

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 2003.

TITLE II—PROMOTION OF SYSTEMS CHANGE AND CAPACITY BUILDING

SEC. 201. GRANTS TO PROMOTE SYSTEMS CHANGE AND CAPACITY BUILDING.

(a) AUTHORITY TO AWARD GRANTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall award grants to eligible States to carry out the activities described in subsection (b).

(2) APPLICATION.—In order to be eligible for a grant under this section, a State shall submit to the Secretary an application in such form and manner, and that contains such information, as the Secretary may require.

(b) PERMISSIBLE ACTIVITIES.—A State that receives a grant under this section may use funds provided under the grant for any of the following activities, focusing on areas of need identified by the State and the Consumer Task Force established under subsection (c):

(1) The development and implementation of the provision of community-based attendant services and supports under section 1935 of the Social Security Act (as added by section 101(b) and amended by sections 102 and 103) through active collaboration with—

- (A) individuals with disabilities;
- (B) elderly individuals;
- (C) representatives of such individuals; and
- (D) providers of, and advocates for, services and supports for such individuals.

(2) Substantially involving individuals with significant disabilities and representatives of such individuals in jointly developing, implementing, and continually improving a mutually acceptable comprehensive, effectively working statewide plan for preventing and alleviating unnecessary institutionalization of such individuals.

(3) Engaging in system change and other activities deemed necessary to achieve any or all of the goals of such statewide plan.

(4) Identifying and remedying disparities and gaps in services to classes of individuals with disabilities and elderly individuals who are currently experiencing or who face substantial risk of unnecessary institutionalization.

(5) Building and expanding system capacity to offer quality consumer controlled community-based services and supports to individuals with disabilities and elderly individuals, including by—

(A) seeding the development and effective use of community-based attendant services and supports cooperatives, independent living centers, small businesses, microenterprises and similar joint ventures owned and controlled by individuals with disabilities or representatives of such individuals and community-based attendant services and supports workers;

(B) enhancing the choice and control individuals with disabilities and elderly individuals exercise, including through their representatives, with respect to the personal assistance and supports they rely upon to lead independent, self-directed lives;

(C) enhancing the skills, earnings, benefits, supply, career, and future prospects of workers who provide community-based attendant services and supports;

(D) engaging in a variety of needs assessment and data gathering;

(E) developing strategies for modifying policies, practices, and procedures that result in unnecessary institutional bias or the overmedicalization of long-term services and supports;

(F) engaging in interagency coordination and single point of entry activities;

(G) providing training and technical assistance with respect to the provision of community-based attendant services and supports;

(H) engaging in—

- (i) public awareness campaigns;
- (ii) facility-to-community transitional activities; and
- (iii) demonstrations of new approaches; and

(I) engaging in other systems change activities necessary for developing, implementing, or evaluating a comprehensive statewide system of community-based attendant services and supports.

(6) Ensuring that the activities funded by the grant are coordinated with other efforts to increase personal attendant services and supports, including—

(A) programs funded under or amended by the Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170; 113 Stat. 1860);

(B) grants funded under the Families of Children With Disabilities Support Act of 2000 (42 U.S.C. 15091 et seq.); and

(C) other initiatives designed to enhance the delivery of community-based services and supports to individuals with disabilities and elderly individuals.

(7) Engaging in transition partnership activities with nursing facilities and intermediate care facilities for the mentally retarded that utilize and build upon items and services provided to individuals with disabilities or elderly individuals under the medicare program under title XIX of the Social Security Act, or by Federal, State, or local housing agencies, independent living centers, and other organizations controlled by consumers or their representatives.

(c) CONSUMER TASK FORCE.—

(1) ESTABLISHMENT AND DUTIES.—To be eligible to receive a grant under this section, each State shall establish a Consumer Task Force (referred to in this subsection as the “Task Force”) to assist the State in the development, implementation, and evaluation of real choice systems change initiatives.

(2) APPOINTMENT.—Members of the Task Force shall be appointed by the Chief Executive Officer of the State in accordance with the requirements of paragraph (3), after the solicitation of recommendations from representatives of organizations representing a broad range of individuals with disabilities, elderly individuals, representatives of such individuals, and organizations interested in individuals with disabilities and elderly individuals.

(3) COMPOSITION.—

(A) IN GENERAL.—The Task Force shall represent a broad range of individuals with disabilities from diverse backgrounds and shall include representatives from Developmental Disabilities Councils, Mental Health Councils, State Independent Living Centers and Councils, Commissions on Aging, organizations that provide services to individuals with disabilities and consumers of long-term services and supports.

(B) INDIVIDUALS WITH DISABILITIES.—A majority of the members of the Task Force shall be individuals with disabilities or representatives of such individuals.

(C) LIMITATION.—The Task Force shall not include employees of any State agency providing services to individuals with disabilities other than employees of entities described in the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.).

(d) ANNUAL REPORT.—

(1) STATES.—A State that receives a grant under this section shall submit an annual report to the Secretary on the use of funds provided under the grant in such form and manner as the Secretary may require.

(2) SECRETARY.—The Secretary shall submit to Congress an annual report on the grants made under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated to carry out this section, \$50,000,000 for each of fiscal years 2004 through 2006.

(2) AVAILABILITY.—Amounts appropriated to carry out this section shall remain available without fiscal year limitation.

SEC. 202. DEMONSTRATION PROJECT TO ENHANCE COORDINATION OF CARE UNDER THE MEDICARE AND MEDICAID PROGRAMS FOR NON-ELDERLY DUAL ELIGIBLE INDIVIDUALS.

(a) DEFINITIONS.—In this section:

(1) NON-ELDERLY DUALY ELIGIBLE INDIVIDUAL.—The term “non-elderly dually eligible individual” means an individual who—

(A) has not attained age 65; and

(B) is enrolled in the medicare and medicaid programs established under titles XVIII and XIX, respectively, of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq.).

(2) PROJECT.—The term “project” means the demonstration project authorized to be conducted under this section.

(3) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(b) AUTHORITY TO CONDUCT PROJECT.—The Secretary shall conduct a project under this section for the purpose of evaluating service coordination and cost-sharing approaches with respect to the provision of community-based services and supports to non-elderly dually eligible individuals.

(c) REQUIREMENTS.—

(1) NUMBER OF PARTICIPANTS.—Not more than 5 States may participate in the project.

(2) APPLICATION.—A State that desires to participate in the project shall submit an application to the Secretary, at such time and in such form and manner as the Secretary shall specify.

(3) DURATION.—The project shall be conducted for at least 5, but not more than 10 years.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—Not later than 1 year prior to the termination date of the project, the Secretary, in consultation with States participating in the project, representatives of non-elderly dually eligible individuals, and others, shall evaluate the impact and effectiveness of the project.

(2) REPORT.—The Secretary shall submit a report to Congress that contains the findings of the evaluation conducted under paragraph (1) along with recommendations regarding whether the project should be extended or expanded, and any other legislative or administrative actions that the Secretary considers appropriate as a result of the project.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. REID:

S. 986. A bill to designate Colombia under section 244 of the Immigration and Nationality Act in order to make nationals of Colombia eligible for temporary protected status under such section; to the Committee on the Judiciary.

Mr. REID. Mr. President, amid all the discussions about reconstruction in Afghanistan and Iraq, it is easy for us

to lose sight of other humanitarian crises. One particularly pressing yet overlooked crisis is taking place right here in this hemisphere. For almost 40 years, an internal conflict has ravaged Colombia. Rebel and paramilitary groups designated as terrorist organizations by the State Department have committed thousands of kidnappings, executions and other brutalities. With an estimated combined force of 25,000 insurgents, they have disrupted life throughout the country and have displaced nearly 2 million people, creating the third largest internal refugee crisis in the world. The Colombian people are doing everything in their power to fight the rebels and rein in the paramilitaries, but the conflict shows no signs of ending anytime soon.

We should continue to help Colombia battle the terrorists in its midst. In the meantime, however, it would be unconscionable for us to forcibly deport law-abiding nationals currently residing in the United States, thereby placing them in danger of being tortured, kidnaped, or even murdered upon their return to their war-torn homeland. The bill I am introducing today will grant many of these people temporary protected status from deportation until it is safe for them to return to Colombia. The bill will not grant amnesty to any illegal aliens, nor will it place any immigrants on the path to citizenship. It is a purely humanitarian act that enjoys plenty of precedent—refugees from several Central American and African nations have benefited from temporary protected status in the wake of natural disasters and political turmoil. Immigration laws state that this protection covers only extraordinary circumstances, but we must not hesitate to invoke it when those circumstances arise. Extending temporary protected status to Colombians is the right thing to do, and I urge my colleagues to support this bill.

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. 986

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 “Colombian Temporary Protected Status Act of 2003”.

SEC. 2. FINDINGS.

Congress finds that—

(1) Colombia has been embroiled in a 38-year internal conflict, resulting in the death of tens of thousands of civilians and combatants;

(2) the 2 main armed anti-government rebel groups, the Revolutionary Armed Forces of Colombia (Fuerzas Armadas Revolucionarias de Colombia, or FARC) and the National Liberation Army (Ejercito de Liberacion Nacional, or ELN), have engaged in military activities in 700 of 1,098 municipalities in Colombia, and in recent years have influenced local governments in as much as 40 percent to 50 percent of Colombian territory;

(3) the FARC and ELN not only attack police and military forces but also regularly

attack civilian populations, commit massacres and extrajudicial killings, collect war taxes, compel citizens into their ranks, force farmers to grow illicit crops, and regulate travel, commerce, and other activities;

(4) paramilitary groups such as the United Self-Defense Groups of Colombia (Autodefensas Unidas de Colombia or AUC), originally established to protect rural landowners, have grown dramatically in recent years to become a major national military force in Colombia;

(5) paramilitary groups are responsible, according to human rights groups, for the greatest number of extrajudicial killings and forced disappearances in Colombia since 1995;

(6) the FARC, ELN, and AUC, all designated by the State Department as foreign terrorist organizations, have an estimated combined force of 25,000 combatants;

(7) the Government of Colombia, particularly during the administration of President Andres Pastrana, has afforded armed rebel groups numerous opportunities to negotiate a peace agreement, including the extraordinary step in November 1998 of creating a safe haven for the FARC by withdrawing its security forces from 5 municipalities covering some 16,000 to 17,000 square miles;

(8) despite having been given the opportunity to seek peace, the FARC instead used the safe haven to enhance its military capability to further its violent campaign against the government and people of Colombia;

(9) while President Pastrana and the Colombian government negotiated in good faith, the FARC proceeded to kidnap political officials;

(10) in February 2002, the FARC's actions forced President Pastrana to withdraw from the peace process and begin the process of re-taking the safe zone he had previously ceded to the FARC and other rebel groups;

(11) after the election of Alvaro Uribe as Colombia's President, the FARC began targeting mayors with letters declaring that they had 24 hours to leave or would be considered “military targets”;

(12) although before the recent Presidential election the violence had been mostly contained in rural areas, it has now spread to the urban areas, with cities such as Medellin experiencing an average of 13 killings a day;

(13) an average of 2.8 rebel bombs go off every day in Colombia while bomb squads disarm another 5;

(14) the middle and upper classes have been targeted for kidnaping, with an average of 3,250 Colombians being kidnaped each year since 1998;

(15) between 1,500,000 and 2,000,000 people have been forced to leave their homes, representing the third largest internal refugee crisis in the world; and

(16) between 1,500 and 2,500 Colombians were massacred in contested rural areas in 2001.

SEC. 3. SENSE OF CONGRESS.

It is the sense of Congress that, in view of the recent escalation of the current civil war in Colombia, Colombia qualifies for designation under section 244(b)(1)(A) of the Immigration and Nationality Act (8 U.S.C. 1254a(b)(1)(A)), pursuant to which Colombian nationals would be eligible for temporary protected status in the United States.

SEC. 4. DESIGNATION FOR PURPOSES OF GRANTING TEMPORARY PROTECTED STATUS TO COLOMBIANS.

(a) DESIGNATION.—

(1) IN GENERAL.—For purposes of section 244 of the Immigration and Nationality Act (8 U.S.C. 1254a), Colombia shall be treated as if it had been designated under subsection (b) of that section, subject to the provisions of this section.

(2) PERIOD OF DESIGNATION.—The initial period of such designation shall begin on the

date of enactment of this Act and shall remain in effect for 1 year.

(b) ALIENS ELIGIBLE.—In applying section 244 of the Immigration and Nationality Act (8 U.S.C. 1254a) pursuant to the designation made under this section, subject to section 244(c)(3) of the Immigration and Nationality Act (8 U.S.C. 1254a(c)(3)), an alien who is a national of Colombia meets the requirements of section 244(c)(1) of that Act (8 U.S.C. 1254a(c)(1)) only if—

(1) the alien has been continuously physically present in the United States since the date of enactment of this Act;

(2) the alien is admissible as an immigrant, except as otherwise provided under section 244(c)(2)(A) of the Immigration and Nationality Act (8 U.S.C. 1254a(c)(2)(A)), and is not ineligible for temporary protected status under section 244(c)(2)(B) of that Act (8 U.S.C. 1254a(c)(2)(B)); and

(3) the alien registers for temporary protected status in a manner that the Secretary of Homeland Security shall establish.

(c) CONSENT TO TRAVEL ABROAD.—The Secretary of Homeland Security shall give the prior consent to travel abroad described in section 244(f)(3) of the Immigration and Nationality Act (8 U.S.C. 1254a(f)(3)) to an alien who is granted temporary protected status pursuant to the designation made under this section, if the alien establishes to the satisfaction of the Secretary of Homeland Security that emergency and extenuating circumstances beyond the control of the alien require the alien to depart for a brief, temporary trip abroad. An alien returning to the United States in accordance with such an authorization shall be treated the same as any other returning alien provided temporary protected status under section 244 of the Immigration and Nationality Act (8 U.S.C. 1254a).

By Mr. DORGAN (for himself and Mr. BURNS):

S. 987. A bill to amend title XVIII of the Social Security Act to provide for national standardized payment amounts for inpatient hospital services furnished under the medicare program and to make other rural health care improvements; to the Committee on Finance.

Mr. DORGAN. Mr. President, today I am introducing legislation, the Rural Health Care Fairness and Medicare Equity Act, that will help to make Medicare reimbursement more fair and equitable for rural and small urban hospitals and physicians. I am pleased to be joined in introducing this bill by Senator BURNS.

First, let me 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, emergency ambulance services, and other members of our rural health care system. And because of past cuts in Medicare reimbursement, plus the historical unfairness in Medicare payments, these vital services are in jeopardy. Fortunately, Congress acted in 1999 and again in 2000 to address some of the cuts that turned out to have a larger impact than intended.

However, 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 fifth oldest in the Nation, and about two-thirds of North Dakota's 103,000 Medicare beneficiaries live in rural areas. In addition, North Dakota's population—and the population of many rural states in our Nation's Heartland—is shrinking daily. In fact, in 13 of North Dakota's counties, there were 20 or fewer births for the entire county in 2001.

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 75 to 80 percent of the revenue for some rural hospitals. Obviously, given this reality, Medicare reimbursement has 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. North Dakota Medicare beneficiaries pay the exact same Medicare payroll taxes and premiums as beneficiaries elsewhere but receive less benefit from the Medicare program. Medicare beneficiaries in North Dakota receive an average of \$4,458 in Medicare benefits. This is \$632 less than the national average spending per Medicare beneficiary of \$5,490, and \$5,500 less than the spending for Medicare beneficiaries in Washington, DC. Moreover, most North Dakotans do not even have the option of Medicare+Choice plans because Medicare reimbursement for these plans is so low in rural areas that they are not offered.

As a result of the skewed Medicare formula, North Dakota hospitals are reimbursed significantly less than hospitals of similar size and type elsewhere in the country. For instance, North Dakota hospitals are reimbursed as much as \$2,000 less for a Medicare beneficiary with heart failure compared to hospitals of a similar size and mission in Minnesota, New York and California. More specifically, for example, St. Alexius Medical Center in Bismarck, North Dakota is paid about \$4,000 for a heart failure patient. A similar sized hospital, with a similar

mission, would be paid \$5,900 in California, \$6,500 in New York, and \$6,800 in Minneapolis, MN for caring for the same patient.

Likewise, a similar payment inequity exists for physicians. For example, a physician in Beulah, ND is paid about \$46 by Medicare for an office visit, while a doctor in San Francisco is paid \$63 for a comparable office visit. A physician who inserts a pacemaker in a patient in New York City is paid about \$646, but a doctor who performs the exact same procedure in Fargo, ND is paid only \$481, about a quarter less.

This inequity in Medicare reimbursement has real consequences for hospitals and clinics: They have to reduce services, have greater difficulty recruiting staff, are less able to make capital improvements, and struggle to give their patients access to the latest innovations in medical care.

The bill I am introducing today, the Rural Health Care Fairness and Medicare Equity Act, would address the rural inequity in Medicare reimbursement in five 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. The fiscal year 2003 Omnibus Appropriations bill enacted by Congress earlier this year takes a step in the right direction by equalizing this base payment for the last six months of this fiscal year, but my bill would make this equalization permanent.

Second, my bill would create a wage index floor for the hospitals in this country with the very lowest wage indexes. 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. However, their low wage index has the effect of limiting the salaries that many rural and small urban hospitals can afford to pay their staff. By creating a floor, we would at least level the playing field a bit for hospitals with a wage index under 0.85.

Third, this bill would reduce the importance of the wage index in factoring a hospital's total Medicare reimbursement. The current "labor market share" of 71.1 percent overstates the actual amount that hospitals in North Dakota and nationwide pay for labor. For instance, in North Dakota, a hos-

pital in Bismarck has a labor market share of 58 percent, while a small rural hospital in Cando, ND has a labor market share of 55 percent. For hospitals in North Dakota and other states that already have a low wage index this overstatement of labor costs magnifies the reimbursement inequity. My bill would set the labor market share at 62 percent, which more closely reflects what the correct proportion should be. However, hospitals that would be adversely affected by this change would be held harmless.

In addition, this legislation creates alternative criteria for some hospitals to appeal to the Medicare program for a higher wage index. Hospitals currently can qualify for reclassification to an area with a higher wage index if they can demonstrate that they are proximate to the area to which they seek to be reclassified and pay similar wages or have a similar patient case-mix. The current reclassification process has been used predominantly in areas with high population density as a way for hospitals to increase their Medicare reimbursement. According to a GAO study last year, two-thirds of all hospitals that are able to reclassify are in two areas—California and the northeast.

Unfortunately, however, many rural and small urban hospitals located in states with a large land base and lots of distance between communities largely have not been able to take advantage of the reclassification process because they cannot meet the proximity criteria. This is the case even though, despite the longer distances between communities, hospitals are still competing against each other to recruit nurses and other staff. To address this concern, my bill would create an alternative reclassification process for hospitals in sparsely populated states with large distances between metropolitan areas that do not meet the current proximity criteria but do meet the other reclassification criteria.

Finally, my legislation would establish a floor of 1.00 for the physician work component of the Medicare physician payment system. The Medicare program currently adjusts physician payments based on a "geographic practice cost index" that is intended to reflect regional cost-of-living differences. The result has been that physicians in rural areas are generally reimbursed less by Medicare for providing the same exact level of care as doctors in urban areas. Since rural medical practices tend to serve higher proportions of Medicare beneficiaries, they are doubly impacted by this payment inequity.

As many of my colleagues know, it is already very difficult to recruit physicians to rural underserved areas. In fact, many small towns in my State are increasingly relying on foreign physicians working in the country under J-1 visas because they are unable to recruit American physicians. I am very concerned that the disparity in

Medicare reimbursement for doctors provides yet another reason for physicians to decline to serve in rural areas.

By establishing a floor of 1.00 for the work geographic practice cost index, this legislation will ensure that doctors' work in rural areas would at least be valued at the national average. However, it would still allow for payments higher than the national average for physicians serving in areas with a high cost of living.

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, such as those reflected in this legislation, that reflect rural health care as a strong national priority. I encourage my colleagues to join Senator BURNS and me in cosponsoring this bill.

Mr. BURNS. Mr. President, I rise to introduce The Rural Health Care Fairness and Medicare Equity Act with my good friend and colleague, Senator DORGAN, from North Dakota.

Many predominately rural States, such as my home State of Montana, face difficult challenges in the health care arena. Funding, staffing shortages, and inadequate reimbursement levels have plagued many hospitals and health care providers in the most rural areas of our country since the passage of the Balanced Budget Act of 1997. I have been a strong supporter of improving access to health care in these areas through education and telemedicine, but many rural communities in particular still face dangerous health care-related shortages.

The Rural Health Care Fairness and Medicare Equity Act seeks to make Medicare reimbursement more fair and equitable for rural and small urban hospitals and physicians by correcting the unintended inequities in the Medicare system put in place by the Balanced Budget Act of 1997 with five components. First, this act would provide a single standardized amount under the Medicare inpatient Provider Payment System, PPS, by permanently raising the standardized amount for rural and other hospitals to the same standardized amount level as large urban area hospitals. My colleagues in the Senate and I recognized the importance of doing this in the fiscal year 2003 Omnibus Appropriations package, which made this change for the remaining months of fiscal year 2003. We should now standardize hospital levels by making this change permanent, and this bill does just that.

Second, this bill would change the hospital labor market share from its current level of 71.1 percent, to 62 percent, based on a study done by the Uni-

versity of North Carolina Rural Health Research and Policy Analysis Center demonstrating that the current hospital labor market share is too high. Hospitals that would be harmed by this change would be held harmless. Third, this legislation would create a wage index floor of 0.85 for hospitals that would otherwise have a wage index less than the floor. Thirty of my colleagues and I cosponsored legislation in the 107th Congress that included a 0.925 floor, and I am hopeful that by setting the floor at 0.85, this provision will be better targeted toward rural hospitals with negative Medicare inpatient margins, helping our rural health centers to not only keep their doors open, but to continue providing quality, affordable health services to the rural communities they serve.

Fourth, this bill would create new, alternative criteria for hospital reclassification. This bill would require the Secretary of Health and Human Services to develop a new category of reclassification of hospitals for area wage index and standardized amount purposes. I am greatly concerned that the current reclassification process, particularly the proximity and adjacency criteria, has not been helpful to hospitals in States like Montana, with large land bases and lots of distance between communities, even though these hospitals must still compete with one another for nurses and other health care staff.

Two-thirds of all hospital reclassification take place in California and in the Northeast, largely because of these proximity and adjacency criteria. This bill would allow hospitals located in sparsely populated States that do not meet these prohibitive criteria to reclassify if they otherwise need reclassification criteria. This bill defines a sparsely populated state to be one in which there are fewer than 20 people per square mile of land, under which eight States, including Montana, qualify. Finally, the Rural Health Care Fairness and Medicare Equity Act would create a physician geographic adjustment floor of 1.0 for the physician work component of the Medicare physician payment system, beginning in 2004. This provision would lessen the geographic disparities in Medicare payment so gravely affecting physicians in the field today.

Patients in both rural and urban areas depend on the availability of quality health care providers to offer superior, affordable health services to people across the Nation. Medicare physician payments are intended to correspond to the costs that efficient providers incur. Instead, research has shown that the sustainable growth rate, SGR, under which reimbursement rates are supposed to be adjusted annually fails to account for all the relevant factors that affect the cost of physician payments, and maintains further inequities, such as Medicare paying different amounts for the same service, depending on where the service is provided.

Cuts in Medicare reimbursement to health care providers have forced health providers to make difficult choices, including becoming a non-participating Medicare provider, moving to areas with better reimbursement rates or less Medicare patients, retiring from practice early, limiting or discontinuing charitable care, reducing staff, or leaving Medicare entirely. The impact on these cuts has taken a serious toll on rural communities, such as those in Montana. The most recent cut in physician payment levels was the largest in Medicare history, immediately affecting 1 million health care professionals and the countless millions of elderly and disabled patients they, in turn, serve. Not only does this create a negative health care environment so adverse to the principles of the Medicare system, but the inequities in physician reimbursement rates have created a crisis situation for many patients in rural areas who do not have the luxury of choosing to see a different health care provider who can still afford to take Medicare patients.

This bill is extremely important to ensure that America's seniors and low-income have access to high quality physician services. It is imperative that Congress continue its commitment to rural health care quality, accessibility, and affordability, and the Rural Health Care Fairness and Medicare Equity Act is an important step toward this goal.

By Mr. COLEMAN:

S. 988. A bill to amend the Workforce Investment Act of 1998 to provide for a job training grant pilot program; to the Committee on Health, Education, Labor, and Pensions.

Mr. COLEMAN. Mr. President, I ask unanimous consent that the bill I introduce today to amend the Workforce Investment Act of 1998 to provide for a job training grant pilot program be printed in the RECORD.

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

S. 988

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

SECTION 1. JOB TRAINING GRANT PILOT PROGRAM.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) is amended by striking subsection (d) and inserting the following:

“(d) JOB TRAINING GRANT PILOT PROGRAM.—

“(1) IN GENERAL.—

“(A) GRANTS.—The Secretary shall provide grants to qualified job training programs as follows:

“(i) PLACEMENT GRANTS.—Grants in an amount to be determined by the Secretary shall be provided to qualified job training programs upon placement of a qualified graduate in qualifying employment.

“(ii) RETENTION GRANTS.—An additional grant in an amount to be determined by the Secretary shall be provided to qualified job training programs upon retention of a qualified graduate in qualifying employment for a period of 1 year.

“(B) DETERMINATION.—In determining the amount of the grants to be provided under subparagraph (A), the Secretary shall consider the economic benefit received by the Government from the employment of the qualified graduate, including increased tax revenue and decreased unemployment benefits or other support obligations.

“(2) QUALIFIED JOB TRAINING PROGRAM.—For purposes of this subsection, a qualified job training program is 1 that—

“(A) is operated by a nonprofit or for-profit entity, partnership, or joint venture formed under the laws of—

“(i) the United States or a territory of the United States;

“(ii) any State; or

“(iii) any county or locality;

“(B) offers education and training in—

“(i) basic skills, such as reading, writing, mathematics, information processing, and communications;

“(ii) technical skills, such as accounting, computers, printing, and machining;

“(iii) thinking skills, such as reasoning, creative thinking, decision making, and problem solving; and

“(iv) personal qualities, such as responsibility, self-esteem, self-management, honesty, and integrity;

“(C) provides income supplements when needed to eligible participants (defined for purposes of this paragraph as an individual who meets the criteria described in subparagraphs (A) through (C) of paragraph (3)) for housing, counseling, tuition, and other basic needs;

“(D) provides eligible participants with not less than 160 hours of instruction, assessment, or professional coaching; and

“(E) invests an average of \$10,000 in training per graduate of such program.

“(3) QUALIFIED GRADUATE.—For purposes of this subsection, a qualified graduate is an individual who is a graduate of a qualified job training program and who—

“(A) is 18 years of age or older;

“(B) had in either of the 2 preceding taxable years Federal adjusted gross income not exceeding the maximum income of a very low-income family (as defined in section 3(b)(2) of the United States Housing Act of 1937 (42 U.S.C. 1437a(b)(2))) for a single individual; and

“(C) has assets of not more than \$10,000, exclusive of the value of an owned homestead, indexed for inflation.

“(4) QUALIFYING EMPLOYMENT.—For purposes of this subsection, qualifying employment shall include any permanent job or employment paying annual wages of not less than \$18,000, and not less than \$10,000 more than the qualified graduate earned before receiving training from the qualified job training program.”.

By Mr. INOUE:

S. 991. A bill to amend title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work at certain medicare providers, and for other purposes; to the Committee on Finance.

Mr. INOUE. Mr. President, today I introduce the Registered Nurses' Safe Staffing Act of 2003. I'm introducing this bill on behalf of the American Nurses Association's Chief Executive Officer and President Linda Stierle, MSN, RN, CNAA and Barbara A. Blakeney, MS, APRN, BC, ANP respectively. For over 4 decades I have been a committed supporter of nurses and the

delivery of safe patient care. While enforceable regulations will help to ensure patient safety, the complexity and variability of today's hospitals require that staffing patterns be determined at the hospital and unit level, with the professional input of registered nurses. More than a decade of research demonstrates that nurse staff levels and the skill mix of nursing staff directly affect the clinical outcomes of hospitalized patients. Studies show that when there are more registered nurses, there are lower mortality rates, shorter lengths of stay, reduced costs, and fewer complications.

A study published in the Journal of the American Medical Association found that the risks of patient mortality rose by 7 percent for every additional patient added to the average nurse's workload. In the midst of a nursing shortage and increasing financial pressures, hospitals often find it difficult to maintain adequate staffing. While nursing research indicates that adequate registered nurse staffing is vital to the health and safety of patients, there are no standardized, public reporting or the enforcement of adequate staffing plans. The only regulations addressing nursing staff exists vaguely in Medicare Conditions of Participation which states: “The nursing service must have an adequate number of licensed registered nurses, licensed practice, vocational, nurse, and other personnel to provide nursing care to all patients as needed”.

This bill will require Medicare Participating Hospitals to develop and maintain reliable and valid systems to determine sufficient registered nurse staffing. Given, the demands that the healthcare industry faces today, it is our responsibility to ensure that patients have access to adequate nursing care. However, we must ensure that the decisions in which to provide this care are made by the clinical experts, the registered nurses caring for these patients. Support of this bill supports our nation's nurses during a critical shortage, but more importantly, works to ensure the safety of their patients.

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

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

S. 991

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 “Registered Nurse Safe Staffing Act of 2003”.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) There are hospitals throughout the United States that have inadequate staffing of registered nurses to protect the well-being and health of the patients.

(2) Studies show that the health of patients in hospitals is directly proportionate to the number of registered nurses working in the hospital.

(3) There is a critical shortage of registered nurses in the United States.

(4) The effect of that shortage is revealed in unsafe staffing levels in hospitals.

(5) Patient safety is adversely affected by these unsafe staffing levels, creating a public health crisis.

(6) Registered nurses are being required to perform professional services under conditions that do not support quality health care or a healthful work environment for registered nurses.

(7) As a payer for inpatient and outpatient hospital services for individuals entitled to benefits under the medicare program established under title XVIII of the Social Security Act, the Federal Government has a compelling interest in promoting the safety of such individuals by requiring any hospital participating in such program to establish minimum safe staffing levels for registered nurses.

SEC. 3. ESTABLISHMENT OF MINIMUM STAFFING RATIOS BY MEDICARE PARTICIPATING HOSPITALS.

(a) REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking “and” after the comma at the end;

(2) in subparagraph (S), by striking the period at the end and inserting “, and”; and

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

“(T) in the case of a hospital, to meet the requirements of section 1889.”.

(b) REQUIREMENTS.—Part D of title XVIII of the Social Security Act is amended by inserting after section 1888 the following new section:

“STAFFING REQUIREMENTS FOR MEDICARE PARTICIPATING HOSPITALS

“SEC. 1889. (a) ESTABLISHMENT OF STAFFING SYSTEM.—

“(1) IN GENERAL.—Each participating hospital shall adopt and implement a staffing system that ensures a number of registered nurses on each shift and in each unit of the hospital to ensure appropriate staffing levels for patient care.

“(2) STAFFING SYSTEM REQUIREMENTS.—Subject to paragraph (3), a staffing system adopted and implemented under this section shall—

“(A) be based upon input from the direct care-giving registered nurse staff or their exclusive representatives, as well as the chief nurse executive;

“(B) be based upon the number of patients and the level and variability of intensity of care to be provided, with appropriate consideration given to admissions, discharges, and transfers during each shift;

“(C) account for contextual issues affecting staffing and the delivery of care, including architecture and geography of the environment and available technology;

“(D) reflect the level of preparation and experience of those providing care;

“(E) account for staffing level effectiveness or deficiencies in related health care classifications, including but not limited to, certified nurse assistants, licensed vocational nurses, licensed psychiatric technicians, nursing assistants, aides, and orderlies;

“(F) reflect staffing levels recommended by specialty nursing organizations;

“(G) establish upwardly adjustable registered nurse-to-patient ratios based upon registered nurses' assessment of patient acuity and existing conditions;

“(H) provide that a registered nurse shall not be assigned to work in a particular unit without first having established the ability to provide professional care in such unit; and

“(I) be based on methods that assure validity and reliability.

“(3) LIMITATION.—A staffing system adopted and implemented under paragraph (1) may not—

“(A) set registered-nurse levels below those required by any Federal or State law or regulation; or

“(B) utilize any minimum registered nurse-to-patient ratio established pursuant to paragraph (2)(G) as an upper limit on the staffing of the hospital to which such ratio applies.

“(b) REPORTING, AND RELEASE TO PUBLIC, OF CERTAIN STAFFING INFORMATION.—

“(1) REQUIREMENTS FOR HOSPITALS.—Each participating hospital shall—

“(A) post daily for each shift, in a clearly visible place, a document that specifies in a uniform manner (as prescribed by the Secretary) the current number of licensed and unlicensed nursing staff directly responsible for patient care in each unit of the hospital, identifying specifically the number of registered nurses;

“(B) upon request, make available to the public—

“(i) the nursing staff information described in subparagraph (A); and

“(ii) a detailed written description of the staffing system established by the hospital pursuant to subsection (a); and

“(C) submit to the Secretary in a uniform manner (as prescribed by the Secretary) the nursing staff information described in subparagraph (A) through electronic data submission not less frequently than quarterly.

“(2) SECRETARIAL RESPONSIBILITIES.—The Secretary shall—

“(A) make the information submitted pursuant to paragraph (1)(C) publicly available, including by publication of such information on the Internet site of the Department of Health and Human Services; and

“(B) provide for the auditing of such information for accuracy as a part of the process of determining whether an institution is a hospital for purposes of this title.

“(c) RECORDKEEPING; DATA COLLECTION; EVALUATION.—

“(1) RECORDKEEPING.—Each participating hospital shall maintain for a period of at least 3 years (or, if longer, until the conclusion of pending enforcement activities) such records as the Secretary deems necessary to determine whether the hospital has adopted and implemented a staffing system pursuant to subsection (a).

“(2) DATA COLLECTION ON CERTAIN OUTCOMES.—The Secretary shall require the collection, maintenance, and submission of data by each participating hospital sufficient to establish the link between the staffing system established pursuant to subsection (a) and—

“(A) patient acuity from maintenance of acuity data through entries on patients' charts;

“(B) patient outcomes that are nursing sensitive, such as patient falls, adverse drug events, injuries to patients, skin breakdown, pneumonia, infection rates, upper gastrointestinal bleeding, shock, cardiac arrest, length of stay, and patient readmissions;

“(C) operational outcomes, such as work-related injury or illness, vacancy and turnover rates, nursing care hours per patient day, on-call use, overtime rates, and needle-stick injuries; and

“(D) patient complaints related to staffing levels.

“(3) EVALUATION.—Each participating hospital shall annually evaluate its staffing system and establish minimum registered nurse staffing ratios to assure ongoing reliability and validity of the system and ratios. The evaluation shall be conducted by a joint management-staff committee comprised of at least 50 percent of registered nurses who provide direct patient care.

“(d) ENFORCEMENT.—

“(1) RESPONSIBILITY.—The Secretary shall enforce the requirements and prohibitions of this section in accordance with the succeeding provision of this subsection.

“(2) PROCEDURES FOR RECEIVING AND INVESTIGATING COMPLAINTS.—The Secretary shall establish procedures under which—

“(A) any person may file a complaint that a participating hospital has violated a requirement or a prohibition of this section; and

“(B) such complaints are investigated by the Secretary.

“(3) REMEDIES.—If the Secretary determines that a participating hospital has violated a requirement of this section, the Secretary—

“(A) shall require the facility to establish a corrective action plan to prevent the recurrence of such violation; and

“(B) may impose civil money penalties under paragraph (4).

“(4) CIVIL MONEY PENALTIES.—

“(A) IN GENERAL.—In addition to any other penalties prescribed by law, the Secretary may impose a civil money penalty of not more than \$10,000 for each knowing violation of a requirement of this section, except that the Secretary shall impose a civil money penalty of more than \$10,000 for each such violation in the case of a participating hospital that the Secretary determines has a pattern or practice of such violations (with the amount of such additional penalties being determined in accordance with a schedule or methodology specified in regulations).

“(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A.

“(C) PUBLIC NOTICE OF VIOLATIONS.—

“(i) INTERNET SITE.—The Secretary shall publish on the Internet site of the Department of Health and Human Services the names of participating hospitals on which civil money penalties have been imposed under this section, the violation for which the penalty was imposed, and such additional information as the Secretary determines appropriate.

“(ii) CHANGE OF OWNERSHIP.—With respect to a participating hospital that had a change in ownership, as determined by the Secretary, penalties imposed on the hospital while under previous ownership shall no longer be published by the Secretary of such Internet site after the 1-year period beginning on the date of change in ownership.

“(e) WHISTLEBLOWER PROTECTIONS.—

“(1) PROHIBITION OF DISCRIMINATION AND RETALIATION.—A participating hospital shall not discriminate or retaliate in any manner against any patient or employee of the hospital because that patient or employee, or any other person, has presented a grievance or complaint, or has initiated or cooperated in any investigation or proceeding of any kind, relating to the staffing system or other requirements and prohibitions of this section.

“(2) RELIEF FOR PREVAILING EMPLOYEES.—An employee of a participating hospital who has been discriminated or retaliated against in employment in violation of this subsection may initiate judicial action in a United States district court and shall be entitled to reinstatement, reimbursement for lost wages, and work benefits caused by the unlawful acts of the employing hospital. Prevailing employees are entitled to reasonable attorney's fees and costs associated with pursuing the case.

“(3) RELIEF FOR PREVAILING PATIENTS.—A patient who has been discriminated or retali-

ated against in violation of this subsection may initiate judicial action in a United States district court. A prevailing patient shall be entitled to liquidated damages of \$5,000 for a violation of this statute in addition to any other damages under other applicable statutes, regulations, or common law. Prevailing patients are entitled to reasonable attorney's fees and costs associated with pursuing the case.

“(4) LIMITATION ON ACTIONS.—No action may be brought under paragraph (2) or (3) more than 2 years after the discrimination or retaliation with respect to which the action is brought.

“(5) TREATMENT OF ADVERSE EMPLOYMENT ACTIONS.—For purposes of this subsection—

“(A) an adverse employment action shall be treated as retaliation or discrimination; and

“(B) the term ‘adverse employment’ action includes—

“(i) the failure to promote an individual or provide any other employment-related benefit for which the individual would otherwise be eligible;

“(ii) an adverse evaluation or decision made in relation to accreditation, certification, credentialing, or licensing of the individual; and

“(iii) a personnel action that is adverse to the individual concerned.

“(f) RELATIONSHIP TO STATE LAWS.—Nothing in this section shall be construed as exempting or relieving any person from any liability, duty, penalty, or punishment provided by any present or future law of any State or political subdivision of a State, other than any such law which purports to require or permit the doing of any act which would be an unlawful practice under this title.

“(g) REGULATIONS.—The Secretary shall promulgate such regulations as are appropriate and necessary to implement this section.

“(h) DEFINITIONS.—In this section:

“(1) PARTICIPATING HOSPITAL.—The term ‘participating hospital’ means a hospital that has entered into a provider agreement under section 1866.

“(2) REGISTERED NURSE.—The term ‘registered nurse’ means an individual who has been granted a license to practice as a registered nurse in at least 1 State.

“(3) UNIT.—The term ‘unit’ of a hospital is an organizational department or separate geographic area of a hospital, such as a burn unit, a labor and delivery room, a post-anesthesia service area, an emergency department, an operating room, a pediatric unit, a stepdown or intermediate care unit, a specialty care unit, a telemetry unit, a general medical care unit, a subacute care unit, and a transitional inpatient care unit.

“(4) SHIFT.—The term ‘shift’ means a scheduled set of hours or duty period to be worked at a participating hospital.

“(5) PERSON.—The term ‘person’ means 1 or more individuals, associations, corporations, unincorporated organizations, or labor unions.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2004.

By Mr. NICKLES (for himself,
Mr. CONRAD, and Mr. BUNNING):

S. 992. A bill to amend the Internal Revenue Code of 1986 to repeal the provision taxing policyholder dividends of mutual life insurance companies and to repeal the policyholders surplus account provisions; to the Committee on Finance.

Mr. NICKLES. Mr. President, I rise today to introduce legislation to simplify the taxation of life insurance companies. I am joined by my colleague from North Dakota, Mr. CONRAD, and my colleague from Kentucky, Mr. BUNNING.

Our legislation repeals Sections 809 and Section 815 of the Internal Revenue Code. These provisions are no longer relevant given the significant changes in the life insurance industry over the past 25 years, and repeal will simplify the tax code.

Section 809 was enacted in 1984 as a part of major revisions to the laws governing life insurance companies. It was intended to ensure that mutual life insurance companies do not have a competitive tax advantage over stock life insurance companies. At that time, mutual life insurance companies dominated the market. Now, however, mutuals account for only 10 percent of the industry, and there are very few large mutuals in existence. Section 809 reduces the amount of policyholder dividends a mutual insurance company can deduct according to a complex formula based on the previous 3 years' earnings of stock companies. Section 809 is burdensome and raises very little revenue. Because its original purpose is no longer valid, our bill would repeal the provision permanently. In last year's economic stimulus bill, Congress temporarily suspended Section 809. In addition, President Bush included in his fiscal year 2003 budget submission a proposal to repeal Section 809 permanently.

Section 815 has an even longer history, dating back to 1959. Tax changes in 1959 created an accounting mechanism called a "policyholder surplus account" for stock life insurance companies. Stock companies were permitted to defer tax on one-half of their underwriting income as long as that income was not distributed to shareholders. This income was accounted for through the policyholder surplus account, PSA. In 1984, Congress eliminated deferral of tax on underwriting income, but did not address the issue of PSAs. The amounts in these accounts, which are just an accounting entry, and do not contain real money, remain subject to tax if certain triggering events occur. Because virtually no company is willing to "trigger" the tax on the account, Section 815 also raises little or no revenue. It does, however, directly inhibit the business decisions of stock companies with PSAs.

Congress has worked hard over the last few years to modernize laws governing the financial services industry to encourage growth and enhance competitiveness. Elimination of outdated tax provisions such as Sections 809 and 815 will complement this effort and provide more rational taxation of life insurance companies.

I urge my colleagues to join us in this initiative.

By Mr. LEAHY:

S. 995. A bill to amend the Richard B. Russell National School Lunch Act and the Child Nutrition Act of 1966 to improve certain child nutritional programs, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. LEAHY. Mr. President, I rise today to introduce my Child Nutrition Initiatives Act of 2003. This legislation consists of a number of proposals that I believe will significantly improve the nutrition benefits available to our Nation's children through Federal child nutrition programs.

I am hoping that this legislation will serve as a starting point in the Senate's debate over how to improve child nutrition programs this year. It is not meant to be a comprehensive proposal for reauthorization, nor does it represent all of the potential improvements that could be made to the programs that I will be supporting in the Agriculture Committee. I look forward to working with Chairman COCHRAN and with Senator HARKIN, the ranking Democrat on the Committee, as well as the rest of the Committee to craft a comprehensive bill.

The Committee has already held two hearings on child nutrition legislation, where we heard from a wide variety of nutritionists, school food service operators and others interested in these programs. They presented us with a wide variety of ideas, some of them appearing in my bill, which underlined the immense impact of these programs to the nutritional health and well-being of all of our children and grandchildren. Undersecretary Bost also testified, and he too offered an array of proposals for improving these programs. I look forward to more detailed proposals from the Department of Agriculture on how we can better serve the children in these programs.

I was encouraged to hear that the Administration is interested in providing much-needed financial help for schools choosing to improve their nutritional environment. We know that many school food service directors and employees want to offer healthier, more appetizing options to the children they serve, yet the cost of providing attractive fresh fruits and vegetables, or milk in child-friendly plastic containers kept chilled in a cooler, is often prohibitive. Increased per-meal reimbursements will encourage school cafeterias to spend more on the foods that are healthiest for kids. With these funds, schools will be able to make the salad bar and the milk cooler just as attractive to school children as less nutritious foods.

Healthier food in the school cafeteria does little good if children do not understand the benefits of eating apples over high-fat junk food. For years, the Nutrition Education and Training, NET, program provided critical support for state and local efforts to increase and improve nutrition education in classrooms. It is in the classrooms where the most effective and innova-

tive nutrition education is happening, and NET offered teachers the resources they needed to develop a nutritional curriculum for their students. Unfortunately, this program has not been funded in the last few years. My bill would reinstate funding for the NET program, and encourage strong nutrition education at the local level.

It is amazing how many kids do not know where the food that they eat comes from. It's also amazing how far some farm products travel to get to the cafeteria table. My bill includes a farm-to-cafeteria program that will provide one-time grants to connect farms with their local school system. These grants would be used to buy equipment and pay for other costs to provide the freshest farm products available to our children. Projects funded by the farm-to-cafeteria program would also give children firsthand experience about how food is produced. This new program would also provide economic benefits for small, local firms by keeping food dollars within the community.

My support for these new farm-to-cafeteria projects comes in part from the amazing successes demonstrated by the WIC Farmers Market Nutrition Program. Years ago, I helped create this program, which provides vouchers to WIC families good for fruits and vegetables at their local farmers market. The effects of this program have been stunning. In Vermont, recipients and farmers are raving about this program, which provides fresh, local, and healthy food to those who need it most. There has also been an unexpected educational component to this program, with many recipients reporting that the farmers who sell them the food have also helped them learn how to best prepare it. This is a win-win situation. My bill will secure steady and predictable funding for the Farmers Market Nutrition Program.

Every State receives a small amount of funds to administer and ensure the integrity of all Federal child nutrition programs. Though these funds are distributed based on usage of the programs, there has been an all-State minimum to ensure that all States still have enough funds to meet the basic administrative requirements mandated by law. This minimum, however, has not been raised since 1981, despite inflation and expansion of the responsibilities of the states. My bill updates the minimum funding level to reflect inflation since 1981 and also indexes it for inflation into the future.

I am pleased that my bill has the support of the American School Food Service Association, the National Association for Farmers Market Nutrition Programs, the National Milk Producers Federation, the International Dairy Foods Association, and the Community Food Service Coalition.

Opponents of my bill will undoubtedly point to the cost of these programs, stating "there is no money for such programs." Well, I answer them

with one word: priorities. Our Nation is faced with a growing health crisis. Children are growing up and growing out. They eat more, eat less nutritious foods and exercise less. It is a health epidemic that plagues them throughout life. By acting now, we can increase the quality of life for these children and save in healthcare costs down the line. For example, a study for the American School Food Service Association and the National Dairy Council found that by improving the quality, and therefore consumption, of milk in our school lunch programs, we could save between \$800 million to \$1.1 billion in health care costs every year.

I joined with a number of fellow senators in requesting that Congress provide a modest increase of \$1 billion per year in the Budget Resolution so that we on the authorizing committees might make some long-awaited and essential improvements to the child nutrition programs. I am disappointed that increased funds were not provided. The Senate sent a clear message to America's children: we would rather give a several hundred billion dollar tax cut to a small minority of health adults than protect our children, through \$1 billion in programming, from a health crisis.

The Federal Government reaches well over 25 million children each year with these programs. We have a tremendous opportunity to be proactive—to teach kids about food and give them nutritious options. We have a growing health crisis on our hands as our children grow wider because of unhealthy diets and less exercise. We must get serious about finding solutions to the problem. Or we can wait, and allow a system already doing its very best, working at maximum capacity, to deteriorate. I am for acting now and I hope the Senate is too.

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. 995

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Child Nutrition Initiatives Act of 2003”.

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—SCHOOL LUNCH AND RELATED PROGRAMS

Sec. 101. Incentives for healthier schools.

Sec. 102. Grants to support farm-to-cafeteria projects.

TITLE II—SCHOOL BREAKFAST AND RELATED PROGRAMS

Sec. 201. State administrative expenses.

Sec. 202. Special supplemental program for women, infants and children.

Sec. 203. Nutrition education and training.

TITLE III—EFFECTIVE DATE

Sec. 301. Effective date.

TITLE I—SCHOOL LUNCH AND RELATED PROGRAMS

SEC. 101. INCENTIVES FOR HEALTHIER SCHOOLS.

Section 12 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1760) is amended by adding at the end the following:

“(q) **INCENTIVES FOR HEALTHIER SCHOOLS.**—

“(1) **IN GENERAL.**—To encourage healthier nutritional environments in schools and institutions receiving funds under this Act and the Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.) (other than section 17 of that Act (42 U.S.C. 1786)), the Secretary shall establish a program under which any such school or institution may (in accordance with paragraph (3)) receive an increase in the reimbursement rate for meals otherwise payable under this Act and the Child Nutrition Act of 1966, if the school or institution implements a plan for improving the nutritional value of meals consumed in the school or institution by increasing the consumption of fluid milk, fruits, and vegetables, as approved by the Secretary in accordance with criteria established by the Secretary.

“(2) **PLANS.**—

“(A) **IN GENERAL.**—For purposes of the program established under paragraph (1), the Secretary shall establish criteria for the approval of plans of schools and institutions for increasing consumption of fluid milk, fruits, and vegetables.

“(B) **CRITERIA.**—An approved plan may—

“(i) establish targeted goals for increasing fluid milk, fruit, and vegetable consumption throughout the school or institution or at school or institution activities;

“(ii) improve the accessibility, presentation, positioning, or promotion of fluid milk, fruits, and vegetables throughout the school or institution or at school or institution activities;

“(iii) improve the ability of a school or institution to tailor its food services to the customs and demographic characteristics of—

“(I) the population of the school or institution; and

“(II) the area where the school or institution is located; and

“(iv) provide—

“(I) increased standard serving sizes for fluid milk consumed in middle and high schools; and

“(II) packaging, flavor variety, merchandising, refrigeration, and handling requirements that promote the consumption of fluid milk, fruits, and vegetables.

“(C) **ADMINISTRATION.**—In establishing criteria for approval of plans under this subsection, the Secretary shall—

“(i) take into account relevant research; and

“(ii) consult with school food service professionals, nutrition professionals, food processors, agricultural producers, and other groups, as appropriate.

“(3) **REIMBURSEMENT RATES.**—

“(A) **IN GENERAL.**—For purposes of administering the program established under paragraph (1), the Secretary shall increase reimbursement rates for meals under this Act and the Child Nutrition Act of 1966 in an amount equal to not less than 2 cents and not more than 10 cents per meal, to reflect the additional costs incurred by schools and institutions in increasing the consumption of fluid milk, fruits, and vegetables under the program.

“(B) **CRITERIA.**—The Secretary may vary the increase in reimbursement rates for meals based on the degree to which the school or institution adopts the criteria established by the Secretary under paragraph (2).”.

SEC. 102. GRANTS TO SUPPORT FARM-TO-CAFETERIA PROJECTS.

Section 12 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1760) (as amended by section 101) is amended by adding at the end the following:

“(r) **GRANTS TO SUPPORT FARM-TO-CAFETERIA PROJECTS.**—

“(1) **IN GENERAL.**—To improve access to local foods in schools and institutions receiving funds under this Act and the Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.) (other than section 17 of that Act (42 U.S.C. 1786)), the Secretary shall provide competitive grants to nonprofit entities and educational institutions to establish and carry out farm-to-cafeteria projects that may include the purchase of equipment, the procurement of foods, and the provision of training and education activities.

“(2) **PREFERENCE FOR CERTAIN PROJECTS.**—In selecting farm-to-cafeteria projects to receive assistance under this subsection, the Secretary shall give preference to projects designed to—

“(A) procure local foods from small- and medium-sized farms for the provision of foods for school meals;

“(B) support nutrition education activities or curriculum planning that incorporates the participation of school children in farm and agriculture education projects; and

“(C) develop a sustained commitment to farm-to-cafeteria projects in the community by linking schools, agricultural producers, parents, and other community stakeholders.

“(3) **TECHNICAL ASSISTANCE AND RELATED INFORMATION.**—

“(A) **TECHNICAL ASSISTANCE.**—In carrying out this subsection, the Secretary may provide technical assistance regarding farm-to-cafeteria projects, processes, and development to an entity seeking the assistance.

“(B) **SHARING OF INFORMATION.**—The Secretary may provide for the sharing of information concerning farm-to-cafeteria projects and issues among and between government, private for-profit and nonprofit groups, and the public through publications, conferences, and other appropriate means.

“(4) **GRANTS.**—

“(A) **IN GENERAL.**—From amounts made available to carry out this subsection, the Secretary shall make grants to assist private nonprofit entities and educational institutions to establish and carry out farm-to-cafeteria projects.

“(B) **MAXIMUM AMOUNT.**—The maximum amount of a grant provided to an entity under this subsection shall be \$100,000.

“(C) **MATCHING FUNDS REQUIREMENTS.**—

“(i) **IN GENERAL.**—The Federal share of the cost of establishing or carrying out a farm-to-cafeteria project that receives assistance under this subsection may not exceed 75 percent of the cost of the project during the term of the grant, as determined by the Secretary.

“(ii) **FORM.**—In providing the non-Federal share of the cost of carrying out a farm-to-cafeteria project, the grantee shall provide the share through a payment in cash or in kind, fairly evaluated, including facilities, equipment, or services.

“(iii) **SOURCE.**—An entity may provide the non-Federal share through State government, local government, or private sources.

“(D) **ADMINISTRATION.**—

“(i) **SINGLE GRANT.**—A farm-to-cafeteria project may be supported by only a single grant under this subsection.

“(ii) **TERM.**—The term of a grant made under this subsection may not exceed 3 years.

“(5) **EVALUATION.**—Not later than January 30, 2008, the Secretary shall—

“(A) provide for the evaluation of the projects funded under this subsection; and

“(B) submit to the Committee on Education and the Workforce of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate a report on the results of the evaluation.”

“(6) FUNDING.—

“(A) IN GENERAL.—On October 1, 2002, and on each October 1 thereafter through October 1, 2007, out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall transfer to the Secretary of Agriculture to carry out this subsection \$10,000,000, to remain available until expended.”

“(B) RECEIPT AND ACCEPTANCE.—The Secretary shall be entitled to receive, shall accept, and shall use to carry out this subsection the funds transferred under subparagraph (A), without further appropriation.”

TITLE II—SCHOOL BREAKFAST AND RELATED PROGRAMS

SEC. 201. STATE ADMINISTRATIVE EXPENSES.

(a) MINIMUM AMOUNT.—Section 7(a)(2) of the Child Nutrition Act of 1966 (42 U.S.C.1776(a)(2)) is amended by striking the last sentence and inserting the following: “In no case shall the grant available to any State under this subsection be less than \$200,000, as adjusted in accordance with section 11(a)(3)(B) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1759a(a)(3)(B)).”

(b) EXTENSION.—Section 7(g) of the Child Nutrition Act of 1966 (42 U.S.C. 1776(g)) is amended by striking “2003” and inserting “2008”.

SEC. 202. SPECIAL SUPPLEMENTAL PROGRAM FOR WOMEN, INFANTS AND CHILDREN.

(a) SENSE OF CONGRESS ON FULL FUNDING FOR WIC.—It is the sense of Congress that the special supplemental nutrition program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) should be fully funded for fiscal year 2004 and each subsequent fiscal year so that all eligible participants for the program will be permitted to participate at the full level of participation for individuals in their category, in accordance with regulations promulgated by the Secretary of Agriculture.

(b) REAUTHORIZATION OF PROGRAM.—Section 17(g)(1) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(g)(1)) is amended in the first sentence by striking “2003” and inserting “2008”.

(c) NUTRITION SERVICES AND ADMINISTRATION FUNDS.—Section 17(h) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(h)) is amended—

(1) in paragraph (2)(A), by striking “2003” and inserting “2008”; and

(2) in paragraph (10)(A), by striking “2003” and inserting “2008”.

(d) FARMERS’ MARKET NUTRITION PROGRAM.—Section 17(m) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(m)) is amended—

(1) in paragraph (1), by striking “(m)(1) Subject” and all that follows through “the Secretary” and inserting the following:

“(m) FARMERS’ MARKET NUTRITION PROGRAM.—

“(1) IN GENERAL.—The Secretary”;

(2) in paragraph (6)(B)—

(A) by striking “(B)(i) Subject to the availability of appropriations, if” and inserting the following:

“(B) MINIMUM AMOUNT.—If”;

(B) by striking clause (ii); and

(3) in paragraph (9), by striking “(9)(A)” and all that follows through the end of subparagraph (A) and inserting the following:

“(9) FUNDING.—

“(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall transfer to

the Secretary of Agriculture to carry out this subsection—

“(i) on October 1, 2003, \$25,000,000;

“(ii) on October 1, 2004, \$29,000,000;

“(iii) on October 1, 2005, \$33,000,000;

“(iv) on October 1, 2006, \$37,000,000; and

“(v) on October 1, 2007, \$41,000,000.”

“(B) RECEIPT AND ACCEPTANCE.—The Secretary shall be entitled to receive, shall accept, and shall use to carry out this subsection the funds transferred under subparagraph (A), without further appropriation.”

“(C) AVAILABILITY OF FUNDS.—Funds transferred under subparagraph (A) shall remain available until expended.”

SEC. 203. NUTRITION EDUCATION AND TRAINING.

Section 19(i) of the Child Nutrition Act of 1966 (42 U.S.C. 1788 (i)) is amended by striking “(i) AUTHORIZATION OF APPROPRIATIONS.—” and all that follows through the end of paragraph (1) and inserting the following:

“(i) FUNDING.—

“(1) PAYMENTS.—

“(A) IN GENERAL.—On October 1, 2003, and on each October 1 thereafter through October 1, 2007, out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall transfer to the Secretary of Agriculture to carry out this section \$27,000,000, to remain available until expended.”

“(B) RECEIPT AND ACCEPTANCE.—The Secretary shall be entitled to receive, shall accept, and shall use to carry out this section the funds transferred under subparagraph (A), without further appropriation.”

“(2) GRANTS.—

“(A) IN GENERAL.—Grants to each State from the amounts made available under subparagraph (A) shall be based on a rate of 50 cents for each child enrolled in schools or institutions within the State.”

“(B) MINIMUM AMOUNT.—The minimum amount of a grant provided to a State for a fiscal year under this section shall be \$200,000, as adjusted in accordance with section 11(a)(3)(B) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1759a(a)(3)(B)).”

TITLE III—EFFECTIVE DATE

SEC. 301. EFFECTIVE DATE.

This Act and the amendments made by this Act take effect on October 1, 2003.

McCAIN-FEINGOLD CAMPAIGN FINANCE LAW

Mr. FEINGOLD. Mr. President, at 3:45 p.m. on Friday afternoon, a three-judge panel of the United States District Court for the District of Columbia released a long-awaited decision in the case of *McCain v. FEC*. That is the lawsuit challenging the constitutionality of the Bipartisan Campaign Reform Act of 2002, sometimes known as the McCain-Feingold bill.

Over 80 different plaintiffs participated in the case, which was defended by the Department of Justice and the Federal Election Commission. Six congressional sponsors of the law, Senator JOHN MCCAIN, Senator OLYMPIA SNOWE, Senator JAMES JEFFORDS, Representative CHRISTOPHER SHAYS, Representative MARTY MEEHAN, and I, intervened as defendants in the case.

A number of commentators and lawyers for the parties have commented that the most important aspect of this decision is that it has finally come down. I agree with that. From the very beginning of our effort to reform the

campaign laws over a period of 7 years, we knew that the Supreme Court of the United States would decide the fate of the law. We provided for expedited consideration of any challenge to the law’s constitutionality by having a three-judge panel hear the case as the trial court with a direct appeal to the Supreme Court.

Discovery and briefing in the case proceeded on a very fast track, and the court heard oral argument on December 4, 2002, an argument which I had a chance to attend in part. At that argument, the chief judge of the panel suggested that the panel would rule by the end of January. It took considerably longer than that, and now we know why. On Friday, the court released over 1,600 pages of opinions. A shifting majority among the three judges upheld some of the most important portions of the law while it struck down some others.

Now that the three-judge panel has finally ruled, the Supreme Court can take the case and begin its consideration of the constitutional issues raised by the law. I hope the Court will act quickly, but I also hope it will act carefully and judiciously as, of course, we assume it will. The decision of the Court will shape the conduct of elections and fundraising in this country for many years to come.

While the district court opinion will become a mere footnote to history once the Supreme Court rules, I believe it is useful to comment on the decision today because the press coverage of the details of the ruling has been sometimes contradictory, and unfortunately in a number of cases the press reports were simply inaccurate about what had happened with the court decision. This is not surprising given the complexity of the ruling and the length of the opinions. For the benefit of my colleagues, particularly those who supported our long effort to pass reform, I wanted to discuss today what the court did and did not do.

The court’s ruling was shaped by two different 2-1 majorities. U.S. Circuit Judge Karen Henderson would have struck down much of the law, while U.S. District Judge Colleen Kollar-Kotelly would have upheld most of it. The deciding vote in most cases was U.S. District Judge Richard Leon, who sided with Judge Henderson on some issues and with Judge Kollar-Kotelly on others. The three judges were unanimous on a handful of issues, mostly on some of the minor provisions in the bill, but also on one very significant portion of the soft money ban.

Let me start with soft money, especially in light of the headlines that screamed “soft money ban struck down.” Those headlines were not correct.

Let me start with soft money, which was the core of the reform effort and was dealt with in title I of the McCain-Feingold bill.

The court struck down our prohibition on national parties raising soft