net hospitals that provide critical health care access to our Nation's 41.2 million uninsured citizens, including 373,000 in New Mexico, through the Medicaid disproportionate share hospital, or DSH, program.

In recognition of the burden certain hospitals bear in providing a large share of health services to the low-income patients, including Medicaid and the uninsured, the Congress established the Medicaid DSH program in the mid-1980's 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: Infact 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.

Unfortunately, as the Commonwealth Fund report notes, ''. . . there are large inequities in how these funds are distributed among states.'' In fact, for a number of 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, Lea Regional Hospital, Plains Regional Medical Center, Memorial Medical Center, 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 ''extremely low-DSH states'' from 1 percent to 3 percent of Medicaid program costs, which remains far less, or just about one-third, of the national average. The 18 States that would benefit from this legislation include: Alaska, Arkansas, Delaware, Idaho, Iowa, Kansas, Maryland, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Wisconsin, and Wyoming. 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 would like to thank Senators BAUCUS and GRASSLEY, the leaders of the Senate Finance Committee, for their recognition of this problem and inclusion of this language in several bills they introduced in the last Congress, S. 3018, ''Beneficiary Access to Care and Medicare Equity Act of 2002'' and S. 2873, ''Improving Our Well-Being Act of 2002.''

Our Nation's governors remain very concerned as well. In a letter written to Senators BAUCUS and GRASSLEY on October 23, 2002, the governors of the States of Arkansas, Idaho, Iowa, Nebraska, New Mexico, Utah, Wisconsin, and Minnesota wrote, ''Our 15, which is now 18, States are in distress and cannot wait another year for some measure of relief. We strongly urge you to use any vehicle available to include the low-DSH issue. The States are seeking to raise the cap implemented two years ago from 1 percent to 3 percent to provide them some flexibility in addressing the increasing strain facing our safety net hospitals.''

The governors add, ''The survival of many community hospitals, the lifeline for many rural community's health care and economy in our States, are being threatened. Current disparities in DSH funding severely harm our States' most vulnerable safety net hospitals.''

At a time of growing numbers of uninsured and increased financial strain on our Nation's safety net, we need to increase the ability of ''extremely low-DSH States'' to address the problems facing their safety net and to reduce the current inequity in funding among the States.

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. 204

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 2003''.

SEC. 2. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE TO 3 PERCENT IN FISCAL YEAR 2003.

(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 2001'';

(2) by striking ''August 31, 2000'' and inserting ''August 31, 2002'';

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

(4) by striking ''fiscal year 2001'' and inserting ''fiscal year 2003''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect as if enacted on October 1, 2002, and apply to DSH allotments under title XIX of the Social Security Act for fiscal year 2003 and each fiscal year thereafter.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Ms. COLLINS. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Wednesday, January 22, 2003, at 2:30 p.m., in SR–253, to consider the nomination of Asa Hutchinson to be Under Secretary of the Department of Homeland Security.

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

PRIVILEGE OF THE FLOOR

Mr. KOHL. Madam President, I ask unanimous consent that Michelle Weddle, a detailee on my Appropriations staff, be granted the privilege of the floor during consideration of H.J. Res. 2.

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

Mr. REID. Madam President, I ask unanimous consent that Erica Pagel, a fellow in the office of Senator CLINTON, be granted floor privileges for the duration of the debate on this bill.

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