S. 2085

At the request of Mr. CLELAND, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 2085, a bill to amend title XVIII of the Social Security Act to clarify the definition of homebound with respect to home health services under the medicare program.

S. 2108

At the request of Ms. STABENOW, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 2108, a bill to amend the Agriculture and Consumer Protection Act of 1973 to assist the neediest of senior citizens by modifying the eligibility criteria for supplemental foods provided under the commodity supplemental food program to take into account the extraordinarily high out-of-pocket medical expenses that senior citizens pay, and for other purposes.

S. 2233

At the request of Mr. THOMAS, the names of the Senator from North Dakota (Mr. CONRAD), the Senator from Massachusetts (Mr. KERRY), and the Senator from Illinois (Mr. DURBIN) were added as cosponsors of S. 2233, a bill to amend title XVIII of the Social Security Act to establish a medicare subvention demonstration project for veterans.

S. 2425

At the request of Mr. BAYH, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 2425, a bill to prohibit United States assistance and commercial arms exports to countries and entities supporting international terrorism.

S. 2458

At the request of Mrs. HUTCHISON, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 2458, a bill to enhance United States diplomacy, and for other purposes.

S. 2489

At the request of Mrs. CLINTON, the name of the Senator from South Carolina (Mr. HOLLINGS) was added as a cosponsor of S. 2489, a bill to amend the Public Health Service Act to establish a program to assist family caregivers in accessing affordable and high-quality respite care, and for other purposes.

S. 2548

At the request of Mr. BINGAMAN, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 2548, a bill to amend the temporary assistance to needy families program under part A of title IV of the Social Security Act to improve the provision of education and job training under that program, and for other purposes.

S. 2560

At the request of Mr. ALLARD, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 2560, a bill to provide for a multi-agency cooperative effort to encourage further research regarding the causes of chronic wasting disease and methods to control the further spread of the disease in deer and elk herds, to monitor the incidence of the disease, to support State efforts to control the disease, and for other purposes.

S. 2572

At the request of Mr. KERRY, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 2572, a bill to amend title VII of the Civil Rights Act of 1964 to establish provisions with respect to religious accommodation in employment, and for other purposes.

S. 2573

At the request of Mr. REED, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 2573, a bill to amend the McKinney-Vento Homeless Assistance Act to reauthorize the Act, and for other purposes.

S. 2600

At the request of Mr. DODD, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 2600, a bill to ensure the continued financial capacity of insurers to provide coverage for risks from terrorism.

S. 2608

At the request of Mr. GREGG, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 2608, a bill to amend the Coastal Zone Management Act of 1972 to authorize the acquisition of coastal areas in order better to ensure their protection from conversion or development.

S. 2611

At the request of Mr. REED, the names of the Senator from New York (Mrs. CLINTON), the Senator from South Dakota (Mr. DASCHLE), and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 2611, a bill to reauthorize the Museum and Library Services Act, and for other purposes.

S.J. RES. 37

At the request of Mr. WELLSTONE, the names of the Senator from New Jersey (Mr. CORZINE) and the Senator from New Jersey (Mr. TORRICELLI) were added as cosponsors of S. J. Res. 37, a joint resolution providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by Centers for Medicare & Medicaid Services within the Department of Health and Human Services relating to modification of the medicaid upper payment limit for non-State government owned or operated hospitals published in the Federal Register on January 18, 2002. and submitted to the Senate on March 15, 2002.

S. RES. 266

At the request of Mr. ROBERTS, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. Res. 266, a resolution designating October 10, 2002, as ''Put the Brakes on Fatalities Day.''

S. CON. RES. 3

At the request of Mr. FEINGOLD, the names of the Senator from Colorado (Mr. CAMPBELL) and the Senator from Kansas (Mr. ROBERTS) were added as cosponsors of S. Con. Res. 3, a concurrent resolution expressing the sense of Congress that a commemorative postage stamp should be issued in honor of the U.S.S. *Wisconsin* and all those who served aboard her.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. LIEBERMAN (for himself and Mr. MILLER):

S. 2613. A bill to amend section 507 of the Omnibus Parks and Public Lands Management Act of 1996 to authorize additional appropriations for historically black colleges and universities, to decrease the cost-sharing requirement relating to the additional appropriations, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. LIEBERMAN. Mr. President, on behalf of myself and Senator MILLER, I am submitting legislation that is designed to facilitate historic preservation activities at historically black colleges and universities. Specifically, this legislation would amend section 507 of the Omnibus Parks and Public Lands Management Act of 1996 to decrease the cost-sharing requirement for those seeking Federal funds for historic preservation activities at historically black colleges and universities. I am proud to say that the legislation I am submitting today is a companion bill to H.R. 1606, submitted by Congressman JAMES CLYBURN of South Carolina.

American history has been a constant, if not always consistent, march toward an ideal. That ideal is equal opportunity for all.

In every generation, it's taken the work of pioneers to open the gates of the American community to people who had previously been excluded. Pioneers have stepped forward when others would not to defiantly state, in effect, that we as a Nation will not be defined by surface characteristics. We will look deeper and try harder. The pioneers have held us to our national promise, and reminded us that America and Americanism are not about where you came from, what language you speak, what religion you practice, or what you look like, but about belief in basic ideals of responsibility, opportunity and community.

Historically Black Colleges and Universities have been such pioneers for generations, and they continue today to help America become its best self.

Today, America has 103 historically black colleges and universities in twenty-two States and the Virgin Islands, which educate about 300,000 undergraduate students and thousands of graduate, professional and doctoral students. In fact, 8 of the top 10 producers of African-American engineers are HBCUs. 42 percent of all the PhDs earned each year by African-Americans are earned by graduates of HBCUs.

Despite playing such a central role in our economy, society, and culture, HBCUs have been physically eroding for years. In 1998, the National Trust for Historic Preservation reported that most of the HBCUs in the United States are showing serious signs of neglect. The Trust said that campus landmarks are decaying and college grounds are badly in need of attention. And a 1998 General Accounting Office report estimated that in HBCUs nationwide, there were more than 700 historic buildings in states of disrepair.

That's why I am proudly sponsoring Representative CLYBURN's bill to provide more restoration funding for historic sites at Historically Black Colleges and Universities throughout the Nation.

These beautiful, architecturally significant structures are in most cases over a hundred years old, and were often built using the help of the students themselves. Their architectural beauty is a sign of something deeper, the fact that they have served as critical portals of opportunity for African-Americans throughout our history. That's why they deserve our strong protection and sensitive preservation.

I saw this firsthand. When I visited Allen University in South Carolina in April of this year, I went to Arnett Hall, a building that had been transformed from an eyesore into a beautiful and stately facility with the help of Federal funds, thanks to Representative CLYBURN. In the past, students and faculty would walk into the hall and get the message that we as a Nation were neglecting these historic treasures. Now, they absorb the message that we consider historically black colleges and universities central to our history and to our future.

Thanks in no small part to these institutions, the overarching history of African-Americans in this country has been not a tragedy, as it once was, but a brilliant movement toward dignity, inclusion, freedom, and opportunity. That's the right message for African-Americans and all Americans.

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. 2613

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

SECTION 1. DECREASED MATCHING REQUIREMENT; AUTHORIZATION OF APPROPRIATIONS.

(a) DECREASED MATCHING REQUIREMENT.—Section 507(c) of the Omnibus Parks and Public Lands Management Act of 1996 (16 U.S.C. 470a note) is amended—

(1) by striking ''(1) Except'' and inserting the following:

''(1) IN GENERAL.—Except'';

(2) by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)'';

(3) by striking ''(2) The Secretary'' and inserting the following:

''(2) WAIVER.—The Secretary'';

(4) by striking ''paragraph (1)'' and inserting ''paragraphs (1) and (3)''; and

(5) by adding at the end the following new paragraph:

''(3) EXCEPTION.—The Secretary may obligate funds made available under subsection (d)(2) for a grant with respect to a building or structure listed on, or eligible for listing on, the National Register of Historic Places only if the grantee agrees to provide, from funds derived from non-Federal sources, an amount that is equal to 30 percent of the total cost of the project for which the grant is provided.''.

(b) AUTHORIZATION OF APPROPRIATION.—Section 507(d) of the Omnibus Parks and Public Lands Management Act of 1996 (16 U.S.C. 470a note) is amended—

(1) by striking ''Pursuant to'' and inserting the following:

''(1) 1996 AUTHORIZATION.—Pursuant to''; and

(2) by adding at the end the following new paragraph:

''(2) ADDITIONAL AUTHORIZATION.—In addition to amounts made available under paragraph (1), pursuant to section 108 of the National Historic Preservation Act, there are authorized to be appropriated such sums as are necessary to carry out the purposes of this section.''.

By Mr. CORZINE:

S. 2614. A bill to amend title XVIII of the Social Security Act to reduce the work hours and increase the supervision of resident physicians to ensure the safety of patients and resident physicians themselves; to the Committee on Finance.

Mr. CORZINE. Mr. President, I rise today to introduce legislation, the Patient and Physician Safety and Protection Act of 2002, to limit medical resident work hours to 80 hours a week and to provide real protections for patients and resident physicians who are negatively affected by excessive work hours. This is a companion bill to legislation introduced in the House of Representatives by Representative JOHN CONYERS.

It is very troubling that hospitals across the Nation are requiring young doctors to work 36 hour shifts and as many as 120 hours a week in order to complete their residency programs. These long hours lead to a deterioration of cognitive function similar to the effects of blood alcohol levels of 0.1 percent. This is a level of cognitive impairment that would make these doctors unsafe to drive, yet these physicians are not only allowed but in fact are required to care for patients and perform procedures on patients under these conditions.

While the medical community has been aware of this problem for many years, the issue has largely been pushed under the rug. Only recently has the medical community taken a more serious look at the problem. In the last couple of months, my office has worked with the Association of American Medical Colleges and teaching hospitals in New Jersey and New York to address this problem and to try to find a workable solution.

As a result of these efforts and increased public pressure on the medical community to address this quality of care and labor issue, the Accreditation Council for Graduate Medical Education, ACGME, announced today new work hour recommendations. This is an important first step. But while some of their recommendations are commendable, they would still require residents to work in excess of 80 hours a week and 30-hour shifts. I look forward to working with the Council to adapt strong standards that are not only recommendations, but are enforceable requirements that truly protect patients and residents.

Today, I am introducing legislation that not only recognizes the problem of excessive work hours, but also creates strong enforcement mechanisms. The bill also provides funding support to teaching hospitals to implement new work hour standards. Without enforcement and financial support, efforts to reduce work hours are not likely to be successful.

Let me again emphasize that the Patient and Physician Safety and Protection Act of 2002 will limit medical resident work hours to 80 hours a week. Not 40 hours or 60 hours. 80 hours a week. It is hard to argue that this standard is excessively strict. In fact, it is unconscionable that we now have resident physicians, or any physicians for that matter, caring for very sick patients 120 hours a week and 36 hours straight with fewer than 10 hours between shifts. This is an outrageous violation of a patient's right to quality care. And, for many patients, it is literally a matter of life and death.

In addition to limiting work hours to 80 hours week, my bill limits the length of any one shift to 24 consecutive hours and limits the length of an emergency room shift to 12 hours. The bill also ensures that residents have at least one out of seven days off and ''on-call'' shifts no more often than every third night.

Finally, my legislation provides meaningful enforcement mechanisms that will protect the identity of resident physicians who file complaints about work hour violations. The guidelines that the ACGME released today do not contain any whistleblower protections for residents that seek to report program violations. Without this important protection, residents will be reluctant to report these violations, which in turn will weaken enforcement.

My legislation also makes compliance with these work hour requirements a condition of Medicare participation. Each year, Congress provides $8 billion to teaching hospitals to train new physicians. While Congress must continue to vigorously support adequate funding so that teaching hospitals are able to carryout this important public service, these hospitals must also make a commitment to ensuring safe work conditions for these physicians and providing the highest quality of care to the patients they treat.

In closing I would like to read a quote from an Orthopedic Surgery

Resident from Northern California, which I think illustrates why we need this legislation:

I was operating post-call after being up for over 36 hours and was holding retractors. I literally fell asleep standing up and nearly face-planted into the wound. My upper arm hit the side of the gurney, and I caught myself before I fell to the floor. I nearly put my face in the open wound, which would have contaminated the entire field and could have resulted in an infection for the patient.

This is a very serious problem that must be addressed before medical errors like this occur. I hope every member of the Senate will consider this legislation and the potential it has to reduce medical errors, improve patient care, and create a safer working environment for the backbone of our Nation's healthcare system.

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. 2614

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 ''Patient and Physician Safety and Protection Act of 2002''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) The Federal Government, through the medicare program, pays approximately $8,000,000,000 per year solely to train resident-physicians in the United States, and as a result, has an interest in assuring the safety of patients treated by resident-physicians and the safety of resident-physicians themselves.

(2) Resident-physicians spend a significant amount of their time performing activities not related to the educational mission of training competent physicians.

(3) The excessive numbers of hours worked by resident-physicians is inherently dangerous for patient care and for the lives of resident-physicians.

(4) The scientific literature has consistently demonstrated that the sleep deprivation of the magnitude seen in residency training programs leads to cognitive impairment.

(5) A substantial body of research indicates that excessive hours worked by resident-physicians lead to higher rates of medical error, motor vehicle accidents, depression, and pregnancy complications.

(6) The medical community has not adequately addressed the issue of excessive resident-physician work hours.

(7) Different medical specialty training programs have different patient care considerations but the effects of sleep deprivation on resident-physicians does not change between specialties.

(8) The Federal Government has regulated the work hours of other industries when the safety of employees or the public is at risk.

SEC. 3. REVISION OF MEDICARE HOSPITAL CONDITIONS OF PARTICIPATION REGARDING WORKING HOURS OF RESIDENTS.

(a) IN GENERAL.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) by striking ''and'' at the end of subparagraph (R);

(B) by striking the period at the end of subparagraph (S) and inserting '', and''; and

(C) by inserting after subparagraph (S) the following new subparagraph:

''(T) in the case of a hospital that uses the services of physician residents or postgraduate trainees, to meet the requirements of subsection (j).''; and

(2) by adding at the end the following new subsection:

''(j)(1)(A) In order that the working conditions and working hours of physicians and postgraduate trainees promote the provision of quality medical care in hospitals, as a condition of participation under this title each hospital shall establish the following limits on working hours for certain members of the medical staff and postgraduate trainees:

''(i) Subject to subparagraph (C), postgraduate trainees may work no more than a total of 80 hours per week and 24 hours per shift.

''(ii) Subject to subparagraph (C), postgraduate trainees—

''(I) shall have at least 10 hours between scheduled shifts;

''(II) shall have at least 1 full day out of every 7 days off and 1 full weekend off per month;

''(III) who are assigned to patient care responsibilities in an emergency department shall work no more than 12 continuous hours in that department; and

''(IV) shall not be scheduled to be on call in the hospital more often than every third night.

''(B) The Secretary shall promulgate such regulations as may be necessary to ensure quality of care is maintained during the transfer of direct patient care from 1 postgraduate trainee to another at the end of each such 24-hour period referred to in subparagraph (A) and shall take into account cases of individual patient emergencies.

''(C) The work hour limitations under subparagraph (A) and requirements of subparagraph (B) shall not apply to a hospital during a state of emergency declared by the Secretary that applies with respect to that hospital.

''(2) The Secretary shall promulgate such regulations as may be necessary to monitor and supervise postgraduate trainees assigned patient care responsibilities as part of an approved medical training program, as well as to assure quality patient care.

''(3) Each hospital shall inform postgraduate trainees of—

''(A) their rights under this subsection, including methods to enforce such rights (including so-called whistle-blower protections); and

''(B) the effects of their acute and chronic sleep deprivation both on themselves and on their patients.

''(4) For purposes of this subsection, the term 'postgraduate trainee' includes a postgraduate intern, resident, or fellow.''.

(b) DESIGNATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall designate an individual within the Department of Health and Human Services to handle all complaints of violations that arise from residents who report that their programs are in violation of the requirements of section 1866(j) of the Social Security Act (as added by subsection (a)).

(2) GRIEVANCE RIGHTS.—A postgraduate trainee or physician resident may file a complaint with the Secretary of Health and Human Services concerning a violation of such requirements. Such a complaint may be filed anonymously. The Secretary may conduct an investigation and take such corrective action with respect to such a violation.

(3) CIVIL MONEY PENALTY ENFORCEMENT.—Any hospital that violates such requirement is subject to a civil money penalty not to exceed $100,000 for each resident training program in any 6-month period. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this paragraph in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(4) DISCLOSURE OF VIOLATIONS AND ANNUAL REPORTS.—The individual designated under paragraph (1) shall—

(A) provide for annual anonymous surveys of postgraduate trainees to determine compliance with such requirements and for the disclosure of the results of such surveys to the public on a residency-program specific basis;

(B) based on such surveys, conduct appropriate on-site investigations;

(C) provide for disclosure to the public of violations of and compliance with, on a hospital and residence-program specific basis, such requirements; and

(D) make an annual report to Congress on the compliance of hospitals with such requirements, including providing a list of hospitals found to be in violation of such requirements.

(c) WHISTLEBLOWER PROTECTIONS.—

(1) IN GENERAL.—A hospital covered by the requirements of section 1866(j)(1) of the Social Security Act (as added by subsection (a)) shall not penalize, discriminate, or retaliate in any manner against an employee with respect to compensation, terms, conditions, or privileges of employment, who in good faith (as defined in paragraph (2)), individually or in conjunction with another person or persons—

(A) reports a violation or suspected violation of such requirements to a public regulatory agency, a private accreditation body, or management personnel of the hospital;

(B) initiates, cooperates or otherwise participates in an investigation or proceeding brought by a regulatory agency or private accreditation body concerning matters covered by such requirements;

(C) informs or discusses with other employees, with a representative of the employees, with patients or patient representatives, or with the public, violations or suspected violations of such requirements; or

(D) otherwise avails himself or herself of the rights set forth in such section or this subsection.

(2) GOOD FAITH DEFINED.—For purposes of this subsection, an employee is deemed to act ''in good faith'' if the employee reasonably believes—

(A) that the information reported or disclosed is true; and

(B) that a violation has occurred or may occur.

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the first July 1 that begins at least 1 year after the date of enactment of this Act.

SEC. 4. ADDITIONAL FUNDING FOR HOSPITAL COSTS.

There are hereby appropriated to the Secretary of Health and Human Services such amounts as may be required to provide for additional payments to hospitals for their reasonable additional, incremental costs incurred in order to comply with the requirements imposed by this Act (and the amendments made by this Act).

By Mr. MURKOWSKI (for himself and Mr. WELLSTONE):

S. 2615. A bill to amend title XVII of the Social Security Act to provide for improvements in access to services in rural hospitals and critical access hospitals; to the Committee on Finance.

Mr. MURKOWSKI. Mr. President, today I am introducing legislation that is designed to strengthen and improve the health care delivered to rural Medicare beneficiaries. The ''Rural Community Hospital Assistance Act of 2002'' ensures that our Nation's seniors will be able to receive the same quality of inpatient care throughout the country, regardless of whether they live in New York City or Petersburg, AK.

The best insurance in the world is worthless if there is not a provider or facility nearby to deliver quality health care. Right now, in communities across the country, many Medicare beneficiaries are underserved because they have no access to care. This is wrong and intolerable. I remain committed to ensuring that all Americans, and especially those in currently underserved rural communities, received the care they deserve.

Unfortunately, a number of the problems facing rural health care arise from the actions and construct of the federal Medicare system. Its historical one-size-fits-all approach to health care delivery and reimbursement has led to small community facilities that lack the ability to make payroll, expand services, add new technologies, and guarantee comparable care to more urban providers.

In recent years, Congress has moved to even the playing field between urban and rural medicine. New classifications, such as Critical Access Hospitals, have allowed these truly safety-net facilities to remain in operation and serve their community. But more work must be done.

In 1994, a new payment system for hospital inpatient services was created to bring efficiency and cost savings into the Medicare program. The new prospective payment system paid hospitals a fixed amount before services were provided, and severed the historical link between reimbursement and reasonable costs. In 2000, hospital outpatient services were added to this payment system.

But what has this system meant for the small rural hospital that has only a handful of beds and cares for a small number of patients? Quite simply, lower volumes hurt the ability of rural hospitals to handle a prospective payment system. They have limited financial reserves, lack available funds to make capital improvements and, especially in the case of Alaska, have difficulty dealing with volume fluctuations that are often times tied to seasonal travel.

The ''Rural Community Hospital Assistance Act'' seeks to remedy this problem and a few others that are facing rural America. This legislation would proved enhanced cost-based reimbursement for critical access hospitals. Cost-based reimbursement for inpatient and outpatient services would include a ''return on equity'' to assist the small facilities in addressing technology and infrastructure needs. It would also provide an option for rural hospitals with less than 50 inpatient beds to receive enhanced cost-based reimbursement for inpatient, outpatient, and select post-acute care services.

Hospitals are resorting to Critical Access status for financial reasons. Rural hospitals are facing a financial crisis. In fact, rural facilities have a Medicare inpatient margin that is almost 10 percentage points lower than urban hospitals. And with these financial constraints, they have often been forced to pass on facility upgrades and acquiring new technologies. Who suffers? The seniors who can't receive the same state-of-the-art care simply because they aren't fortunate to live in a urban zip code.

This legislation is vital to the state of Alaska. Hospitals such as Petersburg Medical Center, Sitka Community, Valdez Community, Seward Medical Center, and Wrangell Medical Center will be able to modernize and expand services to their growing elderly population. Access and quality will increase. Seniors will reap the benefits.

I would like to remind my colleagues that many Alaskan hospitals are not on a road system. They are true safety-net facilities. If they are not there, a need will go unmet.

We must work together to strengthen Medicare. I encourage my colleagues to reflect upon the burdens placed upon rural hospitals and to consider this worthy bill. It is an incremental step towards leveling the playing field between rural and urban medicine. I urge my colleagues to act swiftly upon this bill.

I ask unanimous consent that the text of the ''Rural Community Hospital Assistance Act of 2002'' be printed in the RECORD.

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

S. 2615

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

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT.

(a) SHORT TITLE.—This Act may be cited as the ''Rural Community Hospital Assistance Act of 2002''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered a reference to that section or other provision of the Social Security Act.

SEC. 2. ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end of the following new subsection:

''Rural Community Hospital; Rural Community Hospital Services

''(ww)(1) The term 'rural community hospital' means a hospital (as defined in subsection (e)) that—

''(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

''(B) subject to subparagraph (B), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

''(C) makes available 24-hour emergency care services;

''(D) subject to subparagraph (C), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2002; and

''(E) applies to the Secretary for such designation.

''(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

''(3) Subparagraph (1)(C) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

''(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2002) with the same service area (as defined by the Secretary in regulations in effect on such date).

''(B) A facility obtaining a new provider number pursuant to a change of ownership.

''(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2002.

''(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.''.

(b) PAYMENT.—

(1) INPATIENT SERVICES.—Section 1814 (42 U.S.C. 1395f) is amended by adding at the end the following new subsection:

''Payment for Inpatient Services Furnished in Rural Community Hospitals

''(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(ww)(1)(D)—

''(1) the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

''(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).''.

(2) OUTPATIENT SERVICES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) PAYMENT FOR OUTPATIENT SERVICES FURNISHED IN RURAL COMMUNITY HOSPITALS.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in section 1861(ww)(1)(D)—

''(1) the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U), or

''(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).''.

(3) HOME HEALTH SERVICES.—

(A) EXCLUSION FROM HOME HEALTH PPS.—

(i) IN GENERAL.—Section 1895 (42 U.S.C. 1395fff) is amended by adding at the end the following:

''(f) EXCLUSION.—

''(1) IN GENERAL.—In determining payments under this title for home health services furnished on or after October 1, 2002, by a qualified RCH-based home health agency (as defined in paragraph (2))—

''(A) the agency may make a one-time election to waive application of the prospective payment system established under this section to such services furnished by the agency shall not apply; and

''(B) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

''(2) QUALIFIED RCH-BASED HOME HEALTH AGENCY DEFINED.—For purposes of paragraph (1), a 'qualified RCH-based home health agency' is a home health agency that is a provider-based entity (as defined in section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554; Appendix F, 114 Stat. 2763A–506) of a rural community hospital that is located—

''(A) in a county in which no main or branch office of another home health agency is located; or

''(B) at least 35 miles from any main or branch office of another home health agency.''.

(ii) CONFORMING CHANGES.—

(I) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended by inserting ''or with respect to services to which section 1895(f) applies'' after ''equipment'' in the matter preceding paragraph (1).

(II) PAYMENTS UNDER PART B.—Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) is amended by striking ''the prospective payment system under''.

(III) PER VISIT LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended by inserting ''(other than by a qualified RCH-based home health agency (as defined in section 1895(f)(2))'' after ''with respect to services furnished by home health agencies''.

(iii) CONSOLIDATED BILLING.—

(I) RECIPIENT OF PAYMENT.—Section 1842(b)(6)(F) (42 U.S.C. 1395u(b)(6)(F)) is amended by inserting ''and excluding home health services to which section to which section 1895(f) applies'' after ''provided for in such section''.

(II) EXCEPTION TO EXCLUSION FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended by inserting before the period at the end of the second sentence the following: ''and paragraph (21) shall not apply to home health services to which section 1895(f) applies''.

(4) RETURN ON EQUITY.—Section 1861(v)(1)(P) (42 U.S.C. 1395x(v)(1)(P)) is amended—

(A) by inserting ''(i)'' after ''(P)''; and

(B) by adding at the end the following:

''(ii)(I) Notwithstanding clause (i), subparagraph (S)(i), and section 1886(g)(2), such regulations shall provide, in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital on or after October 1, 2002, for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in clause (i):

''(II) The services referred to in subclause (I) are inpatient hospital services, outpatient hospital services, home health services furnished by an RCH-based home health agency (as defined in section 1895(f)(2)), and ambulance services.

''(III) Payment under this clause shall be made without regard to whether a provider is a proprietary provider.''.

(5) EXEMPTION FROM 30 PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is amended by inserting ''(other than a rural community hospital)'' after ''In determining such reasonable costs for hospitals''.

(c) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—Section 1834(n) (as added by subsection (b)(2)) is amended—

(1) by inserting ''(1)'' after ''(n)''; and

(2) adding at the end the following:

''(2) The amounts of beneficiary cost sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

''(A) For items and services that would have been paid under section 1833(t) if provided by a hospital, the amount of cost sharing determined under paragraph (8) of such section.

''(B) For items and services that would have been paid under section 1833(h) if furnished by a provider or supplier, no cost sharing shall apply.

''(C) For all other items and services, the amount of cost sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.''.

(d) CONFORMING AMENDMENTS.—

(1) PART A PAYMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended by inserting ''other than inpatient hospital services furnished by a rural community hospital,'' after ''critical access hospital services,''.

(2) PART B PAYMENT.—

(A) IN GENERAL.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(i) in paragraph (2), in the matter before subparagraph (A), by striking ''and (I)'' and inserting ''(I), and (K)'';

(ii) by striking ''and'' at the end of paragraph (8);

(iii) by striking the period at the end of paragraph (9) and inserting ''; and''; and

(iv) by adding at the end the following:

''(10) in the case of outpatient services furnished by a rural community hospital, the amounts described in section 1834(n).''.

(B) AMBULANCE SERVICES.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(i) in the heading, by striking ''CRITICAL ACCESS HOSPITALS'' and inserting ''CERTAIN FACILITIES'';

(ii) by striking ''or'' at the end of subparagraph (A);

(iii) by redesignating subparagraph (B) as subparagraph (C);

(iv) by inserting after subparagraph (A) the following new subparagraph:

''(B) by a rural community hospital (as defined in section 1861(ww)(1)), or''; and

(v) in subparagraph (C), as so redesignated, by inserting ''or a rural community hospital'' after ''critical access hospital''.

(3) TECHNICAL AMENDMENTS.—

(A) CONSULTATION WITH STATE AGENCIES.—Section 1863 (42 U.S.C. 1395z) is amended by striking ''and (dd)(2)'' and inserting ''(dd)(2), (mm)(1), and (ww)(1)''.

(B) PROVIDER AGREEMENTS.—Section 1866(a)(2)(A) (42 U.S. C. 1395cc(a)(2)(A)) is amended by inserting ''section 1834(n)(2),'' after ''section 1833(b),''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2002.

SEC. 3. REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY RCH AND CAH FACILITIES.

(a) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by striking ''a distinct part of the hospital (as defined by the Secretary)'' in the matter following cause (v) and inserting ''a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital or a rural community hospital''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to determinations with respect to distinct part unit status that are made on or after October 1, 2002.

SEC. 4. IMPROVEMENTS TO MEDICARE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM.

(a) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended by adding at the end the following:

''(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 10.''.

(b) PAYMENTS TO HOME HEALTH AGENCIES OWNED AND OPERATED BY A CAH.—Section 1895(f) (42 U.S.C. 1395fff(f)), as added by section 2(b)(3), is further amended by inserting ''or by a home health agency that is owned and operated by a critical access hospital (as defined in section 1861(mm)(1))'' after ''as defined in paragraph (2))''.

(c) PAYMENTS TO CAH-OWNED SNFS.—

(1) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(A) in paragraph (1), by striking ''and (12)'' and inserting ''(12), and (13)''; and

(B) by adding at the end thereof the following:

''(13) EXEMPTION OF CAH FACILITIES FROM PPS.—In determining payments under this part for covered skilled nursing facility services furnished on or after October 1, 2002, by a skilled nursing facility that is a distinct part unit of a critical access hospital (as defined in section 1861(mm)(1)) or is owned and operated by a critical access hospital—

''(A) the prospective payment system established under this subsection shall not apply; and

''(B) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under subsection (a).''.

(2) CONFORMING CHANGES.—

(A) IN GENERAL.—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by subsection (b)(2)(A), is further amended in the matter preceding paragraph (1)—

(i) by inserting ''other than a skilled nursing facility providing covered skilled nursing facility services (as defined in section 1888(e)(2)) or posthospital extended care services to which section 1888(e)(13) applies,'' after ''inpatient critical access hospital services''; and

(ii) by striking ''1813 1886,'' and inserting ''1813, 1886, 1888,''.

(B) CONSOLIDATED BILLING.—

(i) RECIPIENT OF PAYMENT.—Section 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by inserting ''services to which paragraph (7)(C) or (13) of section 1888(e) applies and'' after ''other than''.

(ii) EXCEPTION TO EXCLUSION FROM COVERAGE.—Section 1862(a)(18) (42 U.S.C. 1395y(a)(18)) is amended by inserting ''(other than services to which paragraph (7)(C) or (13) of section 1888(e) applies)'' after ''section 1888(e)(2)(A)(i)''.

(d) PAYMENTS TO DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS OF CAHS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting '', other than a distinct part psychiatric or rehabilitation unit to which paragraph (8) applies,'' after ''subsection (d)(1)(B)''; and

(2) by adding at the end the following:

''(8) EXEMPTION OF CERTAIN DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS FROM COST LIMITS.—In determining payments under this part for inpatient hospital services furnished on or after October 1, 2002, by a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of subsection (d)(1)(B)) of a critical access hospital (as defined in section 1861(mm)(1))—

''(A) the limits imposed under the preceding paragraphs of this subsection shall not apply; and

''(B) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services.''.

(e) ELIMINATION OF ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—Paragraph (8) of section 1834(l) (42 U.S.C. 1395m(l)), as added by section 205(a) of BIPA, is amended by striking the comma at the end of the last subparagraph and all that follows and inserting a period.

(f) RETURN ON EQUITY.—Section 1861(v)(1)(P) (42 U.S.C. 1395x(v)(1)(P)), as amended by section 2(b)(4), is further amended by adding at the end the following:

''(iii)(I) Notwithstanding clause (i), subparagraph (S)(i), and section 1886(g)(2), such regulations shall provide, in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital on or after October 1, 2002, for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in clause (i):

''(II) The services referred to in subclause (I) are inpatient critical access hospital services (as defined in section 1861(mm)(2)), outpatient critical access hospital services (as defined in section 1861(mm)(3)), extended care services provided pursuant to an agreement under section 1883, posthospital extended care services to which section 1888(e)(13) applies, home health services to which section 1895(f) applies, ambulance services to which section 1834(l) applies, and inpatient hospital services to which section 1886(b)(8) applies.

''(III) Payment under this clause shall be made without regard to whether a provider is a proprietary provider.''.

(g) TECHNICAL CORRECTIONS.—

(1) SECTION 403(b) OF BBRA 1999.—Section 1820(b)(2) (42 U.S.C. 1395i–4(b)(2)) is amended by striking ''nonprofit or public hospitals'' and inserting ''hospitals''.

(2) SECTION 203(b) OF BIPA 2000.—Section 1883(a)(3) (42 U.S.C. 1395tt(a)(3)) is amended—

(A) by inserting ''section 1861(v)(1)(G) or'' after ''Notwithstanding''; and

(B) by striking ''covered skilled nursing facility''.

(h) EFFECTIVE DATES.—

(1) ELIMINATION OF REQUIREMENTS.—The amendment made by subsections (a) and (b) shall apply to services furnished on or after October 1, 2002.

(2) TECHNICAL CORRECTIONS.—

(A) BBRA.—The amendment made by subsection (f)(1) shall be effective as if included in the enactment of section 403(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–321), as enacted into law by section 1000(a)(6) of Public Law 106–113.

(B) BIPA.—The amendment made by subsection (f)(2) shall be effective as if included in the enactment of section 203(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.

Mr. WELLSTONE. Mr. President, I rise today along with my colleague, the Senator from Alaska, to introduce the Rural Community Hospital Assistance Act. Senator MURKOWSKI and I don't agree on a lot of issues. But one thing we both care very deeply about is the health of this Nation's rural hospitals. Rural hospitals provide essential care for more than 54 million people. They provide essential inpatient, outpatient and post-acute care, including skilled nursing, home health and rehabilitation services. Minnesota has more rural hospitals than any other state in the United States with the exception of Texas. The hospitals of rural America are the heart of our health care system. In rural America, how far away you are from your community hospital can be a matter of life and death.

But the health of our rural hospitals in 2002 is not good. Many are struggling to survive. Rural hospitals have Medicare inpatient margins that are 10 percent less than urban hospitals. Rural hospital total Medicare margins have declined significantly, falling to an average of negative 3.2 percent since 1999, and even lower margins, negative 5.4 percent, for rural hospitals with 50 or fewer beds. Rural hospital costs are increasing at a greater rate than urban hospitals. They can't survive on the Medicare prospective payment system that we've set up for them. That payment system provides a fixed hospital payment established in advance of the provisions of services, rather than providing reimbursement retroactively on the basis of costs. The Medicare Payment Advisory Commission (MedPAC) told the Congress last June that the Prospective Payment System is not working for small rural hospitals. We set up that system to contain costs and save money. But we can't have the kind of healthcare system that the people who live in the small towns and on the farms of America deserve, if we try to finance it on the cheap. This is about values. This is about priorities. This is about giving people who work hard all their lives the healthcare they deserve.

I voted against the Balanced Budget Act of 1997 because I was worried that it would lead to significant harm for our healthcare system. I was worried that it would hurt healthcare in our rural areas, in our cities, and that it would damage our healthcare safety net. Unfortunately, I was right and we have seen exactly the kind of problems I warned about. But one good thing we included was the Medicare Rural Hospital Flexibility Act which set up ''Critical Access Hospitals.'' The Critical Access Hospital (CAH) program provides cost based Medicare reimbursement for qualifying rural hospitals with 15 of fewer inpatient beds. Small rural hospitals face unique circumstances that require special consideration when developing Medicare payment policies. Because of their small size, a median of 58 beds compared to 186 beds for urban hospitals, rural hospitals have a much more difficult time surviving within a prospective payment system. Rural hospitals have fewer financial reserves and greater volume fluctuations than urban hospitals. They rely on Medicare as a source of revenue more than other hospitals. They have to deal with isolation, high levels of poverty, and shortages of critical health care professionals, making it much more difficult for small rural hospitals to absorb the impact of policy and market changes.

The Critical Access Hospital Program has done a good job. There are 43 Critical Access Hospitals in Minnesota. But this program needs to be updated and it needs to be extended and enhanced if we are going to restore our rural hospitals to financial health. The Rural Community Hospital Assistance Act will provide enhanced cost based reimbursement for Critical Access Hospitals, and extend such reimbursement to post acute care services. It will permit and extend enhanced reimbursement fore geriatric psychiatric care. It will provide enhanced cost based reimbursement for ambulance services. It would also provide an option for rural hospitals with less than 50 acute care beds to receive cost based reimbursement for inpatient, outpatient, and ambulance services. This is very important because so many rural hospitals with less than 50 beds are struggling just to survive. It is essential that the doors of our rural hospitals remain open. I ask my colleagues to join Senator MURKOWSKI and me in supporting this important legislation for rural America.

By Mr. THURMOND:

S. 2616. A bill to amend the Public Health Service Act to establish an Office of Men's Health; to the Committee on Health, Education, Labor, and Pensions.

Mr. THURMOND. Mr. President, this week in the United States we are commemorating Men's Health Week. The National Men's Health Week Act was passed by Congress and signed into law in 1994. Since then Men's Health Week has been celebrated each year as the week leading up to and including Father's Day. I was proud to be a cosponsor of that Act. Today, I rise to introduce the Men's Health Act of 2002, to establish an Office of Men's Health within the Department of Health and Human Services to promote men's health in America.

In this Nation, there is an ongoing, increasing, and predominantly silent crisis in the health and well-being of men. Due to a lack of awareness, poor health education, and culturally-induced behavior patterns, the state of men's health and well-being is deteriorating steadily. Heart disease, stroke, and various cancers, including prostate and testicular cancer, continue to be

major areas of concern. We must address these issues with diligent educational efforts, prevention and treatment as we seek to enhance the quality and duration of men's lives. Improved distribution of information concerning the health challenges men face and the utilization of the appropriate preventive measures are imperative to addressing this need.

As a lifelong advocate of regular medical exams, daily exercise, and a balanced diet, I feel strongly that an Office of Men's Health should be established to help improve the overall health of America's male population. The bill I am introducing is similar to a bill introduced in the House of Representatives. I invite my colleagues to join me in supporting this important measure. 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. 2616

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 ''Men's Health Act of 2002''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) A silent health crisis is affecting the health and well-being of America's men.

(2) While this health crisis is of particular concern to men, it is also a concern for women regarding their fathers, husbands, sons, and brothers.

(3) Men's health is a concern for employers who pay the costs of medical care, and lose productive employees.

(4) Men's health is a concern to Federal and State governments which absorb the enormous costs of premature death and disability, including the costs of caring for dependents left behind.

(5) The life expectancy gap between men and women has increased from one year in 1920 to almost six years in 1998.

(6) Prostate cancer is the most frequently diagnosed cancer in the United States among men, accounting for 36 percent of all cancer cases.

(7) An estimated 180,000 men will be newly diagnosed with prostate cancer this year alone, and 37,000 will die.

(8) The American Heart Association reports that heart attack is the single biggest killer of American males. Men are more likely to die of stroke and are almost twice as likely to die of heart disease than are women. High blood pressure increases the risk for stroke and heart attack and men under age 55 are much more likely to suffer from high blood pressure than are women.

(9) An estimated 7,600 men will be diagnosed this year with testicular cancer, and 400 of these men will die of this disease in 2002. A common reason for delay in treatment of this disease is a delay in seeking medical attention after discovering a testicular mass.

(10) Studies show that men are at least 25 percent less likely than women to visit a doctor, and are significantly less likely to have regular physician check-ups and obtain preventive screening tests for serious diseases.

(11) Appropriate use of tests such as prostate specific antigen (PSA) exams and blood pressure, blood sugar, and cholesterol screens, in conjunction with clinical exams and self-testing, can result in the early detection of many problems and in increased survival rates.

(12) Educating men, their families, and health care providers about the importance of early detection of male health problems can result in reducing rates of mortality for male-specific diseases, as well as improve the health of America's men and its overall economic well-being.

(13) Recent scientific studies have shown that regular medical exams, preventive screenings, regular exercise, and healthy eating habits can help save lives.

(14) Establishing an Office of Men's Health is needed to investigate these findings and take such further actions as may be needed to promote men's health.

SEC. 3. ESTABLISHMENT OF OFFICE OF MEN'S HEALTH.

(a) IN GENERAL.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by adding at the end the following:

''OFFICE OF MEN'S HEALTH

''SEC. 1711. The Secretary shall establish within the Department of Health and Human Services an office to be known as the Office of Men's Health, which shall be headed by a director appointed by the Secretary. The Secretary, acting through the Director of the Office, shall coordinate and promote the status of men's health in the United States.''.

(b) REPORT.—Not later than two years after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Director of the Office of Men's Health (established under section 1711 of the Public Health Service Act as added by subsection (a)), shall submit to Congress a report describing the activities of such Office, including findings that the Director has made regarding men's health.

STATEMENTS ON SUBMITTED RESOLUTIONS

SENATE RESOLUTION 283—RECOGNIZING THE SUCCESSFUL COMPLETION OF DEMOCRATIC ELECTIONS IN THE REPUBLIC OF COLOMBIA

Mr. GRAHAM (for himself, Mr. DEWINE, Mr. MCCAIN, Mr. TORRICELLI, Mr. MILLER, Mr. LEAHY, Mr. FEINGOLD, Mr. DODD, Mr. NELSON of Florida, Mr. GRASSLEY, Mr. BREAUX, Mr. WARNER, Mr. NELSON of Nebraska, Mr. COCHRAN, Mr. HELMS, Mr. CHAFEE, Mr. REID, Mr. ROCKEFELLER, Mr. BAYH, Mr. LUGAR, Mr. BROWNBACK, Mr. ALLEN, and Mr. SESSIONS) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 283

Whereas on May 26, 2002, the Republic of Colombia successfully completed democratic multiparty elections for President and Vice President;

Whereas these elections were deemed by international and domestic observers, including the United Nations and the Organization of American States, to be free, fair, and a legitimate nonviolent expression of the will of the people of the Republic of Colombia;

Whereas the United States has consistently supported the efforts of the people of the Republic of Colombia to strengthen and continue their democracy;

Whereas the Senate notes the courage of the millions of citizens of the Republic of Colombia that turned out to vote in order to freely and directly express their opinion; and

Whereas these open, fair, and democratic elections of the new President and Vice President of the Republic of Colombia, and the speedy posting of election results, should be broadly commended: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates the government and the people of the Republic of Colombia for the successful completion of democratic elections held on May 26, 2002, for President and Vice President;

(2) congratulates President-elect Alvaro Uribe Velez and Vice President-elect Francisco Santos Calderon on their recent victory and their continuing strong commitment to democracy, national reconciliation, and reconstruction;

(3) congratulates Colombian President Andres Pastrana, who has been a strong ally of the United States, a long-standing supporter of peace process negotiations, and a builder of national unity in the Republic of Colombia, for his personal commitment to democracy;

(4) commends all Colombian citizens and political parties for their efforts to work together to take risks for democracy and to willfully pursue national reconciliation in order to cement a lasting peace and to strengthen democratic traditions in the Republic of Colombia;

(5) supports Colombian attempts to—

(A) ensure democracy, national reconciliation, and economic prosperity;

(B) support human rights and rule of law; and

(C) abide by all the essential elements of representative democracy as enshrined in the Inter-American Democratic Charter, Organization of American States, and United Nations principles;

(6) encourages the government and people of the Republic of Colombia to continue their struggle against the evils of narcotics and all forms of terrorism;

(7) encourages the government of the Republic of Colombia to continue to promote—

(A) the professionalism of the Colombian Armed Forces and Colombian National Police; and

(B) judicial and legal reforms; and

(8) reaffirms that the United States is unequivocally committed to encouraging and supporting democracy, human rights, rule of law, and peaceful development in the Republic of Colombia and throughout the Americas.

Mr. GRAHAM. Mr. President, I rise, along with 21 of my colleagues, to submit a resolution commending the country and the people of Colombia on continuing the tradition of democracy, with a plurality freely and fairly voting for President-elect Alvaro Uribe Velez and Vice President-elect Francisco Santos Calderon on May 26, 2002.

In Colombia, the evil hand of terror and suffering and fear and death has been an everyday reality for too long. In 2000, over 44 percent of the worldwide incidents of terrorist attacks against U.S. citizens and United States interests were in the country of Colombia. These attacks pose a threat to Colombia, the stability of Latin America, the security of the Western Hemisphere, and the direct and indirect security of many United States citizens, businesses, and interests.

Yet, despite the constant threat and reality of violence in Colombia, the