

Flag Day is a day especially revered by veterans and one which deserves the special attention of each of us.

The Flag of the United States of America has been a constant throughout our nation's history; through its high and low points. In its long and distinguished history, our flag has taken various versions. Just as our country has grown from the original 13 colonies to the great country it is today, so too has our flag. At the time of the original 13 colonies and the Continental Congress, it was a flag of red and blue stripes, with 13 stars, representing the union of those colonies, set in a blue field, representing a new constellation. From the Star Spangled Banner, to the Flag of 1818 with its 20 stars, to today's flag, with its 50 stars, Old Glory has been a symbol of liberty and freedom for people around the world.

I am always touched by the efforts of people across the country to preserve, protect, and honor America's flag. One example that stands out, is the effort of four veterans in my district, who I have recognized as June Citizens of the Month, for their flag education program, which has taken to almost thirty different schools to talk to more than 12,000 students. Another, was the placement of a flag receptacle by a VFW Post in Levittown, Long Island, in which old and worn flags can be placed so that they can be disposed of by the U.S. Post in a manner that is befitting their importance.

As demonstrated by these men and the community in Levittown, the American flag is more than a piece of cloth—it is a national symbol. For this reason, I believe our flag is worth a constitutional sanctuary. Therefore, as we celebrate National Flag Day, let me remind my colleagues of the need to pass legislation that prohibits the desecration of the flag. It is time to give our flag the honor and respect it deserves as our most sacred national symbol.

INTRODUCTION OF THE DISTRICT OF COLUMBIA POLICE COORDINATION AMENDMENT ACT OF 2001

HON. ELEANOR HOLMES NORTON

OF THE DISTRICT OF COLUMBIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 14, 2001

Ms. NORTON. Mr. Speaker, today, I introduce a bill to amend P.L. 105–33, legislation that has done much to cure uncoordinated efforts of federal and local law enforcement officials in the nation's capital. The District of Columbia Police Coordination Amendment Act of 2001 amends the Police Coordination Act I introduced in 1997, and that was signed that year, by allowing those agencies not named in the original legislation to assist the Metropolitan Police Department (MPD) with local law enforcement in the District. Inadvertently, P.L. 105–33 failed to make the language sufficiently open-ended to include agencies not mentioned in the original bill.

Prior to the Police Coordination Act, federal agencies often were confined to agency premises and were unable to enforce local laws on or near their premises. Instead, for example, federal officers sometimes called 911, taking

hard-pressed D.C. police officers from urgent work in neighborhoods experiencing serious crime. Federal officers were trained and willing to do the job, but lacked the authority to do so before the passage of the Police Coordination Act.

Agencies have already signed agreements with the U.S. Attorney for the District of Columbia enabling them to participate. Federal agencies understand that the extension of their jurisdiction will enhance safety and security within and around their agencies while offering needed assistance as well to District residents. The Capitol Police and Amtrak Police, who have the longest experience with expanded jurisdiction, report that the morale of their officers was affected positively because of the satisfaction that comes from being integrated into efforts to reduce and prevent crime in and around their agencies and in the nation's capital. This non-controversial technical amendment to the Police Coordination Act is another step to achieving my goal of assuring the most efficient use of all the available police resources to protect federal agency staff, visitors and D.C. residents.

INTRODUCTION OF THE ALL-PAYER GRADUATE MEDICAL EDUCATION ACT OF 2001

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 14, 2001

Mr. CARDIN. Mr. Speaker, I rise today to introduce legislation that is vital to the future of our nation's health care system. America's academic medical centers and their affiliated hospitals are essential to the nation's health. These centers do much more than train each new generation of health professionals. Every American benefits from advances in medical research and well-trained providers. Medical advances have dramatically improved the quality of life for millions of Americans, and our academic medical centers are at the heart of the new era of biotechnology, which holds the promise of effective treatments for so many diseases.

Although academic medical centers constitute only two percent of our nation's non-federal community hospital beds, they conduct 42% of all health research and development in the United States, they contain 33% of all trauma units and 31% of all AIDS units, and they treat a disproportionate share of the country's indigent patients. However, funding for these critical tasks is at risk in the new competitive health care marketplace. Commercial insurers are displaying increasing reluctance to pay academic medical centers adequately to support their educational and research missions, and managed care companies steer patients away from these centers as well. Generally, managed care companies cut costs by seeking the lowest cost hospitals and physicians. An academic medical center cannot compete if forced to cover part of its teaching costs through the rates that it charges for medical services. Without a separate funding source for academic costs, these centers run the risk of being non-competitive

for managed care contracts through no fault of their own.

Two years ago, The National Bipartisan Commission on the Future of Medicare studied graduate medical education funding and proposed eliminating Medicare's funding role and moving GME into the general appropriations process. It was an approach that would have seriously undermined not only academic medical centers, but also the future of the medical profession. Fortunately, this recommendation was not enacted.

There is a better way, a much fairer way, to provide for graduate medical education, while ensuring the health of the Medicare Trust Fund. To ensure stability of funding for GME in the increasingly turbulent health economic climate, continued predictable support from Medicare is essential. But even Medicare's contribution does not fully cover the costs of residents' salaries, and more importantly, our current funding system fails to recognize that a well-trained physician workforce benefits all segments of society, not just Medicare beneficiaries.

Today, I am introducing the All-Payer Graduate Medical Education Act of 2001 to create a fair and rational system for the support of graduate medical education—fair in the distribution of costs to all payers of medical care, and fair in the allocation of payments to hospitals. This bill establishes a Trust funded by a 1% fee on all private health insurance premiums. Teaching hospitals will see their direct and indirect GME payments increase by \$2.2 billion each year. In addition, because the current formula for direct GME is based on cost reports generated nearly twenty years ago, it unfairly rewards some hospitals and penalizes others. This bill replaces that outdated formula with an equitable, national system for direct GME payments based on actual resident wages.

Many critics of federal GME support fail to recognize its vast societal benefits. They have attacked indirect GME payments, complaining that hospitals are not required to account for their use of these funds. The All-Payer Graduate Medical Education Act provides a structured mechanism for hospitals to inform Congress and the public about their contributions to improved patient care, education, clinical research, and community services.

My bill also addresses the supply of physicians in the United States. Nearly every commission studying the physician workforce has recommended reducing the number of first-year residencies to 110% of American medical school graduates, down from the current level of 138%. This bill directs the Secretary of HHS, working with the medical community, to develop and implement a plan to accomplish this goal within five years.

This legislation will also ensure that hospitals are compensated fairly for the indigent patients they treat. Medicare disproportionate share (DSH) payments are particularly important to our safety-net hospitals. Many of these are in dire financial straits. This bill reallocates DSH payments, at no cost to the federal budget, to hospitals that carry the greatest burden of poor patients. Hospitals that treat Medicaid-eligible and indigent patients will be able to count these patients in applying for disproportionate share payments. This provision builds