire it, realizing that no other document devised by the hand of man ever brought so much progress and happiness to humanity.''

I rise to acknowledge this special day of celebrating our Constitution and I join all Americans in paying tribute to the patriots who produced it.

For many Americans, one of the signs of our deep respect for the Constitution is our acknowledgment that, in exceptional cases, a problem rises to such a level that it can be adequately addressed only in the Constitution, by way of a Constitutional amendment.